ABUHB - Supporting Papers

Tue 28 January 2025, 13:00 - 16:00

Microsoft Teams

Agenda

13:00 - 13:00
0 min

1. Agenda Item 3.2: Update on the Development of the Annual Plan 2025/26, including NCN Plans. Appendix 3 NCN Plans

13:00 - 13:00
0 min

2. Agenda Item 3.2, Appendix 3 - Blaenau Gwent NCN Annual Plan

- Agenda Item 3.2 Appendix 3a BG NCN Annual Plan 25_26.pdf (16 pages)
- BG Appendix 1a.b.pdf (1 pages)
- BG Appendix 1.a.c.pdf (1 pages)
- BG Appendix 1.a.c2.pdf (1 pages)

13:00 - 13:00
0 min

3. Agenda Item 3.2, Appendix 3 - Caerphilly NCN Annual Plan

- Agenda Item 3.2 Appendix 3b Caerphilly NCN Annual Plan 25_26 (1).pdf (20 pages)

13:00 - 13:00
0 min

4. Agenda Item 3.2, Appendix 3 - Monmouthshire NCN Annual Plan

- Agenda Item 3.2 Appendix 3c Monmouthshire NCN Annual Plan 25_26 (1).pdf (16 pages)

13:00 - 13:00
0 min

5. Agenda Item 3.2, Appendix 3 - Newport NCN Annual Plan

- Agenda Item 3.2 Appendix 3d Newport NCN Annual Plan 25_26.pdf (17 pages)
- Newport Appendix 3.d. Finance Summary.pdf (1 pages)

13:00 - 13:00
0 min

6. Agenda Item 3.2, Appendix 3 - Torfaen NCN Annual Plan

- Agenda Item 3.2 Appendix 3e Torfaen NCN Annual Plan 25_26.pdf (18 pages)
- Appendix 3e.1 - Torfaen Spending Plan.pdf (1 pages)
- Appendix 3e.2 - Torfaen Plan on a Page.pdf (1 pages)

BLAENAU GWENT NCNs (East &*West*) ANNUAL PLAN 2025-26

Cluster Executive Summary:

Blaenau Gwent sees a significant gap in healthy life expectancy between the wealthiest and poorest in our communities. As a result of the inverse care law which aims to improve the management of chronic conditions and reduce premature mortality, we see a high number of patients with multiple health needs accessing our services. Through this plan we strive to meet these needs.

Our plan evidences our commitment to the Care Aims Framework which helps to achieve better outcomes for our service users, by providing a set of principles that focuses on decision making with an overarching duty for all public services to "do the most good, least harm, for the most people in a fair way". We aim to build a resilient community by embedding a person-centred approach to service provision and supporting citizens and their families to take ownership of their health and wellbeing needs through prevention, self-care and early intervention to deliver the change communities need.

Using data and anecdotal evidence we know that Blaenau Gwent statistically has a lower healthy life expectancy than Wales as a whole, males and females in Blaenau Gwent have a reduced healthy life expectancy which is 6 years less that the Wales average. Services are often overwhelmed with demand and therefore citizens are unable to access the help and support they need in a timely manner. The Neighbourhood Care Network (NCN), in this plan, will demonstrate a continued drive to implement services on a local level to meet the needs of the population through working across key service areas whether in acute, secondary, social care, independent contractor, primary care, community care or third sector services.

Our areas of focus will align to the priorities of Aneurin Bevan University Health Board (ABUHB), Blaenau Gwent Integrated Service Partnership Board (ISPB) and Gwent Regional Partnership Board (RPB) and the actions will take a distributed leadership approach ensuring full engagement from all partners to provide the highest quality services for the population of Blaenau Gwent. The areas of focus set out in this plan remain the same as our 2024/25 plan and uses the Primary Care Model for Wales as a key strategic driver. We aim to set out how primary and community health care services can work as a whole system to deliver our place-based care strategy of a "Happy Healthy Blaenau Gwent" bringing together local and health care services to ensure care is better coordinated.

Strategic Partners:

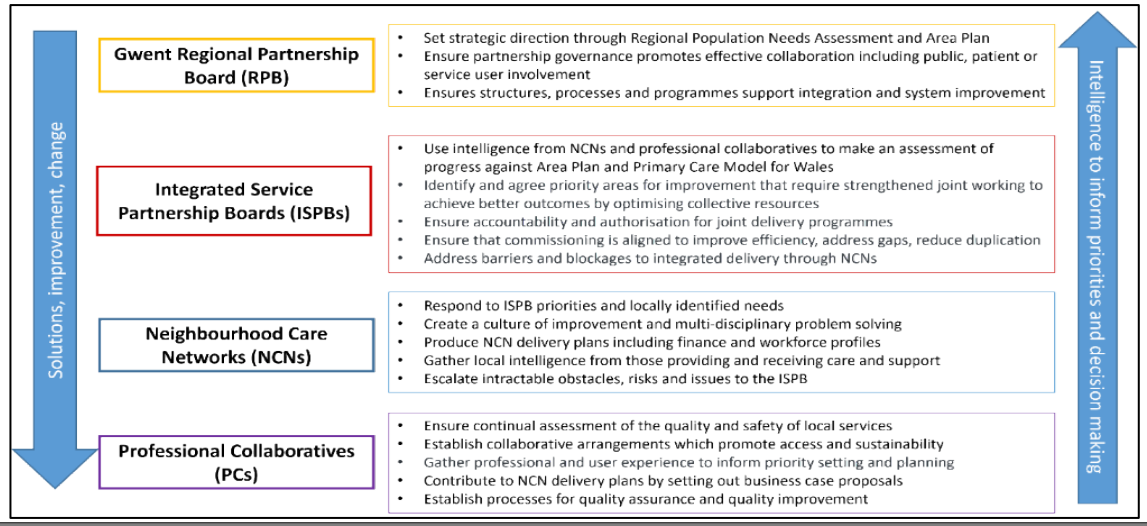
Gwent Regional Partnership Board (RPB)

The aim of the Gwent RPB is to work in collaboration to support all public services to help reduce inequalities. The RPB has committed to ensuring Gwent is the first Marmot region in Wales. Adopting the Marmot principles sets a strong strategic direction for partners to tackle these challenges, work collaboratively, pool resources and transform services for the benefit of our communities. ***"Working together for a Healthier Gwent for the right care and support, in the right place, at the right time"***

Blaenau Gwent Integrated Service Partnership Board (ISPB)
ISPBs are local partnerships between representatives of the Borough's footprint with the aim of developing and delivering shared plans and priorities for the need of the local population. The Blaenau Gwent ISPB aligns with the strategic priorities of the Health Board, Local authority and A Healthier Wales's vision of a whole system approach to health and social care, focussed on health and well-being and on preventing illness with access to a wide range of seamless community-based services. It is heavily influenced by the marmot principles that come out of the Gwent RPB. BG ISPB is a sub group of the RPB allowing the dissemination of information and a two-way mechanism for decision making and strategic leadership.

Collaborative (NCN) Clusters
The objectives of the NCN are to bring together all local services involved in health and social care to deliver local solutions and promote the wellbeing of individuals and communities. NCNs are a key component of the ISPBs and will operationally deliver needs that are identified through this forum and aim to tackle the inequalities that present in Blaenau Gwent. The Integrated Wellbeing Network (IWN) forms the community arm of the NCN allowing local intelligence to be gathered on the needs of the community that can be considered within plans.

Professional Collaboratives - Accelerated Cluster Development Programme (ACD)
The aim of ACD is to meet the cluster population health need through effective and robust planning and service delivery. The professional collaboratives widen stakeholder attendance across our NCN/Cluster to ensure full collaboration to meet population needs. We seek to create sustainable system change through the integration of health and social care services, raising awareness of the benefits and opportunities for improving population outcomes through collaboration and strengthening partnership arrangements.



Areas of Focus

Our priorities have all been aimed at aligning to the priorities of ABUHB, Blaenau Gwent ISPB and RPB. The priorities and actions set out in this plan remain the same with the added key component of delivering our place-based care strategy aligned to the key areas of focus for NCNs.

Our 2025/26 Annual Plan will aim to align to the key areas of focus set out for NCNs by developing a community orientated model of primary care through a deeper understanding of the community assets and local needs within the population, particularly for socially vulnerable or marginalised groups. This will be delivered through our "Happy, Healthy Blaenau Gwent" placed based care strategy.

Happy Healthy Blaenau Gwent is our locally driven project, it is our vision for Blaenau Gwent to be a considerate and caring locality, working in a collaborative approach to support people's health and wellbeing. Our aim is to **build more resilient communities** so that our citizens can be empowered to directly access community assets across Blaenau Gwent to support their health and wellbeing.

The Happy Healthy Blaenau Gwent framework aligns to the Welsh Government National Framework for Social Prescribing. The core objectives in this framework will be interpreted at a local level in Blaenau Gwent to provide the driving force for the programme. We want to:

- Empower people who look after themselves and each other
- Build stronger and more resilient communities together
- Work collaboratively with all our partners to deliver high quality and equitable services for now and the future

This vision is validated by the strategic direction set out in The National Primary Care Programme, A Healthier Wales and Prosperity for All setting out strategic ambitions for increasing workforce sustainability and utilising the third sector to meet the increasing demands upon our core services. Transformation funding has provided the opportunity to progress this vision through embedding a Happy Healthy Blaenau Gwent model of care to support our place-based strategy.

Through embedding MDT principles, we can deliver appropriate care to people with long terms conditions and support the management of demand for our services collectively across social care and health. Our IWN partners will be instrumental in delivery of this model of care to ensure NCNs have an understanding of the community assets such as community groups and voluntary organisations that help people maintain or develop social support networks and improve outcomes for our residents.

ABUHB Priority 1- Every Child has the best start in life

- Development of Health Prevention services in collaboration with the third sector, Integrated Wellbeing Networks (IWN) and Information Advice and Assistance service (IAA), identifying social networks to help address the wider determinants of health such as Vaccination programmes, Expert Patient Programmes (EPP), mental health initiatives, improving access to and awareness of Dental, Pharmacy, Optometry and GP / General Medical Services. Our focus is on building resilience through prevention and early interventions to enhance wellbeing and self-care by, improving access to social support in community settings to address loneliness and isolation, ***(aligns to 1.1,1.2,4.2,4.3 – refer to action plan)***
- We will continue to support the immunisation and vaccination programmes through the delivery and development of innovative projects to increase uptake rates (***aligns to 4.2 – refer to action plan).***
- The NCN will collectively work with the Primary Care Immunisation Team in regards to reviewing the childhood immunisation queues across the borough identifying uptake in the lower preforming practices and support (***aligns to 4.2 – refer to action plan).***
- The 2025-26 flu campaign will be for all childcare providers and education settings across Blaenau Gwent (***aligns to 4.2 – refer to action plan).***
- Blaenau Gwent has the highest rate of childhood tooth decay in Wales, the NCN will liaise with ABUHB Community Dental Service and Dental collaborative to explore opportunities of promoting the importance of Oral Hygiene and visiting the dentist.

- Gwent has been declared a Marmot region, the NCNs will support the Marmot Review which sets out a framework for action under two policy goals: to create an enabling society that maximizes individual and community potential; and to ensure social justice, health and sustainability are at the heart of all policies.

ABUHB Priority 2- Getting it right for children and young adult

- Future service model for the development of sustainable Placed Based primary care services across the Cluster areas, the NCN will continue to profile hub timetables to enable Care Closer to Home in terms of delivering services for children.
- Health Visitors will be based within the development of each Health and Wellbeing hub.
- Seek to establish a whole system approach to deliver place-based care where people can access a range of seamless care and support at or close to home, based on their unique needs and what matters to them as part of our Happy Healthy Blaenau Gwent strategy. This relaunch will also include access into the service where needed for children and young adults ***(aligns to 1.1,1.2,3.3,4.3 – refer to action plan).***

ABUHB Priority 3- Adults in Gwent live healthy and age well

- The Primary Care Model for Wales sets out how primary and community health care services will work across the whole system to deliver place-based care. Our priorities which will be delivered through a place-based care approach, with a focus on local population need and will include Immunisation and Vaccination, GMS sustainability and access, Psychological Wellbeing, Diabetes Prevention, CVD risk factor management, Obesity Pathway, Oral Health, Advanced Paramedic for home visiting/CRT/Care Home and FCP ***(aligns to 4.1,4.2 – refer to action plan).***
- Continue to support delivery of the housebound vaccination programme and promotion to increase uptake rates for Flu and Covid-19 vaccinations for our clinically vulnerable groups ***(aligns to 4.2 – refer to action plan).***
- Continue to Support community wellbeing schemes –reviewed yearly from local intelligence on what the priority need for the community is each year ***(aligns to 1.1, 1.2 – refer to action plan).***
- Continue to collaborate with social care and our third sector colleagues in response to the increase in anxiety levels across the county, mapping current activity and developing initiatives where gaps exist ***(aligns to 1.1, 1.2 – refer to action plan).***
- Continue to progress Pan Cluster Planning Group/ISPB, with partners, to be responsible for reviewing the population needs assessment, gap analysis, development of costed plans and commissioning services that would benefit the population of Blaenau Gwent in its entirety.
- Continue to review the ISPB priority actions with our partnership board to ensure that they remain relevant to the changing landscape.
- To develop and strengthen the relationship with the Gwent Regional Partnership Board to enable and promote an integrated response to the needs of the local population and support any implementations at local level of the joint partnership agenda.
- Participation in the All-Wales Diabetes Prevention Programme across both Clusters for pre diabetic patients to be offered a brief intervention, including lifestyle advice, to reduce or prevent the progression of diabetes ***(aligns to 4.1 – refer to action plan).***
- Improve low participation rates for cancer screening through a targeted communication programme in partnership with secondary care colleagues to increase awareness, providing screening opportunities closer to home and collaborate with our Integrated Wellbeing Networks and Happy Healthy Blaenau Gwent programme to raise awareness through a focused marketing campaign tailored to suit our community's needs ***(aligns to 1.1,1.2 – refer to action plan).***
- The global challenge of climate change will require collective efforts on an unprecedented scale. The Welsh Government is committed to creating a greener, stronger and fairer Wales and has a statutory duty to act on climate change across all sectors. The locality team will explore and coordinate training opportunities to raise awareness of how practices can become more environmentally sustainable.
- Utilise funding to innovate and test concepts to improve outcomes for all our residents, these include SEM Scanners, assisted technology, locality based FCP programmes, development of the mental health practitioner role, responding to dermatology and audiology demands as a mechanism for reducing the

impact of on the day demand. Developing exit strategies to enable proven concepts such as Psychological Wellbeing Practitioners and Practice Based Pharmacists to be core funded.

- Continue to focus on optimising all resources available maintaining a focus on responding to the needs of urgent primary care through assessment of on the day demand. We recognise that there is a finite number of resources available in both health and social care and the backlogs and demand on primary care has grown significantly cost. Traditional models of working must change and we understand the need to focus on value and sustainability.
- Seek to develop services that are high quality and equitably across the Borough for supplementary/enhanced services with an initial focus on IUD, minor surgery, substance misuse, homelessness and asylum seeker and refugees. We have an opportunity as part of mapping to identify where the gaps are in services and work more collaboratively between our GMS partners to deliver services that are more equitable and, on a population, needs basis ***(align to 4.4 – refer to action plan).***
- Widening stakeholder attendance across our NCN to ensure full collaboration to meet population needs and maintain local voice. Seek to create sustainable system change through our place-based care strategy of creating a Happy Healthy Blaenau Gwent. This will include the integration of health and social care services, raising awareness of the benefits and opportunities for improving population outcomes through collaboration, MDT working for citizens who have more complex needs, strengthening partnership arrangements with the collaboratives, third sector, health colleagues, local authority, WAST, Direct care and other key partners to meet the specific health and wellbeing needs of our communities ***(aligns to 1.1,1.2,3.3,4.3 – refer to action plan).***
- Continue to progress student support for university entry, as well as support the primary care academies with their onward programme and in turn support services with the academy placements of clinical roles within primary care setting
- During 25/26 the NCN will work with collaboratives leads as part of the ACD programme to improve the care for our local population.
- The ongoing sustainability of all health and social care services on an operational footing level is paramount and although prioritised we have high levels of recruitment and retention which impacts on delivery. Key areas most notably being WAST / paramedics, GPs, Pharmacists, nursing, FCP professions and social care i.e., domiciliary care providers.
- Our assets are a key component for delivering our Happy Healthy Blaenau Gwent place-based care strategy. Undertaking an asset mapping of all estates provision alongside a mapping of services – both clinical and non-clinical to ensure that people with the right skills and experience work in an environment that is fit for purpose. Our estate is a key enabler and must take account of other necessary infrastructure, such as information and community technology (ICT); the need for health and care staff to work together in partnership through co-location/design and integration to enable delivery of services in the right place to support the best outcomes and experience for patients.
- In the next 5 years approximately 763 new housing builds will take place, the NCN will need to scope the impact it may have on our primary care independent contractor's sustainability.
- Seek to establish a whole system approach to deliver place-based care where people can access a range of seamless care and support at or close to home, based on their unique needs and what matters to them – Happy Healthy Blaenau Gwent strategy ***(aligns to 1.1,1.2,3.3,4.3 – refer to action plan)***
- Seamless work between partners at a community level across the cluster range to ensure that, where possible, care can be undertaken as close to home as possible, where necessary and appropriate, interventions are undertaken at hot clinics and/or community based step-up facilities.
- Building community resilience through connections to increase social prescribing and community development in collaboration with the third sector, Integrated Wellbeing Networks and IAA – Happy Healthy Blaenau Gwent programme ***(aligns to 1.1,1.2,4.3 – refer to action plan)***
- Review of the existing Physiological Health Practitioners delivery programme, ensuring that it meet the needs of our population and the GMS Service demands as part of the development of clear pathways across the locality for mental health provision.

ABUHB Priority 4- Older Adults are supported to live well and independently

- Focusing on the principles of right care, right place, first time we will coordinate support for our communities at greater risk of needing urgent or emergency care through development of our community teams and having piloted the High-Risk Adults (HRA) initiative across Blaenau Gwent we understand that this patient cohort is driving 2/3^{rds} of the Health Boards bed base.
- Deliver complex care closer to home through a sustainable community resource model which encompasses hospital @ home/step closer to home pathways.
- Support with the new admission process of the nurse led Tyleri Ward direct admission pathway beds.
- Development of a programme of support to our care homes which includes the implementation of a plan to ensure that all care home residents are in receipt of care in line with care home DES and widening the HRA model to support admission avoidance.

ABUHB Priority 5 - Dying well as part of life

- Continue to work in partnership with the Hospice of the Valleys and Ysbyty Aneurin Bevan on the CWCTH pilot, striving to offer patients the choice with regards to their preferred place of death. Hospice staff work closely with the staff of Ysbyty Aneurin Bevan if inpatient care is the preferred choice, likewise if the patients preferred place of death is at home, the hospice work with the ward staff and medics to ensure a quick and safe transfer back to their chosen location.

Key Achievements from 2024/2025 Annual Plan:

- The 2024-25 flu campaign has been extended to all childcare providers and education settings across Blaenau Gwent. The NCN working in partnership with the ABUHB Immunisation service delivered the programme across a total of 45 settings during the month of September. Early signs of data (IVOR) identify that there has been an increase in uptake amongst the 2–3-year-old cohort in comparison to this time during 2023-24 flu season as a result of the implementation of this programme. The success of this programme has been recognised Nationally and the NCN were invited to present their programme at a workshop event with Vaccination Programme Wales.
- We have continued to support the needs of the local population in terms of the cost-of-living crisis, the NCN provided funded to support the Aneurin Leisure Fit and Fed Programme which is a programme designed to tackle holiday hunger in disadvantaged areas. Aneurin Leisure Adult Community Learning was able to purchase ten air fryers from the funding received from NCN. The air fryers are used by learners in numerous courses at Adult Community Learning venues throughout Blaenau Gwent. Adult Community Learning tutors developed courses to engage and upskill learners' cooking knowledge and abilities as well as contextualising literacy and numeracy essential skills within the sessions. The learners have used the air fryers to cook quick, healthy, budget friendly meals from scratch including pizzas, cottage pies and even bread.
- The NCN in partnership with the IWN have launched an online map that will connect the people of Blaenau Gwent to everything that is within the local area that can help with their mental and physical well-being. Communities can use the map to find groups, services and organisations to help them and their families enhance their health and wellbeing.
- During early 2024 Blaenau Gwent Neighbourhood Care Network meetings have been re structured to align to the ACD Development programme:
    - Section 1- Joint Blaenau Gwent East and West GMS Collaborative – *The collaborative will contribute to NCN delivery plans gathering professional and user experience to inform priority setting and planning. Ensuring continual assessment of quality and safety of local services.*
    - Section 2- Joint Blaenau Gwent East and West Partnership Meeting (Market Place)
    - Section 3- Joint Blaenau Gwent East and West Collaborative Leads Meeting
- All collaboratives have started to support our NCN priorities with an overall aim of staff wellbeing, recruitment with retention as well as the advancement of both medical and social prescribing initiatives, including the launch of Happy Healthy Blaenau Gwent and the pursuit of 56-day prescribing.
- The NCN have successfully implemented and delivered a First Contact Physiotherapy Service across the West Cluster of Blaenau Gwent. The service is designed to maximise benefits for patients with conditions affecting the joints, bones and muscles. which is the redesign of self-referral, self-management and community therapy support through the development of a self-management culture which empowers people to build resilience and manage

conditions independently of secondary services, where appropriate, through a more preventative, proactive and coordinated approach which works collaboratively with Connected Communities to access the full range of community and voluntary based services.

- Successfully implemented the Advanced Paramedic Practitioner – Hospital Admission Avoidance Project across the both clusters– APP are specialised and autonomous clinicians APPs provide advanced clinical assessment skills, diagnosis, treatment and referral of patients using a medical/management model of care. Providing Care Closer to Home, reducing the impact of patients accessing the 999 system and proportionate conveyance to secondary care as well as supporting Primary Care capacity to help mitigate the pressure on the wider care systems by undertaking Home and care home visits working collaboratively with General Practitioners (GPs), Community Resource Teams/Rapid Response (CRT/RR), District Nurses (DNs) teams to deliver care. APPs have increased medicines formulary supports by Patient Group Directives to treat a range of acute medical presentations. This project is in the very early stages and will be full evaluated at the end of the 18 months pilot.
- Introduced a new service in Blaenau Gwent West to deliver a pharmacy service to housebound patients. The NCN Pharmacist has been carrying out in-home reviews, the aim is by targeting this group of patients who often only receive reactive care we will be able to identify those at most risk, make appropriate medication change suggestions to the practices, reduce waste and medications harms / risks. There is also an opportunity to make cross service links for patients using our integrated wellbeing network and feed in to the social prescribing / Happy Healthy Blaenau Gwent model to improve patient wellbeing.
- Fully supported the opening of the Bevan Health and Wellbeing Centred which includes:
    - Supporting the co-location of General Medical Services being provided by two well established General Practitioner Practices within Tredegar, Glan-Yr- Afon and Tredegar Surgeries for a population of approximately 13,000
    - To support the increased service provision and improved integration of Health and Wellbeing services within the Tredegar area of Blaenau Gwent West, which includes development and assuming responsibility for the clinical schedule of services operating from the building that addresses the health inequalities and inequities in the local population.
    - Implementation of the benefit realisation dashboard.
    - Site management responsibilities.
- As part of the NCN run PLT sessions, a winter planning event has taken place which was organised and delivered by the Blaenau Gwent Locality Team. The event focuses on supporting our collaboratives with the significant pressures we know are faced during winter periods and had representatives from services across health, social and third sector who can assist with sustainability, admission avoidance and / or early discharge.
- Fully reinstated the Blaenau Gwent ISPB with good representation from all key stakeholders. Joint priorities have been agreed in collaboration and are progressing all aligned to meet the needs of the population and maintain a local voice.
- A roadshow of staff wellbeing events was delivered. They were designed collaboratively with the Mental Health and Learning Disabilities Team. The events offered a warm and personable welcome, relaxation area, creative tables, dog therapy, wellbeing information and raffle prizes donated by local businesses. 173 staff benefitted from the staff wellbeing pop ups.
- We have developed a partnership working group which includes the Integrated Wellbeing Network and GAVO to deliver Market Place Events to ensure that the third sector is represented.
- A calendar of Community wellbeing events has been delivered based on population needs. 4 events have been delivered during this financial year to date. Topics have included mental health, best start in life and childhood immunisations. A number of partner organisations have presented information including Aneurin Leisure, Health Visiting, Family Information Service, Gwent Association of Voluntary Organisations, Expert Patient Programme, Llais, Age Cymru, Adferiad, Small Woods, School Nursing, Flying Start and Help me Quit. 162 community members have attended these events.
- The NCN team were approached by Tredegar Town Council to host Health and Wellbeing workshops as part of Tredegar Comprehensive Schools Immersion Day. We hosted over 100 pupils through 5 workshops that focused on young people taking ownership for their own health and wellbeing. Aneurin Leisure

and the IWN co delivered workshops. Pupils were signposted to relevant health and wellbeing resources. They also took part in the engagement exercise for the Health Boards 10-year strategy.

- The Civica system for call scheduling was piloted within BG CRT Team. It has replaced a paper diary and improved staff safety by utilising the check in and check out function to home visits. This has The DN team supported this with training as they were already using Civica. This has enabled each team to access details on each other's patient visits allowing for a more efficient service for patients. The pilot was successful and is under review with the steer of rolling it out to the other boroughs across AB.
- Successful roll out of the All-Wales Diabetes Prevention Programme across both clusters where patients, in the pre-diabetic stage, are offered a brief in intervention which includes lifestyle advice with the hope of reducing their HBA1c over the longer term to reduce or prevent the progression of diabetes.
- Fully established a Children and Young Adult Task and Finish Group to improve outcomes through early intervention with a key focus on dental and immunisation.
- Participated in the SPPC Peer Review with Cwm Taff Health Board.
- As part of our evaluation process, we have developed dashboards to highlight key data as part of each project. We have successfully developed and implemented a dashboard for our FCP Pilot and Pharmacy Home Visit and will continue to use this process across all projects going forward.
- Although the NCN have had to put a pause on full implementation on delivering our key priority of a "Happy Health Blaenau Gwent" service we have made progress during 2024/25. In order to deliver on the vision of creating a Happy Healthy Blaenau Gwent Service, we have been working in partnership to not only develop a model of care that will be right for the citizens of Blaenau Gwent but also the success of the project is reliant on engagement of all partners. This proposed model has had full support and endorsement from the ISPB, recognising that there is a drive to "Deliver a Healthier Wales".
- We have only been able to deliver elements of the model on a small scale to date because of the delay with recruitment and procurement however basing the Placed Based Care coordinator at the Bevan Health and Wellbeing Centre has meant we have been able to deliver support to patients that present with a social need so that the public have access to advice and information on a range of integrated health and social care services.
- A logic model has been developed to evaluate and communicate the project in a concise and compelling way. The model will enable an overview of the project and provides a roadmap or simplifies picture that displays connections between resources, activities and outcomes of the project

Logic Model.pdf

- The locality team has sourced a system that will provide a single point of entry for all social and community services referrals which is currently going through the procurement process, in order to deliver a person-centred approach to connect people to local community assets.
- We have developed the role of the Wellbeing Coach and are currently working with two providers regarding recruitment into those roles.

Key Difficulties Related to the 2024/2025 Cluster Plan

Key Reflections / Challenges in 2024/25	
Finance	Impact of reduced budgets and pay awards has caused fluctuations beyond our control making it difficult to commit to plan / test new schemes.
Workforce retention, recruitment & resilience	Lack of staffing to support the delivery of our priorities Uncertainty around workforce capacity, fluctuation in staffing levels and inability to recruit clinical staff, impacting significantly on ability to forward plan activities.

Increasing deprivation levels	Our population is characterised by large pockets of health inequalities, linked to social-economic deprivation and the current financial crisis which further impacts these areas. Demand for health and social care is growing and continues to grow; our ageing population is living longer with more complex needs, increasing the pressure on an already challenged social care, health and third sector.
Cost of living pressures	Continued impact on people's mental health & wellbeing leading to a growing demand for support locally.
Estates	While it is noted that estates across some areas of the locality are improving there are still a significant amount that are not fit for purpose to deliver place-based care. Lack of capacity and buildings fit for purpose means we are unable to support opportunities to reduce service demands.
Bureaucracy	Lengthy processes often hinder our ability to deliver key priorities in a timely manner.

Finance Profile 2025/2026:

Finance Profile

Current forecast for budget allocation next year is indicative, we are basing our spend plan on the assumption that there will be no change to the allocation for 25/26 for both East and West. In order to achieve a breakeven position, the following projects are at risk:

- Community Wellbeing Schemes
- Chronic Diseases Management / Expert Patient Programme
- Practice Manager Facilitator
- Mental Health and Wellbeing
- Flu Delivery Support
- Digital Solutions and Inclusion
- Staff Wellbeing
- Winter Planning / PLT

BG NCN Forecast 25-26.xlsx

Workforce Profile

Clinical recruitment continues to be the highest risk for our locality. Change fatigue is one of many limiters affecting the Borough, an aging workforce and a gender imbalance has been identified across the Blaenau Gwent workforce compounded by the many challenges; a lack of workforce sustainability across all our core services, high levels of deprivation and comorbidities also provide opportunities to develop and grow alternative skillsets to bring additional capacity and the Primary Care Plan for Wales sets out opportunities for implementing a workforce which utilises a wide range of skillsets to deliver our services. A key priority for our locality is to take a holistic view on the needs of our population and develop a workforce that has the clinical and non-clinical skillset to meet these changing needs. Alternative skillsets are currently being explored.

Blaenau Gwent is a pilot area, working in partnership with ABUHB Workforce and OD, to undertake a baseline workforce assessment for our GMS services. This identifies the workforce challenges and risks currently being faced in general practice. The key objectives of this pilot are to:

- Review workforce supply pipelines

- Consider how they align to our gaps
- Identify training needs to fulfil gaps in supply/meet demand
- Explore competency-based roles and new ways of working i.e., community hubs

Potential Challenges / Issues Delivering the 2025/2026

- Lack of building capacity across our Estates to supporting opportunities to reduce service demands
- Lack of staffing to support the delivery of our priorities
- Uncertainty around workforce capacity, fluctuation in staffing levels and inability to recruit clinical staff, impacting significantly on ability to forward plan activities.
- Operational pressures and responding to increases in service demands and priorities redirect focus from service development work, new initiatives and opportunities designed to reduce pressures.
- System pressures impacting on delivery
- Lack of digital inclusion and confidence to access health and social care systems has impacted on efficient and effective communication across the locality.
- Dental access– practices are prioritising care/treatments but there continues to be delays and appointment backlog with a cohort of our community unable to access NHS dental provision.
- The impact to patients of previously Health Board managed practices across the cluster becoming independent and being able to access services.
- Number of single-handed practices operating in cluster and uncertainty of practice in next 2 – 3 years.
- Uncertainty around tapering of funding to continue programmes e.g., Compassionate Communities and Integrated Wellbeing Networks
- Pay awards being absorbed into NCN budgets with no NCN uplift will lead to a negative financial position for both NCNs, any further pay awards will lead to a further overspend in both spend plans. In order to achieve a breakeven position, there are several projects that are at risk which have been highlighted above. In addition, we are unable to offer any commitment to be able to undertake to any new projects or pilots.
- BG West saw a reduction in their budget for 2024/25 financial year, any further impact to either budget for the next financial year will lead to a negative financial position for both NCNs and will see an overspend in both spend plans. In order to offer assurance of a breakeven position there are several projects that would be at risk should the allocation decrease; in addition, we would be unable to offer any commitment to ay new projects or pilots to maintain a breakeven position.
- Reliance on limited capital programme to progress estates strategy
- Lengthy procurement and recruitment process could possibly delay implementation and delivery of key objectives.

List activities or projects planned to commence during 2025-26, as well as those planned/ initiated in 2024-25 (or earlier, if ongoing)

Activity/Project Title	New or Existing Activity	Brief Activity Project Description	Results/Benefits Expected by End March 2026	Strategic alignment/ Ministerial priorities/ SPPC key programme priorities/Other Strategy or Policy	Life Course Area	Alignment to NCN Focus and Priorities – where applicable							Activity/ project budget	Funding source(s)	Current Status
						1.1	1.2	3.3	4.1	4.2	4.3	4.4			
Health Protection Services/ Building Community Resilience	Existing	Development of Health Prevention services in collaboration with the third sector, IWN and IAA, identifying social networks to help address the wider determinants of health	To improve uptake amongst the 2–3-year-old cohort across the borough in 23/24 the NCN Flu programme will- Work in partnership with Local Education Authority Leads to jointly promote the importance uptake with parents and careers Programme to deliver vaccinations to all eligible 2–3-year-olds across all education and preschool settings.	Prevention & Wellbeing Communication and Engagement Transformation and Vision for cluster	1	1.1	1.2			4.2	4.3		Funding at risk	NCN	Ongoing - funding at risk
Health Protection Services	Existing	Dental - Development of Health Prevention services in collaboration with the third sector, IWN and IAA, identifying social networks to help address the wider determinants of health.	The NCN will liaise with ABUHB Community Dental Service and Dental collaborative, through our fully established Children and Young Adult Task and Finish Group, to explore opportunities of promoting the importance of Oral Hygiene and visiting the dentist.	Healthier Wales Population Health	1	1.1	1.2			4.2	4.3			Funding to be identified	Ongoing
Building Community Resilience **Population Health**	New	Marmot Region	NCNs will support the Marmot Review which sets out a framework for action under two policy goals: to create an enabling society that maximizes individual and community potential; and to ensure social justice, health and sustainability are at the heart of all policies.	Healthier Wales Population Health Transformation and Vision for clusters Prevention and Wellbeing Communication and Engagement Mental Health and Emotional Wellbeing	1	1.1	1.2	3.3	4.1	4.2	4.3		£0	No funding	Ongoing
Care Closer to Home/Pathway re-design	Existing	Future service model for the development of sustainable Placed Based primary care services across both clusters	The NCN is undertaking work to profile timetables to enable Care Closer to Home in terms of delivering services for all our citizens and sustainable placed based care:	Supporting Social Care/Health Workforce Healthier Wales Prevention & Wellbeing Population Health Communication and Engagement Transformation and Vision for clusters	2								£0	No funding	Ongoing
Pathway Optimisation	Existing	The ongoing sustainability of all health and social care services on an operational footing level is paramount,	To support the NCN will undertake a mapping of services – both clinical and non-clinical to ensure that people with the right skills and experience work in an environment that is fit for purpose. Keeping a key focus on local population need and will include Immunisation and Vaccination, GMS sustainability and access, Psychological Wellbeing, Diabetes Prevention, CVD risk factor management, Obesity Pathway, Oral Health, Advanced Paramedic for home visiting/CRT/Care Home and FCP.	Supporting Social Care/Health Workforce Healthier Wales Working alongside Social Care Population Health	3				4.1	4.2			£0	No funding	Ongoing
Health Protection Services	Existing	Supporting the needs of the local population with the cost-of-living crisis	Work in partnership with IWN to use local intelligence of where funding should be directed to support with the cost-of-living crisis.	Supporting Social Care/Health Workforce Healthier Wales Working alongside Social Care Population Health Prevention & Wellbeing Transformation and Vision for clusters Communication and Engagement	1,2,3,4	1.1	1.2						Funding at risk	NCN funding	Ongoing - funding at risk

Key: Alignment to NCN Focus & Priorities

1.1

To align the work of NCNs and Integrated Wellbeing Networks to develop a more community orientated model of primary care through a deeper understanding of the community assets and local needs within the population, particularly for socially vulnerable or marginalised groups.

1.2

To ensure NCNs have a good understanding of Integrated Wellbeing Networks in order to utilise community assets such as community groups and voluntary organisations that help people maintain or develop social support networks.

3. 3

To establish MDT working for people who have greater complexity and are most at risk of deterioration and adverse events such as hospitalisation. This MDT approach will require care coordination and committed involvement of reablement workers, specialist nursing teams, clinical pharmacists, CMHT, social workers, occupational therapists, housing and third sector organisations

4.1

To facilitate a collaborative approach in the delivery of diabetes prevention and CVD risk factor management to ensure that these programmes can be delivered systematically and at scale across NCNs.

4.2

To lead collaborative models for improving uptake of routine immunisations and the Winter respiratory vaccination programme.

4.3

To co-produce a 'social prescribing' model that connects people to activities, groups, and services in their community which can address their practical, social and emotional needs.

4.4

To establish high quality and equitable provision of supplementary/enhanced service across each NCN with an initial focus on IUD.

Cluster Annual Plan 2024-25

Accelerated Cluster Development	Existing	prioritise the establishment of Pan Cluster Groups	Continue to develop the ISPB priority actions with our partnership board landscape. To develop and strengthen the relationship with the Gwent Regional Partnership Board		3								£0	No funding	Ongoing
Health Protection Services	Existing	Diabetes Prevention Programme	Participation in the Diabetes Prevention Programme across both clusters for pre diabetic patients to be offered a brief intervention which includes lifestyle advice with the hope of reducing their HBA1c over the longer term to reduce or prevent the progression of diabetes	Population Health Healthier Wales Prevention & Wellbeing	3				4.1					WG Funding	Ongoing
Green Agenda	New	Committing to creating a greener, stronger and fairer Wales.	The locality team will explore and coordinate training opportunities to raise awareness of how practices can become more environmentally sustainable.		1,2,3,4								Funding at risk	NCN funding	New funding at risk
Accelerated Cluster Development	Existing	Utilise NCN funding to innovate and test concepts relevant to our population needs which improve outcomes for all our residents.	To utilise NCN funding to innovate and test concepts which are relevant to our population needs and able to improve outcomes for all our residents, these include, SEM Scanners, assisted technology, ***locality based FCP and Advanced Paramedic programmes***, reducing the impact of on the day demand. Developing exit strategies to enable proven concepts such as Psychological Wellbeing Practitioners and Practice Based Pharmacists to be core funded.	Healthier Wales Working alongside Social Care Population Health Prevention & Wellbeing Communication and Engagement Transformation and Vision for clusters Workforce & Organisational Development	1,2,3,4								As per attached spend plan	NCN funding	Ongoing GP Cluster Commitment to continue to 25/26
Health Protection Services	New	Seek to develop services that are high quality and equitably across the Borough for supplementary/enhanced services with an initial focus on IUD, minor surgery, substance misuse, homelessness and asylum seeker and refugees.	We will look to map our services to identify where the gaps are and work more collaboratively between our GMS partners to deliver services that are more equitable and, on a population, needs basis	Healthier Wales Population Health Prevention & Wellbeing	3							4.4		Funding to be identified	New
Accelerated Cluster Development	Existing	Widening stakeholder attendance at NCN	Widening stakeholder attendance across our NCN to ensure full collaboration to meet population needs and maintain local voice. We will seek to implements our place based care strategy of a Happy Healthy Blaenau Gwent by creating a sustainable system of change through the integration of health and social care services, raising awareness of the benefits and opportunities for improving population outcomes through collaboration, strengthening partnership arrangements with the third sector and health colleagues such as the local authority, WAST, Direct care and other key partners to meet the specific health and wellbeing needs of our communities	Healthier Wales Working alongside Social Care Population Health NHS Recovery Supporting Social Care/Health Workforce Prevention & Wellbeing Transformation and Vision for clusters Workforce & Organisational Development	3	1.1	1.2	3.3			4.3			No funding	Ongoing

Cluster Annual Plan 2024-25

Training and Education	Existing	Continue to support with training programmes for primary care settings	Continue to progress student support for university entry, as well as support the primary care academies with their onward programme and in turn support services with the academy placements of clinical roles within primary care settings. Continue with NCN Nurse model to support practices with nursing skills i.e., shingles, childhood immunisations, chronic disease management, wound care. Explore NCN nurse facilitator role to train and upskill general practice nurses this will include supporting the training and development of academy nurses and making the academy attractive to practices within the Blaenau Gwent area.	Supporting Social Care/Health Workforce Healthier Wales Population Health Prevention & Wellbeing Transformation and Vision for clusters Workforce & Organisational Development	All									Funding to be identified	Ongoing
Building Community Resistance **Population Health** **Health Protection Services** **Pathway Optimisation** **Care Closer to Home/Pathway re-design** **Estates Mapping** **Accelerated Cluster Development**	Existing	Happy Healthy Blaenau Gwent - establish a whole system approach to deliver place-based care where people can access a range of seamless care and support at or close to home, based on their unique needs and what matters to them	The NCN in partnership with our all our IWN partners will build community resilience through connections to increase social prescribing and community development in collaboration with the third sector. Align the work of the NCN and IWN to develop a more community orientated model of primary care through a deeper understanding of the community assets and local needs within the population, particularly for socially vulnerable or marginalised groups	Healthier Wales Population Health Transformation and Vision for clusters Prevention and Wellbeing Communication and Engagement Mental Health and Emotional Wellbeing	1,2,3,4	1.1	1.2	3.3			4.3			RIF Funding	Ongoing
Redesigning Community Services for Older People	Existing	Explore opportunities to deliver a sustainable community resource model.	Explore opportunities to deliver complex care closer to home through a sustainable community resource model which encompasses hospital @ home/step closer to home pathways , helping our residents to have their health and social care needs met as close to home as possible in a seamless and integrated way through models of care which reduce admission and long term care dependence, utilising a varied clinical skillset able to meet the demands of changing service needs and deliver on the D2RA pathways to provide preventative care and where needed a rapid response to prevent admission or, where admission is needed, the CRT Tyleri model will be available to provide a short clinical interventions prior to supporting individuals to be discharged to recover at home as quickly and safely as possible.		3,4								Other	Ongoing
Redesigning Community Services for Older People **Reablement Hospital Liaison OT**	Existing	Building on D2RA Project	Blaenau Gwent ISPB to align with the strategic priorities of the Health Board, Local authority and A Healthier Wales's vision of a whole system approach to health and social care, focussed on health and well-being and on preventing illness with access to a wide range of seamless community-based services.	Supporting Social Care/Health Workforce Healthier Wales Population Health Prevention & Wellbeing 24/7 model and Vision for clusters Workforce & Organisational Development	3,4								£0	No funding	Ongoing

Cluster Annual Plan 2024-25

Redesigning Community Services for Older People	Existing		As part of the redesign of Frailty services we will review our existing hot clinic pathways and ensure that these are fit for purpose, providing rapid access clinics for older people to undertake assessment, diagnostics, and treatment on an ambulatory basis. CRT In-reach Model which brings alignment between health and social care services to support residents to remain in their usual place of residence for as long as possible. Within YAB the locality team have supported and developed an additional staffing resource which will support a nurse led Tyleri Ward service. Part of the model includes direct admission and transfer pathways to support an 8 bedded CRT unit. Facilitate the introduction of the Graduated Care model across to supports seamless pathways from hospital to home utilising nurse led units to minimise the time being spent in hospital settings.	Supporting Social Care/Health Workforce Healthier Wales Population Health Prevention & Wellbeing 24/7 model and Vision for clusters Workforce & Organisational Development	3,4								None, staff attending clinic will be from the core district nursing teams		Planned to commence when staffing levels improve
Health Protection Services **Building Community Resilience**	/Existing	Building community resilience through connections to increased social prescribing and community development in collaboration with the third sector, Integrated Wellbeing Networks, Social Care and 3rd Sector as part of Happy Healthy Blaenau Gwent	Increased social prescribing and community development in collaboration with the third sector, Integrated Wellbeing Networks, Social Care and 3rd Sector. Development of Wellbeing Friends (training for front line staff such as Care Navigators, DNs, CRT etc) improving access to and awareness of GDS, Optometry, Pharmacy and GMS services. Our focus is on building resilience through prevention and early interventions to enhance wellbeing and self-care, identifying social networks to help address the wider determinants of health such as Vaccination programmes, EPP mental health initiatives,	Working alongside Social Care Mental Health and Emotional Wellbeing Population Health Healthier Wales Prevention & Wellbeing Transformation and Vision for clusters Workforce & Organisational Development Data & Digital technology	3,4	1.1	1.2				4.3			RIF funding	Ongoing GP cluster commitment to continue to 2024/25
Accelerated Cluster Development	Existing	Practice Managers Forum will continue to innovate, transform, and provide new ways of working collaboratively across the NCN footprint.	Innovate, transform, and provide new ways of working collaboratively across the NCN footprint.	Healthier Wales Working alongside Social Care Population Health Prevention & Wellbeing Communication and Engagement Transformation and Vision for clusters	All				4.1				Funding at risk	NCN Funded	ongoing
Accelerated Cluster Development	Existing	Utilising opportunities that technology can bring to increase access to services	The principles of the Primary Care Model for Wales to increase the digital offer around triage and signposting to ensure patients are seen by the right person at the right time in the right place. Working with Blaenau Gwent GP surgeries to increase numbers utilising technology to improve access to GMS services.	*Supporting Social Care/Health Workforce* *Healthier Wales* *Working alongside Social Care* *Population Health* Prevention & Wellbeing Transformation and Vision for clusters Workforce & Organisational Development Data & Digital technology	All								Funding at risk	NCN Funded	ongoing

Cluster Annual Plan 2024-25

Accelerated Cluster Development	Existing	Continue to progress with the ACD Programme	Develop and support both exit strategies and business cases to enable proven concepts to be transitioned over to core funding. Raising awareness of the benefits and opportunities for improving population outcomes through collaboration and strengthening partnership arrangements. Support with the Happy Healthy Blaenau Gwent strategy as a key priority across all professional collaboratives.	Healthier Wales Population Health Supporting Social Care/Health Workforce Working alongside Social Care Prevention & Wellbeing Transformation and Vision for clusters Workforce & Organisational Development	All								£0	No funding	Ongoing
Estates Mapping	New/Existing	Utilising an assets-based approach to refine our Estates Strategy	Utilise an assets-based approach to refine our Estates Strategy around our four places – Tredegar, Ebbw Vale, Abertillery and Brynmawr, harnessing existing infrastructure to support integrated delivery on the ground.	Supporting Social Care/Health Workforce Healthier Wales Population Health Prevention & Wellbeing 24/7 model Transformation and Vision for clusters Workforce & Organisational Development Data & Digital technology	All								£0	No funding	Ongoing
Staff wellbeing	Existing	Supporting our Health and Social Care staff within Blaenau Gwent staff within Primary and Community Care to feel valued, engaged with in a positive sense of wellbeing at work	The NCN is committed to providing wellbeing support to well deserving staff, offering a wellbeing space, but also to provide a warm personal welcome from the Blaenau Gwent Health and Social Care Team and well-being support and guidance.	Supporting Social Care/Health Workforce									£0	No funding	Ongoing

Working Together to Develop, Deliver & Sustain Service on a Local Level

Blaenau Gwent NCN (East & West) Plan – 2025/2026

NCN Areas of Focus:

Developing our Blaenau Gwent Vision of creating a "Happy Healthy Blaenau Gwent" by building resilient communities.

Creating solid foundations across core primary care and community services by standardising our approach to MDT working.

Building integrated neighbourhood teams across our four hub areas of Brynmawr, Abertillery, Tredegar and Ebbw Vale.

Working together on prevention programmes and enhanced services to ensure we have high quality and equitable services across our four hub areas of Brynmawr, Abertillery, Tredegar and Ebbw Vale to improve outcomes for our citizens.

Key Actions – What We Are Doing/Going to Do

ABUHB Priority 1- Every Child has the best start in life

- Continue to support the immunisation and vaccination programmes through delivery and development of innovative projects to improve uptake rates
- The 2025-26 flu campaign will be for all childcare providers and education settings across Blaenau Gwent
- Continue to work with ABUHB Community Dental Service and Dental collaborative to explore opportunities of promoting the importance of Oral Hygiene and visiting the dentist.

ABUHB Priority 2- Getting it right for children and young adult

- Continue to profile hub timetables to enable Care Closer to Home in terms of delivering services for children.

ABUHB Priority 3- Adults in Gwent live healthy and age well

- Continue to fund and support locality-based pilots that will improve outcomes for all our residents and focus on responding to the needs of urgent primary care, which will include First Contact Physiotherapy Service and the Advanced Paramedic Pilot.
- Seek to develop services that are high quality and equitably across the Borough for supplementary/enhanced services by mapping current services and identifying where the gaps are.
- Continue to support community wellbeing scheme based on local intelligence of need.
- Continue to participate and support the All-Wales Diabetes Prevention Programme across both Clusters for pre diabetic patients.
- Progress our strategy of "Happy Health Blaenau Gwent" which seeks to establish a whole system approach to deliver place-based care where people can access a range of seamless care and support at or close to home, based on their unique needs and what matters to them.
- Continue to profile hub timetables to enable care closer to home. This encompasses all services from cradle to grave.
- Continue to progress Pan Cluster Planning Group/ISPB, with partners,
- Undertake an asset mapping of all estates provision alongside a mapping of services – both clinical and non-clinical to ensure that people with the right skills and experience work in an environment that is fit for purpose.

Underpin the delivery of all services with the Marmot principles

"Enablers"

Quality & Patient Safety
Workforce
Staff Wellbeing
Communication and Engagement Plan
Fit For Purpose Estate
Digital Technologies

How Are We Delivering Change?

Blaenau Gwent County Borough Council

GIG CYMRU NHS WALES – Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

Through Healthy Happy Blaenau Gwent establish an MDT model for people who have greater complexity.

By utilising community assets that help people maintain or develop social support networks.

By using co production to develop Healthy Happy Blaenau Gwent Strategy. Providing the framework for social prescribing.

Develop a community orientated model of primary care

By establishing high quality and equitable provision of supplementary/enhanced service across each NCN.

Delivering collaborative and innovative models for improving uptake of routine immunisations.

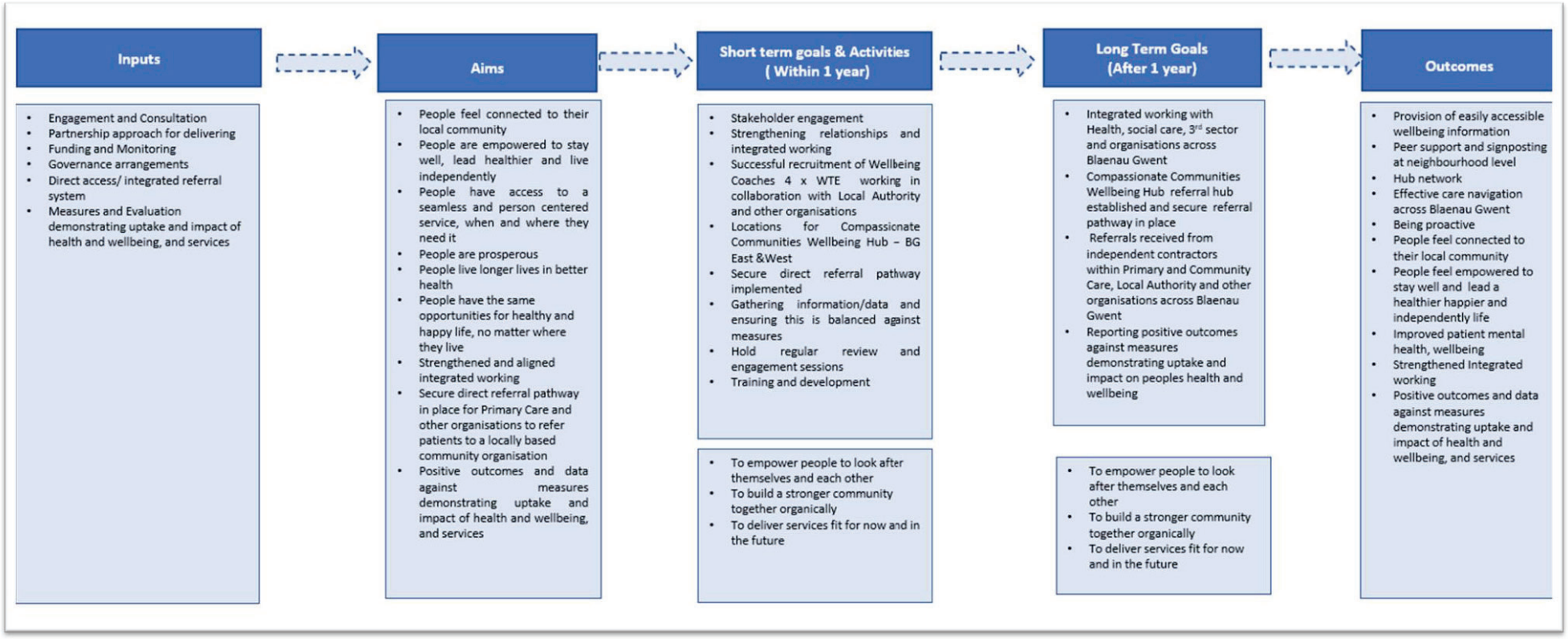
Facilitating a collaborative approach in the delivery of diabetes prevention and CVD risk factor management.

GAVO – Gwent Association of Voluntary Organisations / Cymdeithas Mudiadau Gwirfoddol Gwent

RHWYDWEITHIAU LLES INTEGREDIG GWENT INTEGRATED WELL-BEING NETWORKS

How Will We Know If We Have Made A Difference?

NCN Accelerated Development Evaluation Reporting Process/Patient Experience


Inputs
Engagement and Consultation
Partnership approach for delivering
Funding and Monitoring
Governance arrangements
Direct access/ integrated referral system
Measures and Evaluation demonstrating uptake and impact of health and wellbeing, and services
Aims
People feel connected to their local community
People are empowered to stay well, lead healthier and live independently
People have access to a seamless and person centered service, when and where they need it
People are prosperous
People live longer lives in better health
People have the same opportunities for healthy and happy life, no matter where they live
Strengthened and aligned integrated working
Secure direct referral pathway in place for Primary Care and other organisations to refer patients to a locally based community organisation
Positive outcomes and data against measures demonstrating uptake and impact of health and wellbeing, and services
Short term goals & Activities (Within 1 year)
Stakeholder engagement
Strengthening relationships and integrated working
Successful recruitment of Wellbeing Coaches 4 x WTE working in collaboration with Local Authority and other organisations
Locations for Compassionate Communities Wellbeing Hub – BG East &West
Secure direct referral pathway implemented
Gathering information/data and ensuring this is balanced against measures
Hold regular review and engagement sessions
Training and development
To empower people to look after themselves and each other
To build a stronger community together organically
To deliver services fit for now and in the future
Long Term Goals (After 1 year)
Integrated working with Health, social care, 3rd sector and organisations across Blaenau Gwent
Compassionate Communities Wellbeing Hub referral hub established and secure referral pathway in place
Referrals received from independent contractors within Primary and Community Care, Local Authority and other organisations across Blaenau Gwent
Reporting positive outcomes against measures demonstrating uptake and impact on peoples health and wellbeing
To empower people to look after themselves and each other
To build a stronger community together organically
To deliver services fit for now and in the future
Outcomes
Provision of easily accessible wellbeing information
Peer support and signposting at neighbourhood level
Hub network
Effective care navigation across Blaenau Gwent
Being proactive
People feel connected to their local community
People feel empowered to stay well and lead a healthier happier and independently life
Improved patient mental health, wellbeing
Strengthened Integrated working
Positive outcomes and data against measures demonstrating uptake and impact of health and wellbeing, and services

Blaenau Gwent East - Detail

7206-BLAENAU GWENT EAST

Cost Centre: 7206

NCN Lead: Isolde Shore-nye

Pay - assuming a 3% pay award

Subjective	Scheme	Name	Salary	WTE	1	2	3	4	5	6	7	8	9	10	11	12	2025/26 Total
22250-Independent Contractors	Top Slice - Independent Advisers	*Recharge	-	-	116	116	116	116	116	116	116	116	116	116	116	116	**1,395**
2AA31-Nursing HCA/HCSW Band 3	Top Slice - Phlebotomy	Phlebotomy Recharge	-	-	857	857	857	857	857	857	857	857	857	857	857	857	**10,288**
2E481-Pharmacist Band 8A	Practice Based Pharmacists	Iain Smeethe	58,919	0.80	5,340	5,340	5,340	5,340	5,340	5,340	5,340	5,340	5,340	5,340	5,340	5,340	**64,082**
2E351 Psychological Health Practitioner	Psychological Wellbeing Practitioners	wef 1st nov Julia Miles (0.4), S Morgan (0.8)	2.40	2.40	8,439	8,439	8,439	8,439	8,439	8,439	8,439	8,439	8,439	8,439	8,439	8,420	**101,245**
2A471 - Hospital Admission Avoidance Par	Hospital Admissions Avoidance Paramedic		41000.00		3,300	3,300	3,300	3,300	3,300	3,300	3,300	3,300	3,300	3,300	3,300	2,105	**38,405**
					18,052	**18,052**	**18,052**	**18,052**	**18,052**	**18,052**	**18,052**	**18,052**	**18,052**	**18,052**	**18,052**	**16,839**	**215,415**
					18.052	18.052	18.052	18.052	18.052	18.052	18.052	18.052	18.052	18.052	18.052	16.839	

Non Pay

Details	Scheme	Practice															Total
33610 Travel & Subsistence	Practice Based Pharmacists	All					75						75				**150**
Dementia Road Map	Top Slice - Dementia Roadmap												375				**375**
Community Wellbeing schemes (Winter/Dental)	Community Wellbeing Schemes																
Chronic Disease Management	Expert Patient Programme (EPP)																
Practice manger facilitator	Practice Manager Conference																
Mental Health / Wellbeing	Mental Health / Wellbeing																-
Flu Delivery Plan Support	Room Hire - Flu Vaccinations																
Digital Solutions and Inclusion	Telehealth																-
Staff Wellbeing	Wellbeing workshop																-
Release of prior year accruals	Accountancy gains																-
Winter Planning/PLT	Training - Workflow Optimisation																-
Independent Prescriber	Independent Prescriber																-
					-	**-**	**75**	**-**	**-**	**-**	**-**	**-**	**450**	**-**	**-**	**-**	**525**

Allocation	215,940
Brokerage	
Total Funding	215,940
Overcommitted	**- 0**

North Spend Plan Summary	2025/26
Annual Budget	215,940
Top Slice: Advisers, Phlebotomy, Dementia Roadmap	12,059
Practice Based Pharmacists	64,232
PWPs	101,245
Community Based Paramedic	38,405
Community Wellbeing Schemes	-
Expert Patient Programme	-
Practice Manager Facilitator	-
MIND	-
Flu	-
Digital Solutions	-
Staff Wellbeing	-
Accountancy Gains	-
Training Professional	-
Total Expenditure	**215,940**
Uncommitted Expenditure	**- 0**

Blaenau Gwent West - Detail
Cost Centre: 7205
NCN Lead: Simon Donovan

7205-BLAENAU GWENT WEST

Pay - assuming a 3% pay award

Subjective	Scheme	Name	Salary	WTE	1	2	3	4	5	6	7	8	9	10	11	12	2025/26 Total
22250-Independent Contractors	Top Slice - Independent Advisers	*Recharge	-	-	137	137	137	137	137	137	137	137	137	137	137	137	**1,643**
2AA31-Nursing HCA/HCSW Band 3	Top Slice - Phlebotomy	Phlebotomy Recharge	-	-	750	750	750	750	750	750	750	750	750	750	750	750	**8,997**
2E481-Pharmacist Band 8A	Practice Based Pharmacists	Tracey Witherall	36,825	0.50	3,338	3,338	3,338	3,338	3,338	3,338	3,338	3,338	3,338	3,338	3,338	3,338	**40,051**
2E351 Psychological Well-being Practitioner	Psychological Wellbeing Practitioners	1st Nov N. Currie (0.4), J. Miles (0.2), M. Fitzgerald/Williams (0.8)		2.60	9,142	9,142	9,142	9,142	9,142	9,142	9,142	9,142	9,142	9,142	9,142	9,142	**109,702**
2A471 - Hospital Admission avoidance param	Hospital Admissions Avoidance Paramedic		39000.00		3,300	3,300	3,300	3,300	3,300	3,300	3,300	3,300	3,300	3,300	3,300	4,495	**40,795**
					16,666	**16,666**	**16,666**	**16,666**	**16,666**	**16,666**	**16,666**	**15,378**	**16,666**	**16,666**	**16,666**	**17,861**	**201,188**
					16.67	16.67	16.67	16.67	16.67	16.67	16.67	15.38	16.67	16.67	16.67	17.86	

Other Non-Pay

Details	Scheme	Practice															Total
33610 Travel & Subsistence	Practice Based Pharmacists																-
Community Wellbeing schemes (Winter/Dental)	Community Wellbeing Schemes																
Dementia Road Map	Top Slice - Dementia Roadmap															375	**375**
Chronic Disease Management	Expert Patient Programme (EPP)																
Digital Solutions and Inclusion	Telehealth				-												-
Practice manger facilitator	Practice Manager Conference																
Mental Health / Wellbeing	Community Wellbeing Schemes																-
Flu Delivery Plan Support	Room Hire - Flu Vaccinations																
Staff wellbeing	Wellbeing Workshop																
Development of Hubs/BG West	Physiotherapist				4,167	4,167	4,167	4,167	4,167	4,167	4,167	4166.67	4,167	4,167	4,167	4,167	**50,000**
Independent prescribing qualification	Independent Prescriber																-
Winter Planning PLT	Training - Workflow Optimisation																-
					4,167	**4,167**	**4,167**	**4,167**	**4,167**	**4,167**	**4,167**	**4,167**	**4,167**	**4,167**	**4,167**	**4,542**	**50,375**
					4	4	4	4	4	4	4	4	4	4	4	5	
		Forecast Expenditure			**20,833**	**20,833**	**20,833**	**20,833**	**20,833**	**20,833**	**20,832.8**	**-**	**20,833**	**20,833**	**20,833**	**22,403**	**251,563**

Allocation	251,563
Brokerage	
Total Funding	251,563
Overcommitted	**- 0**

North Spend Plan Summary	2025-26`
Annual Budget	251,563
Top Slice: Advisers, Phlebotomy, Dementia Roadmap	11,015
Practice Based Pharmacists	40,051
PWPs	109,702
Community Based Paramedic	40,795
Community Wellbeing Schemes	-
Expert Patient Programme	-
Practice Manager Facilitator	-
MIND	-
Staff Wellbeing	-
Development of hubs	50,000
Flu	-
Digital Inclusion	-
Training Professional	-
Total Expenditure	**251,563**
Uncommitted Expenditure	**- 0**

PAN CAERPHILLY NCN ANNUAL PLAN 2025-26

East, North & South NCNs

CONTENTS:	Page
Executive Summary / Background	2
Strategic Direction	3 – 4
Population Need	5
Key Priorities & Achievements from 2024/25	6
Key Reflections & Challenges 2024/25	6
PLANNED ACTIONS 2025/26:	
Building Resilient Communities	7 – 8
Working collaboratively on prevention programmes and enhanced services	8 - 9
Long Term Conditions	10
Financial Plan	11
ENABLERS:	
Quality & Patient Safety	12
Workforce & Staff Wellbeing	12 – 13
Access & Sustainability	13 - 14
Fit For Purpose Estate	14
Digital Technologies	15
Communication and Engagement	15
APPENDICES:	
Appendix 1 - Plan on a Page	16
Appendix 2 - SWOT Analysis	17
Appendix 3 - Action Table	18 – 20

Working Together to Develop, Deliver & Sustain Services on a Local Level

Executive Summary / Background:

This plan covers all three Caerphilly Locality Neighbourhood Care Networks (NCN); NCNs are split across the East, North and South of the Borough. The collective aim is to support, sustain, develop, and improve services on a local level, working across sectors including both public and third sectors. The needs of the local populations are at the forefront of all we do, recognising and responding to areas of inequity and enabling people and communities to be healthy and independent.

Caerphilly Borough covers a large geographical area of 278 km^2 (107 square miles) and borders with two other health boards, Cwm Taf Health Board and Cardiff & Vale University Health Board. It has a resident population of approximately 176,831 *(Mid-Year 2021 Stats Wales)* with a General Practitioner (GP) registered population higher than the residency at 187,000 people. Registered patients receive out of hospital health and social care from independent contractors, local authority and third sector organisations. Across Caerphilly independent contractors comprise of 20 GP practices, 43 community pharmacies, 25 dental practices and 17 optometry practices.

This plan outlines key elements of need and our priority areas on which the core NCN business will be delivered, allowing us to monitor and be accountable for plan delivery.

Health and social care delivery needs to be fit for purpose, robust and responsive to the population need now and in the future. Service pressures are well known and to alleviate this we need to be adaptable and innovative in the way we work. Key factors to be addressed include:

- Increasing demand on health and social care as a result of a sicker and older population with more complex health needs.
- Lack of funding and staff shortages impacting on service sustainability in the short, medium and longer term.
- Inequalities across the borough linked to socio-economic deprivation which is further exacerbated by the current financial climate.
- Lack of fit for purpose estate.

During 2025-26 the focus of the NCNs will be to deliver areas of focus outlined within this plan as well as scoping and implementing new initiatives and work streams as opportunities arise. NCNs will continue to implement services on a local level to meet the needs of its population working across key service areas including acute care, secondary care, social care, independent contractor, primary care, community care or third sector service settings. The accelerated NCN development programme and associated collaboratives will act as enablers to help deliver priorities at a local level.

All three NCNs within Caerphilly borough are clear on the importance of our local communities and citizens as an integral part of what we do. The work of the Integrated Wellbeing Network (IWN) will be key, encouraging and enabling communities to take ownership of their wellbeing and health to become more resilient. The IWN connects people and services, supports new and existing community wellbeing initiatives, and provides accessible wellbeing information.

Key priorities outlined are areas where the Caerphilly NCNs will have a focus through 2025-26. These will be underpinned by enablers including Quality & Patient Safety, Financial Management, Communication & Engagement, Workforce and Staff Wellbeing.

Strategic Direction

There is ever-increasing complexity and demand on health and social care. In order to provide care at home or as close to home as possible we need to change how we provide our services. This in turn will assist with hospitals only being accessed when no other alternative exists.

There are multiple strategic drivers with 'A Healthier Wales' remaining as the overarching policy context for health and social care in Wales. This drives our commitments to deliver seamless, place-based care. Some key models are the Primary Care Model for Wales (PCMW) and Strategic Plan for Primary Care. These put what matters to people at their core and aim to ensure the right care is available at the right time from the right source.

In order to transform effectively, we must ensure the infrastructure for enhanced multi-professionals working across health, social care and third sector is in place. Local facilities and data systems need to be flexible and responsive to future changes and support multi-professional working. People should have access to digital options to seek and receive care. Direct access to services in the community will deliver quality care closer to home. Improving health and well-being, building stronger communities and improving the well-being of our staff will increase recruitment and retention and ultimately provide longer lasting models of care.

On a local level the redesign of older persons services and the embedding of community integrated teams to support people who are at risk of deterioration in their long-term health conditions is a priority. The aim is to be able to provide care 24/7and as close to home as possible. Undertaking preventative measures is also essential to ensure we have resilient communities and sustainable services.

All the above aligns with the 6 Goals to Urgent Care which aims to ensure that patients get the right care, in the right place, first time.

1. Co-ordination planning and support for populations at greater risk of needing urgent or emergency care

2. Signposting people with urgent care needs to the right place, first time

3. Clinically safe alternatives to admission to hospital

4. Rapid response in a physical or mental health crisis

5. Optimal hospital care and discharge practice from the point of admission

6. Home first approach and reduce the risk of readmission

Caerphilly NCNs Annual Plan 2025-2026

Within Gwent and to support the Social Services Wellbeing Act to improve the wellbeing of the population and improve how health and care services are delivered, we have the Gwent Regional Partnership Board (RPB) which has 3 key aims to apply locally:

1. Start Well - improving outcomes for children and families, working together to start well.
2. Live Well - people at the heart of everything we do, working together to live well.
3. Stay Well - ensuring the right help is available at the right time, working together to stary well.

In Caerphilly the Integrated Services Partnership Board (ISPB) is fully established with a plan identifying three key priority areas that the NCNs can relate to:

1. Early Years & Best Start in Life
2. Mental Health & Wellbeing
3. Community Resilience

In addition, as a Health Board the priority areas for the Primary Care and Community Services Division over the period 2025/26 will be to progress and deliver on the following areas:

- Long Term Conditions – Management and Prevention
- Access & Sustainability
- Redesigning of Older Persons Services
- NCN Development & Partnerships

To be able to achieve actions in relation to the above priority areas it will be essential to ensure that all the underpinning enablers are effective. These include:

- Quality & Patient Safety
- Workforce, Staff Wellbeing and Culture
- Communication and Engagement
- Financial Management
- Fit For Purpose Estate
- Digital Technologies
- Value Innovation and Research

This plan outlines the overarching national and regional strategic directions and the local priorities in more detail. The population need and local intelligence will assist in how we plan and address this and what the anticipated outcomes and benefits will be.

Population Need:

There are varying levels of deprivation across Caerphilly borough and it is clear that the North of the borough is generally the most deprived, however pockets of high deprivation also exist in the East and South. The consequent health inequalities mean people in the most deprived areas have significantly shorter lifespans than those in deprived areas. These consequences impact people of all ages and throughout the life course goals / journey.

Caerphilly NCNs recognise:

- the increase in the number of people, of varying ages, presenting with mental health issues across services
- the increase in loneliness specifically in our aging population
- the forecasted increase of older people living with comorbidities and complex needs.
- the increase in people with diabetes and pre-diabetes.
- the increase in people with obesity and increase in the demand on weight management services
- the continued high levels of smokers and undiagnosed COPD
- the increase in cardiovascular disease and hypertension. Also there are increasing numbers of patients with undiagnosed hypertension and/or risk factors for cardiovascular disease

Healthy Weight	Diet and alcohol	Exercise	Smoking
• % older people of healthy weight **27.3%** (2022/23) – 41.3% Gwent, 39.6% Wales	• % adults eating 5 fruit or vegetable portions a day **18.6%** (2022/2023) – 23.4% Gwent 28.5% Wales	• % adults meeting physical activity guidelines **51.1%** (2022/2023) - 49.9% Gwent; 55.4% Wales	• % adults who smoke **11.4%** (2022/2023) – 13.6% Gwent, 12.8% Wales
• % working age adults of health weight **25.6%** (2022/23) – 33.4% Gwent, 36.1% Wales	• % adults drinking above guidelines **15.7%** (2022/2023) – 17.3% Gwent, 17.2% Wales	• % adolescents meeting physical activity guidelines **14.5%** (2021/2022) **-** 15.1% Gwent; 16.5% Wales	• % smoking in pregnancy **13.1%** Gwent (2022)
• % adolescents of healthy weight **62.4%** (2021) – 65% Wales, 63.3% Gwent	• % adolescents drinking sugary drinks once a day or more **21.2%** (2021) - 18.5% Gwent, 16.4% Wales		• % adolescents who smoke **2.9%** (2021) – 3% Gwent, 3% Wales • *NB **26.8%** 11-16 year olds reported tried vapes

'Building a Fairer Gwent' initiative based on Marmot principles sets out to address the inequalities, which is essential to improve quality of life as well as develop and sustain services in the longer term. The IWN area outline plans are based on community input, dictate a local assets based approach to address inequalities and reduce demand on services. Community resilience is a key focus to promote sustainability of health and social care services for the future.

Preventative approaches are key to ensure people and communities are resilient which includes both screening and immunisation programmes being accessible to the population incorporated with place based care models.

Caerphilly NCNs Annual Plan 2025-2026

Caerphilly locality and NCNs reviewed last years annual plan, and below have highlighted the key achievements and any challenges that we have faced.

Key Priorities & Achievements from 2024/25:

Five priority areas:

- Workforce Sustainability
- Building Community Resilience
- Early Years & The Best Start in Life
- Mental Health Wellbeing
- Long Term Condition Management

Some of the achievements delivered by the NCNs in Caerphilly are:

- Increasing Community Wellbeing Connectors and embedding them in GP practices and communities
- Extended Interval Prescribing - GMS and Pharmacy collaboratives working in partnership
- MDT Coordinator / MDT Meetings - Supporting ABUHB Apprenticeship Programme
- Staff Wellbeing – The Zen Den
- Professional collaborative implementation –Nursing, Optometry, GMS, AHP, Dental and Pharmacy.
- Collaborative localised programmes i.e. Optometry have tripled the referrals to Help me Quit and presented at NCN Event, Pharmacy Extended Interval Prescribing.
- Diabetic Prevention Programme – Roll out across Caerphilly
- 3 borough teams/members received high commendation and regition at the ABUHB Staff awards:
    - Population Health & Wellbeing Award – Caerphilly IWN
    - Green Healthcare Award – Mari Burland Highly
    - Employee Health & Wellbeing Award – Stella Montgomery
- Participatory budgeting supported 8 health & wellbeing projects in Upper Rhymney Valley – chosen by local residents

Key Reflections & Challenges 2024/25:

Challenges identified across services and delivery models are:

- Recruitment and retention difficulties
- Staff resilience (i.e. sickness/burnout etc)
- Increased demand on services / worsening social determinants of health
- Demographic changes
- IT – Vision / EMIS, Audit+ withdrawal
- Funding allocated to long term posts
- NCN budgets - no uplift and having to absorb uplift in staff costs. This is an unsustainable situation
- NCN budgets flexibility – spend required halfway through the financial year removes flexibility

Further details highlighted in the SWOT analysis in appendix 2.

3 areas of focus for 2025/26:

1. Building resilient communities (Natural geographies)

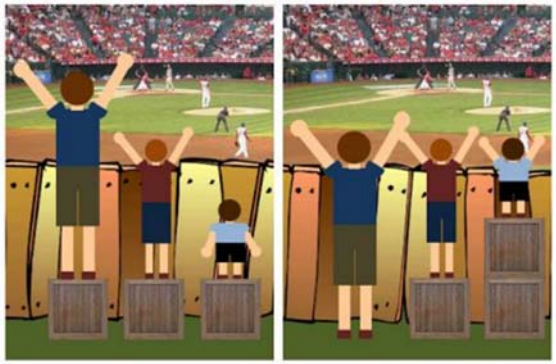
Reference to NCN priorities and focus areas:

1.1 To align the work of NCNs and Integrated Wellbeing networks to develop a more community orientated model of primary care through a deeper understanding of the community assets and local needs within the population, particularly for socially vulnerable or marginalised groups.

1.2 To ensure NCNs have a good understanding of Integrated Wellbeing Networks in order to utilise community assets such as community groups and voluntary organisations that help people maintain or develop social support networks.

4.3 To co-produce a social prescribing model that connects people to activities, groups and services in their community which can address their practical, social and emotional needs.

What do we mean by equity?



Equality Equity

Equality means individuals or a group of people have access to the same resources/opportunities. Equity recognises that people have different circumstances and allocates the exact resources and opportunities needed to reach an equal outcome.

To address health inequities, we recognise that collaborative working of stakeholders is required through effective planning and operational delivery of services. It is imperative that we work with individuals to promote healthy lifestyle choices. This is key to reducing the risk of poor health and potentially premature death.

The work of the IWN, developing initiatives and helping to connect people, groups and services at a local level will empower communities and will ensure they meet their local community needs. The IWN local team are engaged with all sectors to seek to promote community physical and mental health & wellbeing in contributing to creating healthy communities. Outline plans have been developed in conjunction with and for each IWN community, which supports and reference NCN priority and focus areas 1.1, 1.2 and 4.3 above. The Caerphilly IWN team despite its small size and large geographical and population coverage has a very positive impact and is key to continued progress going forward.

RHWYDWEITHIAU LLES INTEGREDIG GWENT
INTEGRATED WELL-BEING NETWORKS

The roll out of participatory budgeting in Caerphilly (hosted through GAVO and supported by the IWN programme along with partners in Caerphilly CBC), provides local people opportunity to spend part of the public budget to support local health and wellbeing initiatives This encourages meaningful community involvement and ownership and helps to increase overall community resilience.

In empowering, advising and supporting people to take ownership of their own health and wellbeing we can tackle the population needs:

- The NCN will work with partners to review and consider a plan to identify people at risk of becoming diabetic (pre-diabetic) learning from and continuing the work of the diabetes prevention programme.
- Preventative Screening & Immunisation Programmes are also part of the localities ongoing focus

Caerphilly NCNs work well with their partners across local authority and third sector e.g., the NCNs work closely with GAVO in Caerphilly promoting the help and advice to voluntary and community organisations, increasing the resilience and helping to develop a thriving third sector.

Local hubs have supported providing care closer to home and are a key development within the boroughs place based care strategy.

Through partnership working with Caerphilly Cares, a single point of contact for end-to-end support for Caerphilly residents has been provided.

The NCNs have and continue to support Community Wellbeing Connectors, which are aligned to individual GP practices and have working links with IWN and the Nature Wellbeing Programme. They provide support and advice to adults and their families to enhance wellbeing, independence and engagement with local communities. This promotes long term independence and identifies appropriate solutions to complex needs.

In alignment with Welsh Governments strategic framework for social prescribing, we have invested in the Nature Wellbeing programme, with a coordinator as a single point of access. This encourages and empowers people to take steps to improve their own health and wellbeing. Nature/social prescribing activities are provided by voluntary organisations, registered charities and a small number of "social businesses". These services provide a pathway for individuals to discuss and consider their best options e.g., outdoor activities such as walking and cycling, and activities such as environmental conservation and horticulture etc.

2 Encouraging Collaborative Working with a focus on Enhanced Services

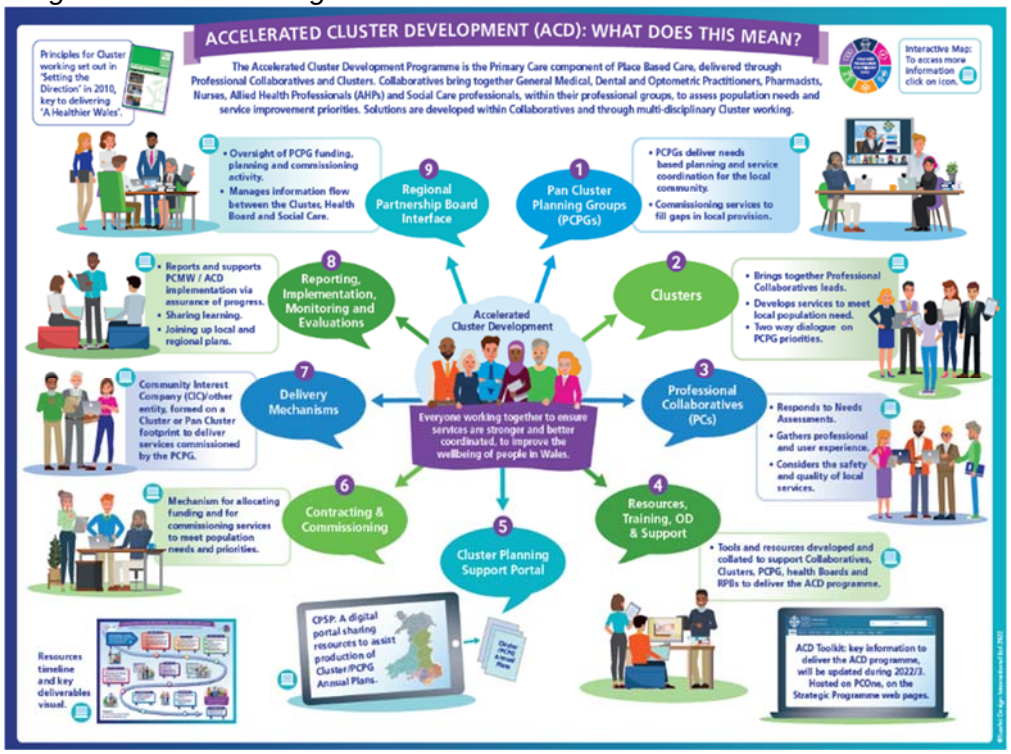
Reference to NCN priorities and focus areas:

3.3 To establish MDT working for people who have greater complexity and are most at risk of deterioration and adverse events, such as hospitalisation, to live safe, independent and fulfilled lives. This MDT approach will require care coordination and committed involvement of reablement workers, specialist nursing teams, clinical pharmacists, CMHT, social workers, occupational therapists, housing and third sector organisations.

4.4 To establish high quality and equitable provision of supplementary / enhanced service across each NCN with an initial focus on IUD, minor surgery, substance misuse, homelessness and asylum seeker and refugees.

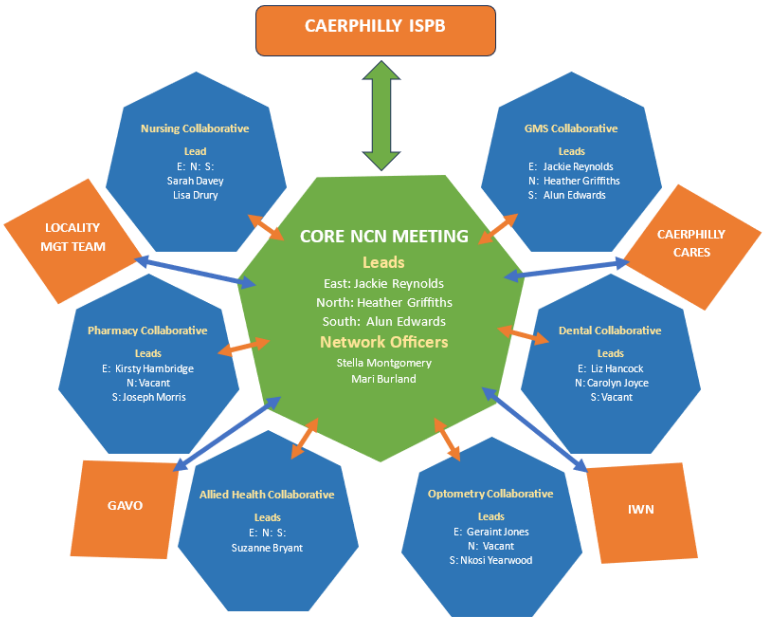
The NCNs will continue to develop and enhance partnership working across all sectors. The governance arrangements for Caerphilly ensure a multi partner/organisation, bottom up and top-down approach to ensure we both support and continually identify the local need in line with the overarching strategic direction.

Continuation of the Accelerated NCN Development (ACD) Programme is to meet the cluster population health and social care needs through effective and robust planning and service delivery. The outcomes which continue to be worked towards, are outlined in the illustration.



Caerphilly will continue the programme by meeting the programmes milestones, monitor and evaluate projects / proven concepts of change, develop exit strategies and support business case development to enable movement of funding, implement and innovate projects to improve outcomes for all our residents reducing the impact of on the day demand as well as support the local collaborative leads and assist with further empowering and progressing the collaboratives. Work will be continued to further progress the development of place-based care and services offered from strategically located "hubs."

Each Professional Collaborative provides structure to support connection with peers to review the quality and safety of local services, share experience and good practice for the area of expertise and to advocate for service improvement. The speciality areas for collaboratives are within each of the independent contractor groups (GMS, Pharmacy, Dental and Optometry) as well as the Nursing and Allied Health Professionals (AHP) workforce.



The diagram opposite shows how each collaborative feed between themselves and the core NCN.

The purpose and aims of each Collaborative are:

- To promote inter and intra-professional dialogue and cooperation to improve patient care and experience.
- Gather professional and user experience of the health and care system to inform priority setting and planning.
- Improve Caerphilly population health and wellbeing.
- Increase value from the care and support provided.
- Improve quality and safety of services.
- Engage and develop the workforce.

The approach within Caerphilly is that we use the ACD framework to enhance all aspects of collaborative working. In the last year the locality is already starting to see some of the positive outcomes of this approach and how by working across boundaries the local populations can receive the best outcomes. A good example of this is the success that the optometry collaborative has had in relation to smoking cessation.

The NCN has funded a pilot to establish formal MDT meetings to give opportunity for partners to work together to discuss complex individual cases with a view to developing plans to best support people to receive appropriate services to meet their needs, ref areas of focus 3.3.

The Caerphilly locality link directly with the primary care contracting team to support and promote GP engagement with enhanced services and delivery within local practices. The locality is identifying gaps within the service provision and scoping local need options. There has been a long-standing issue in relation to the provision of an enhanced service to residents within care homes (124 patients 13.82% as at Oct 2024). The NCN will continue to explore opportunities to address this gap to ensure equity of provision.

3 Long Term Conditions – Prevention and Management

Reference to NCN priorities and focus areas:

4.1 To facilitate a collaborative approach in the prevention and management of diabetes and wider CVD risk factors (including hypertension) to ensure that these programmes can be delivered systematically and at scale across NCNs.

An ageing adult population leads to increased numbers of people with chronic long-term conditions and complex needs. The primary care contract has already recognised the importance of addressing unhealthy behaviours and forms part of the GMS contract Quality Improvement Framework (QIF) programme. Within Caerphilly town there is a new sports and wellbeing development being progressed and the NCNs/ISPBs are linking with partners to ensure that collaborative working across this and other sites is enhanced to prevent the onset of ill health and enable people who live with long term conditions to maintain their health and wellbeing as best as possible.

Services need to be preventative but also be reactive to respond to the needs of people with long term conditions to ensure their health and wellbeing is optimised. Some key focus areas for this will be about good weight management, healthy lifestyle choices including exercise referral programmes, smoking cessation, green prescribing etc.

Cardiovascular Disease (CVD) Prevention is a key focus for Caerphilly, we can support people by educating them to make healthy lifestyle choices. By identifying risk factors earlier, there is reduced chance of developing life-threatening conditions such as heart attacks, strokes, dementia. To support this Caerphilly aim to look at implementing a Health Trainer to support individuals within the borough. A health trainer could: help people identify how their behaviours may be affecting their health, support individuals to create a health plan to help make changes to improve their health, help individuals to become more knowledgeable about things that can affect their health and wellbeing as well as signpost to other agencies and professionals.

One of the risk factors for CVD is diabetes. Diabetes prevalence is increasing and it is recognised that if we don't manage to address the pre-diabetic risks in the short term then this will further increase the numbers of diabetics. The diabetes prevention programme is rolling out across Caerphilly working with all GP practices within the borough. As indicated in its area outline plans, the IWN programme will continue to focus on enabling community approaches to addressing conditions such as Type-2 diabetes and obesity by supporting and signposting people to become more active through local activities, as well as linking up with local food initiatives to support better access to healthy food, growing projects, and cooking skills, working with community health programme and the healthy weight management programmes for example.

Respiratory conditions have been a longstanding issue for people living in and around ex industrial and mining communities - the impact of the Covid pandemic has worsened/increased the number of people living with respiratory conditions. Across Gwent there is an ongoing workstream in relation to the longer-term model for respiratory services and the NCNs will inform this work and support the implementation of the model where required. The NCNs have supported spirometry service as part of the place based hub model to support those patients awaiting a diagnosis. The NCNs will continue to support the health boards drive for a Gwent wide approach to support spirometry in the future.

Another area where the NCN plans to give a greater focus for working together is in the delivery of the preventative agenda. It is recognised that immunisation leads to improved outcomes for individuals and can result in a reduced demand on services. The NCNs will continue to promote and support the vaccination programmes across all services and specifically independent contractors i.e. flu vaccination programme – nursery and pre-school settings pilot undertaken in North Caerphilly to support delivery of vaccine to 2 – 3 year olds, there are options to potentially roll this out across the borough.

For the conditions outlined above the Nature Wellbeing initiative will encourage greater community activity outdoors and continue to link people on cardiac, pulmonary, and neurological rehabilitation programmes to assist in ensuring people's health and wellbeing is optimised.

Caerphilly NCNs Annual Plan 2025-2026

Finance Profiles 2025/26:

Recurrent funding for a range of support roles and services in Caerphilly will continue including specialist advisor roles in Optometry and investment in a Community Phlebotomy Service. The remaining Practice Based Pharmacists, Psychological Health Practitioners, First Contact Physiotherapists and expansion of the Community Wellbeing Connectors continue to be supported via NCN funding for 2025/26. The introduction of innovative use of digital and clinical technology and equipment has also been supported to enable Primary Care services to provide a wider range of options for patient access and care.

The NCNs continue to horizon scan with the aim of developing a portfolio of existing and proven schemes, and potential new pilot projects. Other funding streams such as Regional Integrated Fund (RIF), Participatory Budgets, Further Faster funding, pooled budgets through Integrated Services Partnership Board (ISPB) or Regional Partnership Board (RPB) are options for proposal applications to support the current NCN budgets.

Caerphilly NCNs Spend Forecast 2025/26							
Project/Role/Item	**East NCN**		**North NCN**		**South NCN**		**Caerphilly NCNs Combined Costs**
	WTE	**COST (£)**	**WTE**	**(£)**	**WTE**	**COST (£)**	**(£)**
Community Phlebotomy Team (Top Sliced across all ABUHB NCNs)	-	12,837	-	16,173	-	15,267	44,277
Independent Contractors (Top Sliced across all ABUHB NCNs)	-	2,411	-	2,543	-	2,021	6,975
Psychological Health Practitioners	3.8	160,059	3.8	160,059	3.0	126,326	446,444
Community Wellbeing Connectors	1.33	64,350	1.33	64,350	1.33	64,350	193,050
First Contact Physiotherapists	1.0	69,680	1.0	69,680	1.0	69,680	209,040
Practice Based Pharmacists	0.6	48,018	1.52	89,634	0.2	16,005	153,657
MDT Coordinator (Pilot in East & South NCNs)	0.5	8,390	-	-	0.5	8,390	16,780
Pan Caerphilly NCN Conference Event	-	500	-	500	-	500	1,500
Room Hire	-	-	-	-	-	400	400
MIND – Caerphilly Counselling Service	-	1,613	-	1,613	-	1,613	4,839
My Surgery App - Annual Costs for Practices	-	1,440	-	1,800	-	1,440	4,680
Accurx for Practices / Primary Care Online Texting	-	7,000	-	3,500	-	5,700	16,200
eConsult for Practices	-	14,600	-	4,500	-	8,800	27,900
Education & Staff Development	-	2,500	-	1,500	-	2,500	6,500
Place Based Care/Hub Development	-	2,500	-	1,500	-	2,500	6,500
Pharmacists – Subsistence costs	-	200	-	1,500	-	200	1,900
Staff Wellbeing - Consumables	-	500	-	500	-	500	1,500
Allocation (£)		**396,915**		**419,379**		**333,488**	**1,149,782**
Forecast Spend (£) - before red (text) items		**396,598**		**419,352**		**326,192**	**1,142,142**
Underspend (£)		**317**		**27**		**7,296**	**7,640**
Overspend (£)							

The practice systems are currently being reviewed divisionally with an aim to go to one system ABUHB wide. This will impact on the budgets to support NCNs in being able to release funding and come slightly in budget.

Enablers

Quality & Patient Safety

Caerphilly Quality & Patient Safety Group (QPS) is an established health and social care forum which provides Divisional assurance for all quality and patient safety issues across the borough. Any NCN related incidents or complaints are fed into this group. Emphasis for 2025/26 will be to ensure that outcomes of the group meetings produce salient learning / improvements that are disseminated to relevant teams and services.

A focus within the locality is being able to offer safe and effective services to our population. Regular attendance of an NCN lead to our local Quality & Patient Safety (QPS) meetings ensures that we can reflect on and implement any learning as a result of complaints and incidences that may have occurred. The NCN will work with all established collaboratives to support the QPS agenda.

The locality management team has established quarterly assurance meetings with individual services and managers within its budget responsibility. These will focus on opportunities to share good practice and escalate areas where support is required. The agenda for these meetings include review of team rosters, risk registers, budgets, QPS aspects such as compliments, complaints, and incidents. To support these meetings, nominated locality team leads have been identified to ensure robust team arrangements are in place.

The GMS QIF supports the QPS agenda within GP practices. Another key focus area for the NCNs is a collaborative approach between practices and pharmacies with Extended Interval Prescribing. A positive impact from this will be to improve patient experience, reduce patient trips to GP and pharmacy, supports sustainability, reduces need for frequent attendance releasing capacity.

Workforce & Staff Wellbeing

To enable a robust and sustainable workforce model there is a requirement to review current profiles, identify gaps in resource and any deficits in skill bases. There are a number of posts that are not funded on a permanent basis which require a plan to be able to bring these roles into core budgets. Development of Place Based Care to ensure local residents are able to access services as close to where their live as possible will be achieved through development of the following:

<u>Primary Care</u>

- Availability of a broader range of clinicians to undertake appropriate interventions and as alternatives to GP consultation. This may include paramedics, physiotherapy, occupational therapists, mental health workers, pharmacists, and advanced nurse practitioners.
- Development of a sustainable and effective lower-level community service through continued funding of additional community wellbeing connectors who are able to signpost and where necessary escalate individual cases, reducing the demand on higher level intervention services.
- Improved GP aligned multidisciplinary care approach with regular opportunity/meetings to discuss and react to specific cases before crisis point. The NCNs (East and South) currently fund an apprentice who facilitates and administers the meetings.

<u>Community Resource Team</u>

- There is an ongoing review of the frailty service in association with the redesign of the older persons pathway. This will inform the service model and locally embed that the CRT is an integral part of place-based care and is essential in terms of admission avoidance and expediting discharge from hospital.

District Nursing

- The District Nursing Service within the Borough provides a broad range of nursing services to support acute, complex and end of life care at home. The service is a key member of the NCN cluster and works in collaboration with other members of the NCN to ensure service sustainability.
- The service consists of 7 teams aligned to 20 practices within Caerphilly, and also to a number of tertiary GP practices within other Health Boards. The service operates from 8am to 8pm 7 days per week and referrals can be made by both professionals and the general public.
- There is also a requirement to review the role of the Health Care Support Worker where limitations currently exist in the ability to undertake specific duties/tasks, thus necessitating a registered nurse to undertake lower-level interventions.
- There will need to be a rolling programme of recruitment in line with turnover and the senior nurse is working with HR and divisional nurse educational leads in relation to this.

The ongoing pressures within all clinical services brings challenges to our workforce and it is essential that we are able to recognise the impact of these on staff wellbeing and our ability to be able to retain and recruit staff. The NCNs have supported local wellbeing events within the borough and have implemented The Zen Den as a staff wellbeing therapy initiative, this has been impactful and is being taken on tour throughout the borough.

Access & Sustainability

Our residents need to be able to access any appropriate service they require via clearly defined means and in a timely manner. Our services need to be effective, robust, and sustainable now and into the future. The Primary Care Model for Wales is an area which can support both access and sustainability and by using prudent healthcare principles to ensure that people are seen by the most appropriate practitioner will be key moving forward.

General Practice is a key “anchor” in local communities and often the first port of call when people’s health and wellbeing is affected. There are multiple workforce models, orthodox, hybrid partial skill mix and hybrid full skill mix. In Caerphilly we have worked on the assumption of a partial hybrid model for this plan, this identifies gaps and deficits of clinical posts as well as looking at future challenges and workforce needs to inform robust succession planning. Extended roles include professionals such as practice based pharmacists, psychological health practitioners, community connectors. This information will also inform estate requirements / capital project prioritisation where more diverse skill mix requires greater physical space.

Sustainability risks have been identified for independent contractors within Primary Care in relation to the funding pressures – especially in light of the recent increase in minimum wage and national insurance contributions.

It is important to be aware that the number of vacancies and absences we have within other community teams impacts on staff and their respective teams and makes delivery of services to our patients challenging. Our clinical teams work tirelessly to ensure they provide timely and appropriate services.

Within the borough there are seven District Nursing teams who are aligned to the 20 GP practices. Although this has improved, there are longstanding recruitment and retention difficulties within the service and operational delivery is only currently sustained due to the dedication and flexible working of the staff in post.

The ongoing local and national workstreams in relation to the requirement and provision of community-based nursing services will be essential to ensure that Caerphilly is appropriately resourced to care for people at home or as close to home as possible and that the borough is in receipt of an equitable population-based resource. These workstreams needs to include all aspects of nursing such as rapid nursing teams (CRT), specialist nurses etc.

The borough in association with other localities are exploring opportunities to develop and enhance our community-based services which will bolster core services and enable more people to be cared for at home. These roles will include aspects such as generalist palliative care, care home in-reach and other condition specific specialist roles.

The NCNs are conscious that on occasions when services and roles are developed across Gwent, they are not always allocated on a WTE per resident population basis and as a result the borough can be at detriment when compared to other smaller locality areas. The NCNs in 2025/26 will explore opportunities to further enhance our recruitment and retention and will do this via a number of means, including working with the Divisional Academy and exploring apprenticeship opportunities across both admin and clinical support roles, working across collaboratives, working with communications and engagement on a recruitment campaign. It has been recognised that there is need to collaborate with colleagues across sectors to understand the barriers in recruitment including promotion of working in the local area, communication and engagements teams will be sought for support.

The NCNs have funded education and training for upskilling and/or training needs, with the aim to enhance skillsets within teams to deliver need.

Fit for purpose estate

The large geographical area and high population of Caerphilly are key considerations when planning the integrated “Place Based Care” hub approach. It is recognised that in some areas physical site developments offer an opportunity to progress place-based care, however where estate infrastructure is more difficult, “hub & spoke” models will be considered.

The borough is served from an enhanced local general hospital perspective by Ysbyty Ystrad Fawr for acute and sub-acute care. The borough has 12 community inpatient beds located within Rhymney Integrated Health and Social Care Centre. Both these sites are modern built units that are fit for purpose. The location of Redwood Unit in Rhymney is geographically challenging. The Caerphilly Community Resource Team is based at Ty Graddfa in Ystrad Mynach and they provide a service to the entire population of Caerphilly.

GP practices within Caerphilly borough and from a provision of health and care services perspective these sites are the most local core “anchor” within our communities and are often the first place of contact when people seek help. There are a number of identified GP sites that are a priority for reprovision/ development as follows:

Aber Valley **-** Identified as the area of highest estate need. The health board has been successful in securing WG agreement & funding (£750k) awarded to develop outline business case and to appoint a Supply Chain Partner (SCP) for a new development. The main purpose is to provide a new, fully compliant single site for the provision of GMS and broader health, social care and third sector services in the Aber Valley, including advice, treatment, information, and community support. The site will host a range of health, social and voluntary sector services, to enhance and improve access and experience for the local population.

Ystrad Mynach – A key priority area in terms of its need for fit for purpose GMS provision as well as the development of an integrated health and social care hub. Oakfield Street Surgery is at capacity, and within the current infrastructure would not be able to support any further increase in registered list size or offer any additional services within its current location.

The NCN and locality team will continue to explore and bid for capital funding for schemes and in addition will work alongside divisional colleagues in relation to GMS improvement grants. To enable the borough to further develop place-based care and provision of integrated hub services the NCNs Locality team has worked with the Divisional Estates team to develop bids including:

Pontllanfraith Health Centre **-** ABUHB owned site that hosts a GP practice, a community pharmacy as well as a range of health board clinical services. The delay in undertaking any capital improvements has implications for the modernisation of the co-located independent contractors. The site deficits including the lack of DDA compliance and WiFi infrastructure are identified on the Datix Risk Register.

Trethomas Health Centre **-** ABUHB owned site that offers a range of integrated services. With little investment the site has managed to review and develop services on the site. The main site deficit is the lack of DDA compliance and is recorded on the Datix Risk Register.
Both sites have significant maintenance requirement and are limited in their ability to provide modern, fit for purpose health and social care services.

Digital technologies
It is recognised that technology is an enabler to deliver care and it is essential that our estate is equipped with adequate connectivity infrastructure to deliver modernised approaches. Digital solutions were rapidly deployed to maintain and deliver new services, and as part of the 2021 NHS Wales Covid 19 Innovation and Transformation Study Report, the workforce embraced changes and innovations.

There is a need to look to maximise the benefits from digital investment and prioritise digital solutions which will have the greatest impact in providing access both for enhanced patient care and for professionals. Therefore, initiatives across Wales are in the process of being reviewed and identified for national upscale.

We continue to promote the benefits of the NHS 111 service along with the recently implemented 'option 2' for people who have urgent mental health concerns about themselves or someone they know. Providing help to support people to manage a mental health crisis will sit well with our prudent healthcare objectives, to avoid having to access a GP and be an alternative to attending emergency departments or calling the police.

To support a digitally ready and enabled workforce, Welsh Government are developing a 'Think digital' approach to the delivery of services and their redesign to effectively use clinician input and improve care in value-based approaches that will also reduce the burden and pressure of workload. As part of this national workforce implementation plan, digital platforms being used in general practice and supported by NCNs (AccuRx, eConsult, SurgeryApp, Attend Anywhere etc) are being discussed for national funding / implementation solution. ABUHB are currently reviewing all digital platforms and looking to procure one unified system, ensuring value for money. Continued support will also be provided for the ongoing implementation of the CIVICA platform within Community Nursing teams across the borough.

The Welsh Community Care Information System (WCCIS) has been implemented and will continue to give community nurses, mental health teams, social workers, local authority colleagues and therapists the digital tools they need to work better together through storing and sharing of information across teams and services.

We will always embrace and explore opportunities to support the utilisation of assisted technologies within healthcare settings and to support individuals to stay safe and independent in their own home for as long as possible. The NCNs have always been forward thinking regarding funding support for innovative items of equipment which impact on early diagnosis and communication and will continue to do so as appropriate.

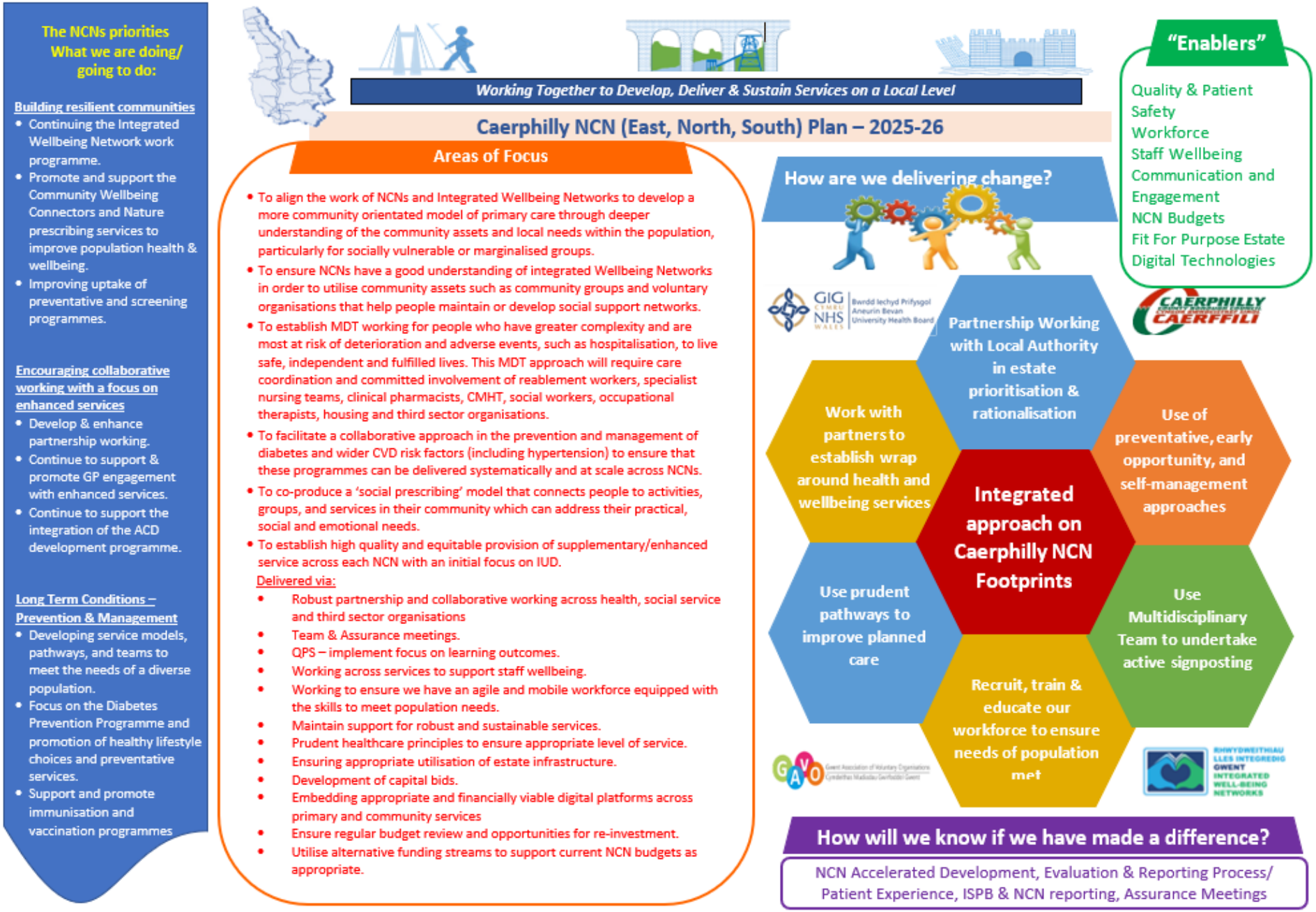
Communication & Engagement
The NCN works with and is supported by the ACD aligned Communication and Engagement Officer who since being in post has made significant progress in this aspect of the work we do. The plans for 2025/26 will be to further enhance across the ISPB partners the ways in which working within Caerphilly can be promoted with the aim to improve recruitment to key posts where deficits exist.

The NCNs will continue to promote the work that is undertaken via the Pulse Intranet pages with the submission of news items/good news stories. The team will continue to meet on a regular basis with the organisational engagement team to share information.

We work with our partners across health, social care and third sector to share information on services including GP information screens, community pharmacies, CWTSH guides, DEWIS etc.

5 Appendices

Appendix 1 – Plan on a Page



Appendix 2 - SWOT Analysis

Strengths	Weaknesses
• Good working relationships across the Core NCN membership. • Strong focus on sustainability of core clinical services • Strong focus on innovation/development of services. • Committed NCN Leadership and Support Team. • Committed and good relationships with IWN. • Clear direction via the NCN plan on a page of what the priorities are and how these can be delivered via integrated/collaborative working. • NCN provides a conduit for two-way partnership working. • Development of place-based care models and hubs across health and social care to support sustainable services for the local population.	• NCN budget committed, therefore limiting development opportunities within the NCN constraints. • Annual variability of funding e.g., sickness, recruitment timescales etc. • Limited resource from management team. • Organisational and silo working creates barriers and can make integration difficult. • Lack of sustainable Primary Care workforce.
Opportunities	**Threats**
• Improved partnership working via ISPB. • Expand and develop extended clinical roles. • Explore funding sources / enablers. • Development of place-based care models and hubs across health and social care to support sustainable services for the local population. • Continue Telehealth option for patients & practices. • NCN Development Programme – robust governance and frameworks. • Collaborative engagement.	• Sustaining core services across health & social care settings due to: – Recruitment and retention difficulties – Increased demand on clinical services – Backlog of waiting list demand – Public expectation regarding access to services • Transitioning NCN funded roles to core service budgets limiting available NCN funds for major project investment. • Loss of engagement when/if pilots/initiatives are discontinued. • Short-term funding arrangements. • The high level of waiting times across the NHS in Wales will impact on an individual's health, wellbeing, and outcomes. • The cost of living pressures impacting on the wellbeing of people and is likely to increase demand across health and social care. • No inflationary increase on budgets • Increase in costs (particularly supported roles / uplifts) thus decreasing service provision • Primary care contractors increased cost pressures i.e. NI contribution • Insufficient funding for collaborative roles limits engagement • Non contractual participation across some collaboratives – impacts engagement

Caerphilly NCNs Annual Plan 2025-2026

Appendix 3 – Action Log: List activities or projects planned to commence during 2025-26, as well as those planned/ initiated in previous years (E = East NCN, N = North NCN, S = South NCN)

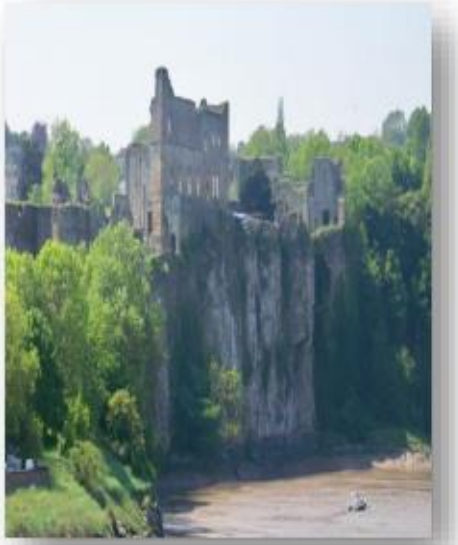
Activity/ project title	New or existing activity	**Brief** activity/ project description	Results/ benefits expected by end March 2026	Life Course Area	Areas of Focus	**Strategic alignment**: Ministerial priorities, SPPC key programme priorities	Activity/ project budget	Funding source(s)	Current status – link with key actions
Independent Advisors	*Existing*	*Long standing top-sliced initiative, across all ABUHB NCNs*	*Specialist Contractors providing expertise and support to NCNs*	*3*	*3.3 4.4*	*Supporting the Health & Care Workforce. NCN Development.*	*E - £2,411 N - £2,543 S - £2,019*	*Cluster Funding*	*Active - NCN Development & Partnerships. Support collaboratives.*
Community Phlebotomy	*Existing*	*Long standing top-sliced initiative, across all ABUHB NCNs*	*Community based Phlebotomists sitting within locality District Nursing teams providing increased capacity.*	*3*	*3.3 4.1*	*Provide effective, high quality, sustainable healthcare. Supporting the Health& Care Workforce. NCN Development*	*E - £12,837 N - £16,173 S - £15,266*	*Cluster Funding*	*Active - Access & Sustainability.*
Cluster Pharmacy Team	*Existing*	*Practice Based Pharmacists*	*Improved GP access. Improved patient safety and medicines management in general practice.*	*2 3 4*	*3.3*	*Provide effective, high quality, sustainable healthcare. Supporting the Health & Care Workforce. NCN Development. Development of PCMW*	*E - £48,018 N - £89,634 S - £16,005*	*Cluster funding – proven move to central funding*	*Active - NCN Development & Partnerships. Access & Sustainability.*
Psychological Health Practitioner (PHP) Team	*Existing*	*Practice Based Psychological Health Practitioners (PHP)*	*Enables GP to focus on GP time to spend on patients with complex medical needs. Prudent healthcare with low-level MH issues dealt with in by qualified practitioners.*	*3 4*	*3.3*	*Provide effective, high quality, sustainable healthcare. Supporting the Health & Care Workforce. Mental Health & Emotional Wellbeing. Development of PCMW*	*E- £160,059 N- £160,059 S- £126,326*	*Cluster funding – proven move to central funding*	*Active - Mental Health & Wellbeing. Access & Sustainability.*
Community Wellbeing Connectors	*New*	*Aligned with GP surgeries to provide non-clinical social prescribing and isolation avoidance*	*Enables GP to focus on GP time to spend on patients with complex medical needs.*	*1 2 3 4*	*1.1 1.2 3.3 4.3*	*Mental Health & Emotional Wellbeing. Population Health. Development of PCMW. NCN Development. Community Infrastructure*	*E- £64,350 N- £64,350 S- £64,350*	*Cluster funding*	*Active - Community Resilience. Mental Health & Wellbeing.*
First Contact Physiotherapy Team	*Existing*	*Re-established face to face appts within GP practices*	*Improved access to GPs. Provision of MSK assessment with direct referral from within community.*	*3 4*	*3.3*	*Supporting the Health and Care Workforce. PCMW. NCN Development.*	*E- £69,680 N- £69,680 S- £69,680*	*Cluster funding – proven move to central funding*	*Active. NCN Development & Partnerships. Access & Sustainability.*
MDT Coordinator (Pilot)	*Existing*	*Coordinator role to facilitate practice virtual MDTs,.*	*Practices discuss individual patients by linking with other practitioners from the CRT, DN teams, Social Services, Mental Health for example.*	*3 4*	*3.3 4.3*	*Provide effective, high quality, sustainable healthcare. Supporting the Health & Care Workforce*	*E - £8,390 S - £8,390*	*Cluster funding*	*Supported via apprenticeship programme. Access & Sustainability. Workforce & Staff Wellbeing*
Flu/COVID Vaccination Programme Support	*Existing*	*Funding to bolster vaccination programmes*	*Continued public awareness campaigns via publications. Support staff to provide increased programme support.*	*1 3 4*	*4.1 4.4*	*Population Health. Covid-19 Response. Community Infrastructure.*	*E - £500 N - £500 S - £500*	*Cluster Funding*	*Active - Community Resilience. Long-term Conditions.*
Pan Caerphilly NCN Conference Event	*Existing*	*Pan Caerphilly NCN (East, North, South) themed conference event*	*Lead to joint working opportunities across services to benefit patients / public and associated service providers*	*3 4*	*1.1 1.2 3.3 4.1 4.3*	*Working alongside Social Care. Supporting the Health & Care Workforce. PCMW. NCN Development*	*E - £500 N - £500 S - £500*	*Cluster funding*	*Active - NCN Development & Partnerships.*

Caerphilly MIND-Counselling service	*Existing*	*Provision of one-to-one counselling service to residents of Caerphilly Borough to support people to address mild to moderate mental Health issues*	*Continue to provide additional mental health resource to support the Primary Care Mental Health Team for Caerphilly residents. Reduce demand on PCMHSS by providing additional sessions.*	*3 4*	*3.3 4.3*	*Mental Health & Emotional Wellbeing. Population Health. Development of PCMW. NCN Development.*	*E - £1,613 N - £1,613 S - £1,613*	*Cluster funding (Joint funding with RIF)*	*Active - Community Resilience. Mental Health & Wellbeing.*
eConsult	*Existing*	*Funding support for GP practices to continue with providing the eConsult service to patients#*	*Improved access to GPs. Patients forms-based service to request GP advice without the need to book an appointment or contact the GP practice face to face or by telephone*	*3*	*3.3*	*Population Health. Community Infrastructure.*	*E - £16,950 N - £7,050 S - £8,702*	*Cluster funding - interim to national solution*	*Active. Digital Technologies. Access & Sustainability.*
Accurx	*Existing #*	*Funding support for GP practices to continue with providing the eConsult service to patients*	*Improved access to GPs. Patients able to use this forms-based service to request advice without need to book appts or contact the practice*	*3*	*3.3*	*Population Health. Community Infrastructure.*	*E - £7,000 N - £0 S - £5,800*	*Cluster funding - interim to national solution*	*Active. Digital Technologies. Access & Sustainability.*
SurgeryApp Annual Costs	*Existing #*	*App providing patients a central resource to access their surgery's services and health information*	*Patients to have the ability to utilise the App to manage their health and connect with their GP surgery*	*3*	*3.3*	*Population Health. Community Infrastructure.*	*E - £1,440 N - £1,400 S - £1,140*	*Cluster Funding*	*Active. Digital Technologies. Access & Sustainability.*
Primary Care Online Texting	*New*	*Addition to SurgeryApp providing 2-way SMS messaging service*	*Provide an, efficient and secure communication system with One-Way, Two-Way, and batch messaging capabilities, along with a robust two-way chat system.*	*3*	*3.3*	*Population Health. Community Infrastructure.*	*E - £3,500 N - £3,500 S - £3,000*	*Cluster Funding*	*New. Digital Technologies. Access & Sustainability.*
Education & Staff Development	*Existing*	*Provision of funding to upskill of NCN affiliated services staff across the locality*	*Improved knowledge and skills for health and wellbeing staff. Resulting in the provision of high quality care and support for the residents of Caerphilly borough.*	*2 3 4*	*1.1 4.1 4.4*	*Supporting the Health and Care Workforce. NCN Development. Community Infrastructure.*	*E - £5,000 N - £5,000 S - £5,000*	*Cluster Funding*	*Active. NCN Development & Partnerships.*
Place Based Care / HUB Development	*Existing*	*Funding to provide opportunities to develop/improve community-based health and wellbeing hubs.*	*Versatility to existing HUBs across the NCN localities. Enables a variety of services to offer clinics within community settings and out of hospital.*	*4*	*1,1 3.3 4.1 4.3 4.4*	*NCN Development. Community Infrastructure.*	*E - £5,000 N - £5,000 S - £5,000*	*Cluster Funding*	*Active. NCN Development & Partnerships. Access & Sustainability.*
Staff Wellbeing	*Existing*	*Funding for consumables*	*HUB based staff wellbeing service in Caerphilly (The Zen Den). Offers Caerphilly staff from across services to receive complimentary therapies and improve stress/mental health.*		*4.3*	*Supporting the Health and Care Workforce*	*E - £500 N - £500 S - £500*	*Cluster Funding*	*Active. Workforce & Staff Wellbeing. Mental Health & Wellbeing.*
Community Health Wellbeing Workers	*Potential*	*Provide support and advise on healthy lifestyle choices and educational programmes.*	*Reduce demand on GP appointment time which will be freed up to enable clinicians to focus on more medical needs.*			*Provide effective, high quality, sustainable healthcare. Supporting the Health and Care Workforce. PCMW and NCN Development*	*E- £117,060 N- £117,060 S- £117,060*	*Proposed cluster funding*	*On Hold. Access & Sustainability. Community Resilience.*
Specialist Pharmacist to support Chronic Disease Management	*Potential*	*Introduce 1 WTE IP Pharmacist to work alongside the PCDSN Team*	*Improved access to medicines expert for chronic disease conditions and support PCDSNs.*			*Provide effective, high quality, sustainable healthcare. Supporting the Health and Care Workforce PCMW and NCN Development*	*E - £22,433 N - £22,433 S - £22,433*	*Proposed cluster funding*	*On Hold. Access & Sustainability. Long-term Conditions.*
Minor Illness Hub	*Potential*	*Development of a Minor Illness Hub, run by clinicians i.e ANP, MSK specialists,*	*Improved access for GPs by freeing up their time to enable them to see more complex and relevant patients*			*Supporting the Health & Care Workforce Population Health*	*E - TBC N - TBC S - TBC*	*TBC*	*On Hold. NCN Development & Partnerships. Workforce & Staff Wellbeing.*

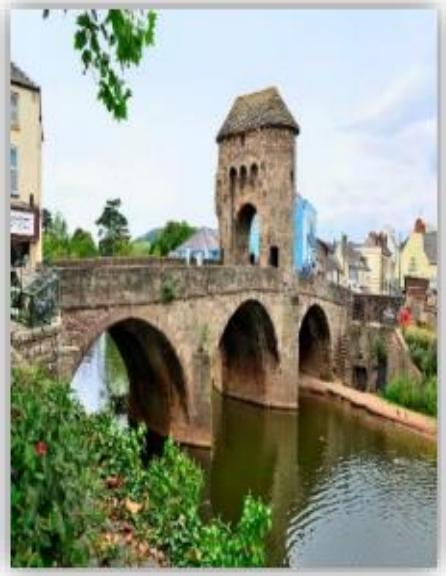
		Paramedics, Prescribing Pharmacists.							
NCN Development Programme	*Existing*	*Maintaining and enhancing the Caerphilly ISPB*	*Create sustainable system change through integration of health and social care services,*			*Healthier Wales, Working alongside Social Care, Population Health, Supporting Social Care/ Health Workforce, Prevention & Wellbeing, Communication and Engagement, Transformation and Vision for clusters*	*SPPC*		*Active*
	Existing	*Evaluate and implement exit strategies*	*Enable proven concepts to be diverted from NCN budgets.*				*SPPC*		*Active*
	Existing	*Continue local working with collaboratives*	*GMS, Optometry, Dental, Pharmacy, Allied Health professionals, Nursing*				*SPPC*		*Active*

Monmouthshire (North and South) NCN Cluster Networks
2025/26 Annual Plan

Chepstow



Monmouth



Cluster Executive Summary:

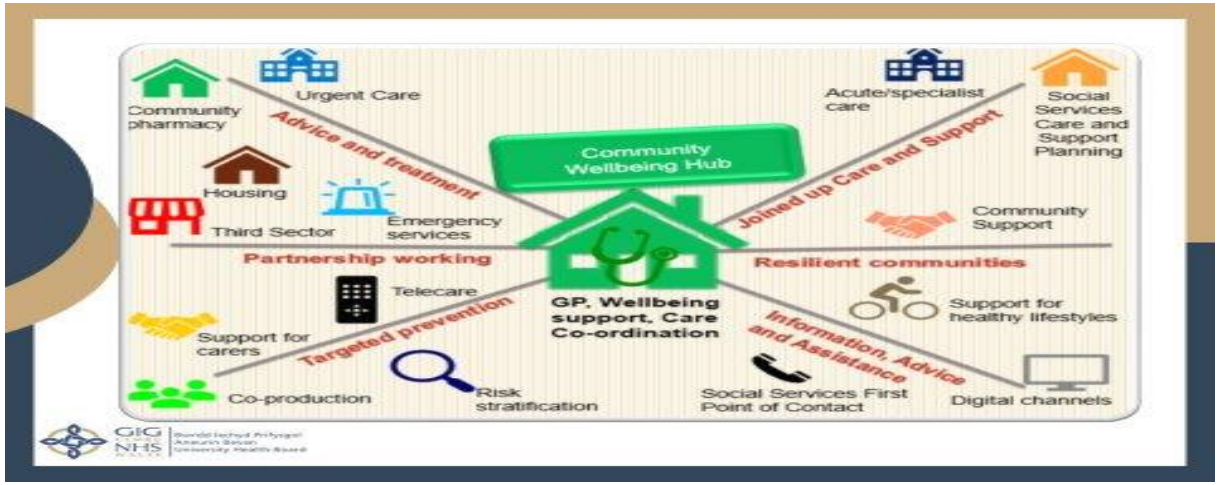
Monmouthshire's two (North and South) **Neighbourhood Care Networks (NCN Clusters)**, are required to publish plans on an annual basis, that reflect local need, successes, challenges and key projects to help the people of Monmouthshire, and surrounding areas. Information within this new 2025/26 plan, has been gained from a range of sources such as the **Regional Partnership Board's (RPB)** Population Needs Assessment, and includes strong anecdotal information from local partners and colleagues across Monmouthshire. This plan, with the **Primary Care Model for Wales (PCMW)** as a key driver, follows previous NCN plans in being closely aligned with both Health Board, and national strategies. The RPB and Monmouthshire **Integrated Services Partnership Board (ISPB)** provide a strategic focus for our NCN Cluster plans, and as Cluster Leads, we recognise and welcome the important role played by such key partners in helping to ensure this plan accurately reflects the needs of people in and around Monmouthshire.

The focus for this 2025/26 plan will not only continue to reference progress made with previous plans and priorities, but also strengthen our approach to delivering **'Place Based Care'**, strengthened by 5 **'Focus Areas'** (please see figure 3), including Building resilient communities, underpinned by our well-established integrated health, social care and third sector teams in every 'place'. **Figure 1** below shows the Continuum of place-based care, that will help focus our workstreams in 2025/26:

As recognised by the RPB's needs assessment, small pockets of deprivation can be found in Monmouthshire, focussed generally in the 5 key towns of **Abergavenny, Caldicot, Chepstow, Monmouth and Usk**. It also tells us that opportunities to earn higher wages outside of Monmouthshire are available, and that 43% of economically active residents commute away, which can lead to increased stress and a poor sense of wellbeing due to reduced job satisfaction and less leisure time. Therefore, at the heart of our vision for place-based care in Monmouthshire, is bringing together previously siloed teams and professionals to do things differently to improve care for the whole population and to promote Monmouthshire as an excellent place to work and live. Evidence suggests that better continuity and preventive healthcare can be achieved, as well as improved access to support, through a blended generalist and specialist workforce drawn from all sectors. Integrated neighbourhood 'teams of teams' need to evolve from NCNs and be rooted in a sense of shared ownership for improving the health and wellbeing of the local population. This requires a strong integrated workforce, culture of collaboration across a continuum of care (above), with the time and space within these teams to solve problems together and to build relationships and trust. With a key partnership aim of retaining local talent within Monmouthshire, we hope to future-proof our workforce and build on our ambition to deliver place-based care in each town.

A key priority in the development of building community resilience on a place-based basis, is the Welsh Government's: **Accelerated Cluster Development (ACD)** programme. ACD brings **'Professional Collaboratives'** together i.e.; GPs, Pharmacists, Optometrists, Community Nursing Teams, Dentists and Allied Health Professionals in each 'place', to help us as Cluster Leads build a shared understanding and commitment to working together, to improve the lives of people in and around Monmouthshire. In partnership with the ISPB, we have agreed that the **Gwent Association of Voluntary Organisations (GAVO)**, will be considered and consulted with as an equal collaborative partner due to its already strong presence at local and strategic level. We continue to work together as clusters, professional collaboratives and strategic partners, to ensure we understand the needs of people in Monmouthshire. We continue to focus on promoting the strong network of community/ place-based support under the umbrella of the **Integrated Wellbeing Network (IWN).** The IWN is a valuable resource and helps connect people to a range of community assets and resources, supporting individuals to understand what really matters to them.

Figure 2 on the right demonstrates best practice in terms of the role community hubs can play in the delivery of place-based support and care. A potentially exciting development in the North East of Monmouthshire, is a proposed new Health, Social Care and Wellbeing Hub, to hopefully be based at Monmouth Town and form part of a wellbeing network linked to Bridges Community Centre, and the Monnow Vale Health and Social Care Facility. This project is supported by funding from the Welsh Government and underpinned by the ethos of best practice as shown in the diagram. This will be a valuable asset and addition to the already strong network of integrated community support available in Monmouthshire.

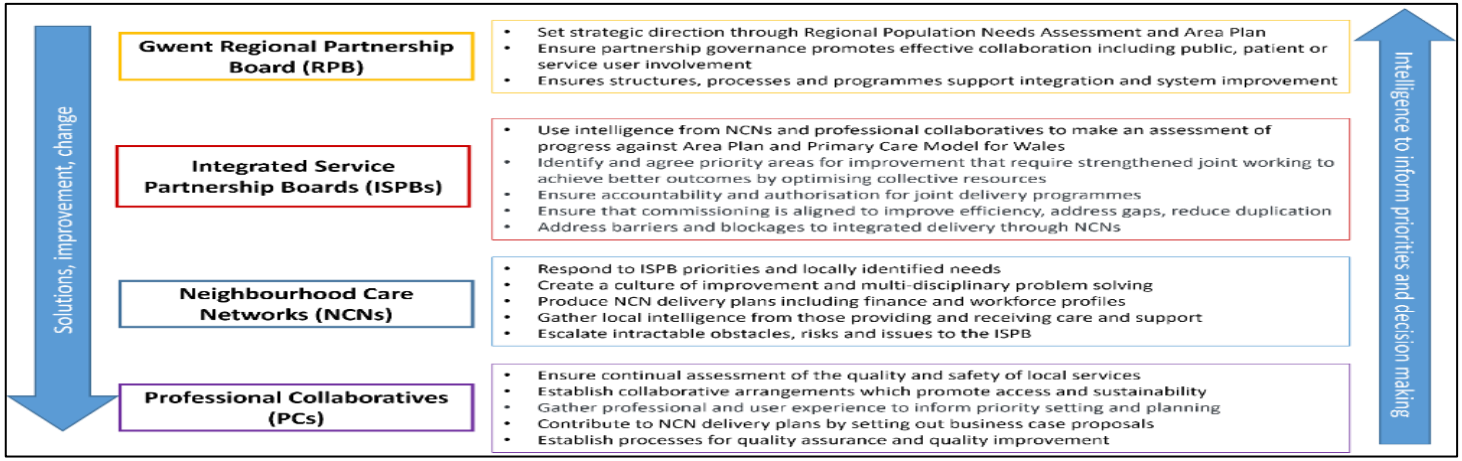


In summary, as clusters leads, we recognise there are differences between the two clusters in terms of the North being a more rural and much larger are than the South, with related challenges in terms of service delivery, but also that we continue to acknowledge and promote the benefits of working together both as clusters, and on a wider integrated borough basis. We commit to continue working as part of an already strong multi-agency partnership in Monmouthshire and further develop our approach and support delivery of the **5 Place-Based Priorities and key Areas of Focus.** For the purpose of this plan, 3 of the 5 priories have been agreed as shown in **figure 3** below (please see appendix 3 for more detail):

Place-Based Priorities		Areas of Focus & Enabler Examples	Sub-Area of Focus
1	**Building resilient communities**	• Enabled by a strong integrated network approach to delivering place-based care in Monmouthshire, facilitated by joint NCN and Public Health Team funded, Wellbeing Link Advisors – reinforcing relationships across statutory and non-statutory agencies. • Aligned with the Monmouthshire Integrated Wellbeing Network, Health, Social Care and Well-Being Partnership Officer, GAVO, Professional Collaboratives etc.	***1.1*** ***1.2***
3	**Building integrated neighbourhood teams in every "place"**	• Enabled by the South Monmouthshire 'S.M.A.R.T.' Multi-Disciplinary Team focused project to identify the most vulnerable older people in Monmouthshire, and agree support across the Integrated MDT, including social services and GAVO • Enabled by the expansion of the Rapid Medical (Frailty) model into North Monmouthshire via R.I.F funding) to provide a Pan-Monmouthshire approach.	***3.3***
4	**Working collaboratively on prevention programmes and enhanced services**	• Enabled by Expert Patient Programme delivery self-care/ diabetes prevention • Enabled via the Wellbeing Link Advisor service, hosted by GAVO underpinned by co-production principles, learning from what matters most to people in Monmouthshire via the Integrate Wellbeing Network • Enabled by local cluster level discussion and monitoring of enhanced service provision, in conjunction with the contracting team and linked to gap-analysis work etc.	***4.1*** ***4.3*** ***4.4***

A Framework for Planning & Delivery - Strategic Partners:

Figure 4 below details the relationship between our strategic and service planning/ delivery partners in Gwent and Monmouthshire. Although not specifically referenced within this table, it is accepted that GAVO is an equal partner within the Monmouthshire planning and delivery framework and therefore, sits across all 4 groups detailed below.



Gwent Regional Partnership Board

An aim of the RPB is to facilitate strategic planning and working together to ensure effective services, care and support are in place to best meet the needs of the population. **Figure 5** below details the 3 key RPB goals that can be applied to the work of our NCN Clusters:

Start Well	Live Well	Stay Well
Improving outcomes for children and families, working together to start well.	People at the heart of everything we do, working together to live well.	Ensuring the right help is available at the right time, working together to stay well.

Monmouthshire Integrated Services Partnership Board: ISPBs or Pan Cluster Planning Groups (PCPGs) as they are known in the ACD Programme, allow partner representatives to work together on strategic, long-term plans, to agree and develop priorities linked to the delivery of the Social Services & Well-being and Wellbeing of Future Generations Acts, the Strategic Programme for Primary Care, and A Healthier Wales. The ISPB is a sub-group of the RPB and is a conduit for information sharing and decision making between frontline services and the ISPB.

Collaborative (NCN) Clusters: NCNs bring together local services across health, social care and the Third Sector (GAVO), to plan and deliver local solutions to meet the needs of Monmouthshire residents at individual and community level. NCNs are a key component of the ISPB and can facilitate service delivery based on need, to help challenge inequalities. The Integrated Wellbeing Network (IWN), is linked to the ISPB, NCNs, GAVO and forms a strong community/ place-based focus allowing local intelligence to be gathered as shown within this plan.

Professional Collaboratives (ACD Programme: The aim of ACD is to enhance progress already made by NCN Clusters, and hasten the impact of NCNs to meet the needs of cluster population health. Professional collaboratives are represented at NCN Cluster meetings and help clusters understand the needs of their service users, to inform planning.

Key NCN Cluster Priorities and Areas of Focus in 2025/26:

NCN Priority: Building resilient communities (Linked to 1.1,1.2,3.3,4.3)

Our continued aim is to work in partnership to ensure people in and around Monmouthshire (there are circa 14,000 people residing across the border and registered with a Monmouthshire GP), can be involved in the large network of community support on a place-based basis. However, as with previous plans, we continue to recognise the significance of working together as a collection of collaboratives, to understand the needs of people within our key 'places', and use it to shape our services in an integrated way, to meet those needs across a vast geographical area. Monmouthshire also has well documented challenges relating to its growing, older population and high levels of demand across primary, community and social services, due to people living longer with long-term conditions. We recognise the need to avoid people being admitted to hospital where possible as we know 'deconditioning' in older people has a significant impact on them. We share this as a priority with the ISPB and continue to work with GAVO as a whole.

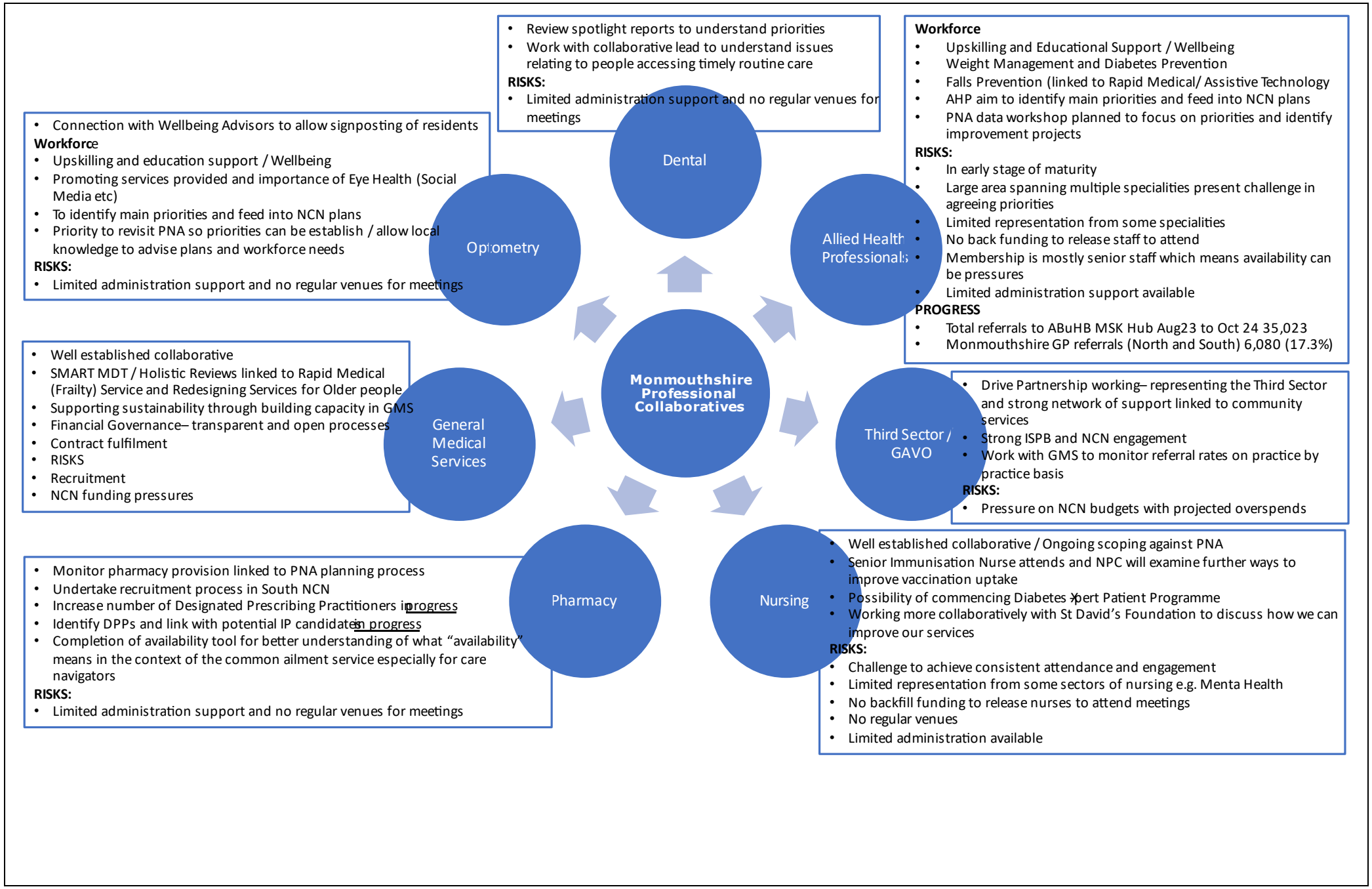
Integrated Wellbeing Network (IWN): The IWN helps us to build community resilience through our connections, by increasing our knowledge and understanding of the need for 'care navigation', or 'Link Advising', in Monmouthshire. Through our partnership networks we collaborate with the IWN to support the early intervention and prevention agenda. The IWN can pilot and evaluate new models of support via a cross-sector workforce e.g.; Community Conversations and Wellbeing Information Hubs. Engagement, influencing and feedback are useful tools, as are consultations and co-production workshops to help build local knowledge. Instrumental also in undertaking facilitation opportunities for cross-sector collaboration, plus advocating new approaches to commissioning to utilise local models of good practice.

NCN Priority: Building integrated neighbourhood teams in every 'place' (Linked to 1.1,1.2,3.3,4.3)

South Monmouthshire S.M.A.R.T.: **"**Working as a cluster ensures care is better co-ordinated to promote the wellbeing of individuals and communities**."** Introducing the South Monmouthshire Agile Response Team (S.M.A.R.T.) project, a programme of MDT meetings and 'holistic' reviews in GMS, helped to protect our most vulnerable older people by identifying as early as possible, any potential harm such as a risk of falling or other vulnerabilities that might need support to avoid a hospital attendance. The review process takes into account psychological, mental, physical and social factors, rather than just the symptoms of an illness, and identifies potential support etc. based on individual need from medical, social and third sector perspective.

North Expansion of the Rapid Medical Service: Following a successful 'Further, Faster Funding' bid, a programme of engagement took place to look at models of service (linked to the successful South Monmouthshire model), to be centred in the towns of Monmouth and Abergavenny. This is a key priority for the ISPB aimed at reducing demand on secondary care hospital admissions, and monitored accordingly.

Accelerated Cluster Development Programme: Place-Based Care as delivered by Professional Collaboratives and Clusters. Professional Collaboratives are the mechanisms by which, GMS practices, Dental practices, Community Pharmacies, Optometry practices, Community Nurses, Allied Health Professions and in Monmouthshire, the Third Sector (GAVO), come together across cluster footprints and towns, to identify local solutions together. **Figure 8** on the next page highlights the progress made to-date, regarding the ACD programme in Monmouthshire:


Monmouthshire Professional Collaboratives
Dental
Optometry
Allied Health Professionals
General Medical Services
Third Sector / GAVO
Pharmacy
Nursing
• Review spotlight reports to understand priorities
• Work with collaborative lead to understand issues relating to people accessing timely routine care
RISKS:
• Limited administration support and no regular venues for meetings
• Connection with Wellbeing Advisors to allow signposting of residents
Workforce
• Upskilling and education support / Wellbeing
• Promoting services provided and importance of Eye Health (Social Media etc)
• To identify main priorities and feed into NCN plans
• Priority to revisit PNA so priorities can be establish / allow local knowledge to advise plans and workforce needs
RISKS:
• Limited administration support and no regular venues for meetings
Workforce
• Upskilling and Educational Support / Wellbeing
• Weight Management and Diabetes Prevention
• Falls Prevention (linked to Rapid Medical/ Assistive Technology
• AHP aim to identify main priorities and feed into NCN plans
• PNA data workshop planned to focus on priorities and identify improvement projects
RISKS:
• In early stage of maturity
• Large area spanning multiple specialities present challenge in agreeing priorities
• Limited representation from some specialities
• No back funding to release staff to attend
• Membership is mostly senior staff which means availability can be pressures
• Limited administration support available
PROGRESS
• Total referrals to ABuHB MSK Hub Aug23 to Oct 24 35,023
• Monmouthshire GP referrals (North and South) 6,080 (17.3%)
• Well established collaborative
• SMART MDT / Holistic Reviews linked to Rapid Medical (Frailty) Service and Redesigning Services for Older people
• Supporting sustainability through building capacity in GMS
• Financial Governance– transparent and open processes
• Contract fulfilment
• RISKS
• Recruitment
• NCN funding pressures
• Drive Partnership working– representing the Third Sector and strong network of support linked to community services
• Strong ISPB and NCN engagement
• Work with GMS to monitor referral rates on practice by practice basis
RISKS:
• Pressure on NCN budgets with projected overspends
• Monitor pharmacy provision linked to PNA planning process
• Undertake recruitment process in South NCN
• Increase number of Designated Prescribing Practitioners in progress
• Identify DPPs and link with potential IP candidates in progress
• Completion of availability tool for better understanding of what "availability" means in the context of the common ailment service especially for care navigators
RISKS:
• Limited administration support and no regular venues for meetings
• Well established collaborative / Ongoing scoping against PNA
• Senior Immunisation Nurse attends and NPC will examine further ways to improve vaccination uptake
• Possibility of commencing Diabetes Expert Patient Programme
• Working more collaboratively with St David's Foundation to discuss how we can improve our services
RISKS:
• Challenge to achieve consistent attendance and engagement
• Limited representation from some sectors of nursing e.g. Menta Health
• No backfill funding to release nurses to attend meetings
• No regular venues
• Limited administration available

Key Achievements in 2024/25: Our 2024/25 plan focussed on the following 3 key priority areas:

NCN Priority 1: Building Resilient & Sustainable Services:

- **Continued investment in schemes linked to enhancing our Primary Care response, building capacity and resilience:**
- **Practice Based Pharmacists** (North) – creating GP capacity with localised expertise
- **Practice Manager lead role** (North & South) – co-ordination of both clusters, creating efficiencies and sharing good practice etc.
- **GP led Safeguarding Forum** (North & South) – shared expertise and knowledge across GMS
- **Wellbeing Link Advisor Service** (North & South) – responding to the social determinants of ill-health
- **Psychological Health Practitioners** (North) – localised access to mental health assessment/ support
- **Annual Winter Planning event:** Both NCN Clusters bring together primary, community, social services and third sector on an annual basis using NCN funds, to discuss and plan for anticipated service pressures, and the needs of our most vulnerable people. In 2024/25 we included our ACD Professional Collaborative Leads, GMS representatives (GPs and Practice Managers), Integrated Health and Social Care teams and GAVO.

Continued support to community/ place-based networking via Third Sector interventions:

- **Weekly Burst** – Information/ newsletter circulated by GAVO to a wide network of over 350 people and shared by NCNs also.
- **Wellbeing Link Advisor service -** Hosted and managed as a partnership between the NCNs and IWN.
- **Collaboration in Practice -** As above (ISPB, GAVO, NCNs, Wellbeing Network, Community Conversations) as part of an ISPB Project sub-group to make finance related recommendations to meet local needs and priorities.
- **Community Action Support Network -** Work closely to support new health and wellbeing initiatives coming from the community (e.g.; supporting the Rural Support Centre based at Raglan Livestock Market), identifying cost of living/Winter pressures – gaps picked up by the Wellbeing link Advisors.
- **ABUHB Nye's Community Champions -** Cascade information from the health board about services, pathways and opportunities for engagement.
- **Dementia Hub Steering Group -** To raise awareness at NCN level of regional priorities re the Welsh Government Dementia Standards and be informed by opportunities locally to reach people living with dementia and their carers e.g.; enabling the Dementia Hub to be within the Wellbeing Information Centre. MAS/Dementia Connector Workstream meetings.

NCN Priority 2: Accelerated Cluster Development (ACD) programme (Please refer to page 6)

- **ACD** programme embedded in 2024/25, post transition phase to ensure a more rapid implementation of the Primary Care Model for Wales with increased engagement from leads
- **ACD** programme Professional Collaboratives growing maturity strengthening clinical engagement at NCN meetings etc. increase influence from community/clusters to Regional Partnership Board) – strengthening the place-based approach to service delivery as a network
- **ACD** Spotlight reporting process helping to identify service risk and population need, raised awareness at cluster level also – support needed to bring all collaborative groups to the same level of maturity in 2025/26

NCN Priority 3: Delivering Care Closer to Home

- **Monmouthshire (South) Rapid Medical Service** encompassing the Community Resource Team (Care Closer to Home) being expanded in North Monmouthshire with Further, Faster Funding
- **Direct Admission Pathway (DAP)** work on-going via ISPB 'Whole-system' workstream
- **GP engagement** with community/secondary care service leads to discuss existing pathways and new initiatives – dedicated NCN lead role
- **South Monmouthshire Agile Response Transformation (S.M.A.R.T.):** MDT Pilot & holistic review projects evaluated well in 2024/25
- Development of Urgent Primary care / Out of Hours service / Rapid Access & Same Day Emergency Care Pathways monitored via the ISPB

Other Key Achievements in 2024/25:

- **Redesign of Services for Older People:** Well-documented in previous plans and noted above, linked to our integrated workforce and strategic context, designed to meet the needs of people living longer with a growing complexity of conditions. The expansion of the successful South Monmouthshire frailty service into the North continues to progress, and expected to further develop into 2025/26.

- **Immunisation uptake:** Influenza uptake data confirms that Monmouthshire GP practices, on a cluster average basis, performed excellently, especially when benchmarked against other Gwent NCN clusters, the Health Board (ABUHB), and Wales. The table below shows that performance against 2023-24 uptake was slightly down in the 2 to 3-year-old cohort in the South. Uptake was also less in the under 65 at risk, and over 65-year-old cohorts in both North and South NCN Clusters. We continue to strive to meet the 75% national target in all cohorts in 2025/26.

	North (22/23)	South (22/23)	North (23/24)	South (23/24)	Uptake
2 to 3 year olds	61.1%	72.4%	66.5%	67.4%	Both NCN Clusters had higher **average** uptake than ABUHB & Wales
Under 65 years at risk	56.9%	57.8%	51.8%	50.5%	
Over 65 year olds	83.2%	84.8%	82.6%	81%	

- Coronavirus: A key difference with COVID-19 vaccination rates in Monmouthshire is that they are delivered by GP practices and a Community Pharmacy. Delivery is focused around our most vulnerable older population, close to their homes in familiar environments and with access to people they are familiar with e.g.; practice receptionists who can help with access difficulties if required such as appointment times etc.

- An October 2024 snapshot of vaccinations confirmed Monmouthshire, at 47.6%, had the highest uptake in ABUHB with next highest Newport, at 23.8% and the Wales average at 21.7%. Monmouthshire also had the highest uptake in Care Home residents in ABUHB, at 78.8%.

- **Community Conversations:** 3 Community Conversations have now been introduced across Monmouthshire linked to an extensive Wellbeing Network facilitated by colleagues from GAVO. Although they are not actual drop-in 'Hubs', they do ensure that people delivering local services are well informed and link with people they meet, to appropriate support.

Key Challenges and Reflections from our 2024/25 Plan:

Figure 6 below highlights some of the key workstreams undertaken in 2024/25 and challenges faced.

Cluster development	• Progressing the Accelerated Cluster Development programme, understanding professional roles and pressures and responding to gaps in service via focussed reporting. Continued uncertainty around the permanency of program, which has contributed significantly to providing a relatively stable collaborative position going forward.
Sustainability & resilience	• A generally improved position on last year, measured via contract meetings and workshops with recovery from the pandemic and previous skills deficits reduced. GMS risk is monitored via the ABUHB escalation process. • Continued pressure on primary and community services from increased population and new housing developments acknowledged. • In terms of financial risk, uncertainty remains due to the Government's increase in National Insurance contributions in 2024/25 – regular discussions held at Cluster contract meetings to monitor the impact. • All projects receiving NCN Cluster funding could potentially be at risk due to the impact of agenda for change pay awards on cluster budgets – increased scrutiny of spend as part of the evaluation process should lead to improved prioritisation processes.
Cost of living pressures	• Continued impact on people's mental health & wellbeing has led to a growing demand for support locally, measured via our jointly funded Wellbeing Link Advisors and Psychological Health Practitioners. Data tell us that the number of contacts for the WLA service has more than doubled in the last 12 months meaning an increased impact from rising costs on people in Monmouthshire.

Key Challenges for delivering our 2025/26 Plan:

Workforce capacity	• Uncertainty around increasing local populations vs potential inability to recruit clinical staff due to Government Policy (National Insurance) – with impact on service delivery in GMS, in parts of Monmouthshire.
Finance	• Pay awards being absorbed into NCN budgets – increased scrutiny of project value and success needed, risk of established services being de-commissioned. • Lack of available finance for new service developments, initiatives and opportunities aimed at reducing pressure.
Accelerated Cluster Development	• Potential fragility around some collaboratives and capacity to mature at the same rate as others – lack of incentive/ contractual recognition/ administrative support/ often senior representation with conflicting priorities (especially Allied Health Professionals).

NCN Cluster Costed Action Plan 2025/26:

Each year, NCN Clusters across Wales are required to produce annual costed plans, aligned with Health Board Integrated Mid-Term Plans (IMTP). The table below details how Monmouthshire NCN Cluster investment aligns with all Priorities and Areas of Focus for 2025/26.

2025/26 Monmouthshire NCN Cluster Costed Action Plan

Title	New or Existing	Brief description	Results/ benefits expected by end of March 2026	Strategic alignment	Alignment to NCN Focus & Priorities (where relevant)						Budget	Funding source(s)	Current status	Comment
					Areas of Focus									
Building resilience	Existing	Continued develop-ment of place-based delivery of care, focused on what matters to them.	Partnerships build community resilience / Community assets align with local need across all 'Places'.	ABUHB, SPPC, AHW, RPB, ISPB, PBCC 1,2,3,4,5	1.1	1.2	3.3	4.1	4.3	4.4	£0	N/A	ISPB/ NCN priority	On-going
Accelerated Cluster Develop-ment	Existing	Professional Collaboratives	Increased maturity & equity across all PC	ABUHB, SPPC, AHW, RPB, ISPB, PBCC 1,2,3,4,5	1.1	1.2	3.3	4.1	4.3	4.4	£0	NCN/WG	On-going	On-going
	Existing	First Contact Physio to release GP time (Fixed Term Contract)	Equity of cluster access, Increased GP capacity (Ref. Rates)	SPPC, AHW, RPB, ISPB, PBCC 1,2,3,4,5	1.1		3.3				£62,559	South	SLA	Positive 2024/25 review
	Existing	First Contact Physio to release GP time (Caldicot M/C SLA)	Service Level Agreement = equity of cluster access	SPPC, AHW, RPB, ISPB, PBCC 1,2,3,4,5	1.1		3.3				£32,600	South	80% Reimburs ement	Positive 2024/25 review
	Existing	Practice Based Pharmacy to release GP time	Equity of access, Increased GP capacity	SPPC, AHW, RPB, ISPB, PBCC 1,2,3,4	1.1		3.3				£233,424	North	Funded	Positive 2024/25 review
	Existing	Protected learning time (GMS)	Shared Learning, Collaborative business monitoring tool	SPPC, AHW, PBCC 1,2,3,4	1.1		3.3				£4,500	South	£ risk	Annual Review
	Existing	Digital innovation/ increased efficiencies	Increased efficiency in business functions	SPPC, AHW, PBCC 1,2,3,4	1.1	1.2	3.3		4.3		£18,602	South	£ risk	Annual Review
	Existing	Practice Manager lead-role to co-ordinate efficiency & learning	Efficiencies in business functions evidenced	SPPC, AHW, ISPB, PBCC 1,2,3,4	1.1	1.2	3.3	4.1	4.3	4.4	£8,950	North & South	SLA	Annual Review

	Existing	GP led Safeguarding role to share expertise	Shared Learning, Cluster level leadership	SPPC, AHW, ISPB, PBCC 1,2,3,4	**1.1**	**1.2**	3.3		**4.3**		£8,696	North & South	SLA	Aspects of MDT/ scrutiny
	Existing	Independent Advisor support (Top sliced)	Professional advisory role	SPPC, AHW							£3,777	North & South	Top sliced	Annual scrutiny
	Existing	Continued promotion of borough to support workforce recruitment & retention	Public facing media demonstrates positive aspects of living & working in Monmouthshire	SPPC, AHW, RPB, ISPB, PBCC 1,2,3,4	1.1	1.2					£0	N/A	Place based care agenda	High level planning
	Existing	ACD development – band 6 S.I.M. support role	Co-ordination of professional collaborative meetings	WG, SPPC, AHW, ISPB, PBCC 1,2,3,4	1.1	1.2	3.3	4.1	4.3		£0	WG	Second-ment	Supports delivery
Integrated Neigh-bourhood Teams	Existing	Monmouthshire S.M.A.R.T. MDT & Holistic 'Frailty' Review project	Identifies & supports most vulnerable using Electronic Frailty Index Tool with Emis-Web data capture	RPB, SPPC, AHW, ISPB, RSfOP, PBCC 1,2,3,4,5	1.1	1.2	3.3	4.1	4.3	4.4	£81,750	South	£ risk	Potential cost savings
	New	S.M.A.R.T. MDT administrative resource	Data capture to evidence effectiveness of service	RPB, SPPC, AHW, ISPB, RSfOP, PBCC 1,2,3,4,5	1.1	1.2	3.3	4.1	4.3	4.4	£5,212	South	£ risk	In progress
Accelerated Cluster Develop-ment	Existing	Psychological Health Practitioners provide local Mental Health support	Providing local access to help locally, Increased GP capacity	RPB, SPPC, AHW, MH Strategy, ISPB, PBCC 1,2,3,4	1.1	1.2	3.3		4.3		£54,807	North	Funded	Annual Review
Integrated Neigh-bourhood Teams	Existing	Wellbeing Link Advisors offering help & support in local communities	Provide support to people experiencing social determinants of ill-health	RPB, SPPC, AHW, WBoFGA (2015), ISPB, PBCC 1,2,3,4	1.1	1.2	3.3	4.1	4.3		£44,000	North & South / IWN	Capped SLA	Annual Review
	Existing	Community hospital-based Phlebotomy service	Care closer to home avoiding long journeys For treatment	RPB, SPPC, AHW, ISPB, PBCC 1,2,3,4,5	1.1	1.2					£6,248	South	SLA	Annual Review
	Existing	Vulnerable/ Housebound Phlebotomy in District Nursing	Provision in the home to avoid long/ difficult journeys	RPB, SPPC, AHW, ISPB, PBCC 1,2,3,4,5	1.1		3.3				£23,465	North & South	Top sliced	Annual Review

	Existing	Influenza immunisation programme – public health impact	IVOR surveillance data benchmarking on local & national level Protects most vulnerable	RPB, SPPC, AHW, ISPB, PBCC 1,2,3,4	1.1	1.2	3.3		4.3		£0	North & South	Seasonal planning	High achieving clusters
Integrated Neigh-bourhood Teams	Existing	Multi-agency Winter Planning event	Annual meeting to inform local plans with increased shared understanding of seasonal pressures.	RPB, SPPC, AHW, ISPB, PBCC 1,2,3,4,5	1.1	1.2	3.3	4.1	4.3	4.4	£1,000	South	£ risk	-
Accelerated Cluster Develop-ment	Existing	Expenses to support delivery e.g.; IT	As above	N/A	1.1	1.2	3.3				£2,000	North & South	£ risk	-
Health Protection Services	New	Seek to develop high quality range of supplementary /enhanced services	Map/ survey of service provision identifies gaps £ focus areas	Prevention & Wellbeing						4.4	£0	North & South	N/A	-
Wish list:	*New*	*Phlebotomy service extension beyond fixed term*	*Care closer to home avoiding long journeys For treatment*	*RPB, SPPC, AHW, ISPB, PBCC 1,2,3,4,5*	*1.1*	*1.2*					*£6,248*	*North / Second-ary Care*	*No £ beyond 31.03.25*	*In planning phase*
	Existing	*Extension of ACD S.I.M. role beyond seconded period*	*Co-ordination of professional collaborative meetings*	*WG, SPPC, AHW, ISPB, PBCC 1,2,3,4*	*1.1*	*1.2*	3.3	*4.1*	*4.3*		*£0*	*WG*	*Second-ment*	*Supports delivery*

Key:

- ***SPPC:*** *Strategic Programme for Primary Care e.g.; Empowering People, Providing Care Closer to Home, Local Integrated Care*
- ***PBCC:*** *Placed Based Care Areas of Focus: 1. Building resilient communities, 2. Creating solid foundations across primary care and community services, 3. Building integrated teams in every "place", 4. Working collaboratively on prevention programmes and enhanced services, 5. Enhancing intermediate care and secondary care interface*
- ***RPB:*** *Regional Partnership Board 3 overarching aims: Start Well, Live Well, Stay Well*
- ***ISPB:*** *Integrated Services Partnership Board priorities*
- ***PCMfW / AHW:*** *Primary Care Model for Wales / A Healthier Wales*
- ***RSfOP:*** *Redesigning Services for Older and/or Frail People*

Appendix 1: The Monmouthshire Plan on a Page

Monmouthshire North and South NCN Clusters – Plan on a Page 2025/26

Our Key Priorities & Focus Areas:

1. Building resilient communities
2. Creating solid foundations across core primary care and community services
3. Building integrated neighbourhood teams in every "place" (circa 10,000 to 20,000)
4. Working collaboratively on prevention programmes and enhanced services
5. Intermediate care and secondary care interface

key action linked to the 5 key Areas of Focus:

Area of Focus 1: *Enabled by a strong integrated network approach to delivering place-based care in Monmouthshire, facilitated by joint NCN and Public Health Team funded, Wellbeing Link Advisors – reinforcing relationships across statutory and non-statutory agencies*

Area of Focus 2: *Enabled by professional collaboratives in Monmouthshire for GMS, Optometry, Nursing and Third Sector*

Area of Focus 3: *Enabled by the South Monmouthshire 'S.M.A.R.T.' project to identify the most frail/ elderly people and agree support across the MDT;*

Enabled by the expansion of the Rapid Medical (Frailty) model into North Monmouthshire via R.I.F funding)

Area of Focus 4: *Enabled by Expert Patient Programme delivery self-care/ diabetes prevention;*

Enabled via the Wellbeing Link Advisor service, hosted by GAVO underpinned by co-production principles, learning from what matters most to people in Monmouthshire via the Integrate Wellbeing Network Enabled by local cluster level discussions and monitoring of enhanced service provision in conjunction with the contracting team;

Linked to on-going project work around gap-analysis etc.

Area of Focus 5: *Enabled by the Integrated Services Partnership Board Integrated Medium Term Plan (IMTP)*

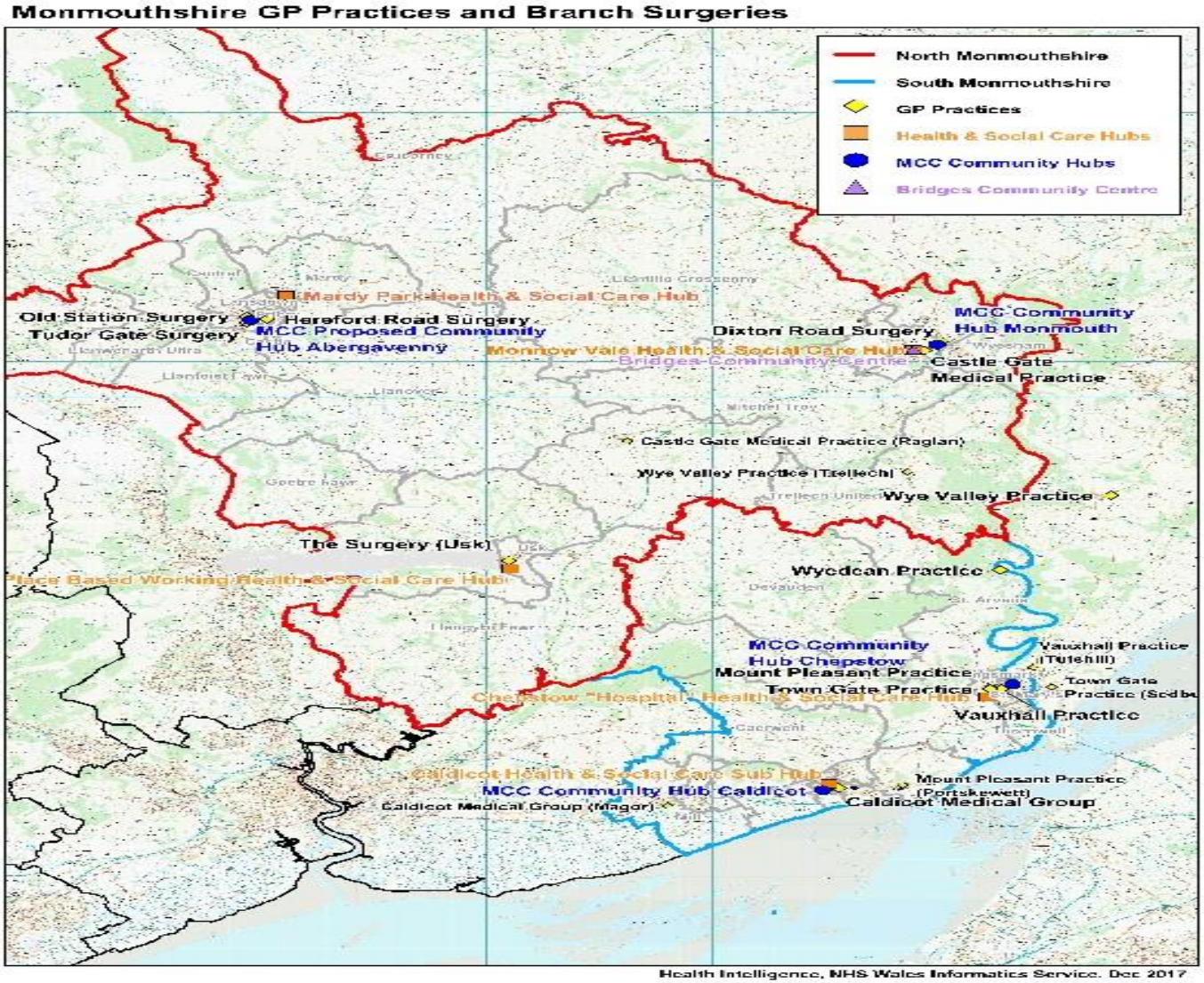
"Enablers"

- Technology
- Co-production principles
- Strong Partnerships
- Prudent financial planning

How will we know if we have made a difference?

Progress monitored via Divisional Assurance meetings, Cluster self-reflection, Integrated Services Partnership Board reporting

Appendix 2: Integrated 'Places' / Wellbeing Network across 5 key Towns in Monmouthshire:



Appendix 3: Key Priorities, Areas of Focus and Sub-categories being taken forward in 2025/26:

Place-Based Priorities		Areas of Focus
1	**Building resilient communities**	***1.1*** *To align the work of NCNs and Integrated Wellbeing Networks to develop a more community orientated model of primary care through a deeper understanding of the community assets and local needs within the population, particularly for socially vulnerable or marginalised groups.* ***1.2*** *To ensure NCNs have a good understanding of Integrated Wellbeing Networks in order to utilise community assets such as community groups and voluntary organisations that help people maintain or develop social support networks.*
3	**Building integrated neighbourhood teams in every "place"**	***3.3*** *To establish MDT working for people who have greater complexity and are most at risk of deterioration and adverse events such as hospitalisation. This MDT approach will require care coordination and committed involvement of reablement workers, specialist nursing teams, clinical pharmacists, CMHT, social workers, occupational therapists, housing and third sector organisations*
4	**Working collaboratively on prevention programmes and enhanced services**	***4.1*** *To facilitate a collaborative approach in the delivery of diabetes prevention and CVD risk factor management to ensure that these programmes can be delivered systematically and at scale across NCNs.* ***4.3*** *To co-produce a 'social prescribing' model that connects people to activities, groups, and services in their community which can address their practical, social and emotional needs.* ***4.4*** *To establish high quality and equitable provision of supplementary/enhanced service across each NCN with an initial focus on IUD, minor surgery, substance misuse, homelessness and asylum seeker and refugees.*
2	*Not taken forward in 2025/26*	*Creating solid foundations across primary care and community services*
5	*Not taken forward in 2025/26*	*Intermediate care and secondary care interface*

Appendix 4: NCN Cluster Finance

Monmouthshire NCN Clusters Spend Forecasts 2025/26 (Includes 3% assumed uplift for NHS Agenda for Change)				
	North NCN		South NCN	
Project / Role / Item	**WTE**	**Total**	**WTE**	**Total**
Practice Based Pharmacy	3.0	£233,424	-	-
Practice Based Physiotherapy (Post & SLA)	-	-	1.0+	£95,159
Psychological Health Practitioners	1.2	£54,807	-	-
Phlebotomy - Community Hospital	-	-	0.2	£6,248
Phlebotomy – District Nursing	1.5	£10,164	2.0	£13,301
Practice Based Wellbeing Link Advisors (match £)	1.0	£22,000	1.0	£22,000
Digital solutions in GMS	-	£0	-	£19,500
Lead Practice Manager	0.5	£4,474	0.5	£4,474
GP Led Safeguarding Forum	0.5	£4,347	0.5	£4,347
Independent Contracting Advisors	-	£2,084	-	£1,693
MDT Winter Planning meeting	-	£0		£1,000
GMS Protected Learning Time	-	£0	-	£4,500
GMS Holistic Reviews	-	-	-	£51,750
GMS/ Community MDT – S.M.A.R.T.	-	-	-	£30,000
GMS/ Community MDT – S.M.A.R.T. Administrative resource	-	-	0.2	£5,212
Pay Award Contingency		£1,000		£1,000
Annual Budget		**£331,386**		**£260,406**
Forecast expenditure		**£332,300**		**£254,972**
Underspend		**£0**		**£222**
Overspend		**-£914**		**£0**

In the Autumn of 2024/25, NCN Cluster budgets faced increasing pressure when NHS Agenda for Change Pay Awards were announced. In the development of each new plan, we are required to demonstrate that we can achieve a financial breakeven position. For the first time, this new pressure means we are unable to offer definitive assurance of this, but will strive to work together to find efficiencies and ensure value for money by working at scale where possible, and ensuring we employ robust scrutiny of our funded projects.

Newport Neighbourhood Care Network (NCN) Annual Plan 2025-26

Cluster Annual Plan 2025-2026

Cluster Executive Summary:

A Healthier Wales remains the overarching policy context for health and social care and drives our commitments to deliver seamless, place-based care. Newport NCN has developed its plans to align with the ministerial focus on improving population health as the mechanism to deliver health equity, learning from the pandemic and addressing the impact of issues such as obesity and poor mental health on people's health and well-being outcomes.

Gwent Regional Partnership Board (RPB)

These decisions will then feed into the Gwent Regional Partnership Board (RPB) which supports the five Gwent local authorities and ABUHB. It is responsible for the integration of services to support older people with complex needs and long-term conditions, people with learning disabilities, carers (including young carers), integrated family support services and supporting children with complex needs. It is envisaged that funding streams will be made available to support the successful business cases from the RPB to support the identified population needs. The Gwent RPB includes the five Gwent local authorities and ABUHB. Through common goal sharing, shared resource, knowledge and expertise it underpins the model of partnership working and service delivery within the Newport NCN.

Newport Integrated Network

Integrated Services Partnership Boards or Pan Cluster Planning Groups (PCPGs) as they are known in the ACD Programme, allow partner representatives to work together on strategic, long-term plans, to agree and develop priorities linked to the delivery of the Social Services & Well-being and Wellbeing of Future Generations Acts, the Strategic Programme for Primary Care, and A Healthier Wales. The ISPB is a sub-group of the RPB and is a conduit for information sharing and decision making between frontline services and the ISPB (Please see explanatory table below):

ISPB objectives:	← Solutions, Improvement, Change →		← Intelligence for priorities & decisionomaking →	ISPB priorities:
• Provide local delivery of RPB priorities • Coordinate available resources to meet need • Provide strategic direction • Support partnership working • Ensure plans reflect population need		Gwent RPB ↕ ISPB ↕ Collaborative (NCN) Clusters ↕ Professional Collaboratives		• Third Sector as full partner • Integrated workforce for the future • Place Based Working • Redesigning services for older people • Ensure fit for purpose estate • Enhanced Financial scrutiny

About Newport

Newport is a multi-cultural city, with a population of 164,702 (as per GP registered individuals), this exceeds the projected population data from Stats Wales by 5 years, it was anticipated that this figure would not be met until 2028.

- Newport has the second highest proportion of population from Black, Asian and Minority Ethnic backgrounds in Wales, with 48 different languages spoken amongst 20 identified communities.
- It has been identified that there are 2340 households within Newport that do not speak English or Welsh as a main language.
- Newport has an ageing population, with a current over 65 years population of 27,510.
- Estimated ageing population projection to 37,241 by 2039
- The recent Ukraine settlement has further impacted upon these figures.
- The registered number of rough sleepers within the city has risen from 21 in January 2021 to 47 in January 2023.
- Newport City Council have also recently announced that there are approximately 9000 individuals on the social housing waiting lists.
- Certain neighbourhoods are disproportionately affected by unemployment, low incomes, poor skill levels and crime and anti-social behaviour. According to Stats Wales data Pillgwenlly within the West ranks as number 10 in Wales most deprived areas and the Ringland area within the East is ranked as 69th.
- The population needs analysis is a data set that outlines the health needs within the city, as below:

Indicator	Indicator	Newport		Indicator	Indicator	Newport	
		East	West			East	West
	Smoking prevalence	18.70%		Mental Health Services	Initial assessments by Primary Care Mental Health Services (per 10,000 GP registered Population)	119	151
	% of adults who reported being overweight or obese	62%			Percentage of MH assessments undertaken within 28 days of referral	85.10%	83.70%
Immunisations	Influenza immunisation rates - over 65s	79.60%	78.20%		Percentage of MH interventions started within 28 days of assessment	49.80%	52.70%
	Influenza immunisation rates - under 65 at risk groups	53.80%	51.10%		Referrals to Child & Adolescent Psychology (per 10,000 GP registered Population)	62	68
	Influenza immunisation rates - 2 - 3-year-olds	50.80%	42.10%	Care Homes	Conveyances to ABUHB Hospital (ED/MAU) from Care Homes (per 10,000 GP registered Population)	26	50
	Childhood Immunisation - MMR1 (Age 2yrs)	89.80%	93.60%		Emergency Admissions to ABUHB Hospital from Care Homes (per 10,000 GP registered Population)	16	28
	Childhood Immunisation - PCVf (Age 2yrs)	88.60%	92.70%	Admissions	Admissions to ABUHB hospital (Elective) (per 10,000 GP registered Population)	106	101

Cluster Annual Plan 2025-2026

	Childhood Immunisation - Hib/MenC (Age 2yrs)	88.60%	95.10%		Admissions to ABUHB hospital (Emergency) (per 10,000 GP registered Population)	546	585
	Childhood Immunisation - MMR2 (Age 5yrs)	86.60%	88.40%		Occupied bed days in ABUHB hospital (per 10,000 GP registered Population)	8,039	8,884
	Childhood Immunisation - PreSchool Booster (Age 5yrs)	84.70%	90.70%		Ambulatory - sensitive admissions (based on ICD-10 coding) (per 10,000 GP registered Population)	123	129
	Childhood Immunisation - MMR1 (Age 16yrs)	92.50%	94.70%	Hospital Discharges	Bed days lost awaiting Social Worker Allocation/Assessment (per 10,000 GP registered Population)	14,440	12,052
	Childhood Immunisation - MMR2 (Age 16yrs)	89.20%	89.70%		Bed days lost awaiting OT/Physio Assessment (per 10,000 GP registered Population)	3,191	3,609
	Childhood Immunisation - PreTeen Booster (Age 16yrs)	69.80%	71.90%		Bed days lost awaiting MDT (per 10,000 GP registered Population)	1,330	1,726
Cancer Detection	GP Referrals for Suspected Cancer (per 10,000 GP registered Population)	5,836	6,116		Bed days lost awaiting Dom Care (per 10,000 GP registered Population)	7,700	6,371
	GP Referrals for Suspected Cancer - Conversion (per 10,000 GP registered Population)	624	563		Bed days lost awaiting Reablement (per 10,000 GP registered Population)	8,000	5,502
	GP Suspected Cancer Conversion Rate	10.70%	9.20%		Bed days lost awaiting Care Home (per 10,000 GP registered Population)	7,399	7,162
	Uptake of AAA Screening Programme	61.70%	64.60%		Number of discharges from (ABUHB) hospitals (per 10,000 GP registered Population)	818	879
	Uptake of Bowel Screening Programme	63.20%	60.90%		Number of discharges from (ABUHB) hospitals to usual place of residence (per 10,000 GP registered Population)	3,500	3,768
	Uptake of Breast Screening Programme	67.00%	63.40%		Proportion of discharges (ABUHB) home to usual place of residence (per 10,000 GP registered Population 65yrs+)	87.70%	87.80%
	Uptake of Cervical Screening Programme	65.30%	63.60%	Sustainability	Substantive GPs (per 10,000 GP registered Population)	3.6	3.7
Disease Registers (per 10,000 GP registered Population)	Asthma (per 10,000 GP registered Population)	665	676		Substantive National Extended Roles (NERs) (per 10,000 GP registered Population)	7.3	13.7
	Atrial fibrillation (per 10,000 GP registered Population)	184	182		*District Nursing Staff in post (WTE)*	*61.99*	
	Chronic obstructive pulmonary disease (per 10,000 GP registered Population)	177	202		Patients on caseload per District Nursing WTE	18	
	Cancer (per 10,000 GP registered Population)	261	263		District Nursing Patient contacts (per 10,000 GP registered Population)	6,346	
	Coronary heart disease (per 10,000 GP registered Population)	301	304		Patient contacts per District Nursing WTE	122	
	Dementia (per 10,000 GP registered Population)	51	70	Long Term Conditions Management	Compliance with 8 care processes for Diabetes	27.90%	26.20%
	Depression/Mental Health (per 10,000 GP registered Population)	86	114		Compliance with treatment targets for Diabetes care	16.20%	17.40%
	Diabetes patients aged 17+ (per 10,000 GP registered Population)	592	622		New diabetic patients receiving structured education	25.30%	42.60%
	Epilepsy ages 18+ (per 10,000 GP registered Population)	71	72		COPD patients who have had a strucuted review in the preceding 15 months (QAIF / COPD003)	65	71
	Heart failure (per 10,000 GP registered Population)	78	82				
	Hypertension (per 10,000 GP registered Population)	1,349	1,430				
	Learning disability (per 10,000 GP registered Population)	40	46				
	Obesity (per 10,000 GP registered Population)	742	848				

Newport is established around 2 Neighbourhood Care Networks (NCNs), East and West, which work collaboratively to strive to improve primary care and community services within the local area.

- Newport East NCN Lead - Dr Graeme Yule, GP Partner at St Julians Medical Centre and Clinician within the COTE service reset.
- Newport East has a population of approximately 80,754 residents. There are 9 GP practices within the area with varying states of deprivation and affluency. There are also 7 Dental practices, 7 Optometrists and 15 Community Pharmacies within the area

- Newport West NCN is led by Dr Susan Thomas, Advanced Nurse Practitioner at Wellspring Medical Practice.
- The Newport West NCN is comprised of 6 main practices and 3 branch surgeries which together have a combined registered population of 83,948. There are also 9 optometrists, 5 dental practices and 12 Community pharmacies situated within Newport West NCN.

Cluster Annual Plan 2025-2026

Demand for healthcare is ever growing and will continue to grow, as evidenced by the population growth and the population needs assessment. The population needs assessment allows us to assess the local health needs which in turn enables us to determine who our population are, what are our aims, who else needs to be involved, what resources are needed and what are the risks? Following this we are then able to assess what the health priorities are and which to prioritise. This then allows the NCN priorities to be set, a plan formulated and funding/actions allocated.

The top 3 NCN priorities are:

- **Building Resilient Communities**

Creating place-based care models and preventative approaches to service delivery in order to help improve the resilience of local communities.
Place-based care is a method of delivering care that focuses on the resources available in a specific area to improve health and reduce health inequalities via:

Collaboration	**Targeted interventions**
Shared resources	**Efficient use of resources**
Local design	

Place-based care can lead to positive outcomes, such as: fewer visits to accident and emergency, reduced waiting times for health assessments, higher satisfaction with the support received, and improved value for money.

Building resilient communities involves developing the capacity of individuals and communities to respond to emergencies and other challenges. Some strategies for building resilience include:

Empowering communities:	**Developing social networks**:
Improving access to services:	**Supporting mental health**:
Involving vulnerable groups:	**Learning new things**:
Improving employment skills:	**Being aware of biases**:

- **Sustainability**

To continue to strive to create a sustainable health and social care workforce that will be able to meet the needs of the population in the immediate term and for the foreseeable future. Continue to support and fund statutory and non-statutory services, to reduce the impact on GP time for example:

Psychological Health Practitioners
NCN Practice Base Pharmacists
Link Workers

- **Accelerated Cluster Development**

Professional Collaboratives (PCs) are networks of professionals with common expertise and skills who work collectively to assess the needs of the population.

The priority for the Newport Collaboratives will be:

- Develop and become empowered within their dedicated areas of expertise to map local service provision, recognise gaps and develop against needs.
- Continue to identify and undertake local improvement projects that can improve patient services.
- Engage with the NCN in regards to proposed projects and solutions.

Key Achievements:

Sustainability

Extended Roles

- Ongoing NCN funding for extended roles such as Practice Based Pharmacists and Psychological Health Practitioners to increase GP's capacity.

Access

- Continue to fund Accurx within Newport West.

Building Resilient Communities

Place Based Care

The Newport place-based care model continues to develop at pace, to deliver sustainable and accessible local health care and preventative services for individuals and communities in Newport. To achieve the 2025 placed based care vision, two thematic workstreams have been prioritised which are aimed at improving the health, wellbeing, experience and the resilience of individuals and communities living in Newport by accessing the right support to meet their specific needs, in the right location at the right time.

Total (East & West)	**APRIL-SEPT 2024**
Number of individuals who have been supported through PLACE BASED CARE	1347

19 Hills Health & Wellbeing Centre

The £28million health and wellbeing development is due for handover to the health board on 28th November 2024. There will be a phased approach to services being provided from the building between January and March 2025. The services that will be available are:

Ringland Medical Practice	**District Nursing**
Park Surgery	**Audiology**
Community Dental Services	**Memory Assessment**
General Dental Services	**CAMHS**
Mental Health Support Services	**Dietetics**
Podiatry	**Weight Management**
Speech and Language	**Looked After Children**
Health Visiting	**Paediatric Recovery from Illness**
School Nursing	**Adferiad**
Sexual Health	**District Nursing**
Lymphedema	**Community Liver Clinic**
Child and Family Psychology	**Community Wellbeing groups**

The aim of the centre is to:

- Ensure healthcare services are provided from high quality, fit for purpose buildings
- Bring healthcare professionals, third sector and other providers under one roof to ensure, a coordinated approach to health and wellbeing.

Aneurin Bevan University Health Board, together with Newport City Council and our third sector partners, the Health and Wellbeing Centre will form part of a vibrant community hub which will be available to Newport East residents.

Early Intervention & Prevention

- Funding was made available to Newport City Council in regards to increasing monies available to a Participatory Budgeting event in which the focus of the event is to encourage individuals and community groups to apply for a share of funding in line with specific themes set by the Participatory Budgeting Steering Group. To define the areas of assistance the theme of the event was as follows:
  Young people's Emotional Wellbeing, Women's Emotional Wellbeing and Loneliness/Social Isolation. 37 community projects presented at the voting event, and 200 people voted. 22 community organisations were awarded funding for 29 projects. Each project was allocated up to £5,000 dependent on their bid.

	• Development and rollout of access to MoveBetterGwent website for access to high quality information on bone, muscle and joint concerns to support prevention and self-management. Access to request for help virtually or by telephone for people across Newport to Therapies services to help with musculoskeletal conditions. This website has identified links with Newport wellbeing network information and infrastructure.
	Integrated Wellbeing Network (IWN) • The NCN has continued to develop strong working relationships and connectivity between with Newport Integrated Wellbeing Network (IWN). Work has continued to in order to extend the IWN's place-based approach across community wellbeing and integrated social care and health services through enhanced links with MDT teams in Newport. As a result of collaborative engagement funding was allocated to 'Kid Care 4 U which is a registered charity that aims to support families to acquire the skills and confidence they need to turn their potential into success at school, the workplace and beyond. The organisation believes it has potential to help ethnic minority communities in deprived areas to further develop themselves in Education, Health, Employment and Integration.
	Social Prescribing • Building on the principles outlined in the Primary Care Model for Wales and the quadruple aims of "A Healthier Wales", Newport NCN continues to work collaboratively with Primary, Community, Social Care, third sector and external providers to maximise all opportunities to achieve place based seamless multi-professional and/or cross sector responses as close to home as possible for individuals to avoid crisis and escalation of their care needs, where feasible. The role of a community connector has been identified as a link role that will be employed by Newport City Council and will sit within the Information, Advice and Assistance service (IAA). They provide face to face appointments and will deliver a person-centred approach to empower patients to recognise their own needs, strengths and personal assets. The community connector will also act as the conduit in connecting patients with their own communities for support with their personal health and wellbeing. A social prescribing pilot has commenced in Newport East, Ringland Practice and in only two weeks twenty-one referrals have been received so far**.** Every patient referred has engaged with the allocated Community Connector who has provided person centred support to meet individual needs. • The creation of a newsletter targeted at General Practitioner's in relation to information around Place Based Care & Integrated Wellbeing Network.
	In-House Weight Management • The District Nursing service and National Exercise Referral Scheme worked in collaboration to identify housebound bariatric patients that would benefit from light exercise sessions within their own home in an attempt to reduce Body Mass Index (BMI).
Communication & Engagement	**Community Engagement – Health Fayres** • The NCN provided support and funding for equipment in relation to Public Health 'Health Fayres' that were held 4 times throughout a 12-month period. All events were held within Mosques and community venues in order to engage with communities that recorded lower uptake in vaccinations and screening. The main focus of the events was: • Coronary vascular disease • Hepatitis screening and advice, • General health advice, • Flu & Covid 19 adult vaccinations, • Childhood immunisations & vaccinations information, • Population screening advice •

Cluster Annual Plan 2025-2026

Challenges & Risks

Sustainability	**Retention** • The appointment and retention of professional collaborative leads within Optometry, Community Pharmacists and Dental is challenging.
	Workforce • Ageing workforce profiles and recruitment challenges within General Medical Services. • Need to consider integrated job plans for AHP roles to improve applications into cluster opportunities and retention of staff • Lack of clarity in description of roles and responsibilities between professional teams potentially limiting applicants
	Estate • Estate and space availability impacting upon the ability to expand services.
	Contracts • The inability to permanently employ to the Place Based Care teams due to RIF funding uncertainties and the risk of Place Based Care team members seeking permanent employment contracts elsewhere.
Building Resilient Communities	**Participation** • Practices not continuing with the Place Based Care multi-disciplinary team (MDT) process if funding is removed.
	Availability • The ability of the extended members of the MDT having capacity to attend weekly meetings.
	Engagement • To effectively engage with the wider community to provide an understanding of health and wellbeing services available to them. Some ethnic communities are historically hard due to cultural behaviours.
	Chronic Conditions • The PNA data indicates that despite efforts to engage with communities, the population has higher rates of particular chronic conditions such as Diabetes. Suspected Cancer Conversion Rates within Newport have been identified as low. • The Diabetes prevention programme (DPP) funding ends at end March 2025, funding has been secured until March 2026 for the program but no identified funding long term.
	Vaccination Uptake • Uptake within particular age cohorts and communities is also a cause for concern, with no cohort meeting the target level. (See Appendix 2)
	In-House Weight Management • The service has halted due to the health complexity of some of the housebound patients on the District Nurse patient list referred to National Exercise Referral Scheme. New patient criteria to be scoped • No integration with Health Board weight management services to support diet and lifestyle advice to support weight loss
Accelerated Cluster Development	**Collaborative Engagement** • The collaboratives are still in the early stages of maturity. • There is limited representation within the locality areas due to work pressures and availability to participate in meetings and projects. • Attendance at meetings is non mandatory so is reliant on individual buy-in for the process. • Winter pressures and the roll out of the flu vaccination process will exacerbate this over the next few months. • Limited NCN funding will also impact on the ability to undertake any new initiatives over the next financial year. • Dispensing compensation issues are yet to be resolved within Pharmacy.
Finance	**Pay Uplifts** • Recent increases in staff pay uplifts of 5.5% has had a significant effect upon the budget due to the number of staff employed within the NCN. The impact is that the NCN budgets will now commence the next financial year in an overspend position. There is now a challenge to balance the NCN budgets in a bid to reduce the overspend. The following table highlights the staff groups within the Place Based Care team.

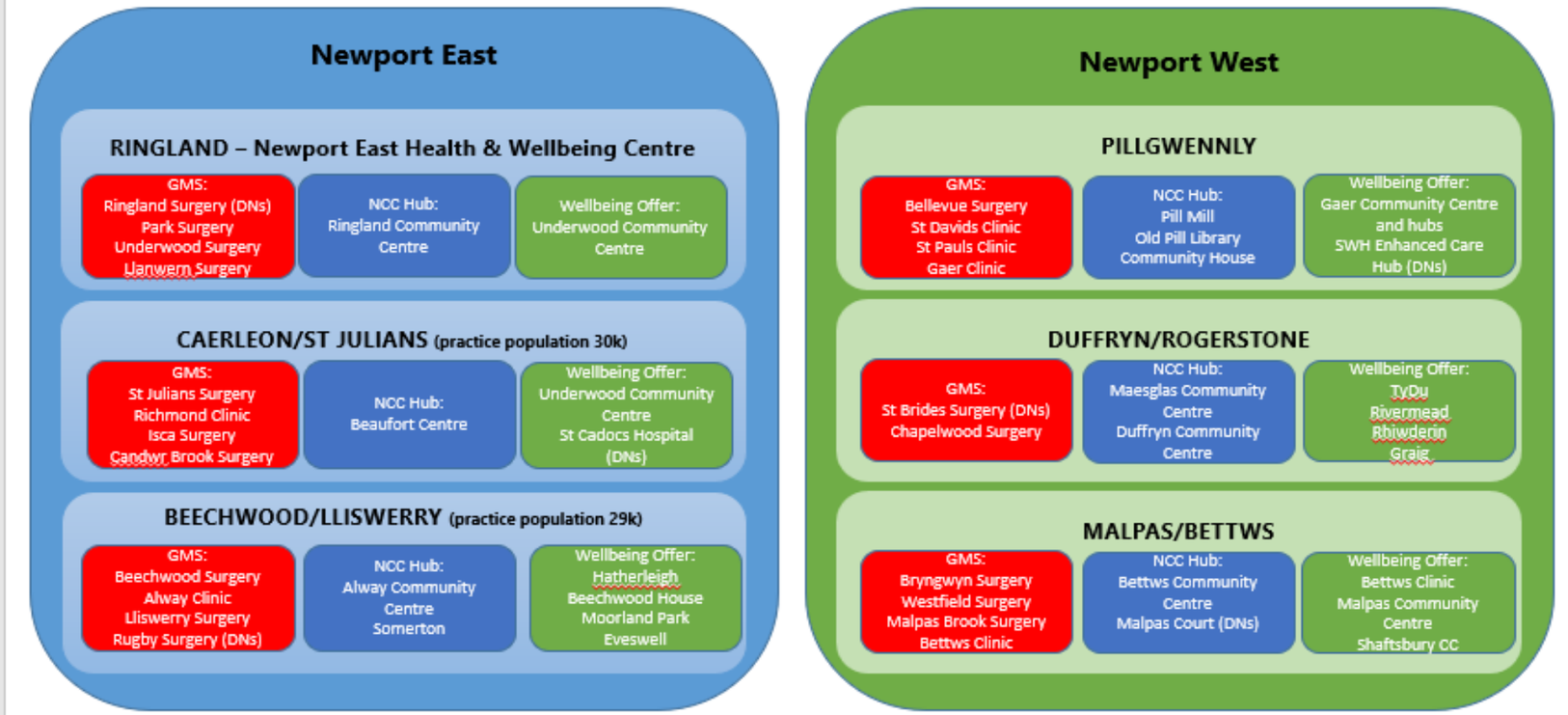
Band 8a NCN Pharmacists	1.6wte
Band 7 Clinical Lead x 2	2wte
Band 7 Occupational Therapist	1wte
Band 4 MDT Coordinator	6wte

In order to provide a balanced budget for 2025/26 there would need to be a reduction in resource which would be in relation to the NCN employed staff resource. This would result in a significant reduction in the place-based care provision which may destabilise a growing resilient community or a funding uplift is received.
Regional Integrated Fund (RIF) • The current advice offered is that RIF funding will terminate in 2026. If terminated, this funding will considerably destabilise the NCN workforce and the ability to deliver place-based care.

	Static Budget • The inability to move proven project concepts such as Practice Based Pharmacists and Psychology Health Practitioners into core health board funding significantly reduces the NCN's ability to fund new projects.

Key Priorities 2025/26:

Sustainability	**Workforce** • Strengthen the existing workforce to ensure business continuity. Fostering employee engagement by developing and supporting employees and transferring knowledge through Continuing Professional Development. Identifying any gaps and actively looking to recruit to extended roles to bolster the existing workforce. • If additional funding were to made available to the NCN then staff resources could be increased within the placed based care team.
Building Resilient Communities	**Place Based Care** • The place-based care model will continue to be the overarching vehicle of driving and delivering NCN priorities within Newport. The NCN will continue to work in partnerships that are collaborative arrangements between organisations responsible for arranging and delivering health and care services and others with a role in improving health and wellbeing. The Newport Placed Based Care model will continue to identify roles that will compliment and strengthen the multi-disciplinary team process. • To continue with the multi-disciplinary team model that people who have greater complexity and are most at risk of deterioration and adverse events, such as hospitalisation, to live safe, independent and fulfilled lives. This multi-disciplinary team approach will require care coordination and committed involvement of Reablement workers, Specialist Nursing teams, Clinical Pharmacists, Community Mental Health Team, Social workers, Occupational Therapists, Housing and Third sector organisations **Newport Area v Places** • A Newport Estates Strategy has been created that provides a footprint of neighbourhoods within the city. This will provide a basis in identifying the correct balance between structures that enable the NCN to plan effective and efficient care for the local population whilst enabling the delivery of person-centred care to meet the needs of individuals within the context of their local community.



Collaborative work is required with the Integrated Services Partnership Board (ISPB) going forward in terms of availability of data sets to improve preventative risk stratification and case identification to prioritise people with, for example, moderate or severe frailty. By analysing and linking unplanned care data sets it would then be possible to identify cohorts who could have been supported earlier in the community through proactive multi-professional support.

19 Hills Health and Wellbeing Centre

- The Health and Wellbeing Centre will support the Newport Locality vision to deliver tiered, seamless health care and wellbeing to empower people to look after themselves and each other, build a stronger community and deliver services fit for now and for the future

Social Prescribing/Community Connector

- To strengthen the multidisciplinary team via additional and varied roles. The role of a community connector has been identified as a link role that will be employed by Newport City Council and will sit within the Information, Assistance and Advice. They provide face to face appointments and will deliver a person-centred approach to empower patients to recognise their own needs, strengths and personal assets. The community connector will also act as the conduit in connecting patients with their own communities for support with their personal health and wellbeing. A Service Level Agreement has been created outlining the purpose and objectives of the role and a paper has been submitted to seek funding to allow a Community Connector pilot with Bellevue Surgery and Ringland Surgery.

Integrated Wellbeing Network

- Work closely with the Integrated Wellbeing Network and Gwent Association Voluntary Organisation (GAVO)and align priorities to improve wellbeing, supporting them to alter unhealthy behaviours and increase their resistance to disease.
- Work collaboratively with Integrated Wellbeing Network regarding Heritage & Health to promote collaboration within diverse communities in Newport to improve both understanding and access to health services and community support including community screenings, vaccinations and raise awareness of preventative health and wellbeing support. Diabetes, Dementia and women's health has been identified as priorities. In addition to delivering peer to peer workshops for Diabetes, Dementia and Women's Health, a need has been identified from community engagement to also provide to support to improve ground level resilience by:
  - Training community leaders & interested individuals on Make Every Contact Count (MECC), Five Ways to Wellbeing, First Aid, Connect 5 & Screening, nutrition skills for life to deliver healthy lifestyle changes to their communities
  - Upskilling unpaid carers –such as training in basic life support particularly those caring for disabled children and other generic
- Work will continue to Identify and develop community-based 'centres' for well-being resources in the community

	• Ensure that community-based 'centres' can connect people with health and wellbeing resources, activities and other people/citizens to support their own wellbeing • To align the work of NCNs and Integrated Wellbeing Network to develop a deeper understanding of a community orientated model of primary care through community assets and local needs within the population, particularly for socially vulnerable or marginalised groups. • To ensure NCNs have a good understanding of Integrated Wellbeing Networks in order to utilise community assets such as community groups and voluntary organisations that help people maintain or develop social support networks. • To co-produce a 'social prescribing' model that connects people to activities, groups, and services in their community which can address their practical, social and emotional needs
	Prevention Programmes and Enhanced Services • To establish high quality and equitable provision of supplementary/enhanced service across each NCN with an initial focus on intrauterine device (IUD), minor surgery, substance misuse, homelessness and asylum seeker and refugees. • To facilitate a collaborative approach in the prevention and management diabetes and wider cardiovascular disease (CVD) risk factors (including hypertension) to ensure that these programmes can be delivered systematically and at scale across NCNs.
	Chronic Conditions • To continue to monitor local rates of chronic conditions via the Population Needs Analysis data. ***Diabetes*** in adults has increased by 40% to 212,716 in 2021/22. Newport has the highest a prevalence of 8.7 which is the highest in Wales and thus diabetes has been determined as one of the divisions key priorities. Aiming to reduce the number of adults living with diabetes.
	Mental Health • To continue to support the local population mental health issues and reduce the demand upon General Medical Services (GMS) in this area.
Accelerated Cluster Development	**Professional Collaboratives** • To provide professional leadership for collaboration or working at scale to create greater stability and to deliver contracted services more efficiently and effectively
Communication & Engagement	**Population Communication & Engagement** • To continue to engage with the population in relation to health and wellbeing.
Finance	**Budgets** • To continue to evaluate NCN funded projects as proof-of-concept, in order to reallocate to core funding and replenish NCN funding to support future initiatives.

Cluster Annual Plan 2025-2026

1.1

To align the work of NCNs and Integrated Wellbeing Networks to develop a more community orientated model of primary care through a deeper understanding of the community assets and local needs within the population, particularly for socially vulnerable or marginalised groups.

1.2

To ensure NCNs have a good understanding of Integrated Wellbeing Networks in order to utilise community assets such as community groups and voluntary organisations that help people maintain or develop social support networks.

3. 3

To establish MDT working for people who have greater complexity and are most at risk of deterioration and adverse events such as hospitalisation. This MDT approach will require care coordination and committed involvement of reablement workers, specialist nursing teams, clinical pharmacists, CMHT, social workers, occupational therapists, housing and third sector organisations

Key: Alignment to NCN Focus & Priorities

4.1

To facilitate a collaborative approach in the delivery of diabetes prevention and CVD risk factor management to ensure that these programmes can be delivered systematically and at scale across NCNs.

4.2

To lead collaborative models for improving uptake of routine immunisations and the Winter respiratory vaccination programme.

4.3

To co-produce a 'social prescribing' model that connects people to activities, groups, and services in their community which can address their practical, social and emotional needs.

2025-26 ACTION PLAN

Activity/ project title	New or Existing	Brief Activity/ Project description	Results/ benefits expected by end March 2026 (SMART)	Life course area	Strategic alignment/ Ministerial priorities/ SPPC key programme priorities/Other Strategy or Policy	Key: Alignment to NCN Focus & Priorities	Activity/ project budget	Funding source(s)	Current status – link with key actions	Current Status	Comments
Sustainability											
1.1 Workforce	Existing	Strengthen existing workforce/services. Identifying any gaps and actively looking to recruit to extended roles to bolster the existing workforce. Need to consider integrated job plans for AHP roles to improve applications into cluster opportunities and retention of staff	Identify training & recruitment opportunities, working with professional collaboratives and. HR		Transformation and Vision for clusters	3.3 4.3				Ongoing	
1.2 Extended Roles	Existing	Continue to fund extended roles in order to strengthen the existing workforce to ensure business continuity. Fostering employee engagement by developing and supporting employees and transferring knowledge through continued professional development. Identifying any gaps and actively looking to recruit to	Practice Based Pharmacists To continue to support general medical services and identify how the roles can		Population Health Transformation and Vision for clusters Prevention and Wellbeing Communication and Engagement	3.3 4.3	East £159,583 West £136,153	NCN Budget		Ongoing	

			extended roles to bolster the existing workforce.	further support place-based care.		Mental Health and Emotional Wellbeing							
				Psychological Health Practitioners Reduce demand on general medical services. To continue to provide low level psychological support and signpost to appropriate services				East £149,430 West £166,872					
				Allied Health Professionals Link with developing services as part of transformation projects for multi-skeletal and Adferiad to provide direct access support for primary care services and communities									
	Building Resilient Communities												

	2.1 **Place Based Care**	Existing	To continue to support patients to remain well and within their own home, by focusing on prevention, early identification and intervention to prevent deterioration in patient's conditions. Strengthen links with IWN, GAVO and ISPB.	***MDT's***		Population Health Transformation and Vision for clusters Prevention and Wellbeing Communication and Engagement Mental Health and Emotional Wellbeing Primary Care Model for Wales / A Healthier Wales	1.1 4.2 4.3	East £43,200 West £33,600	NCN Budget		Ongoing	
				NCN Pharmacist x 2				West £71,777	NCN Budget			
				Clinical Lead Nurse x 2				West £40,395	NCN Budget RIF			
				Occupational Therapist x 1				East £49,409 West £12,970	NCN Budget			
				MDT Co-ordinators x 6				East £36,526 West £31,588	NCN Budget RIF			
	Newport Areas vs Places	Existing	A Newport Estates Strategy has been created that provides a footprint of neighbourhoods within the city. This will provide a basis in identifying the correct balance between structures that enable the NCN to plan effective and efficient care for the local population whilst enabling the delivery of person-centred care to meet the needs of individuals within the context of their local community	Clear strategy to identify the correct balance of services required to meet the needs of the area		Population Health Transformation and Vision for clusters Prevention and Wellbeing Communication and Engagement Mental Health and Emotional Wellbeing Primary Care Model for Wales / A Healthier Wales	1.1 1.2 4.3				Ongoing	
	Social Prescribing/ **Community Connector**	Existing	To strengthen the multi-disciplinary team via additional and varied roles. The role of a community connector has been identified as a link role that will be employed by NCC and will sit within the IAA. The role will be a person-centred approach to empower patients to	Greater population understanding of community services available to them and to empower patients to		Population Health Transformation and Vision for clusters Prevention and Wellbeing	1.1 1.2 4.3				Ongoing	

			recognise their own needs, strengths and personal assets. The community connector will also act as the conduit in connecting patients with their own communities for support with their personal health and wellbeing. A Service Level Agreement has been created outlining the purpose and objectives of the role and a paper has been submitted to seek funding to allow a Community Connector pilot with Bellevue	recognise their own needs, strengths and personal assets.		Communication and Engagement Mental Health and Emotional Wellbeing Primary Care Model for Wales / A Healthier Wales						
	Integrated Wellbeing Network		Work closely with the Integrated Wellbeing Network and third sector organisations to improve local wellbeing, supporting individuals to alter unhealthy behaviours and increase their resistance to disease.			Primary Care Model for Wales / A Healthier Wales Prevention and Wellbeing	1.1 1.2 4.3				Ongoing	
	Vaccination & Screening		Work with GP's and Public Health to increase participation of both the vaccination programme and screening uptake.	To have a marked increase in vaccination & screening uptake.		Population Health Transformation and Vision for clusters Prevention and Wellbeing Communication and Engagement Primary Care Model for Wales / A Healthier Wales	4.2	£0			Ongoing	
	Prevention Programmes and Enhanced Services		To establish high quality and equitable provision of supplementary/enhanced service across each NCN with an initial focus on IUD, minor surgery, substance misuse, homelessness and asylum seeker and refugees			Primary Care Model for Wales / A Healthier Wales Population Health Prevention and Wellbeing Communication and Engagement	1.1 1.2 4.3				Ongoing	

Chronic Conditions		To continue to monitor local rates of chronic conditions via the Population Needs Analysis data. Diabetes and Cardiovascular disease is a key priority set by the division. Need to consider allied health professional roles to provide education and treatment approaches to have impact here.	To reduce the Newport diabetes prevalence of 8.7 which is the highest in Wales. CVD risk management awareness		Primary Care Model for Wales / A Healthier Wales Population Health Prevention and Wellbeing Communication and Engagement	4.1 3.3				Ongoing	
19 Hills Health and Wellbeing Centre		The HWBC will support the Newport Locality vision to deliver tiered, seamless health care and wellbeing to empower people to look after themselves and each other, build a stronger community and deliver services fit for now and for the future	2 x GMS practices to be business as usual. Community services located within the building to be operational and a greater public understanding of local available support.		Prevention and Wellbeing Population Health	1.1 1.2 3.3 4.3	£28 million	Welsh Government		Ongoing	Completion expected January 2025.
Accelerated Cluster Development											
Professional Collaboratives	Existing	Support the development of Professional Collaboratives to identify risk, pressures and areas for possible investment	Independent professional collaboratives in place to identify individual need per professions.		Prevention & Wellbeing Communication and Engagement Transformation and Vision for cluster Primary Care Model for Wales / A Healthier Wales	4.3	£0			Ongoing	
Communication & Engagement											
Population Communication & Engagement	Existing	To continue to engage with the population in relation to health and wellbeing.			Primary Care Model for Wales / A Healthier Wales Prevention & Wellbeing Communication and Engagement	1.1 3.3 4.1 4.2				Ongoing	

	Finance											
	Budgets	Existing	To continue to evaluate NCN funded projects as proof-of-concept, in order to reallocate to core funding and replenish NCN funding to support future initiatives.	To have moved current funding commitments into core funding to provide new NCN project opportunities.				£0			Ongoing	
	Wish List											
		New						£				

Appendix 1

Finance Summary

Newport NCN Finance Summa...

East Spend Plan Summary	2024/25	2025/26	West Spend Plan Summary	2024/25	2025/26
Annual Budget	**443,758**	**443,758**	**Annual Budget**	**481,215**	**481,215**
Brokerage			**Brokerage**		
Top Slice: Advisers, Phlebotomy, Dementia Roadmap	*£19,415*	*£19,415*	*Top Slice: Advisers, Phlebotomy, Dementia Roadmap*	*£20,334*	*£20,334*
Practice Based Pharmacists	*£148,604*	*£159,583*	*Practice Based Pharmacists*	*£124,048*	*£136,153*
B4 Coordinator	*£15,219*	*£36,526*	*PHPs (based on 4wte)*	*£134,894*	*£166,872*
MDTs (based on 2 pm)	*£37,331*	*£43,200*	*Hub Team Lead & Occupational Therapist*	*£4,323*	*£12,970*
PHPs (based on 4wte)	*£150,184*	*£149,430*	*Clinical Nurse Lead*	*£40,395*	*£58,669*
Hub Team Lead	*£35,919*	*£49,409*	*B4 Coordinator*	*£13,162*	*£31,588*
NERS	*£1,500*		*MDTs*	*£43,260*	*£33,600*
Other	*£20,000*		*AccuRx / e-consult*	*£26,782*	*£25,094*
Non Pay Accruals	*-£1,600*		*Link*	*£12,000*	*£12,000*
KB Boxing	*£5,000*		*NERS*	*£10,000*	
Flyers	*£364*		*Red Bag*	*£1,000*	
NCN Priorities			*Room hire*	*£712*	
Room hire	*£108*		*Community Youth Project*	*£5,000*	
KidCare4U	*£6,390*		*NCN Priorities*		
Red Bag	*£1,000*		*KidCare4U*	*£6,390*	
Total Expenditure	**£439,434**	**£457,563**	*Other Non Pay*	*£27,520*	
			Meaningful Measures	*£287*	
Forecast position	**£4,324**	**(-£13,805)**	**Total Expenditure**	**£480,754**	**£497,281**
			Forecast position	**£462**	**-£16,066**

Torfaen NCN Plan 2025-26

Cluster Executive Summary:

The last 2 to 3 years have been a period of change across Wales as we transition from the well-established Neighbourhood Care Network (NCNs) Clusters, to implementing the Welsh Government's: Accelerated Cluster Development (ACD) programme. Historically, NCNs have been required to develop annual plans that reflect local issues across our communities and assessed against a range of evidence including for example, Population Needs Assessments. The development of this plan has relied on contributions from colleagues in health, social care and the Third Sector. This will continue as we move forward but conscious that the clinical focus of the ACD programme, may bring challenges in terms of how we continue to ensure we retain the full engagement of social care and third sector partners. This plan is underpinned by the values of the Gwent Regional Partnership Board in keeping people at the heart of what we do as collaborative clusters, serving Torfaen.

Background Information:

Torfaen is currently established around 2 Neighbourhood Care Networks (NCNs), North and South, which work collaboratively to strive to improve primary care and community services within the local area.

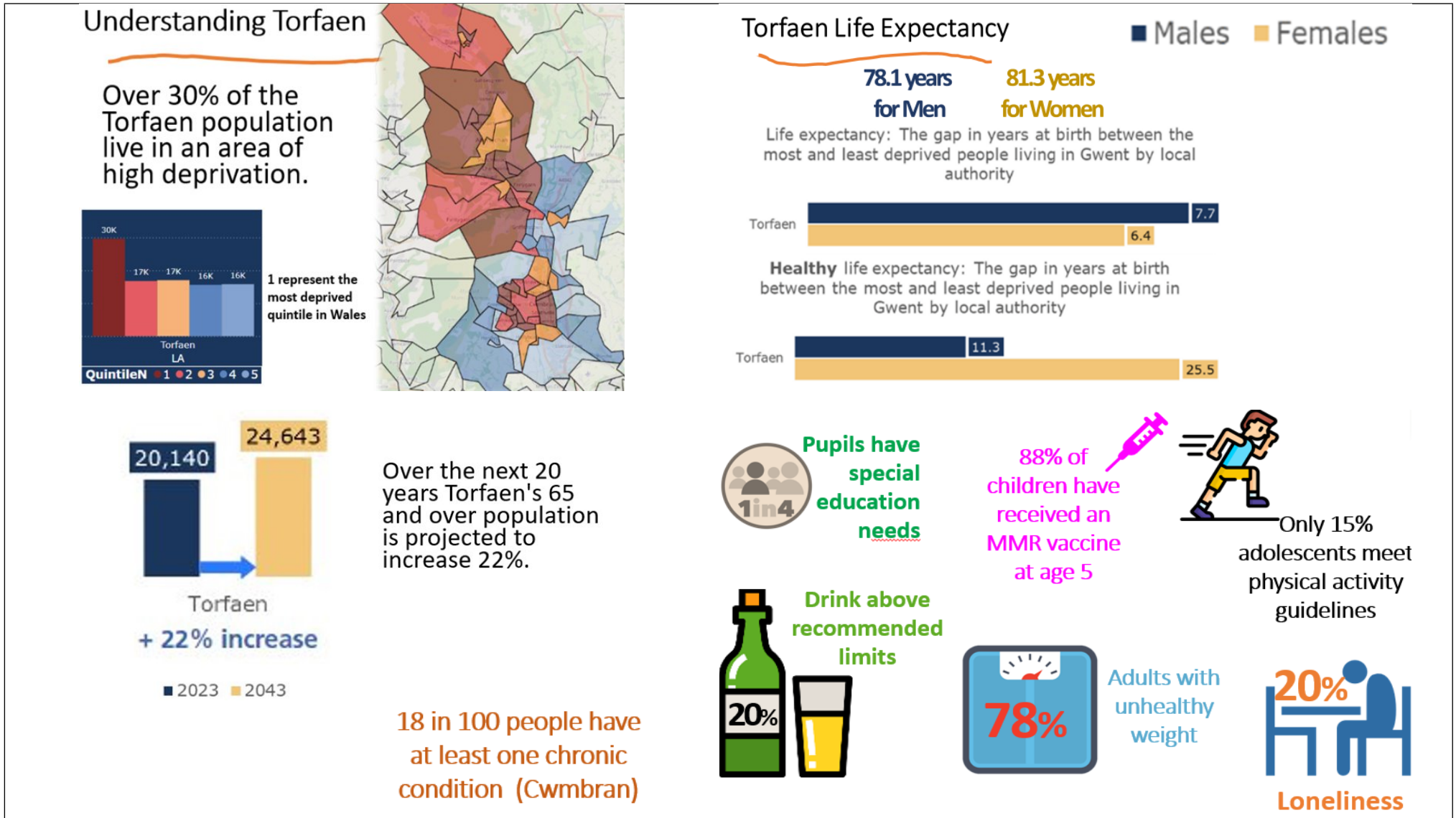
NCN Priorities
Our top 3 key priorities for 2025/26 are:

1. Sustainability of services across the NCN
2. Accelerated Cluster Development – Professional Collaboratives and Multidisciplinary Working
3. Building Resilient Communities

Demand for healthcare continues to escalate in proportion to population growth. We have an ageing population, with patients living longer with more complex needs, further intensifying the challenges faced by the NHS and partners. Torfaen's aim is to provide a more integrated system of primary care with place-based care in community and wellbeing services; offering co-ordinated care, closer to home with collaboration of professional skills across multi-disciplinary teams (MDT). Torfaen has increased collaborative working across the NCN aiming to strengthen community resilience, respond to population need, and deliver patient-centred care through its three key Care Closer to Home workstreams:

- Prevention, Wellbeing and self-care
- Access and Sustainability
- Integrated Primary and Community Care

Understanding Torfaen: Population health and wellbeing analysis.
Torfaen has a population of 98,300 people. Over 30% of these residents live in areas with high levels of deprivation, while another 20% live in the second most deprived areas. High deprivation levels in Torfaen bring significant challenges. These areas often have poorer health, lower education levels, and fewer community and public resources. The main issues linked to deprivation in Torfaen are unemployment, poor housing, and low income. Addressing these problems is key to improving the health and wellbeing of our community.



The number of residents aged over 65 in Torfaen is growing. This shift means we will likely see more chronic illnesses and a greater need for social care and community support. It's crucial that our community are prepared to handle these changes to ensure our older population stays healthy and well-supported.

Primary care data used as part of the WIMD in 2019 showed a recorded prevalence of chronic disease of 18% and a recorded prevalence of mental health conditions of 30% specifically in Cwmbran. Excessive drinking is a major health concern. In 2017/2018, 1,824 Torfaen residents per 100,000 were hospitalised for alcohol-related incidents. 78% of working-age adults in Torfaen are considered to be at an unhealthy weight.

Torfaen has the highest percentage of loneliness among the five Local Authorities, with 20% of residents feeling lonely. This is 7.1% above the Welsh national average. We know that prolonged loneliness can lead to significant mental health problems, and physical effects such as a weakened immune system and increased inflammation in the body.

Data shows 49% of Torfaen's economically inactive population are inactive due to long terms sickness. This equates to 5,800 adults at the end of 2023. This is higher than the Welsh and British rates and has increased since 2014. This will present challenges to many households. These factors collectively strain our community resources and highlight the need for comprehensive, multi-faceted health and wellbeing strategies.

According to the Gwent Joint Strategic Assessment, men in Torfaen have the lowest median earnings in the region at £30,175. In contrast, women in Torfaen have the highest median earnings among women in Gwent, at £30,992.

Torfaen faces a complex mix of health and wellbeing challenges due to deprivation, an aging population, lifestyle factors, and social determinants. By addressing these issues through integrated services, community engagement, and initiatives, we can build a healthier, more resilient community.
Information Provided by PHW Cluster Dashboard

Accelerated Cluster Development

Strategic Context:

Workstreams are managed and taken forward via NCN three-year plans that feed into the Integrated Services Partnership Board plans (ISPB) and into the Regional (RPB). This ensures that NCNs annual plans are aligned with ISPB priorities and RPB needs assessments.

Regional Partnership Board (RPB)

- **Start Well;** Improving outcomes for children and families
- **Live Well;** People at the heart of everything we do, working together to live well
- **Stay Well;** Ensuring the right help is available at the right time, working together to stay well

Torfaen Integrated Services Partnership Board (ISPB)

Excellent engagement and collaboration at Torfaen ISPB have resulted in a rapid maturity since inception. Torfaen ISPB facilitates a whole system approach that improves the health and wellbeing of the area, delivered through collaboration and integration of Health, Local Authority and Third Sector services that provides the best possible services to our residents. Torfaen ISPB has a shared objective, aligning to the Marmot Principles, and delivering against both national and local strategic drivers, ensuring;

- Services are strengthened, with a key focus on prevention and early intervention, and developed based on an evidence base that meet the needs of residents, through a place-based approach
- Services are delivered in an effective and efficient way through consultation with our residents and collaboration by partners
- Services are delivered by a quality workforce.

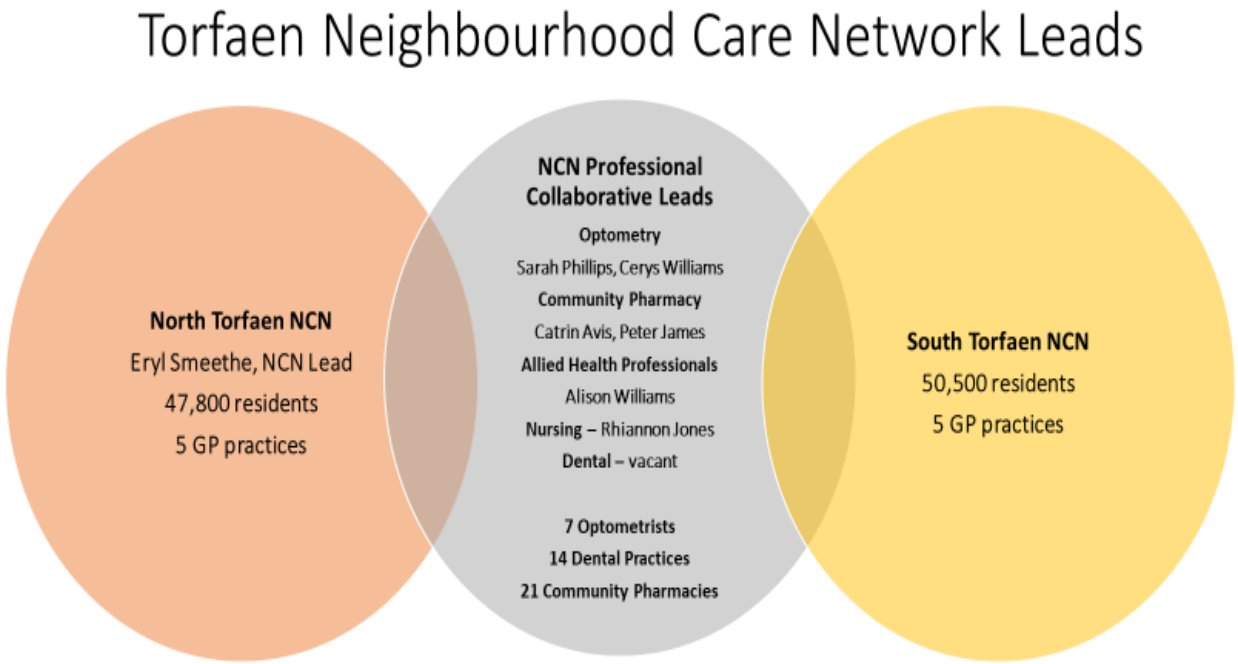
ISPB objectives:		**ISPB priorities:**
• Provide local delivery of RPB priorities • Coordinate available resources to meet need • Provide strategic direction • Support partnership working • Ensure plans reflect population need	**← Solutions, Improvement, Change →** **← Intelligence for priorities & decision making →**	• Third Sector as full partner • Integrated workforce for the future • Place Based Working • Redesigning services for older people • Ensure fit for purpose estate • Enhanced Financial scrutiny

Current services need to evolve to be able to sustain and improve. There is a necessity to change historical ways and patterns of working that no longer meet the needs of today's society and the needs of the future population, notwithstanding the changes to our service delivery and communication brought about by the recent pandemic. Change is required to address several key factors:

- The demand for health and social care is growing and will continue to grow; we have an aging population, with patients living longer and with more complex needs, which intensifies the challenges faced by all sectors.
- All our health, social care and community services need to be sustainable in the short, medium, and longer term.
- Our population is characterised by pockets of health inequalities, linked to socio-economic deprivation the current financial climate will further impact these areas.
- Our demography continues to diversify with an increase in our asylum seeker, Ukrainian resettlement, and refugee population.
- Our estate is not robust to provide services for now and the future

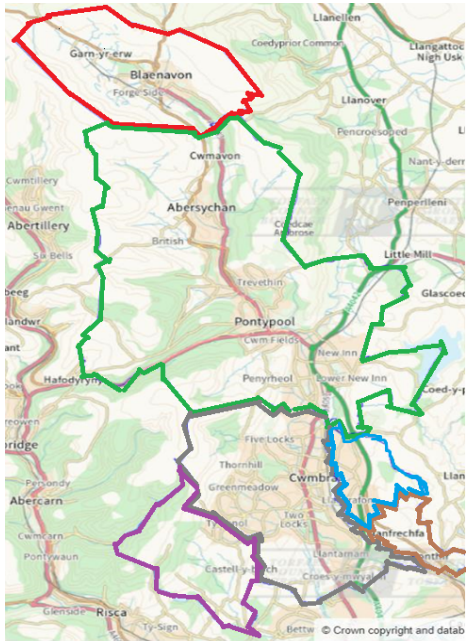
Torfaen NCN Structure

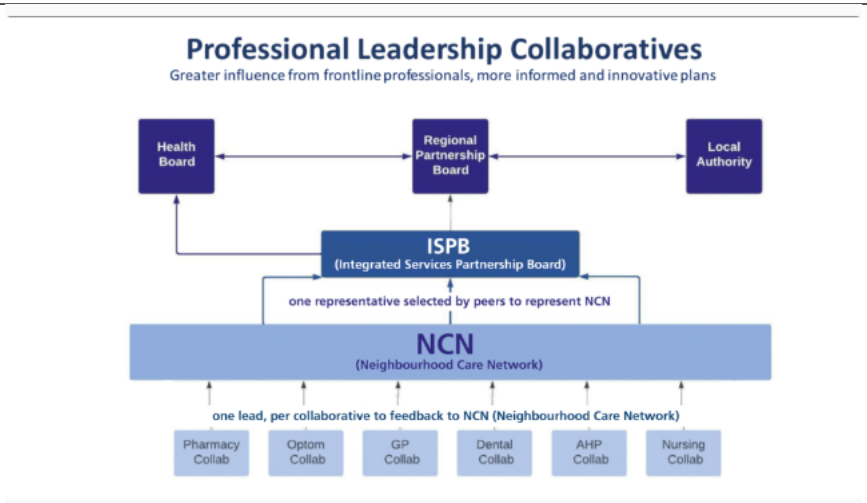
The NCN Leadership structure is under review from its current form illustrated below, to align with Accelerated Cluster Development aims; to trial one cohesive Torfaen NCN membership, with designated GMS Collaborative roles in each locality to accompany the established professional Collaborative Lead roles. This new structure will strengthen our NCN partnership working to facilitate cluster maturity, enable progression of our three priority areas and allow a community orientated model of primary care to develop with a deeper understanding of local needs.



Torfaen's Areas of Focus

Area of Focus	Population
Blaenavon	5,637
Pontypool	29,062
Henllys	2,682
Cwmbran	47,000
Croesyceiliog & Llanyrafon	9,000
Ponthir & Llanfrechfa	2000





Torfaen has welcomed the shared expertise of our network of Professional Collaboratives. As these relationships grow, we input specialist knowledge and unique skills to map and develop service provision, identifying gaps and population need. Working across service boundaries allows our Professional Collaboratives to advocate for their community to achieve wider system improvements within their area of expertise.

Integrated Wellbeing Network

The development of an Integrated Wellbeing Network (IWN), through NCNs or clusters, allows a holistic approach to the complex interplay between material circumstances, the social environment, psychosocial factors and health behaviours. They are likely to be most effective when a community's assets are fully realised and integrated with primary care and community services. Torfaen's ambition is a place-based model of care whereby, people can access the care they need in their own resilient community and homes wherever appropriate and avoid any unnecessary harm, be it from injury at home, medication errors and unnecessary admissions to hospital or from delayed diagnosis or access to treatment. In our vision, services are designed to provide more co-ordinated care, with fewer handoffs and reduced complexity.

We aim to improve the health and wellbeing of our population, supporting people to stay well, lead healthy independent lives and reduce inequalities, building on the assets that are found in the community and mobilising individuals, organisations and services to come together to realise and develop their strengths. To deliver this we need to transform services so that our staff can work in collaboration. Developing new, integrated services, provided by well-trained confident staff, serving an empowered community through local accessible health and wellbeing services; providing the right service, at the right time, by the right person.

Torfaen is delivering place-based care through a hub approach bringing together health, social and third sector services. The first Hub of this kind has been developed in Blaenavon Resource Centre in the North, with further plans to scope out a central hub on the County Hospital site and one in the South of the Borough. This hub approach must be built on our estates strategy to ensure that services, equipment and infrastructure are aligned to make best use of resources and a well-trained sustainable workforce.

This vision is validated by the strategic direction set out in The National Primary Care Programme, A Healthier Wales and Prosperity for All setting out strategic ambitions for increasing workforce sustainability and utilising the third sector to meet the increasing demands upon our core services.

As Torfaen IWN role is vacant, a key aim of Torfaen ISPB is to agree the IWN role structure and key aims to enable our vision to materialise.

Top 3 Cluster Areas of Focus 2025/26:

1. Sustainability of services across the NCN

On-going funding commitment to statutory and non-statutory services, to reduce the impact on GP time for example:

- Gwent House/Cwmbran Town Centre to support additional services and reduce demand in practice, ie vaccinations
- Practice based Pharmacist providing medication reviews etc
- CATCH providing support for GP practices, also providing the Care Home DES on behalf of 2 practices
- Dedicated Psychological Health Practitioners (PHP's) providing access to mental health advice in GMS
- Luton Model Rollout (56-day prescriptions to reduce GP/pharmacy time)
- Continue to identify services, technology and initiatives that can help to increase access and sustainability for General Practice and community services such as AccuRx and Choose Pharmacy platform
- Continue improvement and equitable provision of Enhanced Services

Aligns to priorities 2.1, 2.2, 2.3, 2.6, 3.1, 3.2, 3.3, 4.4

2. Accelerated Cluster Development – Professional Collaboratives and Multidisciplinary Working

Professional Collaboratives (PC's) are Networks of Professionals with shared expertise, working together to use their unique skills to assess the needs of the population where they work

The priorities for the Torfaen Collaboratives will be:

- Capture the knowledge and experience of the local professionals to map service provision, identify gaps and develop against needs.
- Continue to identify and undertake improvement projects that can make a difference across Torfaen

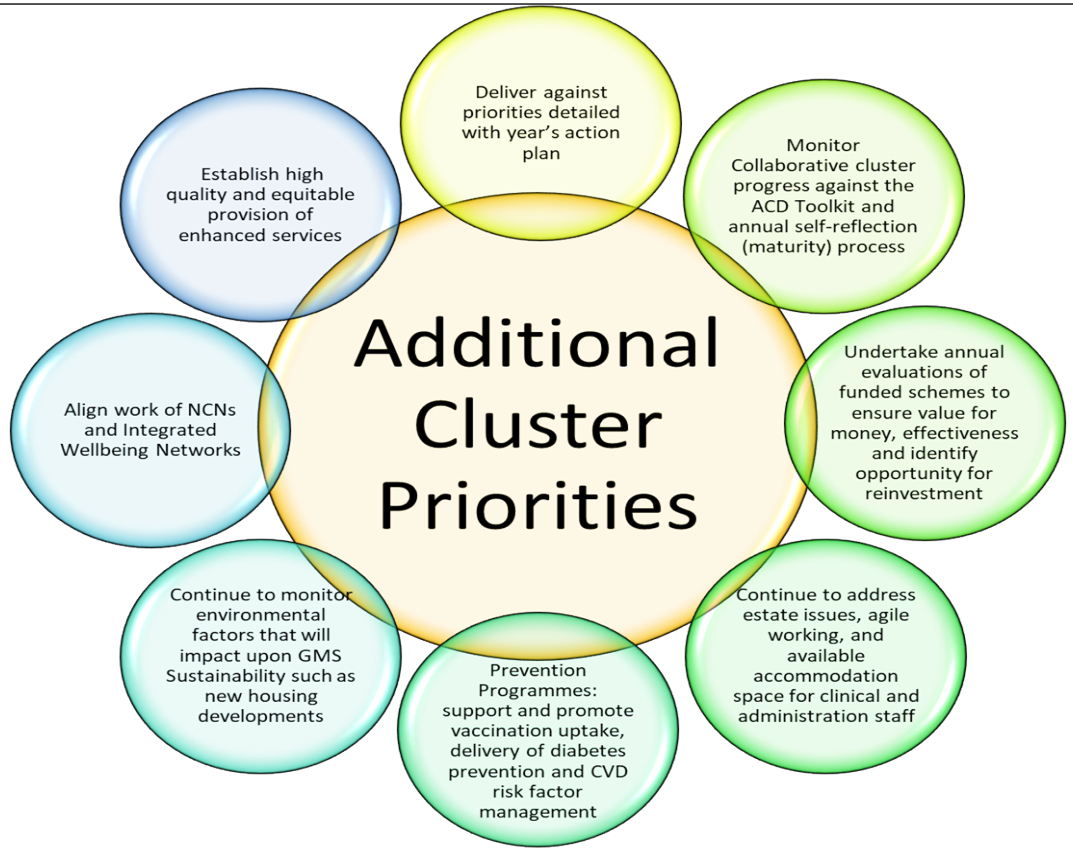
- Inform decision making and propose solutions to be shared with the NCN
- CATCH to become core funding to free up substantial amount of NCN monies to support new initiatives.

Aligns to priorities 1.1,1.2,2.1,2.3, 3.1,3.2, 3.3, 4.1,4.3

3. Building Resilient Communities

- Dedicated Psychological Health Practitioners providing access to mental health advice in GMS
- Practice Based Pharmacy providing medicines reviews
- Community Connectors enables people to find solutions and build confidence by identifying 'what matters' to them with regard to socialisation and community engagement. Work with groups, activities and organisations and other stakeholders in the Community to support, promote, collaborate and ensure community resilience.
- NCN investment in Care Navigation at practice level to be cascaded via ISPB and professional collaboratives.
- Increased working together and appropriate data and information sharing with social housing to maximise the health, well being and sustainability of tenancy at home
- Collaborative working on prevention programmes
- GMS collaborative scoping to ensure a equitable coverage of enhanced services that is inclusive for vulnerable groups, minor surgery and IUD.
- Increased collaboration, appropriate data and information sharing with social housing to maximise the health, well being and sustainability of tenancy at home
- Health & Wellbeing Engagement Officer funded through BSB, supporting the IWN work and acts as a conduit between health services and the 3rd sector.
-

Aligns to priorities 1.1,1.2,2.1, 2.2,2.3, 3.1,3.3, 4.1, 4.2, 4.3,4.4



Top 3 Achievements 2024-25:

1. Accelerated Cluster Development – Professional Collaboratives

- Professional Collaboratives working effectively together and continue to develop.
- Whilst the collaboratives are still in their infancy, they have successfully been able to utilise Population Needs Assessment data to identify service gaps and have subsequently undertaken improvement projects.

2. Clinical Assessment Team for Care Homes (CATCH)

- Highly valued services in Torfaen NCNs
- Positive feedback from patients, practices, care homes, and district nursing

- Permanent Roles have been secured
- Staff completing further education, which enables them to perform more advanced clinical assessments and interventions, to release GP time
- Increased uptake of influenza
- Supporting care homes with the Care Home Enhanced Service for equity of care.

3. Integrated Services Partnership Board

- Increased partnership working through ISPB
- Integrated working
- Engagement from key stakeholders
- Strong representation

Top 3 Challenges:

1. Budgets

- Limited funding available inhibits large scale projects
- NCN budget is tied into valuable roles
- NCN funded projects that have been evaluated with successful outcomes are not progressed with core funding, prohibiting further NCN investment in innovation
- Financial pressure within practices, inflation impacting practice and uplifts do not cover rising costs

2. Sustainability

- Workforce retention and recruitment issues across the NCN
- Aging workforce/retirements pose a threat to future sustainability in the current models
- Issues with the recruitment of particular roles, such as GP Partners, practice nurses and advanced nurse practitioners
- Many practices are dependent upon locums which can be costly and negotiation of services included is often required
- Dental Access and a practice closure (Dental Nova Cwmbran)
- Regular high escalation levels in practice
- Educating patients to access appropriate services

3. Accelerated Cluster Development – Professional Collaboratives

- Moving beyond the transition phase into full development, understand roles and responsibilities proves challenging at times
- Early stages of maturity

- Limited representation where engagement is non-contractual
- Membership of the professional collaboratives are mostly senior staff, which can cause time constraints
- Lack of optometry lead in South Torfaen
- Regular venues to secure meetings
- Winter pressures

Key workstreams in 2025/26 (Linked to the NCN Action Plan):

Bringing clinical professionals together i.e.; GPs, Dentists, Community Pharmacists, Optometrists, Community Nurses and Allied Health Professionals on a regular basis, helps to share learning and understanding, identify gaps in service, risks, barriers to delivery and opportunities. NCN Cluster meetings are the focal point for bringing representatives together to discuss service pressures and population need etc. The table below briefly outlines NCN Cluster workstreams in 2025/26 encompassing ACD. A more detailed ACD action plan can be seen on page 7:

Sustainability/ Accelerated Development	• Building resilient and sustainable services through an on-going funding commitment to statutory and non-statutory services, to reduce the impact on GP time. • To develop clusters through shared learning and expertise, and a greater understanding of their needs via increased, regular engagement to inform planning.
Prevention	• Continued surveillance of fluenz uptake against national targets with local benchmarking, along with bi weekly Flu Group. • On-going investment in wellbeing services to support people, prevent increased mental health and wellbeing concerns. • NCN Cluster funded safeguarding group meets quarterly to discuss a range of topics, including anonymised complex cases providing valuable learning reflections. Meetings also cover Post Traumatic Stress Disorder, Coding, fabricated and induced illness, County Lines & Urban Street Gangs, care of vulnerable groups including refugees, plus a broad review of Level 3 Child Safeguarding. This will continue in 2025/26. • Initiatives between clinical professionals and public services e.g. housing to build higher levels of sustainable wellbeing at home
Care Closer to Home	• Engaging with ABUHB colleagues re the transition of funding away from NCN Clusters in relation to community level Phlebotomy provision. Established to meet the Health Board's Clinical Futures strategy, and endorsing care closer to home – our local services have been validated through continued and increased demand. • Work closely with the IWN (when in post) and TVA and align priorities to improve wellbeing, supporting them to alter unhealthy behaviours and increase their resistance to disease. •

Communication & Engagement	• Regular meetings in 2024/25 helped to build both the profiles of professionals working in Torfaen. The ABUHB communications team has supported NCN Cluster development through promotional on-line videos etc. This will continue into 2025/26.
Financial Governance	• Implementing monthly meetings with finance and service professionals has helped us to develop our financial governance processes through increased transparency and dialogue. We will continue to engage at this level in 2025/26. • To continue to evaluate NCN funded projects as proof-of-concept, in order to reallocate to core funding and replenish NCN funding to support future initiatives.

List activities or projects planned to commence during 2025-26, as well as those planned/ initiated in 2024-25 (or earlier, if ongoing)

Activity/Project Title	**New or Existing Activity**	**Brief Activity Project Description *All within IMTP 2024-25 content**	**Results/Benefits Expected by End March 2025 *All within IMTP 2024-25 content**	**Strategic Alignment**	**1.1**	**1.2**	**3.3**	**4.1**	**4.2**	**4.3**	**Activity/ project budget**	**Funding source(s)**	**Current Status**	**Comments**
Provide a consist activity or project title, one per unique activity	Is this a new activity for 25/26 or part of a previous cluster plan?	Simple and to the point - no need to go into specific objectives	Brief list of main results or benefits anticipated from this activity or project before end of March 2024	Does this fit key priorities?	Alignment to NCN Focus & Priorities (where relevant)						What money has been allocated to this project or activity? Insert total – to include staff, equipment etc. costs	What is the source of this funding? I.e., transformation funding, cluster fundi ng etc.	What is the current status – short description only	comments you feel may be relevant here – for example barriers to success, workforce issues etc.
Health Protection Services/ Building Community Resilience	Existing	Development of Health Prevention services in collaboration with the third sector, IWN and IAA, identifying social networks to help address the wider determinants of health	Flu programme will- Work in partnership with Local Education Authority Leads to jointly promote the importance uptake with parents and careers Programme to deliver vaccinations to all eligible cohorts	Prevention & Wellbeing Communication and Engagement Transformation and Vision for cluster	1.1	1.2			4.2	4.3		NCN Funding	Ongoing GP cluster commitment to continue to 2024/25	
Building Community Resilience **Population Health**	New	Marmot Region	NCNs will support the Marmot Review which sets out a framework for action under two policy goals: to create an enabling society that maximizes individual and community potential; and to ensure social justice, health and sustainability are at the heart of all policies.	Healthier Wales Population Health Transformation and Vision for clusters Prevention and Wellbeing Communication and Engagement Mental Health and Emotional Wellbeing	1.1	1.2	3.3	4.1	4.2	4.3				
Pathway Optimisation	Existing	The ongoing sustainability of all health and social care services on an operational footing level is paramount,	To support the NCN will undertake a mapping of services – both clinical and non-clinical to ensure that people with the right skills and experience work in an environment that is fit for purpose. Keeping a key focus on local population need and will include Immunisation and Vaccination, GMS sustainability and access, Psychological Wellbeing, Diabetes Prevention, CVD risk factor management, Obesity Pathway, Oral Health, Advanced Paramedic for home visiting/CRT/Care Home and FCP.	Supporting Social Care/Health Workforce Healthier Wales Working alongside Social Care Population Health				4.1	4.2					
Health Protection Services	New	Supporting the needs of the local population with the cost-of-living crisis	Work in partnership with ISPB (in absence of IWN role) to use local intelligence of where funding should be directed to support with the cost-of-living crisis. Torfaen ISPB to align with the strategic priorities of the Health Board, Local authority and A Healthier Wales's vision of a whole system approach to health and social care, focussed on health and well-being and on preventing illness with access to a wide range of seamless community-based services	Supporting Social Care/Health Workforce Healthier Wales Working alongside Social Care Population Health	1.1	1.2						NCN Funding		
Accelerated Cluster Development	Existing	prioritise the establishment of Pan Cluster Groups	Continue to develop the ISPB priority actions with our partnership board landscape. To develop and strengthen the relationship with the Gwent Regional Partnership Board		1.1	1.2	3.3	4.1	4.2	4.3				

Key: Alignment to NCN Focus & Priorities

1.1

To align the work of NCNs and Integrated Wellbeing Networks to develop a more community orientated model of primary care through a deeper understanding of the community assets and local needs within the population, particularly for socially vulnerable or marginalised groups.

1.2

To ensure NCNs have a good understanding of Integrated Wellbeing Networks in order to utilise community assets such as community groups and voluntary organisations that help people maintain or develop social support networks.

3. 3

To establish MDT working for people who have greater complexity and are most at risk of deterioration and adverse events such as hospitalisation. This MDT approach will require care coordination and committed involvement of reablement workers, specialist nursing teams, clinical pharmacists, CMHT, social workers, occupational therapists, housing and third sector organisations

4.1

To facilitate a collaborative approach in the delivery of diabetes prevention and CVD risk factor management to ensure that these programmes can be delivered systematically and at scale across NCNs.

4.2

To lead collaborative models for improving uptake of routine immunisations and the Winter respiratory vaccination programme.

4.3

To co-produce a 'social prescribing' model that connects people to activities, groups, and services in their community which can address their practical, social and emotional needs.

Cluster Annual Plan 2025-2026

Health Protection Services	Existing	Diabetes Prevention Programme	Participation in the Diabetes Prevention Programme across both clusters for pre diabetic patients to be offered a brief intervention which includes lifestyle advice with the hope of reducing their HBA1c over the longer term to reduce or prevent the progression of diabetes	Population Health Healthier Wales				4.1				WG Funding		
Health Protection Services	New	Seek to develop services that are high quality and equitably across the Borough for supplementary /enhanced services with an initial focus on IUD, minor surgery, substance misuse, homelessness and asylum seeker and refugees.	We will look to map our services to identify where the gaps are and work more collaboratively between our GMS partners to deliver services that are more equitable and, on a population, needs basis	Healthier Wales Population Health						4.3				
Accelerated Cluster Development	Existing	Widening stakeholder attendance at NCN	Widening stakeholder attendance across our NCN to ensure full collaboration to meet population needs and maintain local voice.	Healthier Wales Working alongside Social Care Population Health NHS Recovery Supporting Social Care/Health Workforce	1.1	1.2	3.3			4.3				
Building Community Resistance **Population Health** **Health Protection Services** **Pathway Optimisation** **Care Closer to Home/Pathway re-design** **Estates Mapping** **Accelerated Cluster Development**	Existing	Delivering place-based care where people can access a range of seamless care and support at or close to home, based on their unique needs and what matters to them	Ongoing work with ISPB to develop the IWN role to optimise delivery. The NCN in partnership with our IWN partners will build community resilience through connections to increase social prescribing and community development in collaboration with the third sector. Align the work of the NCN and IWN to develop a more community orientated model of primary care through a deeper understanding of the community assets and local needs within the population, particularly for socially vulnerable or marginalised groups	Healthier Wales Population Health Transformation and Vision for clusters Prevention and Wellbeing Communication and Engagement Mental Health and Emotional Wellbeing	1.1	1.2	3.3			4.3				

Cluster Annual Plan 2025-2026

Health Protection Services **Building Community Resilience**	Existing	Building community resilience through connections to increased social prescribing and community development in collaboration with TVA, Integrated Wellbeing Networks, Social Care and 3rd Sector	Increased social prescribing and community development in collaboration with TVA, Integrated Wellbeing Networks, Social Care and 3rd Sector. Development of Care Navigation, improving access to and awareness of GDS, Optometry, Pharmacy and GMS services. Our focus is on building resilience through prevention and early interventions to enhance wellbeing and self-care, identifying social networks to help address the wider determinants of health such as Vaccination programmes, Mental Health initiatives,	Working alongside Social Care Mental Health and Emotional Wellbeing Population Health Healthier Wales	1.1	1.2				4.3			Ongoing GP cluster commitment to continue to 2024/25	
Service Resilience & Sustainability **Population Health** **Health Protection Services** **Building Community Resilience** **Pathway Optimisation**	Existing	CATCH Provide support for GP practices, with home visits for patients who are residents in nursing and residential care homes	Support the sustainability of GP practices Torfaen. Provide high quality healthcare for Torfaen care home residents. Enhance relationships and access to the wider community MDT for care homes. Delivery of Care Homes DES to support practices who are not providing the enhanced services.	Healthier Wales Population Health Prevention & Wellbeing Transformation and Vision for cluster	1.1		3.3		4.2		£183,763	NCN Funded		
Service Resilience & Sustainability **Pathway Optimisation**	Existing	Practice Based Pharmacists (North) Support practices with a pharmacist to alleviate pressures and increase medication reviews	Equity of access to service across North Torfaen/supports collaborative sustainability	Healthier Wales Population Health Prevention & Wellbeing Transformation and Vision for cluster			3.3	4.1		4.3	£70,291	NCN Funded		
Service Resilience & Sustainability **Accelerated Cluster Development**	Existing	Independent Advisor support	Professional advisory role in Optometry reviewed as part of the NCN evaluation process	Healthier Wales Population Health Prevention & Wellbeing Transformation and Vision for cluster	1.1		3.3	4.1			£3,500			
Pathway Optimisation **Health Protection Services** **Building Community Resilience** **Service Resilience & Sustainability**	Existing	Psychological Health Practitioners	Provides access close to home/ supports collaborative sustainability	Prevention & Wellbeing Mental Health and Emotional Wellbeing Healthier Wales Population Health	1.1	1.2	3.3			4.3				

Cluster Annual Plan 2025-2026

Accelerated Cluster Development	Existing	Utilising opportunities that technology can bring to increase access to services	The principles of the Primary Care Model for Wales to increase the digital offer around triage and signposting to ensure patients are seen by the right person at the right time in the right place. Working with Torfaen GP surgeries to increase numbers utilising technology to improve access to GMS services.	*NHS Recovery* *Supporting Social Care/Health Workforce* *Healthier Wales* *Working alongside Social Care* *Population Health*	1.1		3.3	4.1	4.2	4.3				
Accelerated Cluster Development	Existing	Continue to progress with the ACD Programme	Develop and support both exit strategies and business cases to enable proven concepts to be transitioned over to core funding. Raising awareness of the benefits and opportunities for improving population outcomes through collaboration and strengthening partnership arrangements.	Healthier Wales Population Health NHS Recovery Supporting Social Care/Health Workforce Working alongside Social Care	1.1	1.2	3.3	4.1	4.2	4.3				
Estates Mapping	New/Existing	Utilising an assets-based approach to refine our Estates Strategy	To scope and understand Torfaen's estate and reviewing to enhance and optimise services care closer to home. Support practices with IG bids to improve sustainability within practice. Scoping out room use and estate costings for Cwmbran high street "health on the high st" and county hospital	NHS Recovery Supporting Social Care/Health Workforce Healthier Wales Population Health	1.1	1.2								
Staff wellbeing	Existing	Supporting our Health and Social Care staff within Torfaen staff within Primary and Community Care to feel valued, engaged with in a positive sense of wellbeing at work	The NCN is committed to providing wellbeing support to well deserving staff, offering a wellbeing space, but also to provide a warm personal welcome from the Torfaen Health and Social Care Team and well-being support and guidance.		1.1	1.2	3.3			4.3				

Additional supporting information for NCN Plan

Appendix 1 - NCN Spend

NCN spend2425.docx

Appendix 2 - Plan on a Page

Plan on a Page new Template.docx

Finance and Workforce Summary Torfaen North and South NCN

North Torfaen Spend Plan Summary		2024-25
Annual Budget	WTE	301,338
Top Slice: Advisers, Phlebotomy, Dementia		
Roadmap		13,924
Practice Based		
Pharmacists	0.90	70,291
Community Connectors	2.00	65,448
CATCH	2.30	84,611
PWPs	1.60	58,900
App Levy		927
Drop TL lewis accrual	-	1,487
Med Equipment		-
HHI		14,997
Telephone Triage		
Flu	-	252
Staff training		780
Laptop		1,534
Total Expenditure		309,672
Uncommitted Expenditure	-	8,334

South Torfaen Spend Plan Summary		2024-25
Annual Budget	WTE	280,450
Top Slice: Advisers, Phlebotomy, Dementia		
Roadmap		12,213
Practice Based		
Pharmacists		-
Community Connectors	2.00	65,448
CATCH	2.30	99,152
PWPs	2.10	53,511
Non Pay		
Iris I		122
HHI		9,998
Med Equipment		526
Postage	-	3,542
Flu	-	288
TM Lewis accrual	-	1,487
Total Expenditure		235,652
Uncommitted Expenditure		44,798

Due to the north deficit, we are exploring an opportunity for external contribution from TVA to the HHI project to come within our budget.

Working Together to Develop, Deliver & Sustain Services on a Local Level

Torfaen NCN Plan – 2025-26

The NCNs priorities are to: -

- Improve the health and wellbeing of the local population.
- Improve and support sustainability of our GP practices and supporting services.
- Support people to stay well, lead healthier lifestyles and live independently.
- Reduce health inequalities.
- Deliver the Clinical Futures Strategy in primary and community care.
- Care closer to home.
- Review and recruit to the integrated wellbeing network role (IWN) to develop established programme.
- Expand on our CRT unit support within the community, working collaboratively.
- Provide more easily accessible , joined up "place based" health and social care in community settings.
- Work towards National Prescribing Indicator targets. Address any outlier prescribing practice and remain below set budgets.
- Ensure that services have the flexibility to meet individual needs
- Improve access to specialist expertise.
- Provide a positive experience for patients and carers.
- Ensure a supportive working environment and career development opportunities for our staff, creating a culture that motivates.

Areas of Focus – what we are doing / going to do?

Sustainability

- CATCH providing support for GP practices, also providing the Care Home DES on behalf of 2 practices with positive evaluation.
- Gwent House and Trevethin estates to support additional services and reduce demand in practice.
- Cluster Pharmacist improving medicines safety.
- Engagement with Medicines Management team to address and improve outlier prescribing.
- Psychological Health Practitioners (PHP's) providing access to mental health advice and support within GP practices.
- Luton Model rollout and promotion of extended prescription intervals.
- Continue to identify services, technology and innovation to help aid access and sustainability for General Practice and community services such as AccuRx and Choose Pharmacy platform.
- Continue improvement and equitable provision of Enhanced Services.

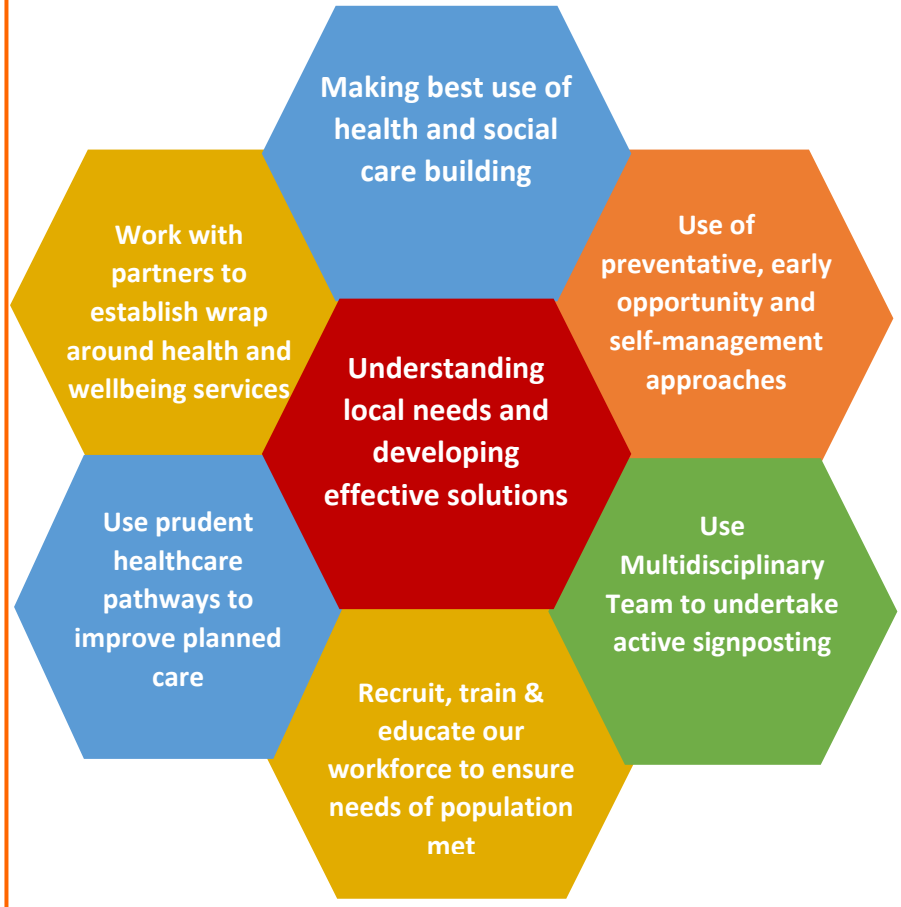
NCN Accelerated Cluster Development & Partnerships.

- Capture the knowledge and experience of the NCN, ISPB and IWN to map service provision, identify gaps and develop community orientated solutions and networks using community assets according to population need.
- Professional Collaboratives inform NCN decision making.
- Care Navigation signposting to local services to ensure the right care at the right time at practice level to be cascaded via ISPB and professional collaboratives.
- Reducing health inequalities CVD Outreach in Torfaen ISPB project.
- Community Pharmacy Independent Prescribing clinic GP practice booking system pilot.
- Robust governance arrangements for NCN funding, SLAs and evaluation of services.

Building Community Resilience

- Local needs analysis to identify priorities and develop effective solutions.
- Promoting referral and increasing access to specialist roles in the community such as Palliative Care services, Diabetic and Respiratory Specialist Nurses.
- Community Connectors link individuals with local groups, activities and organisations to support, promote, socialise and ensure community engagement.
- Highlighting preventative services to keep citizens well including influenza immunization/ childhood immunization / smoking cessation services / weight management services / exercise schemes.

How are we delivering change?



"Enablers"

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

How will we know if we have made a difference?

Evaluation for funded project, review of health and wellbeing outcomes, positive feedback of patients and staff.