



CAERPHILLY NCN IMTP 2026-2029

NCN Executive Summary:

This plan encompasses all three Neighbourhood Care Networks (NCNs) within Caerphilly Locality, which are geographically distributed across the East, North, and South of the Borough. Collectively, the NCNs aim to support, sustain, develop, and enhance services at a local level, working collaboratively across public and third sector organisations. Our approach is rooted in meeting the needs of local populations, addressing inequalities, and empowering individuals and communities to lead healthy, independent lives.

Caerphilly Borough spans a substantial area of 278 km² (107 square miles) and shares borders with Cwm Taf Health Board and Cardiff & Vale University Health Board. It has an estimated resident population of 176,865 (Stats Wales, Mid-Year 2024), with a GP-registered population of approximately 187,000. Out-of-hospital health and social care is delivered by a mix of independent contractors, local authority services, and third sector providers. Within Caerphilly, independent contractors include 20 GP practices, 41 community pharmacies, 21 dental practices, and 18 optometry practices.

This plan sets out the key areas of need and priority areas that will shape the core business of the NCNs. It provides a framework for delivery, monitoring, and accountability.

To meet current and future population needs, health and social care services must be resilient, responsive, and fit for purpose. Recognised service pressures require us to work flexibly and innovatively. Key challenges to address include:

- Rising demand due to an ageing population with increasingly complex health needs.
- Financial constraints and workforce shortages affecting service sustainability short, medium and longer term.
- Persistent inequalities linked to socio-economic deprivation, intensified by the current economic climate.
- Estate limitations that hinder service delivery.

During 2026–29, NCNs will focus on delivering the priorities outlined in this plan, while also exploring and implementing new initiatives and workstreams as opportunities arise. Services will continue to be delivered locally, tailored to population needs, and spanning



NCN IMTP 2026-2029

acute, secondary, social, primary, community, and third sector care settings. The accelerated NCN development programme and its associated collaboratives will serve as key enablers for local delivery.

All three NCNs recognise the vital role of our communities and citizens in shaping and sustaining our work/what we do. The Integrated Wellbeing Network (IWN) will play a central role in fostering community resilience by encouraging individuals to take ownership of their health and wellbeing. The IWN connects people with services, supports both new and existing community wellbeing initiatives, and provides accessible / relevant wellbeing information.

The NCNs' key priorities for 2026–29 will be supported by a set of enabling themes: Quality & Patient Safety, Financial Management, Communication & Engagement, Workforce, and Staff Wellbeing.

Strategic Partners:

Health and social care services are facing increasing complexity and rising demand. To ensure care is delivered at home or as close to home as possible, we must rethink and reshape how services are provided. This shift will help ensure that hospital care is reserved for situations where no other viable option exists.

Our strategic direction is guided by multiple drivers, with *A Healthier Wales* remaining the overarching policy framework for health and social care across Wales. This underpins our commitment to delivering seamless, place-based care. Central to this are the *Primary Care Model for Wales (PCMW)* and the *Strategic Plan for Primary Care*, both of which prioritise what matters most to individuals, ensuring timely access to appropriate care from the right source at the right time.



Effective transformation requires robust infrastructure to support enhanced multi-professional collaboration across health, social care, and the third sector. Local facilities and data systems must be adaptable and responsive to future needs, enabling integrated working. People should be empowered to access care digitally, and direct access to community-based services will help deliver high-quality care closer to home. By improving population health and wellbeing, strengthening communities, and supporting staff wellbeing, we can enhance recruitment and retention and build more sustainable models of care.

Locally, a key priority is the redesign of services of older people and the integration of community teams to support individuals at risk of deterioration due to long-term conditions. The goal is to provide round-the-clock care, delivered as close to home as possible. Preventative approaches are also vital to building resilient communities and ensuring long-term sustainability of services.



These ambitions align with the *Six Goals for Urgent and Emergency Care*, which aim to ensure patients receive the right care, in the right place, first time.

In Gwent, the *Regional Partnership Board (RPB)* supports the implementation of the *Social Services and Wellbeing (Wales) Act*, with three core aims that guide local delivery:

NCN IMTP 2026-2029

1. **Start Well** – Enhancing outcomes for children and families through collaborative early intervention.
2. **Live Well** – Placing people at the centre of service design and delivery.
3. **Stay Well** – Ensuring timely access to appropriate support to maintain health and wellbeing.

In Caerphilly, the *Integrated Services Partnership Board (ISPB)* is well-established and alongside working collaboratively to deliver Place Based Care, has identified three priority areas that align with NCN objectives:

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

For 2026 - 29, the Primary Care and Community Services Division will focus on delivering the following strategic priorities:

- Management and prevention of long-term conditions
- Improving access and service sustainability
- Redesigning services for older people
- Advancing NCN development and partnerships

The Integrated Wellbeing Network priorities include:

- Community engagement and capacity building
- Community asset mapping and organising
- Bridging, linking and co-ordinating wellbeing assets
- Individual and group behaviour change

To successfully deliver these priorities, it is essential that enabling foundations are in place. These include:

- Quality and patient safety
- Workforce, staff wellbeing, and organisational culture
- Communication and engagement
- Financial management
- Fit-for-purpose estate
- Digital technologies
- Value-based innovation and research

This plan sets out the national and regional strategic context alongside detailed local priorities. Population needs and local intelligence will shape our planning and delivery, helping us to define expected outcomes and benefits.

NCN IMTP 2026-2029

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.

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

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

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

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

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

NCN IMTP 2026-2029

The Health Board agreed NCN priorities for the 2025/2026 annual plan and an agreement has been reached that these priorities will continue throughout the 2026 – 2029 IMTP NCN planning cycle:

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

The Caerphilly NCNs have made strong, measurable progress across all priorities by embedding community-led approaches, strengthening cross-sector partnerships, and investing in preventative and wellbeing focused initiatives. This progress has been driven by a commitment to collaborative working, underpinned by the Accelerated NCN Development (ACD) framework and robust governance arrangements.

Key enablers include the integration of the Integrated Wellbeing Network (IWN), participatory budgeting, and social prescribing models all of which support a shift toward sustainable, place-based care that empowers individuals and communities. The establishment of multi-disciplinary team (MDT) model, success in targeted prevention programmes (such as smoking cessation and diabetes management), and the development of strategically located hubs further demonstrate tangible outcomes.

Professional Collaboratives have provided structure for peer learning, service improvement, and workforce engagement. Together, these efforts reflect a clear and ongoing commitment to delivering integrated, equitable, and preventative care, positioning Caerphilly to continue scaling enhanced services and improving population health across its diverse communities.

Priority 1: Delivered via Building resilient communities

In aligning NCN with other partners delivery plans we work towards the development of a community focussed model of primary care, informed by local assets and population needs, especially for vulnerable and marginalised groups. These combined efforts work towards connecting people to non-medical activities, groups, and services in their community to support and address their practical, social and emotional needs. Caerphilly has progressed via:

- **Collaborative Planning:** Stakeholders across sectors are actively engaged in planning and delivering services that address health inequalities and promote healthy lifestyle choices. The collaboratives have promoted awareness of Primary Care & Community Services such as WGOS and Common Ailment scheme to both service users and referring professionals.
- **Empowerment:** The Integrated Wellbeing Network (IWN) has developed localised initiatives that connect people, groups, and services, enabling communities to meet their own health and wellbeing needs.
- **Community-Specific Plans:** Outline plans have been co-produced with each IWN community, directly supporting NCN priorities.
- **Participatory Budgeting:** Delivered in partnership with GAVO and Caerphilly CBC, this initiative gives residents a voice in allocating public funds to local wellbeing projects, strengthening ownership and resilience.
- **Local Hubs:** These hubs are central to the borough's place based care strategy, bringing services closer to home and enhancing accessibility. This strategy is being costed and driven via Caerphilly ISPB ensuring all partners across the borough are engaged with the process.

NCN IMTP 2026-2029

To ensure NCNs understand and utilise IWN and community assets to co-produce a social prescribing model that supports social, emotional, and practical needs, Caerphilly has:

- **IWN:** Embedded within local communities the IWN team have enhanced and further developed CWTSH guides. CWTSH guides provide local detail of social activities available to the local population. Through a shared understanding of our diverse communities and population groups in most “at risk” and/or “high risk” categories, the NCN and IWN are evolving a PBC model. This model will act as a vehicle to design, develop and target community assets and interventions that provide proactive care and support to improve health and wellbeing. This will also proportionate universalism to reduce health inequalities, particularly in areas of high deprivation, cultural diversity and vulnerable and marginalised groups.
We continue to develop a collaborative approach to develop a more community focussed model of primary care, through deeper understanding of the community assets and local needs. Work continues to expand the IWN’s place-based approach across community wellbeing and integrated health and social care services through enhanced links with MDT teams in Caerphilly.
- **Community Wellbeing Connectors:** funded and embedded within GP practices. Linked to IWN and the Nature Wellbeing Programme, these connectors provide tailored support to individuals and families, promoting independence and community engagement. The connectors are integral to the success and delivery of the MDT model, focussing on the non-medical / social factors that impact peoples health and wellbeing.
- **Nature Wellbeing Programme:** initiative which aligns with Welsh Government’s strategic framework, created a single point of access for nature based social prescribing in Caerphilly. Activities include walking, cycling, conservation, and horticulture and are delivered by voluntary and social enterprise partners.
- **Psychological Health Practitioners:** funded and embedded within GP practices. PHPs are experienced and knowledgeable practitioners, who provide low to mid-level mental health support and guidance, including information, self-management and onward referrals to other services.
- **Third Sector Collaboration:** Strong partnerships with GAVO and other third sector organisations have enhanced support for community groups, increasing resilience and enabling a thriving voluntary sector.
- **Preventative Focus:** NCNs continue to prioritise preventative screening, immunisation, and diabetes risk identification, building on the success of the diabetes prevention programme.

Priority 2: Delivered via Long Term Conditions – Prevention and Management

Delivering systematic and scalable prevention and management programmes for long term conditions, including diabetes and cardiovascular disease (CVD).

Caerphilly’s progress is demonstrated via:

- **Diabetes Prevention Programme:** Rolled out across all GP practices, with IWN support for community based interventions targeting Type-2 diabetes and obesity.
- **CVD Prevention Focus:** worked with PHW to introduce a Health Coach role to support individuals in making positive lifestyle changes, identifying risk factors, and accessing appropriate services. The future planning for Behaviour Change Practitioners (BCPs / Health Coaches) is being led via IWN and implemented via NCNs.
- **Respiratory Services:** model has moved to Gwent-wide. NCNs support services through local place-based hubs. Support practice diagnosis of asthma as per NICE guidance with P.O.C.T. FENO testing. Support identification of P.O.C.T. COPD patients with targeted screening using COPD 6 machines.
- **Healthy Lifestyle Initiatives:** Locally programmes include weight management, exercise referral, smoking cessation, nature prescribing, and food access projects.

NCN IMTP 2026-2029

- **Immunisation Expansion:** NCNs have and continue to promote vaccination uptake across the board. Also provided an RSV focus in the North of the borough.
- **First Contact Practitioner:** funded and embedded within practices, offering capacity for patients suffering from Musculoskeletal conditions. The service provides direct access to an MSK specialist within their locality and receive expert assessment, advice, clinical intervention, and accurate referral to secondary care as required.
- **Practice Based Pharmacists:** funded and embedded within practices, PBP's work alongside GPs and other healthcare professionals to provide direct patient care, manage medication-related issues, conduct medication reviews, and help with prescription management to improve patient outcomes and support the wider clinical team.
- **Community Physiotherapy Pilot:** funded to focus on falls and care homes to support and positively impact on waiting lists. Attendance at local MDTs has enabled further partnership working, targeting those patients that are regular referrals or raise concerns.
- **Nature Wellbeing Programme:** Supports rehabilitation and outdoor activity for individuals with cardiac, pulmonary, and neurological conditions, enhancing recovery and wellbeing.
- **Behaviour Change Practitioners (BCP):** employed through PHW, BCP's offer support and interventions to individuals and groups. The roles are a core part of the place-based neighbourhood team and support building the capability of behaviour change through the delivery of formal and informal training. The practitioners apply relevant theory and behavioural science approaches to inform and deliver a range of health promoting interventions in areas such as smoking cessation, diabetes prevention, cardiovascular disease and healthy weight management.

Priority 3: Delivered via Encouraging Collaborative Working with a focus on Enhanced Services

By establishing multi-disciplinary team (MDT) working for individuals with complex needs, involving coordinated input from services within health and social care, Caerphilly has:

- **MDT Initiative:** established structured MDT meetings across all 3 NCNs in Caerphilly, enabling partners to collaboratively plan care for individuals with complex needs.
- **NCN Development (ACD) Programme:** This framework continues to drive robust planning, evaluation, and innovation across Caerphilly, supporting population health needs and reducing reactive demand.
- **Professional Collaboratives:** These groups (GMS, Pharmacy, Dental, Optometry, Nursing, AHPs) provide peer support, share best practice, and advocate for service improvement strengthening inter-professional dialogue and quality assurance, including supporting working relationships and the development of systems for communication.
- **Governance Model:** A bottom up and top down governance approach ensures local needs are identified and addressed in line with strategic direction.
- **Positive Outcomes Emerging:** Early successes, such as the optometry collaborative's contribution to smoking cessation, demonstrate the impact of cross boundary working.

Priority 4: Delivered via Encouraging Collaborative Working with a focus on Enhanced Services

Ensuring high-quality, equitable provision of enhanced services across NCNs, focusing on areas such as IUDs, minor surgery, substance misuse, homelessness, and care for asylum seekers and refugees has been a focus this year, progress includes:

- **Primary Care Contracting Engagement:** Caerphilly locality is working closely with the contracting team to promote GP involvement in enhanced service delivery.

NCN IMTP 2026-2029

- **Service Gap Identification:** Active scoping of local needs undertaken, with a specific focus on addressing longstanding gaps in care home service provision (notably 124 residents identified as underserved)
- **Equity of Access:** NCNs are committed to exploring solutions that ensure all residents, including those in care homes, receive consistent and equitable care.
- **Increased Service Uptake:** focus at NCN meetings on enhanced service provision individually and as NCNs undertaken. Increase in practices service uptake in Homelessness and IUCDs.

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

- Sustaining core services across health & social care settings due to:
 - Recruitment and retention difficulties
 - Increased demand on 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.
- Cost of living pressures impacting on people’s wellbeing, increasing demand across health and social care.
- Increase in costs (particularly supported roles / uplifts) thus decreasing service provision
- Insufficient funding for collaborative roles limits engagement
- Non contractual participation across some collaboratives – impacts engagement
- Deficits in professional collaborative leads.
- NCN Support to Professional Collaboratives temporarily funded (SIM) – risk if not continued to next year.
- Caerphilly IWN support temporarily funded (IWN lead and Community Involvement Officer) – risk if not continued to next year.

NCN Planning - 2026/2027

Identified Quarterly Milestones Against Agreed NCN Priorities for 2026/2027

Priority	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	<ul style="list-style-type: none"> • Map and Understand Community Assets & Needs Continue asset mapping across Caerphilly, using population health data to identify vulnerable groups and highlight local strengths such as voluntary organisations, wellbeing hubs, food initiatives, and green spaces. • Align NCNs and IWNs through Integrated Planning Joint planning sessions to embed Place Based Care principles into strategies and operational plans, ensuring service development reflects community insights and costed model opportunities. • Expand Preventative and Community-Based Services Increase access to programmes like NERS, Behaviour Change Practitioners, Community Wellbeing Connectors, and Nature Wellbeing initiatives through hubs, care homes, and community venues.

NCN IMTP 2026-2029

- **Support Long-Term Conditions via Place-Based Hubs** Develop hubs offering specialist services (e.g. diabetes prevention, rehab pathways) and integrate Nature Wellbeing initiatives across cardiac, pulmonary, and neurological care.
- **Collaborate on Respiratory and CVD Models** Implement the Gwent-wide respiratory model and align CVD prevention with education, early risk identification, and the Hypertension project.
- **Build Resilient Communities through Social Prescribing**
 - Train NCNs on IWN functions and referral pathways, sharing CWTSH guides.
 - Co-produce and pilot social prescribing pathways, linking to food, activity, and wellbeing projects.
 - Embed social prescribing into QIF priorities and place-based hubs, supported by NCN-funded roles.
 - Strengthen community connections via IWN, GAVO, Connectors, and trusted local channels, extending membership and wellbeing friend networks.
- **Enable Delivery through Integration, Workforce, and Infrastructure**
 - Use NCN/IWN governance to embed Place Based Care and social prescribing.
 - Develop and upskill roles (Community Involvement Officers, Health Coaches, Connectors).
 - Enhance hubs and infrastructure to ensure accessibility for marginalised groups.
- **Monitoring and Evaluation**
 - Track and measure outcomes of service delivery provision.
 - Use feedback from community members to refine models and ensure relevance / local need.

- Q1 - Building Resilient Communities**
Foundations & Mapping
- Continue asset mapping across Caerphilly (community groups, voluntary organisations, wellbeing hubs, food initiatives, green spaces).
 - Use population health data to identify socially vulnerable or marginalised groups.
 - Hold NCN–IWN joint planning sessions to align priorities and embed Place Based Care principles.
 - Deliver training for NCNs on IWN functions, referral pathways, and CWTSH guides.
 - Establish governance structures for NCN/IWN integration.
 - Collaboratives - Professional Collaborative Groups in the promotion of community Mental Health services such as MELO, PHP’s and Community Wellbeing Connectors
 - Inter-Collaborative communication and joint working, including digital systems to enhance and improve working

- Q2 - Building Resilient Communities**
Planning & Early Implementation
- Complete first phase of asset mapping and publish findings to partners.
 - Expand access to preventative services (NERS, Behaviour Change Practitioners, Connectors, Nature Wellbeing) in selected hubs and care homes.
 - Co-produce social prescribing model through joint design sessions with NCNs, IWNs, local authority, and voluntary sector partners.
 - Pilot social prescribing pathways in areas with high prevalence of chronic conditions (e.g. diabetes, respiratory illness).
 - Develop workforce roles (Community Involvement Officers, Health Coaches, Connectors) and begin upskilling teams in asset-based approaches.
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NCN IMTP 2026-2029

	relationships and systems of communication (i.e. NHS Futures)	
	<p>Q3 - Building Resilient Communities Service Expansion & Integration</p> <ul style="list-style-type: none"> • Launch place-based hubs offering specialist services (diabetes prevention, rehab pathways). • Integrate Nature Wellbeing initiatives into cardiac, pulmonary, and neurological rehab pathways. • Implement Gwent-wide respiratory model locally and align CVD prevention with education and early risk identification. • Embed social prescribing into QIF priorities and place-based hubs, supported by NCN-funded roles. • Strengthen community connections via IWN, GAVO, Connectors, and trusted local channels; extend membership and wellbeing friend networks. • Enhance community hubs and infrastructure to improve accessibility for marginalised groups. • Collaboratives - Promoting awareness across Primary Care & Community Services such as Welsh General Optometry Services (WGOS), Social Prescribing and Common Ailment scheme (CAS) to service users and referring professionals. 	<p>Q4 - Building Resilient Communities Consolidation & Evaluation</p> <ul style="list-style-type: none"> • Review and refine asset mapping, updating CWTSH directory and community hub resources. • Evaluate pilots of social prescribing pathways and scale successful models across Caerphilly. • Continue expansion of preventative services and long-term condition support through hubs. • Assess impact of respiratory and CVD models, including links to Hypertension project. • Monitor and measure outcomes of service delivery provision, using community feedback to refine models. • Produce end-of-year report embedding Place Based Care principles into strategic documents and operational plans, ensuring sustainability and accountability.
<p>2. Reducing premature mortality and morbidity through prevention and management of diabetes and cardiovascular risk factors</p>	<p>Delivery enablers and recommendations will be:</p> <p>Strategic Alignment</p> <ul style="list-style-type: none"> - Embed diabetes and CVD prevention in NCN planning, QIF priorities, and ABUHB strategic frameworks. - Use ISPBs to ensure top-down and bottom-up alignment across sectors. <p>Workforce and Roles</p> <ul style="list-style-type: none"> - Secure future provision of IWN, Health Coach / Behaviour Change Practitioner and Community Wellbeing Connector roles to support prevention and signposting. - Engage NCN membership including collaboratives to support delivery. <p>Community Infrastructure</p> <ul style="list-style-type: none"> - Scope place-based hubs and care closer to home to deliver prevention programmes. - Ensure accessibility for vulnerable groups through outreach and flexible formats. <p>Resources supporting healthy lifestyle messaging, particularly in areas such as Dental, vaccinations and smoking-cessation in Collaborative members premises</p>	

NCN IMTP 2026-2029

	<p>Q1 - Long Term Conditions – Prevention and Management</p> <ul style="list-style-type: none"> • Embed CVD Risk Management in Community Settings <ul style="list-style-type: none"> – Use sports and wellbeing developments as sites for lifestyle interventions (e.g. exercise referral, smoking cessation, social prescribing). – Promote early identification of CVD risk factors through outreach and education. – Link Nature Wellbeing initiatives to cardiac rehabilitation and outdoor activity programmes. 	<p>Q2 - Long Term Conditions – Prevention and Management</p> <ul style="list-style-type: none"> • Implement Health Coach / Behaviour Change Practitioner Roles <ul style="list-style-type: none"> – Embed roles within NCNs, GP Practices and community hubs. – Support individuals to develop personalised health and wellbeing plans, understand risk factors, and access local support. – Support the roles to link with rehabilitation programmes and voluntary sector partners.
	<p>Q3 - Long Term Conditions – Prevention and Management</p> <ul style="list-style-type: none"> – Develop Collaborative Pathways and Referral Models – Create integrated referral pathways between stakeholders and partners in the Caerphilly borough. – Support access to additional services and extended roles such as weight management, physical activity, and emotional wellbeing support. – Promote and support resources for healthy lifestyle messaging i.e. vaccinations and smoking-cessation (particularly in collaborative practice areas such as Dental, Pharmacy, Optom, GMS). 	<p>Q4 - Long Term Conditions – Prevention and Management</p> <ul style="list-style-type: none"> • Monitor and Evaluate at Scale <ul style="list-style-type: none"> – Use NCN and ISPB structures to monitor programme delivery, uptake, and outcomes. – Evaluate impact on hospitalisation, long-term condition prevalence, and health inequalities. – Share learning
<p>3. MDT working for people with complex needs who are most at risk of deterioration or adverse events</p>	<p><i>Delivery enablers and recommendations will be:</i></p> <p>System-Level Integration</p> <ul style="list-style-type: none"> – Align MDT development with ABUHB’s strategic direction and Caerphilly’s governance model. <p>Community Infrastructure</p> <ul style="list-style-type: none"> – Explore digital infrastructure to support shared care planning and communication. <p>Data and Evaluation</p> <ul style="list-style-type: none"> – Track outcomes for individuals supported by MDTs (e.g. reduced GP attendance, reduced hospitalisation, improved wellbeing). <p>Use feedback loops to refine MDT processes.</p>	
	<p>Q1 - Encouraging Collaborative Working with a focus on Enhanced Services</p> <ul style="list-style-type: none"> • Strengthen Professional Collaboratives <ul style="list-style-type: none"> – Explore the use of existing collaboratives (GMS, Pharmacy, Dental, Optometry, Nursing, AHP), as well 	<p>Q2 - Encouraging Collaborative Working with a focus on Enhanced Services</p> <ul style="list-style-type: none"> • MDT Structures and Governance <ul style="list-style-type: none"> – MDT meetings to continue their delivery in a structured model. – Enhance core membership to support patient need.

NCN IMTP 2026-2029

	<p>as other specialist services, to identify complex cases and escalate to MDTs.</p>	
<p>4. Equity of access to supplementary/enhanced services across Gwent</p>	<p>Q3 - Encouraging Collaborative Working with a focus on Enhanced Services</p> <ul style="list-style-type: none"> • Strengthen Professional Collaboratives <ul style="list-style-type: none"> – Promote inter-professional dialogue and shared learning to improve quality and safety. – IWN to support relationships and networks between Primary Care Teams and Prevention and Inclusion teams including Community Connectors and Adult Services. The sharing of expertise will allow for a more holistic and joined up approach in delivering patient care without any unnecessary duplication and time delay 	<p>Q4 - Encouraging Collaborative Working with a focus on Enhanced Services</p> <ul style="list-style-type: none"> • Monitor, Evaluate and Scale Proven Models <ul style="list-style-type: none"> – Monitor equity of access to MDT support across Caerphilly’s population. – Evaluate MDT impact including patient outcomes, hospitalisation, wellbeing, and service demand. – Share learning across ABUHB to inform wider rollout. – Empower local collaborative leads to champion MDT approaches.
	<p>Q1 - Encouraging Collaborative Working with a focus on Enhanced Services</p> <ul style="list-style-type: none"> • Service Mapping and Gap Analysis <ul style="list-style-type: none"> – Revisit and review provision across NCNs for: <ul style="list-style-type: none"> ○ Intrauterine Device (IUD) services ○ Minor surgery ○ Substance misuse support ○ Services for people experiencing homelessness ○ Services for asylum seekers and refugees – Identify geographic and demographic gaps, including care home populations and underserved communities. 	<p>Q2 - Encouraging Collaborative Working with a focus on Enhanced Services</p> <ul style="list-style-type: none"> • Evaluate Enhanced Services <ul style="list-style-type: none"> – Explore targeted pilots in areas of greatest need (e.g. care homes) – Monitor uptake, outcomes, and equity of access. – Use MDT forums to support complex case management and service coordination.
	<p>Q3 - Encouraging Collaborative Working with a focus on Enhanced Services</p> <ul style="list-style-type: none"> • Develop Capacity and Engagement <ul style="list-style-type: none"> – Collaborative working with Primary Care Contracting to increase the uptake across the borough. – Encourage GP engagement through focused GMS Collaborative meetings / NCNs. – Identify champions or practices to deliver on behalf of the NCNs and share good practice. 	<p>Q4 - Encouraging Collaborative Working with a focus on Enhanced Services</p> <ul style="list-style-type: none"> • Evaluation and Learning <ul style="list-style-type: none"> – Monitor service impact on health outcomes, demand reduction, and equity. – Share learning across NCNs. – Work with IWN communities to utilise their experience and expertise to inform and improve our work.

NCN IMTP 2026-2029

Further Enablers required to deliver 2026/2027 quarterly milestones

Quality & Patient Safety

The Caerphilly Quality & Patient Safety (QPS) Group is a well-established forum bringing together health and social care partners to provide divisional assurance on all matters relating to quality and patient safety across the borough. All NCN-related incidents and complaints are reported through this group. In 2026/27, the focus will be on ensuring that the outcomes of QPS meetings lead to meaningful learning and service improvements, with clear dissemination to relevant teams and services.

A key priority within the locality is the consistent delivery of safe and effective care. Regular participation of an NCN lead in QPS meetings enables timely reflection and implementation of learning from incidents and complaints. The NCNs will continue to work closely with all established collaboratives to advance the QPS agenda.

To strengthen oversight, the locality management team has introduced mini assurance meetings with service leads and budget holders. These sessions provide a platform to share good practice, identify areas requiring support, and review key operational elements such as team rosters, risk registers, budgets, and QPS indicators—including compliments, complaints, and incidents. Dedicated locality leads have been nominated to ensure robust team-level arrangements are in place.

Within primary care, the GMS Quality Improvement Framework (QIF) supports the QPS agenda. A further area of focus is the collaborative implementation between contractors (pharmacies, GPs, Optometrists etc) which aims to enhance patient experience, reduce unnecessary visits, support service sustainability, and free up capacity across the system.

Workforce & Staff Wellbeing

To build a resilient and sustainable workforce, it is essential to review existing staffing profiles, identify resource gaps, and address skill deficits. Several roles currently rely on non-recurrent funding, and a strategic plan is needed to transition these posts into core budgets. The development of Place-Based Care—ensuring residents can access services close to home is being progressed and will be supported through the following workforce initiatives:

Primary Care

- **Diversifying Clinical Roles:** Expanding the range of clinicians available to deliver appropriate interventions and offer alternatives to GP consultations. This includes paramedics, physiotherapists, occupational therapists, mental health practitioners, pharmacists, and advanced nurse practitioners.
- **Community Wellbeing Connectors:** Continued investment in lower-level community services through funding additional connectors who can signpost individuals and escalate cases when needed—helping to reduce pressure on higher-tier services.
- **Multidisciplinary Case Management:** Strengthening GP-aligned multidisciplinary working with regular meetings to proactively manage complex cases.

Community Resource Team

- **Frailty Pathway Review:** An ongoing review of the frailty service is informing the redesign of older persons care. CRT is being embedded as a core component of place-based care, playing a vital role in preventing hospital admissions and supporting timely discharge.

District Nursing

- **Comprehensive Home-Based Care:** The District Nursing Service delivers acute, complex, and end-of-life care in the community and is a key contributor to NCN cluster working and the Nursing Collaborative.
- **Service Coverage:** Operating 7 days a week from 8am to 8pm, the service comprises 7 teams aligned to 20 Caerphilly practices and several tertiary practices across neighbouring Health Boards. Referrals are accepted from both professionals and the public.
- **Role Review:** There is a need to reassess the scope of Health Care Support Workers, as current limitations require registered nurses to carry out lower-level tasks. Addressing this will improve efficiency and role clarity.
- **Recruitment Planning:** A rolling recruitment programme is being developed in collaboration with HR and divisional nurse education leads to manage workforce turnover and maintain service continuity.



Staff Wellbeing

The pressures across clinical services continue to challenge workforce resilience. Recognising the impact on staff wellbeing is critical to retaining and attracting skilled professionals. NCNs have supported a range of wellbeing initiatives, including local events and the introduction of *The Zen Den*—a therapeutic space for staff which has proven successful (winning the staff recognition award) and has been taken on tour across the borough.

Access & Sustainability

Ensuring timely and equitable access to appropriate services is a fundamental priority for Caerphilly. Services must be effective, resilient, and sustainable—both now and into the future. The *Primary Care Model for Wales* provides a framework to support these aims, with prudent healthcare principles guiding the delivery of care by the most appropriate practitioner.

General Practice remains a vital anchor within local communities and is often the first point of contact for individuals experiencing health or wellbeing concerns. Caerphilly has adopted a partial hybrid workforce model for planning purposes, which helps identify current gaps in clinical roles and anticipate future workforce needs. This approach supports robust succession planning and includes extended roles such as practice-based pharmacists, psychological health practitioners, and community wellbeing connectors. These developments also inform estate planning and capital investment prioritisation, as a broader skill mix requires more flexible physical infrastructure.

Sustainability challenges have been identified for independent contractors in Primary Care, particularly in light of rising costs associated with minimum wage increases and national insurance contributions. These pressures pose risks to long-term service viability.

NCN IMTP 2026-2029

Vacancies and staff absences across community teams continue to impact service delivery. Despite these challenges, clinical teams remain committed to providing timely and appropriate care. Within the borough, seven District Nursing teams are aligned to 20 GP practices. While alignment has improved, recruitment and retention remain longstanding issues, and service continuity is currently maintained through the dedication and flexibility of existing staff.

Local and national workstreams focused on community-based nursing provision are critical to ensuring Caerphilly is appropriately resourced to deliver care at or as close to home as possible and provides an equitable service across the borough. These workstreams must encompass all nursing roles, including rapid response teams (CRT), specialist nurses, and condition-specific expertise.

In collaboration with neighbouring localities, Caerphilly is exploring opportunities to strengthen community-based services. This includes expanding roles in generalist palliative care, care home in-reach, and other specialist areas to enhance core services and enable more residents to receive care in their communities.

The NCNs are mindful that service developments across Gwent are not always allocated proportionately based on whole-time equivalent (WTE) per resident population. This can disadvantage larger localities like Caerphilly. In 2026/27, NCNs will actively pursue strategies to improve recruitment and retention, including:

- Partnering with the Divisional Academy to explore apprenticeship pathways in both administrative and clinical support roles
- Collaborating across professional collaboratives to identify workforce solutions
- Working with communications and engagement teams to develop targeted recruitment campaigns
- Engaging with cross-sector partners to understand and address barriers to recruitment, including promoting the benefits of working locally

To support workforce development, NCNs have also invested in education and training initiatives aimed at upskilling staff and enhancing team capabilities to meet evolving service needs.

Fit for purpose estate

The size and population density of Caerphilly are central considerations in planning the borough's integrated *Place-Based Care* hub model. While some areas present opportunities for physical site development to support this approach, others with more limited infrastructure may require a flexible "hub and spoke" configuration to ensure equitable access.

From an acute and sub-acute care perspective, the borough is served by Ysbyty Ystrad Fawr, an enhanced local general hospital. Additionally, Rhymney Integrated Health and Social Care Centre provides 12 community inpatient beds. Both facilities are purpose-built and well-equipped, although the Redwood Unit in Rhymney poses geographical challenges. The Caerphilly Community Resource Team, based at Ty Graddfa in Ystrad Mynach, delivers services across the entire borough.

GP practices remain the most local and accessible "anchor" points for health and care services, often serving as the first contact for people to seek help. Several sites have been identified as priorities for redevelopment:

- **Aber Valley:** This area has the most significant estate need. The Health Board has secured Welsh Government approval for funding to develop an outline business case and appoint a Supply Chain Partner for a new, fully compliant site. The proposed development will integrate GMS, health, social care, and third sector services, providing advice, treatment, information, and community support under one roof.

NCN IMTP 2026-2029

- **Ystrad Mynach:** A key priority for both GMS provision and the creation of an integrated health and social care hub. Oakfield Street Surgery is currently at full capacity and unable to accommodate further growth or service expansion within its existing premises.

To support the development of integrated hub services, the NCN and locality teams continue to pursue capital funding opportunities and collaborate with divisional colleagues on GMS improvement grants. Joint bids have been developed with the Divisional Estates team for the following sites:

- **Pontllanfraith Health Centre:** An ABUHB owned site hosting a GP practice, community pharmacy, and various clinical services. Delays in capital investment have hindered modernisation efforts, particularly for co-located independent contractors. Key deficits such as non-compliance with DDA standards and inadequate WiFi infrastructure, these are recorded on the Datix Risk Register.
- **Trethomas Health Centre:** ABUHB-owned, this site offers integrated services and has made significant progress with minimal investment. However, faces challenges with DDA compliance and maintenance needs, limiting its capacity to deliver modern fit-for-purpose care.

Both centres require substantial upgrades to meet current service expectations and support future delivery models. Addressing these estate challenges is essential to realising the borough's vision for accessible, integrated, and sustainable place-based care.

Digital technologies

Technology is a vital enabler in the delivery of modern, effective care. To fully realise its potential, it is essential that our estate is underpinned by robust digital infrastructure and connectivity. The rapid deployment of digital solutions during the COVID-19 pandemic demonstrated the sector's adaptability, as highlighted in the *2021 NHS Wales COVID-19 Innovation and Transformation Study Report*, where the workforce embraced innovation at pace and scale.



To maximise the return on digital investment, we must prioritise solutions that offer the greatest impact—enhancing access for patients and improving efficiency for professionals. A number of national initiatives are currently under review across Wales, with the aim of identifying those suitable for wider adoption and scale-up.

We continue to promote the benefits of the NHS 111 service, including 111 'Option 2'—a dedicated pathway for individuals experiencing urgent mental health concerns. This aligns with prudent healthcare principles by offering timely support and reducing unnecessary GP appointments, emergency department attendances, or police involvement.

To build a digitally enabled workforce, Welsh Government is advancing a 'Think Digital' approach to service delivery and redesign. This aims to optimise clinical input, support value-based care, and alleviate workload pressures. As part of the national workforce implementation plan, digital platforms currently used in general practice—such as AccuRx, eConsult, SurgeryApp, and Attend Anywhere—are being considered for national funding and standardisation. ABUHB is also reviewing these platforms with a view to procuring a unified system that ensures consistency and value for money.

The utilisation of the CIVICA platform continues across Community Nursing teams in Caerphilly, supports more efficient and coordinated care delivery. The Welsh Community Care Information System (WCCIS) has been successfully implemented, providing a shared digital platform for community nurses, mental health professionals, social workers, local authority teams, and therapists. This system enhances collaboration by enabling secure information sharing across services albeit has its challenges across organisations.

NCN IMTP 2026-2029

Future NHS is being reviewed and developed for the collaboratives ensuring access and information sharing across independent contractors.

We remain committed to exploring and adopting assistive technologies that support people to live safely and independently at home for as long as possible. The NCNs have consistently championed innovation, funding equipment that supports early diagnosis and improved communication—and will continue to do so where it delivers meaningful impact.

Communication & Engagement

The NCNs benefit from dedicated support through the ACD Communication and Engagement Officer, who has made significant strides in strengthening this area of work in Primary and Community Care since taking up post. Looking ahead to 2026/27, the focus will be on further enhancing communication efforts across ISPB partners to promote the benefits of working within Caerphilly, particularly to support recruitment into key roles where workforce gaps exist.

The NCNs will continue to showcase local initiatives and achievements through regular contributions to the *Pulse* intranet, including news updates and good news stories. The team also maintains regular engagement with the organisational communication and engagement team to ensure consistent information sharing and alignment.

Collaborative communication remains central to our approach. We work closely with partners across health, social care, and the third sector to share service information through multiple channels, including GP practice screens, community pharmacies, CWTSH guides, and the DEWIS directory. These efforts help ensure residents and professionals alike are informed and connected to the support available within their communities.

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

- 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
- Digital technology
 - NHS Wales app delays, slow to develop additional functionality
- 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 insufficient funding for collaborative roles limits engagement
- Non contractual participation across some collaboratives – impacts engagement
- 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.

NCN IMTP 2026-2029

- Lack of sustainable Primary Care workforce.
- 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

Finance Profile 2026/2027

Recurrent funding will continue to support a range of key roles and services across Caerphilly, including specialist advisory posts in Optometry and ongoing investment in the Community Phlebotomy Service. NCN funding for 2026/27 will also sustain the remaining Practice-Based Pharmacists, Psychological Health Practitioners, First Contact Physiotherapists, and Community Wellbeing Connectors. Support for innovation remains a priority, with NCNs backing the introduction of digital and clinical technologies to broaden the scope of Primary Care services and improve patient access and experience. However, future provision and planning will be required to sustain current delivery across Caerphilly.

The NCNs maintain a forward-looking approach, actively horizon scanning to build a portfolio of established programmes and explore new pilot initiatives. To supplement core budgets, additional funding opportunities are being considered, including the Regional Integrated Fund (RIF), Participatory Budgeting, Further Faster funding, and pooled budgets via the Integrated Services Partnership Board (ISPB) and Regional Partnership Board (RPB).

A divisional review of practice systems is currently underway, with the aim of implementing a unified digital platform across ABUHB. A business case has also been submitted for the Psychological Health Practitioners. If successful these transitions will support budget optimisation and/or enable NCNs to release funding to reinvest in other initiatives impactful to services, service delivery and ultimately patients / staff.

Caerphilly NCNs Spend Forecast 2026/27

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)	-	2,423	-	2,543	-	2,021	6,987
Psychological Health Practitioners	3.8	164,916	3.6	156,236	3.0	130,197	451,349
Community Wellbeing Connectors	1.33	67,980	1.33	67,980	1.33	67,980	203,940
First Contact Physiotherapists	1.0	71,375	1.0	71,375	1.0	71,375	214,125
Practice Based Pharmacists	0.6	49,130	1.32	108,087*	0.2	16,376	173,595
Pharmacists – Subsistence costs	-	200	-	1,500	-	200	1,900
Pan Caerphilly NCN Conference Event	-	500	-	500	-	500	1,500
Room Hire	-	-	-	-	-	400	400
Caerphilly Borough MIND – Counselling Service	-	1,613	-	1,613	-	1,613	4,839
Digital Systems (Econsult, Accurx, SurgeryApp)	-	21,700	-	1,300	-	16,500	39,500
Education & Staff Development	-	1,500	-	1,500	-	2,500	7,500

NCN IMTP 2026-2029

Place Based Care/Hub Development	-	1,500	-	1,500	-	2,500	7,500
Staff Wellbeing – Consumables	-	500	-	500	-	500	1,500
Winter Initiatives	-	8,383	-	7,939	-	7,344	24,500
Allocation (£)		403,182		447,736		351,468	1,202,386
Forecast Spend (£) - before red (text) items		404,557		438,746		335,273	1,178,576
Underspend (£)				8,990		16,195	25,185
Overspend (£)		-1,375					-1,375

NB: The financial forecast does not include any uplifts.

Workforce Profile 2026/2027

NCN funded roles currently for 2026/27:

Roles	East	North	South	Caerphilly Total
Psychological Health Practitioners	3.8	3.6	3.0	10.4
Community Wellbeing Connectors	1.33	1.33	1.33	3.99
First Contact Physiotherapists	1.0	1.0	1.0	3.0
Practice Based Pharmacists	0.6	1.52	0.2	2.32

As previously noted health and social care is delivered by a mix of independent contractors, local authority services, and third sector providers. Caerphilly independent contractors include 20 GP practices, 41 community pharmacies, 21 dental practices, and 18 optometry practices.

NCN Planning 2027/2028 – 2028/2029

Proposed Milestone for Agreed Priorities for 2027/2028 and 2028/2029

Priority	2027/2028	2028/2029
1. Connecting people to non-medical activities, groups, and services in their community which can address their practical, social and emotional needs.	<p>Continuation of milestones from 2026 / 27. Noting potential evolving and implementation of services.</p> <p>Continue to utilise the IWN Collaboratives and its network of community partners and stakeholders to deepen the links between primary care and the community through an effective ABCD approach to identify local needs and strengths.</p> <p>Establish IWN Collaborative sub/action groups to drive forward specific agendas and programmes in the areas e.g. ASB, community health events, Over 50's, social prescribing.</p>	<p>Continuation of milestones from 2026 / 27. Noting potential evolving and implementation of services.</p> <p>Extend the IWN's place-based approach across community wellbeing, integrated social care and health services through enhance links with MDT teams across the Caerphilly borough.</p> <p>Continue effective partnership working with NCN networks, identifying gaps in provision and utilising NCN data to direct workstreams.</p>
2. Reducing premature mortality and morbidity through prevention and management of diabetes and cardiovascular risk factors	<p>Continuation of milestones from 2026 / 27. Noting potential evolving and implementation of services.</p>	<p>Continuation of milestones from 2026 / 27. Noting potential evolving and implementation of services.</p>

NCN IMTP 2026-2029

	<p>Raise awareness of the smoking cessation service and highlight the increased risks for individuals with respiratory conditions. Messaging will be disseminated through established channels and community-based organisations the Age-Friendly Communities Networks, Cost of Living Networks, IWN Collaboratives, Local Authority Housing Support Services, Registered Social Landlords, COPD support groups, Wellbeing Friends network, and across the network of community hubs.</p>	
<p>3. MDT working for people with complex needs who are most at risk of deterioration or adverse events</p>	<p>Continuation of milestones from 2026 / 27. Noting potential evolving and implementation of services.</p> <p>Behaviour Change Practitioners (BCPs) within the Caerphilly IWN Team to support the management of behavioural risk factors.</p>	<p>Continuation of milestones from 2026 / 27. Noting potential evolving and implementation of services.</p> <p>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.</p>
<p>4. Equity of access to supplementary/enhanced services across Gwent</p>	<p>Continuation of milestones from 2026 / 27. Noting potential evolving and implementation of services.</p>	<p>Continuation of milestones from 2026 / 27. Noting potential evolving and implementation of services.</p>

	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				
Independent Advisors	Existing	Long standing top-sliced initiative, across all ABUHB NCNs	Specialist Contractors providing expertise and support to NCNs	Supporting the Health & Care Workforce. NCN Development.			X	X	E - £2,423 N - £2,543 S - £2,021	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.	Provide effective, high quality, sustainable healthcare. Supporting the Health & Care Workforce. NCN Development		X	X		E - £12,837 N - £16,173 S - £15,267	Cluster Funding	Active - Access & Sustainability.	
Cluster Pharmacy Team	Existing	Practice Based Pharmacists	Improved GP access. Improved patient safety and medicines management in general practice.	Provide effective, high quality, sustainable healthcare. Supporting the Health & Care Workforce. NCN Development. Development of PCMW			X		E - £49,130 N - £108,087 S - £16,376	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.	Provide effective, high quality, sustainable healthcare. Supporting the Health & Care Workforce. Mental Health & Emotional Wellbeing. Development of PCMW			X		E - £164,916 N - £156,236 S - £130,197	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.	Mental Health & Emotional Wellbeing. Population Health. Development of PCMW. NCN Development. Community Infrastructure	X		X		E - £67,980 N - £67,980 S - £67,980	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.	Supporting the Health and Care Workforce. PCMW. NCN Development.			X		E - £71,375 N - £71,375 S - £71,375	Cluster funding – proven move to central funding	Active. NCN Development & Partnerships. Access & Sustainability.	
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	Working alongside Social Care. Supporting the Health & Care Workforce. PCMW. NCN Development	X	X	X		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.	Mental Health & Emotional Wellbeing. Population Health. Development of PCMW. NCN Development.	X		X		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	Population Health. Community Infrastructure.			X		E - £14,600 N - £1,300 S - £5,800	Cluster funding - interim to national solution	Active. Digital Technologies. Access & Sustainability.	
AccuRx	Existing	Funding support for GP practices to continue with providing AccuRx 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	Population Health. Community Infrastructure.			X		E - £7,100 N - £0 S - £10,700	Cluster funding - interim to national solution	Active. 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.	Supporting the Health and Care Workforce. NCN Development. Community Infrastructure.	X	X		X	E - £2,500 N - £2,500 S - £2,500	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.	NCN Development. Community Infrastructure.	X	X	X	X	E - £2,500 N - £2,500 S - £2,500	Cluster Funding	Active. NCN Development & Partnerships. Access & Sustainability.	
Winter Initiatives	Existing	Funding to support asthma diagnosis via Feno machines	Support practice diagnosis of asthma via POCT testing.	Provide effective, high quality, sustainable healthcare. Population Health		X			E - £8,500 N - £8,500 S - £7,500	Cluster Funding	Active - NCN Development & Partnerships. Access & Sustainability.	

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

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

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.

NCN IMTP 2026-2029

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.	Supporting the Health and Care Workforce	X				E - £500 N - £500 S - £500	Cluster Funding	Active. Workforce & Staff Wellbeing. Mental Health & Wellbeing.
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, Paramedics, Prescribing Pharmacists.	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.
Nurse Practitioner	Potential	Review patients for preventative needs. Supporting winter planning / frail elderly.							E - TBC N - TBC S - TBC	TBC	On Hold. NCN Development & Partnerships. Workforce & Staff Wellbeing.
NCN Development Programme / ACD	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 – Fixed Term funding
	Existing	Evaluate and implement exit strategies	Enable proven concepts to be diverted from NCN budgets.							SPPC	Active – Fixed Term funding
	Existing	Continue local working with collaboratives	GMS, Optometry, Dental, Pharmacy, Allied Health professionals, Nursing							SPPC	Active – Fixed Term funding

**The NCNs priorities
What we are doing/
going to do:**

Building resilient communities

- Continuing the Integrated Wellbeing Network work programme.
- Promote and support the Community Wellbeing Connectors and Nature prescribing services to improve population health & wellbeing.
- Improving uptake of preventative and screening programmes.
- Focus on Place Based Care including costed model opportunities.

Encouraging collaborative working with a focus on enhanced services

- Develop & enhance partnership working.
- Continue to support & promote GP engagement with enhanced services.
- Continue and enhance MDT working .
- Continue to support the integration of the ACD development programme.

**Long Term Conditions –
Prevention & Management**

- Developing service models, pathways, and teams to meet the needs of a diverse population.
- Focus on Prevention Programmes and promotion of healthy lifestyle choices and preventative services.
- Support and promote immunisation and vaccination programmes



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

Caerphilly NCN (East, North, South) Plan – 2026-27

Areas of Focus

- To align the work of NCNs and Integrated Wellbeing Networks to develop a more community orientated model of primary care through 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.
- 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.
- 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.
- 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.
- 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 / refugees.

Delivered via:

- Robust partnership and collaborative working across health, social service and third sector organisations
- Team & Assurance meetings.
- QPS – implement focus on learning outcomes.
- Working across services to support staff wellbeing.
- Working to ensure we have an agile and mobile workforce equipped with the skills to meet population needs.
- Maintain support for robust and sustainable services.
- Prudent healthcare principles to ensure appropriate level of service.
- Ensuring appropriate utilisation of estate infrastructure.
- Development of capital bids.
- Embedding appropriate and financially viable digital platforms across primary and community services
- Ensure regular budget review and opportunities for re-investment.
- Utilise alternative funding streams to support current NCN budgets as appropriate.

“Enablers”

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

How are we delivering change?



Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board



Partnership Working with Local Authority in estate prioritisation & rationalisation

Work with partners to establish wrap around health and wellbeing services

Use of preventative, early opportunity, and self-management approaches

Integrated approach on Caerphilly NCN Footprints

Use prudent pathways to improve planned care

Use Multidisciplinary Team to undertake active signposting

Recruit, train & educate our workforce to ensure needs of population met



Gwent Association of Voluntary Organisations Cymdeithas Madidau Gwirfoddol Gwent



How will we know if we have made a difference?

NCN Accelerated Development, Evaluation & Reporting Process/ Patient Experience, ISPB & NCN reporting, Assurance Meetings