



Bwrdd Iechyd Prifysgol
Aneurin Bevan
University Health Board



BLAENAU GWENT (EAST & WEST) NCN IMTP 2026-2029



NCN Executive Summary:

Blaenau Gwent Borough covers a geographical area of 109 km² (42 square miles) with a population of approximately 70,000. Its main towns—Abertillery, Brynmawr, Ebbw Vale, and Tredegar. Health and social care provision in the area relies on a collaborative approach, bringing together independent contractors, the local authority, and third sector organisations.

In Blaenau Gwent, there is a notable disparity in healthy life expectancy between the most affluent and the most disadvantaged members of our community. This inequality is compounded by the inverse care law, which highlights the challenge of managing chronic conditions and reducing premature mortality. Consequently, our services are accessed by a high number of individuals with complex and multiple health needs. This plan sets out our commitment to addressing those needs.

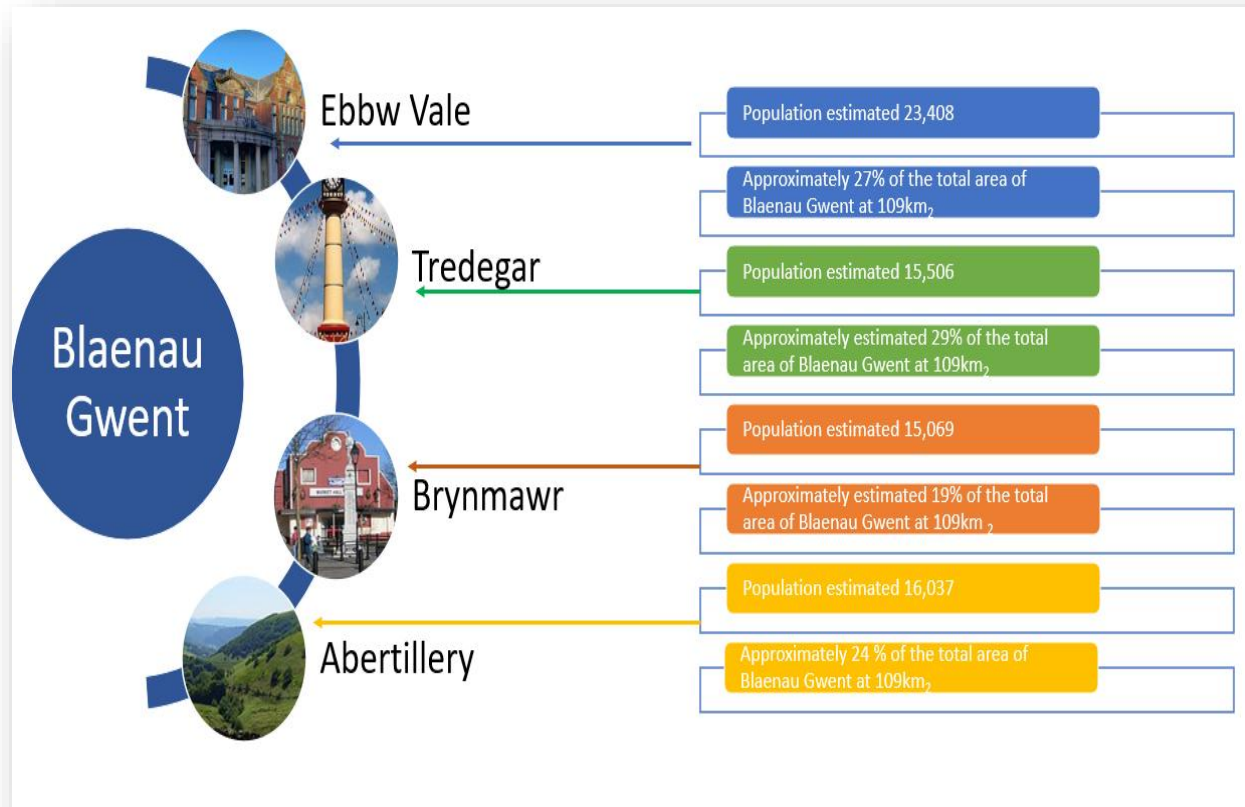
Our approach is grounded in the **Care Aims Framework**, which guides us in achieving better outcomes for service users. It provides a set of principles that support informed decision-making, underpinned by a shared public service duty to “do the most good, least harm, for the most people in a fair way.” We aim to foster a resilient community by embedding person-centred care, empowering individuals and families to take ownership of their health and wellbeing through prevention, self-care, and early intervention—driving the change our communities need.

Data and anecdotal evidence show that Blaenau Gwent has a significantly lower healthy life expectancy compared to the Welsh average—by approximately six years for both males and females. Services are frequently under pressure, resulting in delays in accessing timely support. Through this plan, the **Neighbourhood Care Network (NCN)** will continue to support community led services. This will be achieved by working collaboratively across acute, secondary, social care, independent contractor, primary care, community, and third sector services.

The borough is part of the **Deep End Wales network**, which represents general practices serving the most socioeconomically deprived communities. This status highlights the significant health inequalities faced locally, including a high burden of illness and complex care needs. Practices in these areas experience elevated demand for mental health support, chronic disease management, and face persistent barriers to access, all within the constraints of limited resources.

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Blaenau Gwent (BG) is organised into two **Neighbourhood Care Networks (NCNs)**, each addressing the distinct needs of their communities:



Blaenau Gwent West NCN- Serving approximately 36,800 residents across Ebbw Fawr Valley and Sirhowy Valley. BG West consists of 26 *lower layer super output areas (LSOAs)*, according to the *Welsh Index of Multiple Deprivation WIMD Data 2025 7* (27%) of these are in the top 10% most deprived areas in Wales and 17 (65%) in the top 50%. Notably 81% of LSOAs are in the top 50%

Blaenau Gwent East NCN - Serving approximately 35,000 residents across the Upper Ebbw Fach and Lower Ebbw Fach parts of Blaenau Gwent. BG East consists of 19 LSOAs, according to the *WIMD Data 2025 2* (10%) of these are in the top 10% most deprived areas in Wales and 17 (90%) in the top 50%. Notably 100% of LSOAs are in the top 50% for employment.

Key Findings identified for Blaenau Gwent in Welsh Index of Multiple Deprivation (WIMD) 2025

Blaenau Gwent remains one of Wales most deprived local authorities, with a highest proportion of small areas in the most deprived 10% (20%).

- **Overall Deprivation:** Blaenau Gwent has the highest proportion of its areas in the most deprived 10% and 50% in Wales.
- **Employment:** It has the highest percentage of areas (24%) in the most deprived 10% for employment
- **Health:** The authority shows the lowest (most deprived) median rank for health.
- **Community Safety:** It has a high proportion (28%) of areas in the most deprived 10% for community safety.

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Our priorities align with those of **Aneurin Bevan University Health Board (ABUHB)**, the **Blaenau Gwent Integrated Service Partnership Board (ISPB)**, and the **Gwent Regional Partnership Board (RPB)**. We will adopt a distributed leadership model to ensure full engagement from all partners, enabling us to coordinate high-quality support for the people of Blaenau Gwent. The focus areas outlined in this plan are consistent with our 2026–2029 strategy and are driven by the **Primary Care Model for Wales**.

Our goal is to demonstrate how primary and community health services can work alongside the community, third sector agencies and local authority partners as a unified system to deliver our place-based care vision of a **“Happy, Healthy Blaenau Gwent”**,

Strategic Partners:

Strategic Context:

The NCNs are part of an integrated system of decision making, all of which impacts on the effective functioning of the health and care system.

Workstreams are managed and taken forward via NCN three-year plans. This shapes the decisions taken by the Integrated Services Partnership Board (ISPB) and help to achieve the priorities set out by the Regional Partnership Board (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, working together to start well.
- **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

Blaenau Gwent Integrated Service Partnership Board (ISPB)

Following the federation of Blaenau Gwent and Torfaen Councils, there is now a single Integrated Services Partnership Board (ISPB) serving both Blaenau Gwent and Torfaen. The ISPB comprises representatives from all parts of the health and care system. In Blaenau Gwent and Torfaen, it represents 8 distinct “places”: 4 in Torfaen and 4 in Blaenau Gwent. While these localities share the same board, each set of NCNs will maintain their own distinct identity to reflect the priorities and needs of their own places.

Throughout 2025, the Blaenau Gwent and Torfaen (BGT) ISPB is preparing for the introduction of Place-Based Care (PBC), having been selected as the pilot localities for the new PBC operating model. The PBC operating model has to be more than a shuffling of the existing resources. It has to be more than additional ‘partnership’



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meetings. And it has to be more than a growth in local services. It is a call to arms to do things differently. To think about data and insight differently; to plan services differently; to take decisions differently; and to direct investment differently.

The ISPB is the engine room of Place-Based Care. It will assess our places' performance against the priorities set by the RPB, and coordinate changes/interventions across the system when an outcome is not improving at the level or pace we would have expected. To fulfil this role, in 2026, the BGT ISPB will be reshaping its vision, objectives, priorities, datasets, and meeting structures as it rolls out the new PBC operating model. This will align with and inform the investment plans for the 8 places.

- Recognising that there is still work to do before the ISPB plan is in place, the 2026 NCN plan will retain the objectives and priorities set in the previous year by the Blaenau Gwent ISPB so that it can continue to support people to access local support and community skills within their neighbourhoods.

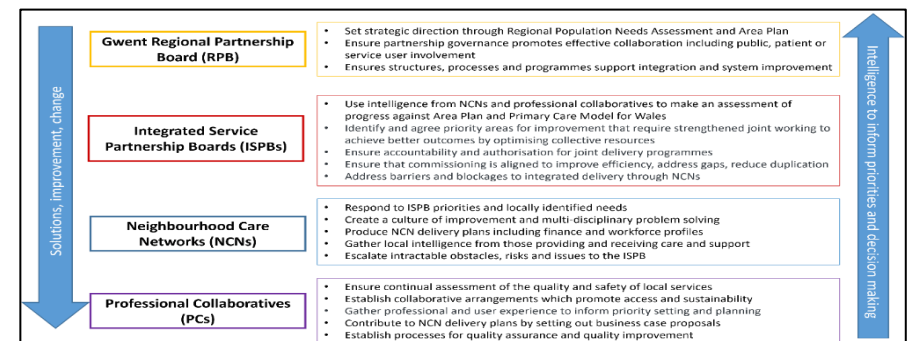
<p>ISPB objectives:</p> <ul style="list-style-type: none"> • Deliver local implementation of RPB priorities • Coordinate available resources to meet population needs • Provide strategic direction • Support partnership working • Ensure plans reflect population health intelligence 	<p>← Solutions, Improvement, Change →</p> <p>← Intelligence for priorities & decision making →</p>	<p>ISPB priorities:</p> <ul style="list-style-type: none"> • 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
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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.



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Health Board and NCN Priorities

ABUHB IMTP 2026 – 2029- & 10-Year Strategic Priorities



Better Health: Together we will support people to be healthy, active, and happy.

OUTCOMES			
There will be positive change in the factors that contribute to poor health	There will be more people who are a Healthy Weight	There will be a reduction in preventable diseases	
PRIORITIES			
Health Protection	Health Improvement	Prevention	Best Start in Life

Better Care: Together we will deliver what matters to people – supporting our staff to thrive and achieving quality, kind, and sustainable care.

OUTCOMES			
People will have more Healthy Days at Home	Our provided and commissioned services will meet the relevant quality and clinical standards	More people will be able to access health services in their local communities	
PRIORITIES			
Place Based Care	Access & Sustainability	Improving Quality & Experience	Embedding Value & Efficiency

Better Lives: Together we will create strong, safe, and connected communities.

OUTCOMES			
People will find it easier to connect with their communities, use local services, and feel respected	Our budget spent on services in the community will have increased	More people will engage with their local community to reduce loneliness and support good health	
PRIORITIES			
Healthy Places	Resilient & Connected Communities	Safe Spaces	Quality of Life

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2025/26 Agreed NCN Priorities

The Health Board agreed NCN priorities for the 2025/2026 annual plan.

1. To align the work of 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. To support the development of Place Based Care
2. To ensure NCNs have good understanding of Integrated Wellbeing Networks (IWN) in order to utilise community assets such as community groups and voluntary organisations that help people maintain or develop social support networks. Coproduction of a 'social prescribing' model that connects people to activities, groups and services in their community addressing practical, social and emotional needs
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 therapist, housing and third sector organisations
4. 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
5. 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

From 2027-2029 Agreed NCN Priorities- 1 and 2 have been combined as one priority reflected below –

1. Connecting people to Non-Medical activities, groups, and services in their community which can address their practical, social and emotional needs
2. Reducing premature mortality and morbidity through prevention and management of diabetes and cardiovascular risk factors
3. MDT working for people with complex needs who are most at risk of deterioration or adverse events
4. Equity of access to supplementary/enhanced services across Gwent

Progress Made Against Agreed NCN Priorities within 2025/2026

Over the next three years, all NCNs across ABUHB have committed to the NCN strategic priorities that will shape their delivery focus. These priorities are fully integrated within the place-based care model, positioning NCNs as the central mechanism for delivering care that is locally responsive, well-coordinated across services, and closer to home.

Priority 1:

To align the work of 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. To support the development of Place Based Care

The following provides a summary of progress made in Blaenau Gwent against the agreed NCN priorities for 2025/2026.



As part of our 2025/26 Annual Plan, our goal was to align with the key priorities set out for Neighbourhood Care Networks (NCNs) by developing a community-focused model of primary care. This approach is rooted in a deeper understanding of local assets and population needs, with particular attention to socially vulnerable and marginalised groups. This is being delivered through our place-based care strategy: **“Happy, Healthy Blaenau Gwent.”** **To note;** *While Happy Healthy Blaenau Gwent includes a social prescribing element, our vision is for it to serve as the overarching framework for place-based care and collaborative working—bringing all initiatives together under one unified brand.*

Launched in July 2025, *Happy Healthy Blaenau Gwent* is a locally driven initiative that reflects our vision for Blaenau Gwent as a compassionate and collaborative community. Our aim was to foster resilience by empowering citizens to access local resources that support their health and wellbeing.

The framework was aligned with the **Welsh Government’s National Framework for Social Prescribing**, and its core objectives are being locally interpreted to drive the programme forward.

Our ambitions include:

1. Empowering individuals to care for themselves and support one another
2. Building stronger, more resilient communities
3. Collaborating with partners to deliver high-quality, equitable services now and into the future

This vision is underpinned by national strategies such as *The National Primary Care Programme*, *A Healthier Wales*, and *Prosperity for All*, which advocate for sustainable workforce models and greater integration of third sector support to meet rising service demands. Regional Integrated Funding (RIF) has enabled us to embed the *Happy Healthy Blaenau Gwent* model as the key component of our place-based approach.

As part of our social prescribing model within **HHBG**, in partnership with Blaenau Gwent Local Authority, GAVO, and Aneurin Leisure Trust, we have recruited four community-based **Wellbeing Coaches** through a service level agreement. These coaches are embedded within the four localities of Blaenau Gwent, rather than being based in GP practices. This model allows for tailored, locally rooted support. Referrals into the programme are facilitated via the **Access Elemental** platform.

- **Strengthening Our Partnership with Trailblazer**

We're proud to be deepening our collaboration with the **Trailblazer project**, a vital initiative focused on supporting economically inactive individuals with health needs. Through this enhanced partnership, **Happy, Healthy Blaenau Gwent (HHBG)** has expanded its reach by offering personalised support that helps people take meaningful steps toward future employment.

This marks a powerful stride in tackling the broader determinants of health and empowering individuals to build better lives. We believe this project will have a lasting impact—not only for the people and families of Blaenau Gwent, but also for the professionals who walk alongside them.

By working together, we're building a more connected, supported, and resilient community—one where everyone has the opportunity to thrive.

- **In-Work Support Service – Blaenau Gwent GP Practice Pilot**

In collaboration with Case UK, we launched an exciting pilot in November 2025 across GP practices in Blaenau Gwent, offering one clinic per week in both the East and West areas of the borough.

The **In-Work Support Service (IWS)** is designed to provide rapid access to work-focused interventions for employees and self-employed individuals across Wales. Its core aim is to support people in managing health conditions—particularly common musculoskeletal and mental health challenges—so they can stay in work or successfully return following sickness absence.

Through a range of **evidence-based interventions**, including psychological therapies, the service empowers individuals to take control of their wellbeing and thrive in their professional lives.

- **Communication and Engagement – 2025/26 in the development stages**

As part of the *Happy Healthy Blaenau Gwent*, the locality is currently developing a Communication and Engagement strategy. This includes scoping the creation of a professional and citizen-facing website, which will host a comprehensive compendium of resources related to HHBG. The platform will be accessible to all residents and organisations across Blaenau Gwent, supporting improved access to information, services, and community wellbeing initiatives.

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- **Championing Community Wellbeing**

We've continued to support local wellbeing schemes, guided by annual reviews and community intelligence to ensure we're addressing the most pressing needs each year.

- **Promoting Oral Health for Young People**

Through our established Children and Young Adult Task and Finish Group, we've worked closely with ABUHB's Community Dental Service and Dental Collaborative to explore innovative ways to promote oral hygiene and education.

- **Improving Dental Access**

Dental access in Blaenau Gwent has significantly improved through the Dental Access Portal.

- **Tackle Poverty and Reduce Inequalities**

In partnership with IWN, we've used local intelligence to direct funding where it's needed most, helping communities navigate the cost-of-living crisis.

- **Expanding Stakeholder Engagement**

We've broadened stakeholder involvement across the NCN to strengthen collaboration and ensure the local voice is central to our work. This supports our vision for **place-based care** and a **Happy, Healthy Blaenau Gwent**, driving sustainable change through integrated health and social care services.

- **Empowering Frontline Staff – Wellbeing Friends Initiative**

We've developed training for frontline staff (Care Navigators, District Nurses, CRT, etc.) to improve awareness and access to GDS, Optometry, Pharmacy, and GMS services. This initiative focuses on prevention, early intervention, and building resilience through self-care and social support networks.

- **Launching the Bevan Health and Wellbeing Centre**

The official opening of the Bevan Health and Wellbeing Centre – a flagship example of integrated, community-based care. It brings together health, social care, and voluntary sector partners under one roof to better serve our population.

- The NCN continued to profile hub timetables to enable Care Closer to Home in terms of delivering services for children and adults.

- **Blaenau Gwent Estates Strategy Development**

A comprehensive estates strategy has been developed for Blaenau Gwent, identifying risks and setting clear priorities across short-, medium-, and long-term timeframes.

- **2–3-Year-Old Flu Programme Delivery**

The flu vaccination programme for 2–3-year-olds continues to strengthen through effective collaboration between NCNs, GP practices, the vaccination service, and preschool/education settings. This strong partnership has led to increased uptake across the area.

- **District Nursing Housebound Flu Delivery Process**

In partnership with Blaenau Gwent District Nursing teams and the vaccination service, a Standard Operating Procedure (SOP) has been created for the 2025/26 flu delivery to housebound patients. This SOP ensures clarity and consistency in delivery and has been shared as an example of good practice with other localities across Gwent.

- **Partnership Working – NCN, Third Sector, and IWN Marketplace & Wellbeing Events**

Community wellbeing events were delivered in response to identified population needs. These events featured contributions from a wide range of partners, 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.

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- **Practice Protected Learning Time (PLT)**

A children-focused PLT session was organised and facilitated by the NCN, in collaboration with Blaenau Gwent Youth Services, Flying Start, Community Dental Service, Health Visiting, School Nursing, SPACE, and Neurodiversity services

- **Green Spaces**

The locality team continues to identify and coordinate relevant training opportunities.

Priority 2:

To ensure NCNs have good understanding of Integrated Wellbeing Networks (IWN) in order to utilise community assets such as community groups and voluntary organisations that help people maintain or develop social support networks. Coproduction of a 'social prescribing' model that connects people to activities, groups and services in their community addressing practical, social and emotional needs

- Worked in partnership with IWN to use local intelligence to direct funding effectively, supporting communities through the cost-of-living crisis.
- Collaborated with IWN to expand the network of Wellbeing Friends, creating a stronger mechanism for sharing information about local support and activities aimed at reducing loneliness and isolation.
- Increased the number of community buildings signed up to the Community Wellbeing Hub network in partnership with IWN. The NCN and IWN applied asset-based approaches to create accessible community resources that support integrated care. These resources were shaped by community aspirations, enabling health, social care, and third-sector services to be delivered in informal, familiar settings. This approach addressed social, economic, and environmental factors contributing to poor health and wellbeing. By using a strength-based model, previously separate services collaborated to develop solutions focused on what matters most to individuals, families, and communities. Through shared understanding, the NCN, IWN, and PBC Team strengthened collaboration with third-sector and community organisations to deliver early intervention, prevention, and chronic disease management, with a focus on diabetes, CVD, mental health, and social prescribing through wellbeing coaches.
- Worked with IWN to further populate the “**BG in This Together**” community map, improving visibility of local resources and support.

Priority 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 therapist, housing and third sector organisations

Blaenau Gwent MDT Progress 2025/2026

During 2025/26, the locality team has worked in collaboration with the Local Authority Community Resource Team (CRT) to develop a joint approach for delivering a Multidisciplinary Team (MDT) model across Blaenau Gwent. As part of the Pathways of Care Transformation Grant, two MDT Coordinators have been appointed to facilitate the model, ensuring coordinated support for individuals with complex needs who are most at risk of deterioration or adverse events.

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- **Professional Stakeholder Engagement**
Engaged with GP practices and NCNs through one-to-one practice visits, focusing on the development and integration of the Multidisciplinary Team (MDT) approach.
- **Collaborative MDT Project Development and Governance**
Jointly developed the MDT project with key stakeholders and established a robust governance framework to ensure effective delivery, accountability, and oversight.

NCN Roles Supporting Multi-Disciplinary Team (MDT) Working: - 25/26 continued to evaluate the progress of-

- Blaenau Gwent & WAST APP Hospital Avoidance Project.
- Ongoing Evaluation of the Blaenau Gwent WEST First Contact Physiotherapy MSK Project
- Rolling Out the Blaenau Gwent WEST NCN Pharmacist Housebound Programme

Priority 4

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

In 2025/26, the locality team completed the initial scoping phase of this priority, identifying key areas and opportunities for collaboration in delivering diabetes prevention and managing CVD risk factors. Insights from this work have informed the design of a systematic and scalable approach for implementation across the locality.

- **Diabetes Prevention Programme**
Successful roll out of the All-Wales Diabetes Prevention Programme across both clusters where patients, in the pre-diabetic stage, are 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.
- **Cardiovascular Risk Quality Improvement**
During 25/26 practices continued to review hypertension registers to identify opportunities to optimise patient care and reduce the risk of future complications. This is a live project, launched in recent months, and forms part of a three-year Quality Improvement (QI). Practices are actively sharing learning and best practices, contributing to improved patient outcomes. There is also potential to collaborate with our collaboratives (GMS, Optometry, Pharmacy, Nursing and Allied Health Professionals) to enhance this work further, which we are keen to explore as the project becomes more embedded.
- **Hypertension Case Finding and Community Engagement**
A targeted hypertension case finding project is underway within GP practices, delivered as part of an enhanced service. The initiative seeks to identify individuals with undiagnosed hypertension through structured screening. Looking ahead, we are working in partnership with the IWN to expand visibility

and engagement through community-based activities, including the “Know Your Numbers” campaign. Subject to securing suitable venues, future plans include delivering opportunistic screening in community settings such as wellbeing cafés, or via mobile units visiting workplaces and local hubs to promote healthy behaviours and early detection

- Through a shared understanding the NCN, IWN and PBC Team have strengthened collaboration with third sector and community organisations to deliver early intervention, prevention and chronic disease management with a focus on diabetes, CVD, mental health and social prescribing through wellbeing coaches.

Priority 5:

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

Enhanced Services and Health Inclusion Mapping

Ongoing collaboration with the General Medical Services (GMS) team is focused on assessing the specific health needs of the Blaenau Gwent locality and identifying the most effective models for delivering place-based services. Where local practices are unable to meet service demand, alternative providers may be commissioned to deliver targeted interventions—such as long-acting reversible contraception (e.g., coils and implants).

In parallel, mapping work is being undertaken in partnership with the Health Inclusion Team to better understand service gaps and opportunities for improving access and equity across the locality.

Certain enhanced services, including those supporting asylum seekers and individuals experiencing homelessness, may be best delivered directly by GP practices. Others, such as contraceptive procedures, may be more appropriately provided through locality-based hubs to ensure accessibility and consistency.

Recognising the operational pressures faced by practices in Blaenau Gwent, discussions are underway with the Primary Care Contracting Team to explore the development of a financial model that would incentivise and support greater uptake of enhanced services. This approach aims to balance service sustainability with meeting local population health needs.

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The table below shows the current service provision and identifies gaps in enhanced services across the Blaenau Gwent locality. *Cells highlighted in yellow indicate services currently delivered by practices, while cells in white represent areas where the enhanced service is not being provided*

Practice Code	Practice Name	List Size- July 2025	NCN	Place- based	Homeless	Asylum Seeker	Substance Misuse	Depo-Provera	Depo/sayana Press	Contraceptive Implants (Nexplanon)	Nexplanon (Non-registered)	IUCD Registered	IUCD Non-Reg	Minor Surgery	Minor Surgery – Fee A	Minor Surgery- Fee B		
W93009	Aberbeeg Medical Practice	4654	East	Abertillery				Y							Y	Y		
W93075	Abertillery Group Practice	5844							Y									Y
W93007	Cwm Calon Surgery	5558							Y								Y	Y
W93115	Blaina Medical Practice	6493		Brynmawr				Y								Y	Y	
W93068	Brynmawr Medical Practice	10825					Y	Y										Y
W93619	Cwm Health Centre	5082	West	Ebbw Vale				Y		Y		Y			Y	Y		
W93032	Glan Rhyd Surgery	10339							Y							Y	Y	
W93623	Pen Y Cae Surgery	9845					Y		Y				Y			Y	Y	
W93065	Glan yr Afon Medical Practice	7019		Tredegar		Y		Y								Y	Y	
W93063	Tredegar Medical Practice	6829							Y									

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Challenges, risks and barriers to successful delivery of agreed milestones within 2025/2026

Challenges, Risks and Barriers 2025/2026	
Financial Constraints	Pay awards have led to unpredictable fluctuations beyond our control, making it difficult to commit to long-term planning or pilot new initiatives. Happy Healthy Blaenau Gwent is a key workstream due to its significant impact on the local population and its alignment with NCN and Place-Based Care priorities. The project currently operates with limited funding and is awaiting confirmation that the Regional Integration Fund (RIF) will be extended to March 2027. If funding is not extended, there is a risk that NCN-funded projects may be withdrawn to ensure resources are focused on initiatives that align with NCN and Place-Based Care priorities.
Workforce retention, recruitment & resilience	<ul style="list-style-type: none"> • Ongoing uncertainty around workforce capacity, fluctuating staffing levels, and challenges in recruiting clinical professionals significantly hinder our ability to plan and deliver services effectively. • There is also uncertainty regarding the continuation of funding for key programmes such as <i>Happy Healthy Blaenau Gwent</i> and <i>Integrated Wellbeing Networks</i>, which impacts sustainability
Rising Deprivation Levels	<ul style="list-style-type: none"> • Blaenau Gwent continues to experience significant health inequalities, closely linked to socio-economic deprivation. The current financial crisis is exacerbating these issues, placing additional strain on services. • Demand for health and social care is increasing, driven by an ageing population with more complex needs, further pressuring already stretched services across health, social care, and the third sector
Poverty and Inequalities	<ul style="list-style-type: none"> • The ongoing cost of living crisis is having a profound impact on mental health and wellbeing, resulting in increased demand for local support services.
Bureaucratic Processes	<ul style="list-style-type: none"> • Lengthy and complex procedures often delay the implementation of key priorities, reducing our ability to respond swiftly to emerging needs
Sustainability of Primary Care Services	<ul style="list-style-type: none"> • Three GP practices (two from January 2026) have recently returned to managed status, raising concerns about long-term sustainability. • A number of single-handed practices operate within the cluster, with uncertainty surrounding their future over the next 2–3 years. • 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.
Estates	<ul style="list-style-type: none"> • While some improvements have been made, many estate facilities remain unfit for delivering place-based care. • Limited capacity and inadequate buildings restrict our ability to reduce service demand and seize opportunities for transformation. • Progress is heavily reliant on a constrained capital programme, which limits the pace of estate strategy implementation.
Demand, Capacity and Operational pressures	<ul style="list-style-type: none"> • Rising service demands and operational pressures continue to divert focus away from service development, • Innovation, and initiatives aimed at alleviating system strain. • System-wide pressures are impacting the delivery and effectiveness of services across the board.

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NCN Planning - 2026/2027		
Identified Quarterly Milestones Against Agreed NCN Priorities for 2026/2027		
Priority	Defined Delivery Milestones	Defined Delivery Milestones
1. Connecting people to non-medical activities, groups, and services in their community which can address their practical, social and emotional needs	Q1	Complete Evaluation of Happy Healthy Blaenau Gwent <ul style="list-style-type: none"> • Gather and analyse data to assess impact on population wellbeing. • Identify gaps and opportunities for service improvement. Dental Collaborative Lead <ul style="list-style-type: none"> • Appoint a designated GDC lead for the Blaenau Gwent West Dental Collaborative to provide leadership, coordination, and support for ongoing progress. Expanding Stakeholder Engagement: <ul style="list-style-type: none"> • Broadening NCN participation to ensure inclusive collaboration and maintain a strong local voice
	Q2	2–3-Year-Old Flu Campaign <ul style="list-style-type: none"> • Plan and agree on the continuation of the flu vaccination campaign for 2–3-year-olds, working collaboratively with GMS, the Vaccination Service, and education and preschool settings. Green Space Initiative <ul style="list-style-type: none"> • Improve health and wellbeing through the use of gardens and outdoor spaces.
	Q3	Support for Community Wellbeing Schemes working with other assets/groups i.e., Local Wellbeing Partnership <ul style="list-style-type: none"> • Reviewed annually using local intelligence to identify priority needs

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Q1, Q2, Q3, Q4
*Ongoing
progress/discussions
throughout 2026*

Define Expansion Strategy for Place-Based Care

- Use evaluation findings to inform future service design.
- Prioritise interventions that address identified population needs.

Secure Long-Term Sustainability

- Initiate discussions at ISPB level regarding funding options.
- Develop a proposal to transition Happy Healthy Blaenau Gwent from a time-limited RIF-funded project to a core service.

Stakeholder Engagement and Governance

- Align plans with ISPB priorities and local care strategies.
- Ensure collaborative input from NCN, IWN, LA, Third Sector and community partners

Place Based Care Implementation Planning

- Draft roadmap for service integration into mainstream provision.
- Set timelines for phased delivery and resource allocation.

Oral Health Promotion

- Continue collaborating with ABUHB Community Dental Service and the Dental Collaborative to identify and implement opportunities for promoting good oral hygiene across the community.

Tackle Poverty and Reduce Inequalities

- Partnering with IWN and Local Wellbeing Partnership to direct funding based on local intelligence

Estates Strategy

- Identify local community needs and priority areas for preventative health campaigns.
- Plan and schedule campaign days across Blaenau Gwent in partnership with IWN.
- Deliver targeted events promoting self-care and symptom management.
- Evaluate impact and refine approach for future campaigns.

Hypertension Case Finding

- Implement enhanced service for targeted screening in practices.
- Partner with IWN and community groups for “Know Your Numbers” campaigns.
- Deliver community-based screening opportunities (well-being cafés, mobile health units at workplaces and local venues).
- Link screening with lifestyle advice and referral pathways; evaluate impact.

Chronic Kidney Disease (CKD) QI Project

- Increase urine ACR testing to identify proteinuria and risk-stratify patients.
- Embed CKD risk profiling into practice workflows.
- Provide targeted clinical reviews and optimise prescribing for high-risk patients.
- Share learning and best practice across NCN through QI meetings.

Q2

Integrated Community-Level Working

- Strengthen collaborative working across cluster partners.
- Expand use of hot clinics and community-based step-up facilities.
- Monitor impact on reducing reliance on acute services and improving care closer to home.

Evaluate outcomes and refine processes for seamless transitions.

Outcome Monitoring

- Jointly monitor and evaluate outcomes, adjusting plans as needed.

Q4

NCN IMTP 2026-2029

		<p>NCN Roles Supporting Multi-Disciplinary Team (MDT) Working:</p> <p>Blaenau Gwent & WAST APP Hospital Avoidance Project</p> <ul style="list-style-type: none"> • Evaluate effectiveness and amend processes as needed. • Complete annual review and report findings. <p>Blaenau Gwent WEST First Contact Physiotherapy MSK Project</p> <ul style="list-style-type: none"> • Continue data collection and monitoring of patient outcomes. • Conduct interim evaluation and identify improvement areas. • Implement amendments based on findings. • Finalise evaluation and share recommendations. <p>Blaenau Gwent WEST NCN Pharmacist Housebound Programme</p> <ul style="list-style-type: none"> • Review medication management outcomes and patient feedback. • Amend processes to optimise delivery. • Complete evaluation and plan next steps for scaling <p>Review of Psychological Health Practitioner Programme</p> <ul style="list-style-type: none"> • Begin comprehensive review of the current delivery model. • Assess alignment with local population needs and GMS requirements. • Draft recommendations for improvement and integration into mental health pathways.
<p>4. Equity of access to supplementary/enhanced services across Gwent</p>	<p>Q1</p> <p>Q3</p>	<p>Enhanced Services Delivery</p> <ul style="list-style-type: none"> • Work with the GMS Collaborative to assess local needs and capacity for enhanced services. • Develop place-based delivery models, including: <ul style="list-style-type: none"> ○ Practice-based services for asylum seekers and homeless health.

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Q3

- Locality hub services for contraceptive care (coils/implants).
- Commission alternative providers where practices cannot meet demand.
- Explore opportunities for new income streams aligned with local health needs.

Enablers required to deliver 2026/2027 quarterly milestones

- Data & Intelligence
- Partnership Infrastructure
- Workforce Development
- Workforce Capacity
- Digital Tools
- Funding & Commissioning:
- Community Engagement
- Evaluation Framework
- Outcome monitoring
- Clinical Support
- Evaluation and Monitoring

NCN IMTP 2026-2029

Challenges, risks and barriers to successful delivery of agreed milestones within 2026/2027

Challenges, Risks and Barriers	2026/2027
Financial Constraints	Pay awards have led to unpredictable fluctuations beyond our control, making it difficult to commit to long-term planning or pilot new initiatives. <i>Happy Healthy Blaenau Gwent</i> is a key workstream due to its significant impact on the local population and its alignment with NCN and Place-Based Care priorities. The project currently operates with limited funding. There is a risk that NCN-funded projects may be withdrawn to ensure resources are focused on initiatives that align with NCN and Place-Based Care priorities.
Workforce retention, recruitment & resilience	<ul style="list-style-type: none"> • Ongoing uncertainty around workforce capacity, fluctuating staffing levels, and challenges in recruiting clinical professionals significantly hinder our ability to plan and deliver services effectively. • There is also uncertainty regarding the continuation of funding for key programmes such as <i>Happy Healthy Blaenau Gwent</i> and <i>Integrated Wellbeing Networks</i>, which impacts sustainability
Rising Deprivation Levels	<ul style="list-style-type: none"> • Blaenau Gwent continues to experience significant health inequalities, closely linked to socio-economic deprivation. The current financial crisis is exacerbating these issues, placing additional strain on services. • Demand for health and social care is increasing, driven by an ageing population with more complex needs, further pressuring already stretched services across health, social care, and the third sector
Poverty and Inequalities	<ul style="list-style-type: none"> • The ongoing cost of living crisis is having a profound impact on mental health and wellbeing, resulting in increased demand for local support services.
Bureaucratic Processes	<ul style="list-style-type: none"> • Lengthy and complex procedures often delay the implementation of key priorities, reducing our ability to respond swiftly to emerging needs
Sustainability of Primary Care Services	<ul style="list-style-type: none"> • Two GP practices have recently returned to managed status, raising concerns about long-term sustainability. • A number of single-handed practices operate within the cluster, with uncertainty surrounding their future over the next 2–3 years.
Estates	<ul style="list-style-type: none"> • While some improvements have been made, many estate facilities remain unfit for delivering place-based care. • Limited capacity and inadequate buildings restrict our ability to reduce service demand and seize opportunities for transformation. • Progress is heavily reliant on a constrained capital programme, which limits the pace of estate strategy implementation.
Demand, Capacity and Operational pressures	<ul style="list-style-type: none"> • Rising service demands and operational pressures continue to divert focus away from service development, innovation, and initiatives aimed at alleviating system strain. • System-wide pressures are impacting the delivery and effectiveness of services across the board.

NCN IMTP 2026-2029

Finance Profile 2026/2027

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 26/27 for both East and West and that there will be pay increase. To achieve a breakeven position, the following projects are at risk:

- Community Wellbeing Schemes
- Chronic Diseases Management
- Mental Health and Wellbeing
- Flu Delivery Support
- Digital Solutions and Inclusion
- Staff Wellbeing
- Winter Planning / PLT
- Training and Education

Blaenau Gwent East		Total Allocation; £239.129
Pay		2026/27
Subjective	Scheme	Total
22250-Independent Contractors	Top Slice - Independent Advisers	161
2AA31-Nursing HCA/HCSW Band 3	Top Slice - Phlebotomy	9,747
2E481-Pharmacist Band 8A	Practice Based Pharmacists	66,173
2E351 Psychological Health Practitioner	Psychological Wellbeing Practitioners	114,347
2A471 - Hospital Admission Avoidance Paramedic	Hospital Admissions Avoidance Paramedic	41,628
		£232,056
Non Pay		
Details	Scheme	Total
33610 Travel & Subsistence	Practice Based Pharmacists	150
Dementia Road Map	Top Slice - Dementia Roadmap	375
Community Wellbeing schemes (Winter/Dental)	Community Wellbeing Schemes	225
Chronic Disease Management	Expert Patient Programme (EPP)	6,323
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	-
		7,073
Total Funding		239,129

Blaenau Gwent West		Total Allocation; £268.589
Pay		2026/27
Subjective	Scheme	Total
22250-Independent Contractors	Top Slice - Independent Advisers	185
2AA31-Nursing HCA/HCSW Band 3	Top Slice - Phlebotomy	8,526
2E481-Pharmacist Band 8A	Practice Based Pharmacists	41,777
2E351 Psychological Well-being Practitioner	Psychological Wellbeing Practitioners	109,217
2A471 - Hospital Admission avoidance paramedic	Hospital Admissions Avoidance Paramedic	41,523
		£ 201,228
Other Non-Pay		
Details	Scheme	Total
33610 Travel & Subsistence	Practice Based Pharmacists	-
Community Wellbeing schemes (Winter/Dental)	Community Wellbeing Schemes	5,463
Dementia Road Map	Top Slice - Dementia Roadmap	375
Chronic Disease Management	Chronic Disease Management	6,523
Digital Solutions and Inclusion	Telehealth	-
Mental Health / Wellbeing	Mental Health / Wellbeing	5,000
Flu Delivery Plan Support	Flu Delivery Plan Support	-
Staff wellbeing	Wellbeing Workshop	-
Development of Hubs/BG West	First Contact Physio	50,000
Independent prescribing qualification	Independent Prescriber	-
Winter Planning PLT	Training - Workflow Optimisation	-
		£ 67,361
Total Funding		£ 268,589

Workforce Profile 2026/2027

Please outline your workforce profile for 2026/2027

Workforce Challenges and Place-Based Opportunities in Blaenau Gwent

Clinical recruitment remains the most significant workforce risk within Blaenau Gwent. The locality is experiencing the effects of change fatigue, alongside an aging workforce and a notable gender imbalance. These factors, combined with high levels of deprivation and complex health needs, have created a fragile workforce landscape across core services.

However, these challenges also present a unique opportunity to adopt a **place-based approach** to workforce planning—one that is rooted in the specific needs, demographics, and strengths of the Blaenau Gwent population. By aligning workforce development with local priorities, we can begin to build a more sustainable and responsive model of care.

The **Primary Care Plan for Wales** supports this direction, encouraging the implementation of multidisciplinary teams that draw on a broad range of clinical and non-clinical skillsets. In Blaenau Gwent, this means exploring alternative roles and competencies that can enhance capacity and better meet the evolving needs of our communities.

A key priority for the locality is to take a holistic, population-focused view—developing a workforce that is not only clinically capable but also equipped to address the wider determinants of health. This includes investing in new ways of working, such as community hubs, and designing roles based on competencies rather than traditional professional boundaries.

Cross-Sector Recruitment Showcase Event

In collaboration with Primary Care, Community Services, Local Authority and Third Sector partners, the locality is planning to design and deliver an interactive recruitment showcase event. The event will provide a unique opportunity for attendees to apply, interview, and be appointed on the day, with the aim of addressing workforce vacancies across all sectors in Blaenau Gwent. This innovative approach supports integrated workforce planning and aims to attract talent from Blaenau Gwent and surrounding localities into key roles within the locality.

Workforce Sustainability Concern (2027–2029)

While this workforce profile focuses on the **2026/2027** period, it is important to highlight a significant emerging concern for the **years 2027 to 2029**. Specifically, within General Medical Services (GMS), the age profile of the GP workforce in Blaenau Gwent indicates a growing proportion of aging practitioners. This trend presents a substantial sustainability challenge for service continuity and workforce planning, requiring proactive strategies to mitigate future risks to primary care delivery within Blaenau Gwent.

	<p>Q2</p> <p>Q1</p> <p>Q2</p> <p>Q3</p> <p>Q4</p>	<ul style="list-style-type: none"> • Broaden NCN participation further to ensure inclusive collaboration. • Increase community representation in decision-making forums. <p>2–3-Year-Old Flu Campaign</p> <ul style="list-style-type: none"> • Deliver flu vaccination campaign in collaboration with GMS, Vaccination Service, and education/preschool settings. • Evaluate uptake and refine approach for future years. <p>Expansion Strategy for Place-Based Care</p> <ul style="list-style-type: none"> • Finalise and begin implementing the expansion plan informed by evaluation findings. • Scale up interventions that address priority population needs across all four place-based areas. • Establish performance metrics for expanded services. <p>Long-Term Sustainability</p> <ul style="list-style-type: none"> • Secure agreement at ISPB level for sustainable funding model. 	<ul style="list-style-type: none"> • Track performance metrics for expanded services. <p>Long-Term Sustainability</p> <ul style="list-style-type: none"> • Embed sustainability principles into all new initiatives and service developments. <p>Stakeholder Engagement and Governance</p> <ul style="list-style-type: none"> • Continue to strengthen governance structures to support the expanded place-based care model. • Continue to deepen collaboration with NCN, IWN, LA, Third Sector, and community partners through quarterly engagement forums. • Ensure continued alignment with updated ISPB priorities and regional strategies. <p>Place-Based Care Implementation</p> <ul style="list-style-type: none"> • Continue to Deliver integration of services into mainstream provision as per the updated roadmap. • Allocate resources and workforce for full implementation. • Review and adjust timelines based on progress and stakeholder feedback. <p>Community Wellbeing Schemes</p> <ul style="list-style-type: none"> • Continue to conduct annual reviews using local intelligence to identify emerging priority needs. • Continue to expand schemes where evidence demonstrates positive impact.
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- Transition Happy Healthy Blaenau Gwent from RIF-funded project to a core service within mainstream provision.
- Embed sustainability principles into all new initiatives.

Stakeholder Engagement and Governance

- Strengthen governance structures to support expanded place-based care.
- Deepen collaboration with NCN, IWN, LA, Third Sector, and community partners through quarterly engagement forums.
- Ensure alignment with updated ISPB priorities and regional strategies.

Place-Based Care Implementation

- Deliver phased integration of services into mainstream provision as per roadmap.
- Allocate resources and workforce for full implementation.
- Review and adjust timelines based on progress and feedback.

Oral Health Promotion

- Continue partnership with ABUHB Community Dental Service and Dental Collaborative.
- Monitor impact on any oral health initiatives implemented 27/28.

Tackle Poverty and Reduce Inequalities

- Continue to work in partnerships with IWN and Local Wellbeing Partnership to refine funding allocation based on updated local intelligence.
- Introduce additional targeted interventions for vulnerable groups based on local informed intelligence.

Community Asset Mapping

- Continue to use findings to address gaps and integrate community resources into service planning.
- Ongoing evaluation of mapping services across 3rd Sector assets

Estates Strategy

- Review and evaluate implementation of short-, medium-, and long-term priorities.
- Ongoing delivery of agreed estate improvements where feasible.

2–3-Year-Old Flu Campaign- depended on outcome 27/28

Community Wellbeing Schemes

- Conduct annual review using local intelligence to identify emerging priority needs.
- Expand schemes where evidence shows positive impact.

Oral Health Promotion

- Continue partnership with ABUHB Community Dental Service and Dental Collaborative.
- Launch new community oral health initiatives based on previous year's learnings.

Tackle Poverty and Reduce Inequalities

- Work with IWN to refine funding allocation based on updated local intelligence.
- Introduce additional targeted interventions for vulnerable groups.

Community Asset Mapping

- Complete comprehensive mapping of third sector assets across Blaenau Gwent.
- Use findings to address gaps and integrate community

- Deliver flu vaccination campaign in collaboration with GMS, Vaccination Service, and education/preschool settings.
- Evaluate uptake and refine approach for future years.

Partnership Working

- Ongoing delivery of Community Wellbeing Events across all four place-based areas.
- Continue to Introduce new engagement formats to strengthen local voice.

Green Space Initiative.

- Continue to develop opportunities to deliver health and wellbeing utilising the green space agenda

resources into service planning.

Estates Strategy

- Progress implementation of short-, medium-, and long-term priorities.

Partnership Working

- Continue delivery of Community Wellbeing Events across all four place-based areas.
- Introduce new engagement formats to strengthen local voice.

Green Space Initiative

- If funding secured, implement green space project to promote health and wellbeing.
- Monitor impact and explore opportunities for scaling.
- Continue with the development of the BG in this together website, hand in hand with community hub development and asset mapping. Build capacity within staff (CIO, Wellbeing Coaches and other link worker

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		<p>roles through PBC model) to develop and update the website.</p> <ul style="list-style-type: none"> Continue the development of 'community wellbeing hubs' in collaboration with the local authority and third sector, ensuring these assets can connect people with health and wellbeing resources, activities and other people to support their own wellbeing. 		
<p>2. Reducing premature mortality and morbidity through prevention and management of diabetes and cardiovascular risk factors</p>	<p>Q1, Q2, Q3, Q4</p>	<p>Community Campaigns for Self-Care and Symptom Management</p> <ul style="list-style-type: none"> BCP to prioritise high risk patients who are still smoking for smoking cessation support. Behaviour Change Practitioners (BCPs) within the Blaenau Gwent IWN Team to support the management of behavioural risk factors. In addition to providing a universal smoking cessation offer, a targeted offer, using a population health management approach, will be implemented to identify and prioritise high-risk patients, particularly those with chronic respiratory conditions, to offer smoking 	<p>Q1, Q2, Q3, Q4</p>	<p>Community Campaigns for Self-Care and Symptom Management</p> <ul style="list-style-type: none"> Continued identification of high-risk patients and planning of behaviour change approaches to support the management of behavioural risk factors, based on prevalence of disease, winter planning priorities or local need. Identify local community needs and priority areas for preventative health campaigns. Plan and schedule campaign days across Blaenau Gwent in partnership with IWN. Deliver targeted events promoting self-care and symptom management. Evaluate impact and refine approach for future campaigns. <p>Diabetes Prevention</p> <ul style="list-style-type: none"> Continue NCN participation in the Diabetes Prevention Programme.

cessation support to. As part of this intervention identified individuals will be encouraged to take up the offer of vaccinations if they are eligible and to engage with warmer home initiatives.

- Identify local community needs and priority areas for preventative health campaigns.
- Plan and schedule campaign days across Blaenau Gwent in partnership with IWN.
- Deliver targeted events promoting self-care and symptom management.
- Evaluate impact and refine approach for future campaigns.

Diabetes Prevention

- Continue NCN participation in the Diabetes Prevention Programme.
- Use data to identify at-risk patients and develop invitation plans for structured education and lifestyle programmes.
- Collaborate with community partners to deliver group sessions and digital support for behaviour change.

- Use data to identify at-risk patients and develop invitation plans for structured education and lifestyle programmes.
- Collaborate with community partners to deliver group sessions and digital support for behaviour change.
- Review outcomes and adjust interventions to reduce progression from pre-diabetes.

Cardiovascular Risk Reduction

- Continue to support practices to review and optimise treatment for patients on hypertension registers.
- Continue to facilitate peer learning and data sharing across practices.
- Continue to Engage pharmacy collaborative for medication optimisation.
- Continue to embed programme as part of a 3-year QI initiative with measurable outcomes.

Hypertension Case Finding

- Monitor and evaluate impact of enhanced service for targeted screening in practices.
- Monitor and evaluate implemented campaigns in partnership with IWN.
- Continue to deliver community-based screening opportunities (well-being cafés, mobile health units at workplaces and local venues).
- Continue screening with lifestyle advice and referral pathways; evaluate impact.

- Review outcomes and adjust interventions to reduce progression from pre-diabetes.

Cardiovascular Risk Reduction

- Support practices to review and optimise treatment for patients on hypertension registers.
- Facilitate peer learning and data sharing across practices.
- Engage pharmacy collaborative for medication optimisation.
- Embed programme as part of a 3-year QI initiative with measurable outcomes.

Hypertension Case Finding

- Implement enhanced service for targeted screening in practices.
- Partner with IWN and community groups for “Know Your Numbers” campaigns.
- Deliver community-based screening opportunities (well-being cafés, mobile health units at workplaces and local venues).

Chronic Kidney Disease (CKD) QI Project

- Monitor the impact of increased urine ACR testing to identify proteinuria and risk-stratify patients.
- Monitor impact of CKD risk profiling into practice workflows.
- Continue to provide and monitor impact
- Continue sharing and learning of best practice across NCN through QI meetings.

		<ul style="list-style-type: none"> • Link screening with lifestyle advice and referral pathways; evaluate impact. <p>Chronic Kidney Disease (CKD) QI Project</p> <ul style="list-style-type: none"> • Increase urine ACR testing to identify proteinuria and risk-stratify patients. • Embed CKD risk profiling into practice workflows. • Provide targeted clinical reviews and optimise prescribing for high-risk patients. • Share learning and best practice across NCN through QI meetings. 		
<p>3. MDT working for people with complex needs who are most at risk of deterioration or adverse events</p>	<p>Q1, Q2, Q3, Q4</p>	<p>Deliver fully integrated, proactive, and person-centred care that consistently improves outcomes for individuals with complex needs, eliminates duplication, and embeds early intervention and prevention as standard practice.</p> <p>Integrated Assessment & Planning</p>	<p>Q1, Q2, Q3, Q4</p>	<p>Continue to deliver fully integrated, proactive, and person-centred care that consistently improves outcomes for individuals with complex needs, eliminates duplication, and embeds early intervention and prevention as standard practice.</p> <p>Integrated Assessment & Planning</p>

- Explore digital tools for joint assessments, ensuring real-time input from clinical, social care, and third-sector partners.
- Standardise integrated care plans across NCN, incorporating predictive analytics for risk stratification.

Effective Coordination

- Automate referral triage through Elemental access system
- Institutionalise MDT scheduling with dynamic rostering to ensure timely access to specialist input.

Information Sharing

- Achieve full interoperability between health and social care systems, enabling seamless data exchange.

Person & Family Engagement

- Co-design care pathways with service users and carers, embedding feedback loops into service improvement.

- Embed digital technology for joint clinical, social care, and third-sector input, ensuring predictive modelling for early risk identification.

Effective Coordination

- Fully automate referral triage and care navigation through Elemental and complementary platforms.

Information Sharing

- Achieve universal interoperability across health, social care, and voluntary sector systems.
- Explore opportunities for patient-controlled data sharing to enhance transparency and trust.

Person & Family Engagement

- Monitor Co-produce care pathways
- Monitor personalised digital engagement tools

Outcome Monitoring

- Continue the use of real-time dashboards for joint outcome monitoring.

- Expand digital engagement tools for goal setting and progress tracking.

Outcome Monitoring

- Implement real-time dashboards for joint outcome monitoring across health and social care.
- Use population health analytics to inform continuous improvement and resource allocation.

Culture of Collaboration

- Formalise cross-sector governance structures to sustain integrated working.
- Develop joint workforce development programmes to strengthen collaborative culture.

NCN Roles Supporting MDT Working

Blaenau Gwent & WAST APP Hospital Avoidance Project

- Explore opportunities to embed the role and associated processes as a core component of place-based care, leveraging alternative

- Continue to use population health analytics to inform proactive resource allocation and service redesign.

Culture of Collaboration

- Embed cross-sector governance, ensuring sustainability of integrated working.
- Deliver joint workforce development programmes to strengthen collaborative culture.

NCN Roles Supporting MDT Working

Blaenau Gwent & WAST APP Hospital Avoidance Project

- Transition the role into a core component of place-based care, supported by sustainable funding models and integrated digital pathways.

Blaenau Gwent First Contact Physiotherapy MSK Project

- Fully embed as a standardised NCN service across East and West, leveraging predictive demand modelling and alternative funding streams.

Blaenau Gwent NCN Pharmacist Housebound Programme

- Fully embed as a standardised NCN service across East and West

Review of Psychological Health Practitioner Programme.

funding streams beyond NCN resources.

Blaenau Gwent WEST First Contact Physiotherapy MSK Project

- Explore opportunities to embed the role and associated processes as a core component of place-based care, leveraging alternative funding streams beyond NCN resources.
- Explore opportunities to expand this service to Blaenau Gwent East NCN to ensure equitable service

Blaenau Gwent WEST NCN Pharmacist Housebound Programme

- Continue to be influenced by programme outcomes.
- Explore opportunities to expand this service to Blaenau Gwent East NCN to ensure equitable service

Review of Physiological Health Practitioner Programme

- Explore opportunities to embed the role and associated processes as a core component of place-based

- Fully embed as a standardised NCN service across East and West, leveraging predictive demand modelling and alternative funding streams.

Integrated Community-Level Working

- Operationalise community hubs as digital-first care centres, offering multi-disciplinary step-up/step-down care with virtual MDT support.
- Embed virtual MDT consultations as default practice, reducing delays and improving access.
- Measure impact using predictive analytics and real-time dashboards, focusing on acute demand reduction and population health outcomes.

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		<p>care, leveraging alternative funding streams beyond NCN resources.</p> <p>Integrated Community-Level Working</p> <ul style="list-style-type: none"> • Establish community hubs offering multi-disciplinary step-up/step-down care. • Embed virtual MDT consultations to reduce delays and improve access. • Measure impact on acute demand reduction using predictive analytics. 		
<p>4 Equity of access to supplementary/enhanced services across Gwent</p>	<p>Q1, Q2, Q3, Q4</p>	<p>Milestones – Enhanced Services Delivery</p> <ul style="list-style-type: none"> • Strengthen collaboration with the GMS Collaborative to implement findings from the 2026/27 needs assessment and ensure equitable access to enhanced services across Blaenau Gwent. <p>Expand place-based delivery models, including:</p> <ul style="list-style-type: none"> • Fully operational practice-based services for asylum seekers and homeless health, 	<p>Q1, Q2, Q3, Q4</p>	<p>Milestones – Enhanced Services Delivery</p> <ul style="list-style-type: none"> • Embed enhanced services into core delivery models, ensuring consistency and resilience across all practices and localities. • Fully integrate place-based services for asylum seekers and homeless health into mainstream pathways, with measurable outcomes on health equity. • Expand contraceptive care hubs to include broader sexual health services. • Diversify income streams through preventative health programs, digital health innovations, and community-based initiatives aligned with population health priorities.

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		<p>with integrated pathways to community support.</p> <ul style="list-style-type: none">• Scale up locality hub services for contraceptive care (coils/implants) to meet increasing demand and improve patient choice.• Introduce alternative provider partnerships where capacity gaps persist, ensuring timely service delivery and reducing patient waiting times.• Develop innovative income streams aligned with population health priorities, exploring digital health solutions and preventative care initiatives.		
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Title	New or Existing project	Brief Description	Results/Benefits expected by end Mar 2027	Strategic alignment against ABUHB and NCN Priorities	Areas of Focus				Budget	Funding Source	Current Status	Comments
					1	2	3	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					£500	NCN	Ongoing – funding at risks	This delivery model is a proven concept; however, without broader system and community support beyond the NCN, the project faces a significant risk of not being implemented in the next campaign.
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.	Working with ABUHB Community Dental Service and the Dental Collaborative via the Children and Young Adult Task and Finish Group to promote oral hygiene health.	Healthier Wales Population Health					£0	Funding to be sourced	Ongoing	A designated collaborative GDC lead must be identified for the Blaenau Gwent West Dental Collaborative to support progress and coordination.
Health Protection Services	Existing	Community Wellbeing Schemes	Work in partnership with IWN to use local intelligence to direct funding towards priority issues identified within the community	Supporting Social Care/Health Workforce Healthier Wales Working alongside Social Care Population Health Prevention & Wellbeing Transformation and Vision for clusters Communication and Engagement					£1000	NCN funding	Ongoing - funding at risk	
Accelerated Cluster Development	Existing	Broadening NCN participation to ensure inclusive collaboration and maintain a strong local voice	Widening stakeholder attendance across our NCN to ensure full collaboration to meet population needs and maintain local voice. We will seek to implement 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						No funding	Ongoing	
Estates Mapping	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					£4,000 financial year 2025/2026	RIF Funding	Ongoing – Funding at risk	Will need partner support to ensure map is as up to date as possible

NCN Delivery Action Plan
Please List activities or projects planned to commence during 2026/2027, as well as those ongoing from 2025/2026
Key: Alignment to NCN Agreed Priorities 2025-2027

1. Connecting people to Non-Medical activities, groups, and services in their community which can address their practical, social and emotional needs

2. Reducing premature mortality and morbidity through prevention and management of diabetes and cardiovascular risk factors

3. MDT working for people with complex needs who are most at risk of deterioration or adverse events

4. Equity of access to supplementary/enhanced services across Gwent

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			Continue with the development of the BG in this together website, community hub and asset mapping.	Prevention & Wellbeing 24/7 model Transformation and Vision for clusters Workforce & Organisational Development Data & Digital technology								
Building Community Resilience Population Health Health Protection Services	New	Utilise the expertise and skills of Behavioural Change Practitioners to educate and support individuals in managing their own health.	Leverage the expertise of Behavioural Change Practitioners to empower individuals in self-management of health, aligning with prevention, patient activation, and population health goals	Healthier Wales Population Health Health Protection Framework Prevention-Based Health and Care Framework					Behaviour coaches funding – Permanent funding	Welsh Government	Ongoing	
Training and Education	New	Embed Active Signposting Through MECC Principles	Embed a culture of active signposting as a 'light touch' approach, based on <i>Making Every Contact Count</i> principles, where existing staff engage people in conversations about what matters to them and provide information to signpost them to services, groups and activities, using local knowledge or directories. The relevant MECC training materials and courses will be promoted to partners.	Healthier Wales Making Every Contact Count (MECC) Promote, Prevent and Prepare for Planned Care					The signposting training can be facilitated by IWN		Ongoing	IWN can facilitate the light touch signposting briefings for professionals and community volunteers and Wellbeing
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, monitor activity and outcomes to avoid duplication 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					£256,054 – HHBG	RIF Funding	Ongoing	
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					£256,054 – HHBG As per spend plan attached	RIF Funding	Ongoing	GP cluster commitment to continue to 2024/25
Pathway Optimisation	New / Existing	The ongoing sustainability of all health and social care services on	To support the NCN will undertake a mapping of services – both clinical and non-clinical to	Supporting Social Care/Health Workforce					TBC	NCN Funding	Ongoing	We are in the early scoping phase of projects aimed at

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		an operational footing level is paramount,	<p>ensure that people with the right skills and experience work in an environment that is fit for purpose.</p> <p>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.</p> <p>Work in partnership with the IWN to explore community assets that can support with preventative interventions for the most vulnerable patients such as those suffering from chronic respiratory disease, these will include opportunities to attend warm hubs.</p>	<p>Healthier Wales</p> <p>Working alongside Social Care</p> <p>Population Health</p>								diabetes prevention and CVD risk factor management, with the goal of delivering these programmes systematically and at scale across NCNs. Funding requirements are still to be determined.
<p>Health Protection Services</p> <p>Building Community Resilience</p> <p>Population Health</p>	New	Integrated, Person-Centred Care for Complex Needs	<p>Deliver proactive, coordinated care through joint assessments, integrated planning, and effective MDT collaboration. Engage individuals and families, share information securely, monitor outcomes, and foster a culture of collaboration across health, social care, and third-sector partners.</p>	<p>Supporting Social Care/Health Workforce</p> <p>Healthier Wales</p> <p>Prevention & Wellbeing</p> <p>Strategic Programme for Primary Care</p>					LA funding	Ongoing		
Health Protection Services	New / Existing	Community-Based Prevention and Risk Reduction for Diabetes and Cardiovascular Health	<p>Deliver targeted campaigns and structured programmes across Blaenau Gwent to support self-care, symptom management, and early intervention. This includes:</p> <p>Diabetes Prevention: Identify and engage individuals with pre-diabetes through education, lifestyle programmes, and community partnerships.</p> <p>Cardiovascular Risk Reduction: Optimise hypertension management, facilitate peer learning, and embed a 3-year QI programme.</p> <p>Hypertension Case Finding: Implement proactive screening via practices, community venues, and mobile health units, linking results to lifestyle advice and referral pathways.</p> <p>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</p>	<p>Population Health</p> <p>Healthier Wales</p> <p>Prevention & Wellbeing</p>								
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	<p>Healthier Wales</p> <p>Working alongside Social Care</p> <p>Population Health</p>					As per attached spend plan	NCN funding	Ongoing GP Cluster Commitment to continue to 26/27	

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			<p>based FCP and Advanced Paramedic programmes, reducing the impact of on the day demand.</p> <p>Developing exit strategies to enable proven concepts such as Psychological Wellbeing Practitioners and Practice Based Pharmacists to be core funded.</p>	<p>Prevention & Wellbeing</p> <p>Communication and Engagement</p> <p>Transformation and Vision for clusters</p> <p>Workforce & Organisational Development</p>								
Health Protection Services	New	Enhanced Services and Chronic Disease Management	<p>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.</p> <p>Deliver equitable access to enhanced services across Blaenau Gwent through place-based models and alternative providers where needed.</p> <p>Focus on improving early identification and management of chronic conditions, including CKD, by embedding risk profiling, optimising treatment, and sharing learning through NCN QI initiatives. Explore new income streams aligned with local health needs to ensure sustainability.</p> <p>Continue 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</p>	<p>Healthier Wales</p> <p>Population Health</p> <p>Prevention & Wellbeing</p>					TBC		New	We are in the early scoping phase of projects aimed at developing services that are high quality and equitably across the Borough, with the goal of delivering these programmes systematically and at scale across NCNs. Funding requirements are still to be determined
Building Community Resilience Population Health	Existing	Marmot Region	<p>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.</p>	<p>Healthier Wales</p> <p>Population Health</p> <p>Transformation and Vision for clusters</p> <p>Prevention and Wellbeing</p> <p>Communication and Engagement</p> <p>Mental Health and Emotional Wellbeing</p>					£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	<p>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:</p>	<p>Supporting Social Care/Health Workforce</p> <p>Healthier Wales</p> <p>Prevention & Wellbeing</p> <p>Population Health</p> <p>Communication and Engagement</p> <p>Transformation and Vision for clusters</p>					£0	No funding	Ongoing	
Accelerated Cluster Development	Existing	prioritise the establishment of Pan Cluster Groups	<p>Continue to develop the ISPB priority actions with our partnership board landscape.</p> <p>To develop and strengthen the relationship with the Gwent Regional Partnership Board</p>						£0	No funding	Ongoing	
Green Agenda	Existing	Committing to creating a greener, stronger and fairer Wales.	<p>The locality team will explore and coordinate training opportunities to raise awareness of how</p>						Funding at risk	NCN funding	New funding at risk	

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			practices can become more environmentally sustainable.								
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.						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				£0	No funding	Ongoing	
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				None, staff attending clinic will be from the core district nursing teams		Planned to commence when staffing levels improve	
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	Supporting Social Care/Health Workforce				Funding at risk	NCN Funded	ongoing	

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			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.	Healthier Wales Working alongside Social Care Population Health Prevention & Wellbeing Transformation and Vision for clusters Workforce & Organisational Development Data & Digital technology								
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					£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	

Blaenau Gwent (East and West) NCN – PLAN ON A PAGE 2026/2029

NCN Priorities

1. Connecting people to Non-Medical activities, groups, and services in their community which can address their practical, social and emotional needs
2. Reducing premature mortality and morbidity through prevention and management of diabetes and cardiovascular risk factors
3. MDT working for people with complex needs who are most at risk of deterioration or adverse events
4. Equity of access to supplementary/enhanced services across Gwent

Our Key Actions

Community-Oriented primary Care & place Based Care, Integrated Wellbeing Networks & Social Prescribing

- Annual Review of Community Wellbeing Schemes using local intelligence.
- Collaborate with Social Care & Third Sector to map services and address gaps.
- Promote Oral Health via partnerships with ABUHB Dental Services.
- Direct Cost-of-Living Support using IWN intelligence.
- Broaden NCN Stakeholder Engagement for inclusive collaboration.
- Map Community Assets across Blaenau Gwent with third sector input.
- Promote Active Signposting using MECC principles and training.
- Utilise Behavioural Change Practitioners for health education.
- Support & Monitor Social prescribing to avoid duplication.
- Develop BG in This Together Website and asset mapping.
- Explore Preventative Interventions (e.g., warm hubs for vulnerable groups).

Diabetes & Cardiovascular Risk Management

- Run Community Campaign Days for self-care and symptom awareness.
- Deliver Diabetes Prevention Programme for pre-diabetic individuals.
- Use NCN Data to identify and invite at-risk patients.
- Collaborate on Group Sessions & Digital Support for lifestyle changes.
- Optimise Hypertension Care via peer learning and pharmacy support.
- Embed CVD QI Programme with measurable outcomes.
- Implement Hypertension Screening in practices and communities.
- Link Screening to Lifestyle Advice & Referrals.

MDT Working for Complex Needs

- Deliver Integrated, Person-Centred Care through MDT collaboration.
- Conduct Joint Assessments and develop tailored care plans.
- Coordinate Referrals via Elemental system.
- Facilitate MDT Meetings with appropriate professionals.
- Enable Secure Information Sharing across sectors.
- Engage Patients & Families in care planning.
- Monitor Outcomes Jointly and adjust plans as needed.
- Foster Collaborative Culture across health, social care, and third sector.

Supplementary/ Enhanced Services Delivery

- Assess Local Needs & Capacity with GMS Collaborative.
- Develop Place-Based Models for services (e.g., IUD, homelessness).
- Commission Alternative Providers where needed.
- Improve CKD Management via ACR testing and risk profiling.
- Share Learning Across Practices through QI meetings.
- Explore New Income Streams aligned with local health needs.



Enablers

- Place Based-Care
- Data & intelligence/Digital Tools
- Partnership Infrastructure
- Workforce Development
- Workforce Capacity
- Funding & Commissioning
- Community Engagement
- Clinical Support
- Evaluation and Monitoring



How will we know if we have made a difference?

Improved patient outcomes, increased access to services, stronger community partnerships