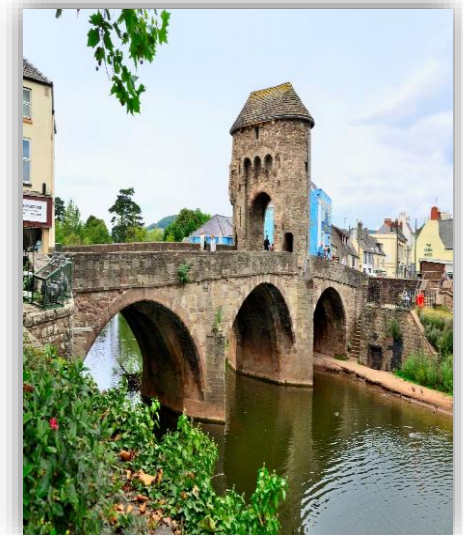


# MONMOUTHSHIRE NORTH and SOUTH Neighbourhood Care Networks (NCN) Integrated Medium Term Plan (IMTP) 2026-2029



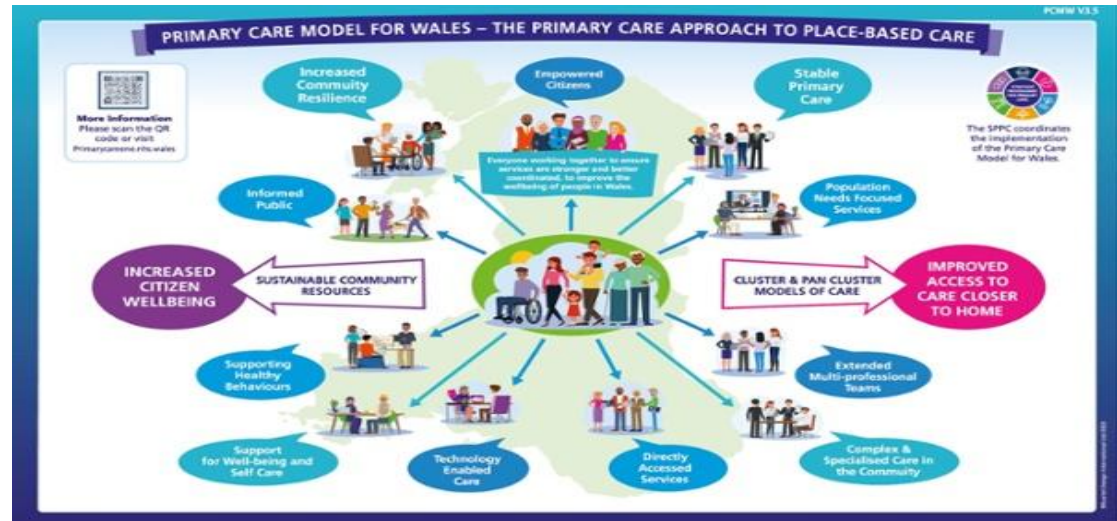
## NCN Executive Summary:

This Monmouthshire Neighbourhood Care Network (NCN) Plan sets out our response to strategic and local priorities for both North and South NCNs over the next three years. We will demonstrate progress we have made against previously agreed priorities, and outline new projects and developments aimed at improving outcomes for people of all ages. We will continue to work at pace with key partners to deliver the Place-Based Care (PBC) agenda and ensure we retain sight of the needs of people living in and around Monmouthshire.

We continue to rely on local and National information sources and guidance to underpin and inform our work. The Primary Care Model for Wales, A Healthier Wales and the Social Services and Wellbeing Act continue to be integral to the direction our NCNs have taken.

We make reference to the Gwent Regional Partnership Board's (RPB) Population Needs Assessment and the Monmouthshire Integrated Services Partnership Board (ISPB), key strategic partners driving the PBC agenda, along with Public Health Wales.

The diagram on the right details how we see our resident population being at the heart of the PBC ethos, with NCNs driving the delivery of care as close to home as possible, as directed by strategic partners.



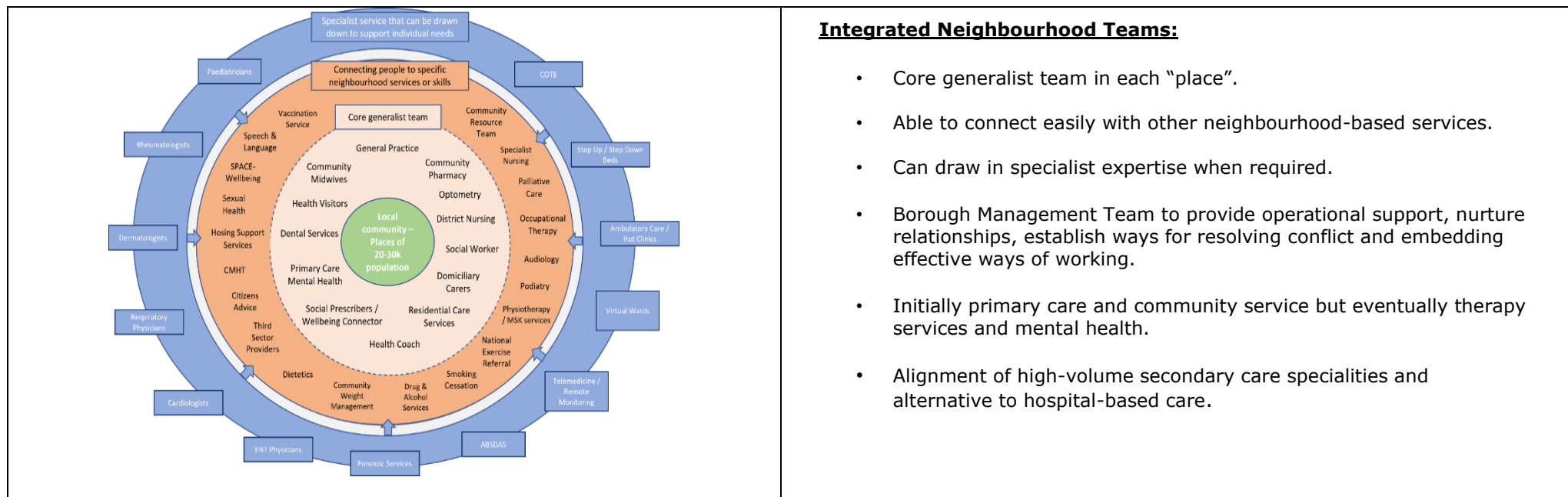
We will set out our priorities and key milestones for the next three years, underpinned by a national policy framework, which includes: A Healthier Wales, the Primary Care Model for Wales and Wellbeing of Future Generations Act, and also demonstrate how our priorities link closely with the Aneurin Bevan University Health Board's 10-year strategy via the continued growth of Integrated Neighbourhood Teams, providing care closer to home, seeking out new digital innovations and by retaining prevention and early intervention as a key priority. We already work closely with Health, Social Care, Integrated Wellbeing Network and Third Sector colleagues to explore new service models and ensure people can access the right support as close to home, or at home, when possible.

By building on existing structures, for example, the multi-disciplinary teams working together in and around each 'place', we will embody the 10-year strategy's ethos of shifting the reliance on hospital-based care, to community-based settings. As NCNs, we have the ability to bring together a range of people and services across health, social care and the Third Sector, to work collaboratively, to plan for delivering integrated, person-centred care based on need.

### Place-Based Care, NCNs and the Integrated Services Partnership Board:

A key driver for the Monmouthshire ISPB, and therefore NCNs, is delivering care as close to home as possible, on a place-based basis. Place-Based Care promotes collaboration amongst local services, the third sector and the community itself. In Monmouthshire, we have identified 5 key 'places': Abergavenny, Monmouth, Usk, Chepstow and Caldicot and as NCN Leads, are currently participating in a number of workshops, with Public Health, ISPB and Third Sector colleagues to develop a business case for the delivery of PBC across Monmouthshire.

Linked to PBC, the diagram below shows an idealistic view of what an Integrated Neighbourhood Team could look like.



### Integrated Neighbourhood Teams:

- Core generalist team in each “place”.
- Able to connect easily with other neighbourhood-based services.
- Can draw in specialist expertise when required.
- Borough Management Team to provide operational support, nurture relationships, establish ways for resolving conflict and embedding effective ways of working.
- Initially primary care and community service but eventually therapy services and mental health.
- Alignment of high-volume secondary care specialities and alternative to hospital-based care.

### **Population and Context:**

Serving a population of approximately 105,000 people, we face continued challenges specific to Monmouthshire, namely a growing older population with increased complexities of long-term conditions, plus, Monmouthshire is a large rural and semi-rural borough surrounding the 5 key towns mentioned. It is important to note that there are approximately 15,000 people who are registered with a Monmouthshire GP and live outside the Monmouthshire border, for example in Powys, Hereford and Gloucester. There are specific challenges in delivering care to this population and some of these will be explored later in this plan. We acknowledge that we need to continue to engage at ISPB level with both Health Board and Monmouthshire County Council service leads e.g.; relating to safeguarding and immunisation programmes, ensuring we meet the needs of children and young people, supporting service leads to deliver high level care for people of all ages in Monmouthshire.

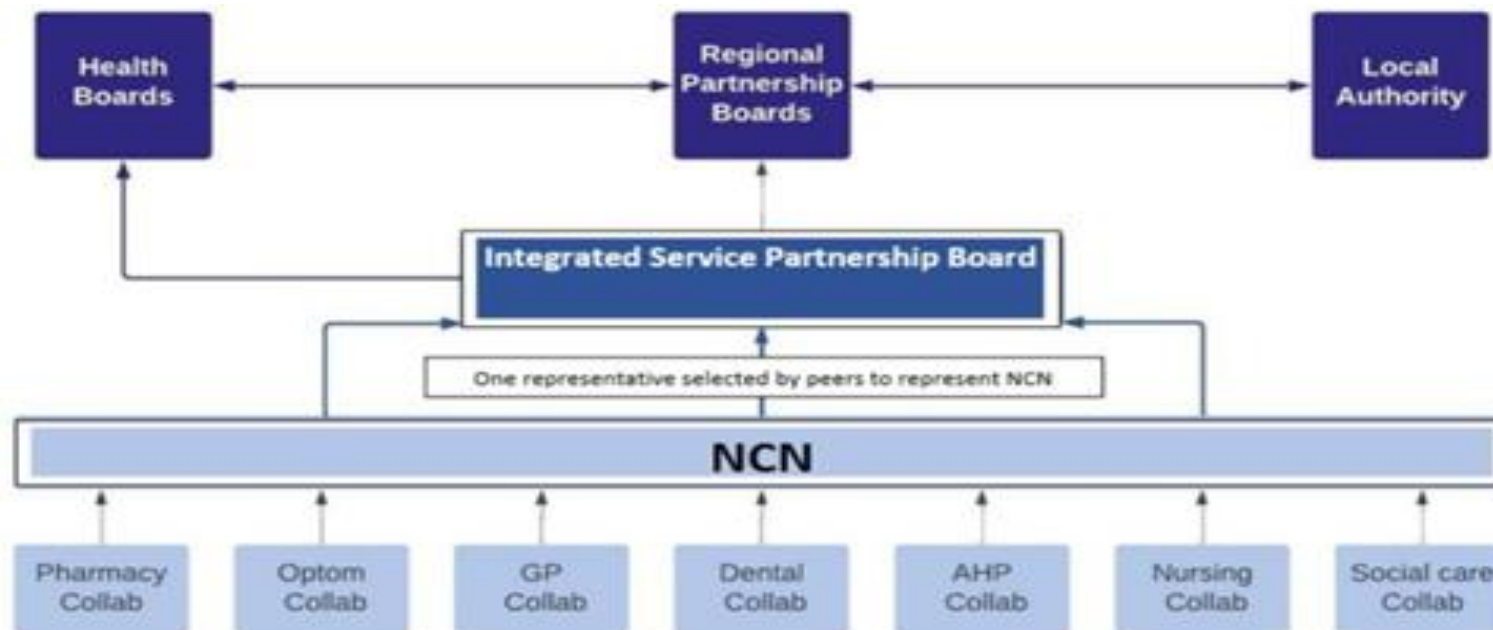
**Summary:** We believe this NCN Plan provides a timely reflection on the positive work already undertaken, and going forward outlines a framework for delivery of shared priorities as stated. Over the next 3-years progress will be measured via a collaborative approach as determined by the ISPB, and include, specifically for the NCNs: project evaluations, service delivery reviews and oversight as provided by the ISPB and Aneurin Bevan University Health Board. This plan reinforces our strong commitment to partnership working through shared values, ensuring local people and communities are can access support locally for their mental health and wellbeing, which is central to the work we do. We will continue to address inequalities as we find them, in-spite of challenging financial circumstances, exploring alternative funding streams where possible. Threaded throughout this plan are examples of joined-up working across clinical and non-clinical teams, demonstrating our ability to deliver against key challenges as already stated. We will continue to enable people in and around Monmouthshire to receive the care and support they need, as close to home as possible through a shared commitment and vision.

*Dr Annabelle Holtam (South Monmouthshire NCN Lead) & Dr Brian Harries (North Monmouthshire NCN Lead)*

## Strategic Partners:

### Governance and Reporting Across Strategic Partners:

The diagram below highlights the current governance and reporting framework providing opportunities for core resources to be optimised with partnership funding held in one place. This framework provides a real opportunity going forward, to shift the focus towards prevention and reducing inequalities.



### Gwent Regional Partnership Board

Gwent’s framework for health and social care planning is implemented through the Gwent Regional Partnership Board (RPB). The RPB is a statutory body bringing together local authorities, the health board, third sector, and others to jointly assess needs, plan, commission, and oversee health, care, and wellbeing services in the Gwent region. The legal basis for this framework comes primarily from the Social Services & Well-being (Wales) Act 2014, which mandates that a Population Needs Assessment (PNA) is made available, providing a joint assessment of the level of care & support needed, including prevention, levels of service and emerging needs. Our NCNs are directly linked to the RPB via Health Board and Local Authority representatives of the ISP. Information provided by the PNA was used to underpin the priorities outlined within this 3-year plan with the 3 key RPB goals below applied across our NCN priorities:

<p><b><u>Start Well</u></b> Improving outcomes for children and families, working together to start well.</p>	<p><b><u>Live Well</u></b> People at the heart of everything we do, working together to live well.</p>	<p><b><u>Stay Well</u></b> Ensuring the right help is available at the right time, working together to stay well.</p>
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## Monmouthshire Integrated Services Partnership Board and NCNs:

The Monmouthshire ISPB or Pan Cluster Planning Group (PCPG), enables key partners to come together, including NCN Leads, to focus on strategic, long-term priorities and agree delivery plans. The ISPB is a sub-group of the RPB and Health Board and acts as a decision making and information sharing forum, providing direction for NCNs based on agreed priorities. NCNs also bring together local services from health, social care and the Third Sector (GAVO), to plan and deliver local solutions, based on ISPB priorities, to meet the needs of people in and around Monmouthshire. We are a key component of the ISPB facilitating service delivery based on need. We link closely with a range of groups and individuals who are a valuable source of information such as GAVO and the Integrated Wellbeing Network (IWN), enabling us to ensure our plans retain a strong community focus.

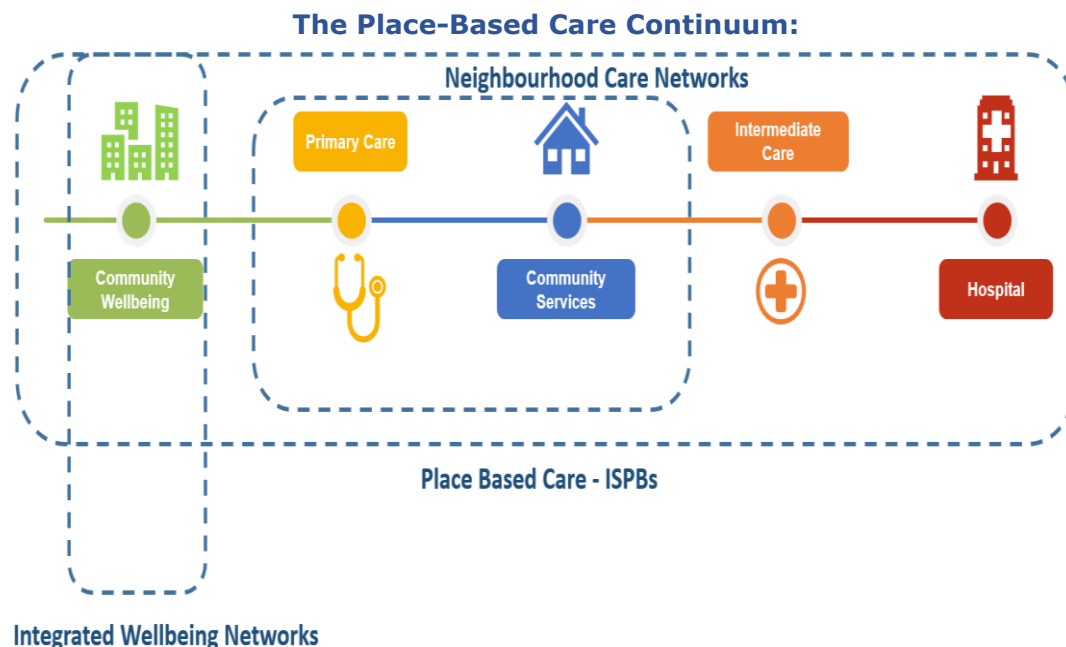
## Professional Collaboratives (ACD) Programme:

The aim of ACD is to enhance progress already made by NCN Clusters, to hasten the impact of NCN delivery in meeting the health and wellbeing needs of local people on a place-based basis where possible. Some Professional Collaborative Leads attend NCN meetings to help us understand complexities of service delivery, and also the needs of their respective service users. It's important to note the varying levels of maturity across the collaboratives. For example, GMS, Community Pharmacy and Optometry representatives are incentivised via their contracts. Nursing Leads undertake this role within their core hours and at the time of writing, there is no incentivisation for a Dental Lead. However, it is understood that this may change in 2026/27.

## Place-Based Care - Integrated Wellbeing Networks, NCNs and the ISPB coming together:

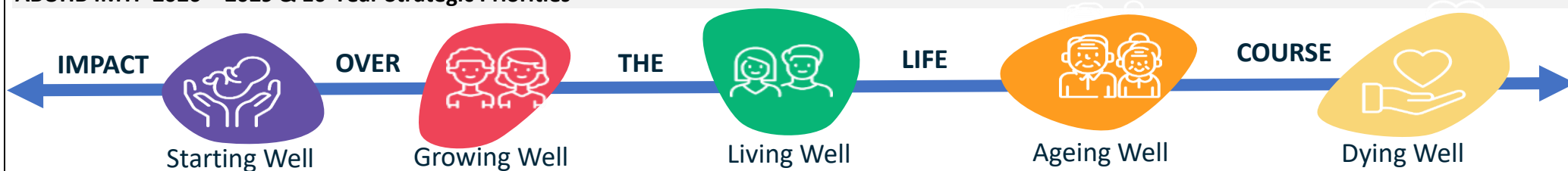
The diagrams below, and on the previous page, highlight the relationship across strategic and operational / delivery partners in Monmouthshire. It is important to not underestimate the complexity of planning and delivery of services across such a large rural and semi-rural borough. We rely on 'joined-up' thinking and working, goodwill and trust across statutory and non-statutory partners to ensure people in Monmouthshire receive the most appropriate support, when they need it, and as close to home as possible.

- **Place-based collaboration:** The network is developed from the ground up, focusing on the unique strengths and assets within specific towns and rural areas in Monmouthshire.
- **Community-based hubs:** These hubs act as central points for connecting residents with local services and support.
- **Connecting people and services:** The IWN works to create better links between people and their communities, connecting them with the support they need, whether through community groups, care navigators, or social care services.
- **Easy access to information:** The network aims to make information about wellbeing support readily available to residents.



## 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

## Progress Made Against Agreed NCN Priorities 2025/26

### **Priority 1:**

**Connecting people to non-medical activities, groups and services in their community which can address their practical, social and emotional needs.**

### **What we have achieved:**

- The IWN increases individual and community resilience. Working closely with the IWN Lead and the wider GAVO, we continually develop our knowledge and understanding of the needs of people in and around Monmouthshire. Through strong partnership working over a number of years, we have collaborated to identify the most useful interventions. The network has a track record of piloting new services and interventions such as Community Conversations, IAA / Wellbeing Information Hubs and the Wellbeing Link Service. As NCNs we understand the importance of building strong partnerships and therefore engage with key stakeholders to test / implement new community based options to help and support people when they need it most.
- We have joint funded the Wellbeing Link Advisor (WLA) service for a number of years, hosted by GAVO, the advisors help us to really understand what matters most to people who may be struggling with the impact of daily living in Monmouthshire. We have the equivalent of two full-time advisors working across the 11 GP practices with promotional literature etc. on display supported by a range of resources via the GAVO network such as weekly publications. The advisors arrange to meet people in the community such as in cafes, community or garden centres. There are also confidential options if necessary with enough time allocated to listen and understand people's concerns. Together they can discuss local support options that will be useful. Our advisors can then follow up by providing relevant information, or introduce the person to other relevant support options as required. The advisors are informal and flexible depending on each person's needs, which has proven a successful approach over the years.
- As NCNs we will continue, where funding allows, to support the service financially. Each year we have regular contact with the advisors and GAVO colleagues, review data, and importantly, powerful individual stories (please see example at appendix 3). We believe these are strong indicators and evidence of the impact the service is having on people who are struggling with their day-to-day lives.

### **Next steps:**

- To be informed by, and support delivery of the Living Well Strategy and Implementation Plan. The strategy articulates Monmouthshire County Council's new approach to enabling people to access vibrant and inclusive places to meet and get appropriate support.
- This will involve partners and stakeholders both within, and external to the council [4c Living Well Implementation plan App 2.pdf](#)
- Outcome of Blaenau Gwent 'Elemental' Pilot if applicable
- Support the development of a Service Directory as required.
- Continue to support development of the Place-Based communications approach

### **Challenges & Risks:**

- Limited capacity to link directly with monthly Community Conversations networking meetings, which allow service staff, organisations and groups to meet, share news and build relations – to remain under review.
- Potential NCN budget restrictions for existing staff to develop their MDT roles and therefore, their ability to connect individuals to community resources.
- Service Directory / Asset-mapping are prone to inaccuracy due to short-term project instability from financial risk e.g.; RIF funding timeframes – additional investment needed in administrative role to maintain the directory.

<p><b>Priority 2: Multi-Disciplinary Team (MDT) working for people with complex needs who are most at risk of deterioration</b></p>	<p><b><u>What we have achieved:</u></b>                  We have established MDTs in both North and South NCNs, which identify, review, assess and plan to ensure people who are vulnerable, with complex needs including frailty, can live safe, independent and fulfilled lives at home where possible. MDTs help minimise risk e.g.; of adverse events that might potentially lead to a hospital attendance.</p> <ul style="list-style-type: none"> <li>• Implemented Terms of Reference (ToR) with annual review</li> <li>• Implemented monthly data sharing to inform learning, planning and aid reviews that help measure progress – linked to the Health Board’s Re-design programme</li> <li>• South NCN funding proposal in place to implement Place-Based Care Coordinators (PBCCs) to work out of the 4 GP practices and link directly with patients, the frailty response team, wellbeing link advisors and Newport MDT colleagues for professional development.</li> </ul>	
	<p><b><u>Next steps:</u></b></p> <ul style="list-style-type: none"> <li>• Implement PBCCs</li> <li>• To implement agreed milestones</li> <li>• Continue to link with Divisional redesign programme to ensure outcomes fulfil Health Board requirements.</li> </ul>	<p><b><u>Challenges &amp; Risks:</u></b></p> <ul style="list-style-type: none"> <li>• Potential impact of NCN budget reduction creates uncertainty re long-term funding plans.</li> <li>• Insufficient capacity for some professional roles to be released to support the MDT process.</li> <li>• Data capture variation across Gwent teams may lead to inconsistent outcomes.</li> </ul>
<p><b>Priority 3: Reducing premature morbidity and mortality through prevention and management of diabetes and cardiovascular risk factors.</b></p>	<p><b><u>What we have achieved:</u></b></p> <ul style="list-style-type: none"> <li>• Each year we acknowledge and report that there are a number of areas of deprivation within Monmouthshire, and therefore, we will continue to monitor data and facilitate relevant discussion re enabling all people in Monmouthshire to reduce the risk of premature morbidity from cardiovascular disease, through hypertension case finding and optimising blood pressure management.</li> <li>• We will also work together to optimise our response to people at risk of diabetes and reduce the risk of macrovascular / microvascular complications in people with type 2 diabetes.</li> </ul>	

# NCN IMTP 2026-2029

## **Next steps:**

**CVD:** Review & discuss progress at collaborative level against the contractual requirement and report accordingly:

- Aggregate practice-level data on the number of hypertensive patients treated to target.
- Accuracy of data and process for refinement.
- Discuss, share best practice, and consider adaptation of QI processes if applicable.
- GMS Collaborative lead themes for discussion shared with the wider cluster.
- GMS Collaborative or Cluster to consider introducing initiatives to benefit the delivery of improved interventions in identified behaviours.
- GMS Collaborative or Cluster escalate deficiencies in systems/services or suggestions for system wide improvement.

**Diabetes:** Benchmark progress of the South Monmouthshire Healthy Living Project across the collaborative, with shared learning and experiences to inform next steps.

## **Challenges & Risks:**

- Increasing up-take of people attending X-PerT Patient and Education Patient Programmes (self-care) programmes.
- GMS Collaborative Healthy Behaviours QI project: Refresh understanding of processes / pathways for systematic referrals into Help Me Quit, NERS, Community Weight Management programmes etc.
- Capacity to work with the Public Health Team and IWN to embed Making Every Contact Count (MECC) principles, linked to ambition for Health Coaches within PBC (Integrated Neighbourhood Teams).
- Engage GMS & Community Pharmacy Collaboratives re the Hypertension Case Finding Supplementary Service to assess provision of brief interventions for those with a new diagnosis of hypertension (e.g.; Farming Communities).
- Map GMS Collaborative engagement in the All-Wales Diabetes Prevention Programme to assess delivery
- Identify successful approaches to increase the proportion of patients with Type 2 diabetes

<p><b>Priority 4: Provision of equity of access to Supplementary Services (SS) across Monmouthshire.</b></p>	<p><b><u>What we have achieved:</u></b></p> <ul style="list-style-type: none"> <li>We have mapped Supplementary Service (SS) up-take across our 11 practices and identified gaps in provision that will inform NCN level discussions. We aim to ensure that we have meaningful discussions as a collaborative, to understand issues and challenges preventing the up-take of some SSs. People can expect to have access to equitable, high-quality care across Monmouthshire and therefore these discussions will help realise if we can overcome barriers especially for our most vulnerable people experiencing homelessness, issues with substance dependency / misuse leading to mental health and wellbeing concerns.</li> <li>We hope that through strengthened collaborative working across cluster boundaries, using data and working where necessary with key partners, we can reduce variation, increase equity and improve outcomes for Monmouthshire people.</li> </ul>	
	<p><b><u>Next steps:</u></b></p> <ul style="list-style-type: none"> <li>Contracting Team formal Inter-practice Referral Agreement for LARC and Substance Misuse.</li> <li>Health Inclusion Service review and report to be considered at NCN level with plans for named HIS Nurses aligned to each locality to liaise/support practices providing the supplementary service for Homelessness and Asylum Seekers and Refugees.</li> <li>Assess residual level of unmet need across the GMS collaborative and facilitate discussions about how gaps in provision and unmet need can be addressed.</li> </ul>	<ul style="list-style-type: none"> <li>Support a proposal to the Enhanced Services Operational Group re investment to improve equity of access.</li> <li>Aim to liaise with the ISPB and Secondary Care directorates engaging specialist services, local authority and third sector to build wrap-around support and reduce inequity.</li> <li>Assess outcome of new digital solutions trial, improving administrative capacity to support increased up-take in SSs.</li> </ul>
	<p><b><u>Challenges &amp; Risks:</u></b></p> <ul style="list-style-type: none"> <li><b>Homelessness:</b> Baseline 2025/26 Information: 263 open homeless cases; 77 open under a prevention duty (at risk of homelessness); and 52 cases open under triage. Of the 263, 161 are in temporary accommodation with Monmouthshire County Council.</li> <li>Only 2 of 11 practices in Monmouthshire have taken up the Supplementary Service with both in the North of the borough. Feedback from GMS colleagues highlights concerns regarding historical remuneration levels.</li> <li><b>Minor Surgery:</b> Mapping tells us 10 of 11 practices are commissioned to provide category A &amp; B Minor Surgery with all 11 providing category B. However, only 1 practice (in the South NCN) provides the service to non-registered practice patients.</li> <li>The NCN aims to review this with both clusters to understand barriers.</li> </ul>	<ul style="list-style-type: none"> <li><b>Substance Misuse:</b> Mapping uptake tells us that 3 of the 11 practices in Monmouthshire, all in the North have taken up the Supplementary Service.</li> <li>The NCN aims to review this with both clusters to understand the barriers but in context, there is a wider issue to explore in that on a Pan-Gwent basis, only 10 of 68 practices have been commissioned to provide this service.</li> <li><b>Asylum Seekers &amp; Refugees:</b> Mapping uptake identified that 7 out of 11 practices (5 from 7 North &amp; 2 from 4 in the South) have taken up the Supplementary Service</li> <li>In comparison, only 15 from 68 Practices have been commissioned across Gwent.</li> <li><b>Please refer to appendix 4 for the outcome of the mapping exercise.</b></li> </ul>

<p><b>Priority 5: Building Sustainability &amp; Resilience in Primary Care</b></p>	<p><b>What we have achieved: Continued investment in schemes linked to enhancing our Primary Care response by delivering Care Close to Home, Building Capacity and Resilience:</b></p> <ul style="list-style-type: none"> <li>• <b>Multi-Disciplinary Teams</b> – Supporting the most vulnerable 0.5% population</li> <li>• <b>Practice Based Pharmacists</b> (North) – Improving GP capacity &amp; access using localised clinical expertise</li> <li>• <b>Practice Manager lead role</b> (North &amp; South) – Collaborative co-ordination &amp; sharing of good practice etc.</li> <li>• <b>GP led Safeguarding Forum</b> (North &amp; South) – Shared expertise and knowledge across GMS</li> <li>• <b>Wellbeing Link Advisor Service</b> (North &amp; South) – Signposting people impacted by social determinants of ill-health</li> <li>• <b>Psychological Health Practitioners</b> (North) – Local access to mental health assessment / support</li> <li>• <b>Multi-agency Winter Planning event:</b> Collaboratives coming together with social services and third sector to plan for service delivery pressures.</li> <li>• <b>Community Clinical Placements (CCPs) / Longitudinal Integrated Clerkship:</b> Partnership between Monmouthshire County Council (MCC) and Cardiff University to place Student Doctors with GP practices and Community Medicines Projects hosted by MCC. Planned placements for 5 students in 2026/27 – projects meet Health Inclusion agenda (Farmer’s Health / Frailty linked to MDTs) and contribute to long-term sustainability in primary care.</li> </ul>	
	<p><b>Next steps:</b></p> <ul style="list-style-type: none"> <li>• Although not included in the priorities included for 2026/29, all of the above examples of projects remain as on-going workstreams (dependent on NCN funding decisions). It may be that the commissioning of some workstreams leads to reinvestment in new priority schemes as part of the NCN IMTP / business cycle.</li> <li>• The CCP scheme is Welsh Government funded and provided on a recurrent basis. The NCN Leads will remain as key partners with MCC and Cardiff University to help support sustainability in primary care in Monmouthshire.</li> </ul>	<p><b>Challenges &amp; Risks:</b></p> <ul style="list-style-type: none"> <li>• Potential impact of further reductions to NCN budget leading to uncertainty regarding long-term financial commitments</li> </ul>

# NCN IMTP 2026-2029

NCN Planning - 2026/2027		
Identified Quarterly Milestones Against Agreed NCN Priorities for 2026/27		
Priority	Milestones	Enablers, Risks, Challenges
<p><b>Priority 1: Connecting people to non-medical activities, groups and services in their community which can address their practical, social and emotional needs</b></p> <p><i>(Linked to the Integrated Wellbeing Network [IWN] &amp; Wellbeing Link Advisor [WLA] Service)</i></p>	<p><b>Quarter 1:</b></p> <ul style="list-style-type: none"> <li>• <b>IWN:</b> To work with the Integrated Wellbeing Network (IWN) Lead to understand the Living Well strategy requirement &amp; contribute to progress measures as necessary</li> <li>• To agree NCN support for delivery via the implementation plan</li> <li>• To support consultation at NCN / ISPB level</li> <li>• <b>WLA:</b> Continue to capture monitoring data for the Wellbeing Link Advisor role to ensure on-track with agreed service specification / business continuity &amp; respond to anticipated fragility around service delivery etc.</li> </ul> <p><b>Quarter 3:</b></p> <ul style="list-style-type: none"> <li>• Continue Q2 milestones</li> <li>• <b>IWN:</b> As defined by the implementation plan</li> <li>• Bi-monthly reporting at ISPB</li> <li>• Progress updates provided to quarterly NCN meetings</li> <li>• Monthly data capture as available demonstrates progress / gaps &amp; impact on local people / communities.</li> <li>• <b>WLA:</b> To review / evaluate the Wellbeing Link Advisor service to inform future commissioning decisions</li> </ul>	<p><b>Quarter 2:</b></p> <ul style="list-style-type: none"> <li>• Continue Q1 milestones</li> <li>• <b>IWN:</b> As defined by the implementation plan</li> <li>• Bi-monthly reporting at ISPB</li> <li>• Progress updates provided to quarterly NCN meetings</li> <li>• Monthly data capture as available demonstrates progress / gaps &amp; impact on local people / communities.</li> <li>• Undertake 6 monthly review of monitoring tool with IWN Lead to measure progress against the implementation plan</li> <li>• <b>WLA:</b> Undertake 6 monthly review to ensure service reach is meeting expectation</li> <li>• Link with NCN Communication Team to promote referrals etc. as required</li> </ul> <p><b>Quarter 4:</b></p> <ul style="list-style-type: none"> <li>• Continue Q3 milestones</li> <li>• <b>IWN:</b> As defined by the implementation plan</li> <li>• Bi-monthly reporting at ISPB</li> <li>• Progress updates provided to quarterly NCN meetings</li> <li>• Monthly data capture as available demonstrates progress / gaps &amp; impact on local people / communities.</li> <li>• Undertake year-end review of progress supporting the IWN Lead &amp; agree measures for year 2.</li> <li>• <b>WLA:</b> NCN budget review determines next steps</li> </ul>
		<ul style="list-style-type: none"> <li>• <b>Enablers:</b> <a href="#">4c Living Well Implementation plan App 2.pdf</a></li> <li>• IWN / ISPB</li> <li>• Data, surveys, case studies and outcomes / evidence of working with individuals</li> <li>• Bridging, linking and co-ordinating well-being assets in a place.</li> <li>• Connecting people to community assets via hubs, active signposting / care navigation and local directories of services</li> <li>• Individual &amp; group behaviour change interventions (PHW)</li> <li>• Opportunities for involving communities in decision making</li> <li>• <b>Risks:</b> Insufficient NCN funding resource</li> <li>• Conflicting professional / agency priorities - mutual understanding linked to delivering core services, roles &amp; responsibilities</li> <li>• Maintaining momentum with phased approach.</li> </ul>

## NCN IMTP 2026-2029

<p><b>Priority 2: Multi-Disciplinary Team (MDT) working for people with complex needs who are most at risk of deterioration</b></p>	<p><b>Quarter 1:</b></p> <ul style="list-style-type: none"> <li>• Monthly NCN led review of South NCN &amp; North Monnow Vale based MDT meetings to understand challenges / issues and evidence</li> <li>• Liaise with Redesign team re evidence of reduced hospitalisation &amp; non-medical support if available</li> <li>• Agree Terms of Reference</li> <li>• Implement Place-Based Co-ordinators</li> </ul>	<p><b>Quarter 2:</b></p> <ul style="list-style-type: none"> <li>• Continue Q1 milestones</li> <li>• Hold collaborative discussions to review progress of both North &amp; South MDTs</li> <li>• Review outcome of Redesign Team evidence base / data</li> <li>• Monitor progress of PBCCs</li> <li>• Facilitate peer sessions with Newport MDT co-ordinators</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Enablers:</b> Budget reviews enable options for reinvestment e.g.; North MDT</li> <li>• ToR review at fixed point</li> <li>• Strong NCN level leadership &amp; support</li> <li>• Clearly defined roles</li> <li>• Effective &amp; timely information sharing</li> <li>• Collaborative, person-centred culture</li> <li>• Partner sign-up / commitment</li> <li>• <b>Risks:</b> Data sharing &amp; inability to integrate IT systems</li> <li>• MDT representatives with different priorities</li> <li>• Lack of patient / carer involvement</li> <li>• Over-inflated expectation related to reducing hospital admissions etc.</li> </ul>
	<p><b>Quarter 3:</b></p> <ul style="list-style-type: none"> <li>• Continue Q2 milestones</li> <li>• Mid-year collaborative discussions &amp; progress review of North &amp; South MDTs</li> <li>• Review outcome of Redesign Team evidence base / data</li> <li>• Continued support to PBCCs</li> <li>• Facilitate peer sessions with Newport MDT co-ordinators</li> </ul>	<p><b>Quarter 4:</b></p> <ul style="list-style-type: none"> <li>• Continue Q3 milestones</li> <li>• Review Terms of Reference ready for year 2</li> <li>• Year-end collaborative discussions to review progress of North &amp; South MDTs</li> <li>• Year-end review of Redesign Team evidence base / data</li> <li>• Undertake year-end review of PBCC role and evaluate progress</li> <li>• Include Newport MDT co-ordinators in PBCC review</li> <li>• Outcome of NCN funding review informs commissioning</li> </ul>	
<p><b>Priority 3: 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</b></p>	<p><b>Quarter 1:</b></p> <ul style="list-style-type: none"> <li>• NCN led data review against baseline measures for NCN funded Healthy Living Project (South)</li> <li>• Aggregate practice-level data on the number of hypertensive patients treated to target – check data accuracy &amp; process</li> <li>• Discuss, share best practice, and consider adaptation of QI processes if applicable at collaborative level.</li> <li>• Consider introducing initiatives to benefit delivery of improved interventions in identified behaviours.</li> <li>• Escalate deficiencies in systems / services with suggestions for improvement if applicable.</li> </ul>	<p><b>Quarter 2:</b></p> <ul style="list-style-type: none"> <li>• Continue Q1 milestones</li> <li>• Respond to aggregated data process &amp; data checks</li> <li>• Follow-up on outcome of QI discussions</li> <li>• Review initiatives to benefit interventions as relevant.</li> <li>• Review need to escalate system concerns with suggestions for improvement if necessary.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Enablers:</b> NCN Led data review</li> <li>• Patient empowerment &amp; education via MDTs</li> <li>• Performance measures for continuous quality improvement</li> <li>• <b>Risks:</b> Lack of sufficient data</li> <li>• Transport links - lack of reliable transportation making it difficult for patients to attend in-person programs.</li> </ul>

## NCN IMTP 2026-2029

	<p><b>Quarter 3:</b></p> <ul style="list-style-type: none"> <li>• Continue Q2 milestones</li> <li>• Review aggregated data process &amp; confirm data confidence.</li> <li>• Follow-up on outcome of QI discussions</li> <li>• On-going review of interventions as required.</li> <li>• Facilitate escalation of system concerns with suggestions for improvement as necessary.</li> </ul>	<p><b>Quarter 4:</b></p> <ul style="list-style-type: none"> <li>• Undertake year-end process of Review re data.</li> <li>• Cluster review and report as necessary to meet QI requirement.</li> <li>• Year-end review of effectiveness of interventions as required.</li> <li>• Review system concerns raised throughout process and report as required.</li> </ul>	
<p><b>Priority 4: Provision of equity of access to Supplementary Services (SS) across Monmouthshire.</b></p>	<p><b>Quarter 1:</b></p> <ul style="list-style-type: none"> <li>• Monitor up-take following increased administrative capacity from new digital innovation (pending approval)</li> <li>• Maintain engagement at NCN &amp; contracting team level to monitor progress re Inter-Practice Referral Agreement (LARC &amp; Substance Misuse)</li> <li>• Explore option to engage on multi-agency basis reducing inequity</li> <li>• Respond to outcome of Health Inclusion Service report &amp; support HIS nurse implementation if applicable</li> <li>• Support proposal to the Enhanced Services Operational Group re investment to improve access</li> </ul>	<p><b>Quarter 2:</b></p> <ul style="list-style-type: none"> <li>• Continue Q1 milestones</li> <li>• Monitor new capacity from potential digital solutions providing increased equity if applicable</li> <li>• Maintain engagement at NCN &amp; contracting team level to understand resistance (if any) to taking on specific SS</li> <li>• Undertake gap analysis, mapping, data review &amp; engagement at fixed points in year and report issues / challenges to contracting team accordingly</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Enablers:</b> New capacity from potential digital solutions</li> <li>• Identify inequities in provision</li> <li>• Engagement with patients, carers, and community representatives, including those from "hard-to-reach" groups</li> <li>• Participate in peer reviews / benchmarking</li> <li>• <b>Risks:</b> Cost of staff training, new technology, resources</li> <li>• Workforce pressure from diverting staff away from core provision</li> <li>• Historic remuneration levels</li> </ul>
	<p><b>Quarter 3:</b></p> <ul style="list-style-type: none"> <li>• Continue Q2 milestones</li> <li>• Undertake gap analysis review and discuss collaboratively to understand if continued resistance / issues &amp; challenges</li> <li>• Liaise with contracting colleagues as required</li> </ul>	<p><b>Quarter 4:</b></p> <ul style="list-style-type: none"> <li>• Continue Q3 milestones</li> <li>• Undertake year-end review &amp; gap analysis</li> <li>• Discuss at final NCN meeting with contracting team as a collaborative looking into year 2 to overcome challenges where possible</li> </ul>	

# NCN IMTP 2026-2029

## Finance Profile 2026/27

Monmouthshire North NCN	Monmouthshire South NCN
<p>The North NCN commits approximately 90% of its annual budget on a recurrent basis for clinical and non-clinical support to meet sustainability concerns and reduce the reliance on GP times. Pharmacists, Psychological Health Practitioners and Wellbeing link advisors reflect the needs of a growing older population. As a result, there is limited option to test new concepts. We anticipate a breakeven position at financial year-end.</p>	<p>The South NCN has circa 10% of its annual budget allocated recurrently to funding clinical and non-clinical roles. As a result, there is greater flexibility in terms of being able to fund short-term projects. The NCN, through dynamic leadership, has a proven track record of testing new concepts successfully e.g.; MDT / Healthy Living project and Digital Innovation packages.</p>

### Monmouthshire NCN Forecasts 2026/27

*(Includes 3.0% uplift assumption for NHS Agenda for Change pay awards)*

Project / Role / Item	North NCN		South NCN	
	WTE	Total	WTE	Total
Practice Based Pharmacists	3.1	£234,732	-	-
Place-Based Co-ordinators x 4	-	-	2.0+	£91,500
Psychological Health Practitioners	1.2	£56,250	-	-
Community Phlebotomy Service	1.5	£9,591	2.0	£18,859
Wellbeing Link Advisors (match funded)	1.0	£23,958	1.0	£23,958
Digital Innovation	-	£6,500	-	£60,100
GMS Collaborative Lead Roles (Safeguarding/Practice Manager)	1.0	£4,742	1.0	£4,742
Multi-Disciplinary meetings / events	-	-	-	£22,500
Healthy Living Project (Diabetes/Hypertension)	-	-	-	£26,000
Protected Learning / Cluster Development		£3,150		£1,600
Other related spend (tech support etc.)		£800		£800
<b>Annual Budget</b>		<b>£340,171</b>		<b>£251,408</b>
<b>Forecast expenditure</b>		<b>£339,723</b>		<b>£250,059</b>
<b>Anticipated Underspend /Overspend</b>		<b>£448</b>		<b>£1,349</b>

### Monmouthshire North and South NCNs Finance (Continued):

- Monthly Divisional & NCN level finance meetings provide greater transparency & governance contributing to confidence, resilience and sustainability;
- Financial flow scrutiny reduces 'bottle-necks' in processing, supports in-year adjustments and offers greater assurance;
- Both NCNs have been subject to budget reductions: a) To support deprivation linked initiatives in other boroughs, and b) By absorbing NHS Wales pay awards (although this was reinstated in 2025/26). As a result, there remains an element of uncertainty around the potential for budget 'remodelling' in future. A number of difficult commissioning decisions were needed in 2024/25 leading to a circa £30k reduction in a number of schemes in the North to underpin our confidence in achieving a breakeven position. In 2025/26 both NCN forecast breakeven positions and we anticipate the same for the 2026/27 financial year.

# NCN IMTP 2026-2029

## NCN Funded Workforce Profile 2026/27

The table below describes the investment in terms of workforce employed to deliver the NCN priorities in 2026/27:

Service	Purpose	Outcomes																																					
Practice Based Pharmacists (North)	Addresses GMS Collaborative sustainability concerns by enhancing the clinical workforce and providing direct benefits to patients from increased local, practice-based pharmacy expertise.	This service has evaluated well year-on-year and demonstrates additional expertise available thus reducing the reliance on GP time. <ul style="list-style-type: none"> <li>➤ Improved quality and effectiveness of medicines management within practices.</li> <li>➤ Provision of patient focussed, prudent healthcare.</li> <li>➤ Promotion of medicines safety and addressing polypharmacy.</li> <li>➤ Progressed the practice pharmacist role as core member of the team working effectively across the MDT to deliver services to patients by providing prudent services &amp; supporting sustainability.</li> </ul>																																					
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<b>Total Monmouthshire Investment: £1,670,159</b>																																							
Psychological Health Practitioners (North)	<ul style="list-style-type: none"> <li>• Supports GMS Collaborative by providing local practice-based access to mental health advice and support. PHPs help reinforce a cycle of support for people by signposting to Wellbeing Link Advisor colleagues where appropriate.</li> <li>• The service has evaluated well and addresses a growing concern in terms of the number of people presenting with mental health issues.</li> </ul>	Led to a reduced reliance on GP involvement and meets the Health Inclusion agenda. <ul style="list-style-type: none"> <li>• Watchful waiting: Information/advice &amp; return option.</li> <li>• Self-directed learning: On-line CBT and/or other evidence-based resources e.g.; Melo.</li> <li>• Signposting to community support e.g.; Wellbeing Links, CAB, other local 3<sup>rd</sup> sector organisations.</li> <li>• Direct referral to Local Primary Care Mental Health Support Service waiting list.</li> <li>• Redirection back to GP – only if necessary.</li> </ul>																																					
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<b>Total Monmouthshire Investment: £453,943 (*South de-commissioned at this point)</b>																																							

# NCN IMTP 2026-2029

Wellbeing Link Advisors (North & South)	<ul style="list-style-type: none"> <li>Service managed by GAVO and linked to the PHP service responding to people presenting with the impact of social related concerns e.g.; housing &amp; finance etc. The service will also link with the Place-Based Care Coordinator role (if funded) to further support the most vulnerable 1% of our population and also reduce the reliance on GP services.</li> <li>This service has evaluated well year-on-year and continues to demonstrate its success in supporting the wellbeing agenda and reducing the reliance on GP time.</li> <li>NCN funding is provided with the proviso that it continues to be 'match-funded' by the Public Health Team.</li> <li>This also meets the Health Inclusion agenda.</li> </ul>																																				
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Community Phlebotomy (North & South)	<p>This service meets the long-standing NCN priority of delivering care at home, or as close to home as possible. The service meets the needs of people requiring blood to be taken as part of their on-going secondary care treatment plan, and avoids long journeys in both Wales and England. As the service is delivered in the main by Health Care Support Workers (2.3 WTE in Monmouthshire), there is contingency in that the District Nurses will cover the service in the event of unplanned absence.</p> <p>If this service was not funded by the NCNs then phlebotomy provision, especially in the vulnerable / housebound cohort would fall to District Nurse and therefore reduced capacity to care for people with long-term complex conditions. This meets the Health Inclusion agenda.</p> <ul style="list-style-type: none"> <li>For the South NCN's community Phlebotomy service, a minimum of 1,400 patients are seen each year with an average appointment time of 5 minutes or less. This suggests a cost saving to secondary care of around £25,900. The saving is likely to be much greater when taking into account the North service also (not NCN funded).</li> </ul>																																				
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# NCN IMTP 2026-2029

<b>GP Safeguarding Lead Role (North &amp; South)</b>	<p>NCN commissioned (nationally recognised) GP led role. Dr Rowena Christmas plans and hosts quarterly meetings of the GMS Collaborative to share experiences, expertise and individual case studies, thus greatly enhancing awareness across Monmouthshire. In 2025, Dr Christmas hosted a workshop which enhanced understanding and awareness of all members of GP practices in relation to safeguarding principles, legislation and the role every member of the team can play. Dr Christmas is also nationally recognised for her work in safeguarding.</p>	<p>This service evaluates well year-on-year and consistently meets its aims:</p> <ul style="list-style-type: none"> <li>Sharing best practice.</li> <li>Reducing workload by sharing protocols, presentations, templates.</li> <li>Discussing interesting / challenging cases in a supportive, confidential setting.</li> <li>Improving resilience through peer support.</li> <li>Focused learning on local Safeguarding issues.</li> <li>Cluster Safeguarding lead availability between meetings</li> </ul> <p>The group addresses growing safeguarding concerns around domestic violence etc. and is regarded best-practice. This meets the Health Inclusion agenda.</p>																										
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<b>Practice Manager Lead Role (North &amp; South)</b>	<p>This role promotes collaborative working across both NCN clusters, planning for and hosting quarterly meetings to discuss GMS related issues, share ideas to create efficiencies in business functions and explore innovative options e.g.; Artificial Intelligence.</p>	<p>Due to financial challenges, finance for this role was reduced following review – remaining key functions are:</p> <ul style="list-style-type: none"> <li>Cluster support, planning and collaboration</li> <li>Business continuity</li> <li>Co-ordinating a positive network of communication</li> <li>Acting as first point of contact for the collaborative</li> <li>Canvassing views relating to new services / innovations</li> <li>Advising Practice colleagues regarding GMS contract detail</li> </ul>																										
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## NCN IMTP 2026-2029

Place-Based Care 'Wish-List'	<p>In order to progress the development of PBC and in partnership with ISPB colleagues, we are undertaking a 'stock-take' in terms of where we sit now, in comparison with where we want to be. This work includes how we re-align existing resources and how PBC might be delivered in the future. We acknowledge that this work forms part of the wider Public Health Wales Business Case development and continue to support that initiative as active members of the ISPB.</p>														
Scoping exercise for examples of possible future investment as part of wider ISPB / PHW planning.	<table border="1" style="margin-left: auto; margin-right: auto;"> <tr> <td style="background-color: #1a3d54; color: white;">Place-Based Co-ordinator(s)</td> <td>£160,209 (x 7 0.53 WTE)</td> </tr> <tr> <td style="background-color: #1a3d54; color: white;">Data Analyst</td> <td>Band &amp; WTE to be agreed</td> </tr> <tr> <td style="background-color: #1a3d54; color: white;">Administrative Support</td> <td>Band 3 - WTE to be agreed</td> </tr> <tr> <td style="background-color: #1a3d54; color: white;">Community Conversation Resources</td> <td>TBC</td> </tr> <tr> <td style="background-color: #1a3d54; color: white;">Health Coaches</td> <td>TBC</td> </tr> <tr> <td style="background-color: #1a3d54; color: white;">Information, Advice &amp; Assistance Role</td> <td>TBC joint funded with MCC</td> </tr> <tr> <td style="background-color: #1a3d54; color: white;">Wellbeing Link Advisors</td> <td>£50,000 (x 2-1.00 WTE match funded or: £100,000 (x 2 not match funded)</td> </tr> </table>	Place-Based Co-ordinator(s)	£160,209 (x 7 0.53 WTE)	Data Analyst	Band & WTE to be agreed	Administrative Support	Band 3 - WTE to be agreed	Community Conversation Resources	TBC	Health Coaches	TBC	Information, Advice & Assistance Role	TBC joint funded with MCC	Wellbeing Link Advisors	£50,000 (x 2-1.00 WTE match funded or: £100,000 (x 2 not match funded)
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# NCN IMTP 2026-2029

## NCN Planning 2027/2028 – 2028/2029

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

	<b>2027/2028</b>	<b>2028/2029</b>
<b>Priority 1: Connecting people to non-medical activities, groups and services in their community which can address their practical, social and emotional needs.</b>	<ul style="list-style-type: none"> <li>• Seek assurance re status of Integrated Wellbeing Network lead role beyond contracted period (RIF)</li> <li>• As detailed by the Living Well Strategy and Implementation Plan</li> <li>• Outcome of annual budget review enabling re-investment where possible.</li> <li>• Annual reviews of funded schemes to ensure fit for purpose and value for money.</li> </ul>	<ul style="list-style-type: none"> <li>• Assurance needed re status of Integrated Wellbeing Network lead role beyond contracted period (RIF)</li> <li>• As informed by the Living Well Strategy and Implementation Plan</li> <li>• Outcome of annual budget review enabling re-investment where possible.</li> <li>• Regular NCN led reviews of funded schemes to ensure fit for purpose and value for money</li> </ul>
<b>Priority 2: Multi-Disciplinary working for people with complex needs who are most at risk of deterioration.</b>	<ul style="list-style-type: none"> <li>• Undertake annual review of funded projects using local data</li> <li>• Assess outcomes against delivery plans</li> <li>• Assess alignment with the Place-Based Care agenda</li> <li>• Undertake Terms of Reference stakeholder review</li> </ul>	<ul style="list-style-type: none"> <li>• Undertake annual review of funded projects using local data</li> <li>• Assess outcomes against delivery plans</li> <li>• Assess alignment with the Place-Based Care agenda</li> <li>• Undertake Terms of Reference stakeholder review</li> </ul>
<b>Priority 3: Reducing premature morbidity and mortality through prevention and management of diabetes and cardiovascular risk factors.</b>	<ul style="list-style-type: none"> <li>• Undertake annual reviews underpinned by locally available data to identify success / deficits</li> <li>• NCN led discussions at Collaborative meetings</li> </ul>	<ul style="list-style-type: none"> <li>• Undertake annual reviews underpinned by locally available data to identify success / deficits</li> <li>• NCN led discussions at Collaborative meetings</li> </ul>
<b>Priority 4: Provision of equity of access to Supplementary Services (SS) across Monmouthshire.</b>	<ul style="list-style-type: none"> <li>• Engage with GMS Collaborative to identify resistance to taking-up SS offer.</li> <li>• Review gap analysis / mapping at fixed points</li> <li>• Review data collaboratively at fixed points &amp; respond to issues &amp; challenges</li> <li>• Continue to review data sources / need on an on-going basis to ensure fit for purpose.</li> </ul>	<ul style="list-style-type: none"> <li>• Engage with GMS Collaborative to identify resistance to taking-up SS offer.</li> <li>• Review gap analysis / mapping at fixed points</li> <li>• Review data collaboratively at fixed points &amp; respond to issues &amp; challenges</li> <li>• Continue to review data sources / need on an on-going basis to ensure fit for purpose.</li> </ul>

**2026-27 Monmouthshire NCN Delivery Plan**

Title	New or Existing project	Brief Description	Results/Benefits expected by end of March 2027	Strategic alignment against ABUHB and NCN Priorities	Areas of Focus				Budget	Funding Source	Current Status	Comments	Activities or projects planned to commence during 2026/2027, as well as those ongoing from 2025/2026
					1	2	3	4					
Multi-Disciplinary working for vulnerable people	Existing	Bi-weekly MDT meetings	Increased intervention for most frail / vulnerable & hospital avoidance	RPB, SPPC, AHW, ISP, RSFOP, PBCC 1,2,3,4,5			✓		£22,550	South	Approved	Annual Review	<div style="border: 1px solid black; padding: 5px; margin-bottom: 5px;"> <b>Key: Alignment to NCN Agreed Priorities</b> </div> <div style="border: 1px solid black; padding: 5px; margin-bottom: 5px;">                     1. Connecting people to non-medical activities, groups and services in their community which can address their practical, social and emotional needs.                 </div> <div style="border: 1px solid black; padding: 5px; margin-bottom: 5px;">                     2. 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                 </div> <div style="border: 1px solid black; padding: 5px; margin-bottom: 5px;">                     3. 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                 </div> <div style="border: 1px solid black; padding: 5px;">                     4. 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.                 </div>
	New	Place Based Care Co-ordinators	4 x 0.53 wte response in post to support most frail population	SPPC, AHW, RPB, ISP, PBCC 1,2,3,4,5	✓	✓	✓		£91,500	NCN	Approved	Annual Review	
	Existing	Multi-Disciplinary / agency Winter Planning event	Integrated Planning across Health & Social Care		RPB, SPPC, AHW, ISP, PBCC 1,2,3,4,5	✓	✓	✓		£1,000	North & South	Approved	
Connecting people to non-Medical Support	Existing	Third Sector / Wellbeing Link Advisors	Supporting people with social determinants of ill-health	RPB, SPPC, AHW, WBoFGA (2015), ISP, PBCC 1,2,3,4	✓	✓			£47,916	North & South / IWN (RIF)	Approved with SLA	Annual Review	
Accelerated Cluster	Existing	GMS Collaborative: Practice Pharmacists	Access to local clinical expertise in GMS	SPPC, AHW, RPB, ISP, PBCC 1,2,3,4			✓		£234,732	North	Approved	Annual review	
	Existing	GMS Collaborative: Protected Learning	Shared Learning Collaborative maturity	SPPC, AHW, PBCC 1,2,3,4			✓		£4,750	North & South	Approved	Annual Review	
	Existing	GMS & Optometry Collaboratives: Digital innovation (AI)	Increased efficiencies in core business functions	SPPC, AHW, PBCC 1,2,3,4			✓		£60,100	South	Approved	Annual Review	
	Existing	GMS Collaborative: Practice Manager lead role	Shared Collaborative learning/best practice	SPPC, AHW, ISP, PBCC 1,2,3,4			✓		£887	North & South	Approved with SLA	Annual Review	
	Existing	GMS Collaborative: GP led Safeguarding role	Shared Learning, Joint cluster level leadership	SPPC, AHW, ISP, PBCC 1,2,3,4			✓		£8,628	North	Approved with SLA	Aspects of MDT/ scrutiny	
	Existing	Independent Advisor support (Top sliced)	Professional advisory role	SPPC, AHW			✓		£1,986	North & South	Top sliced	Annual scrutiny	
	Existing	GMS Collaborative: Psychological Health Practitioners	Increased access to local mental health support	RPB, SPPC, AHW, MH Strategy, PBCC 1,2,3,4	✓	✓	✓		£56,250	North	Approved	Annual Review	
Accelerated Cluster/ Care Closer to Home	Existing	Community Nursing Collaborative: OPD Phlebotomy Service	Access to care closer to home avoiding long journeys	RPB, SPPC, AHW, ISP, PBCC 1,2,3,4,5	✓		✓		£6,662	South	Approved with SLA	Annual Review	
	Existing	Community Nursing Collaborative: DN Phlebotomy	Provision at home for people considered housebound	RPB, SPPC, AHW, ISP, PBCC 1,2,3,4,5	✓		✓		£21,789	North & South	Top sliced	Annual Review	
Supplementary Services	Existing	GMS Collaborative: Influenza immunisation programme	WIS surveillance data benchmarking on local & national level	RPB, SPPC, AHW, ISP, PBCC 1,2,3,4	✓	✓	✓	✓	£0	North & South	Seasonal planning	High achieving clusters	
Supplementary Service linked to NCN Priorities	Existing	GMS Collaborative: Healthy Living Project (Diabetes / CVD risk)	Risk management/Data analysis leads to needs based interventions	RPB, SPPC, AHW, ISP, PBCC 1,2,3,4	✓			✓	£26,000	North & South	Seasonal planning	High achieving clusters	
	New	To map availability of supplementary services	Identify gaps in service for homeless, IUD's, minor surgery, substance misuse, asylum seekers & refugees	RPB, SPPC, AHW, ISP, PBCC 1,2,3,4	✓			✓	£0	South	Approved	Annual Review	

# MONMOUTHSHIRE NORTH and SOUTH NCNs – PLAN ON A PAGE 2026/2027

## NCN Areas of Focus

1. Connecting people to non-medical activities, groups and services in their community which can address their practical, social and emotional needs.
2. 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 health, social care and third sector organisations
3. To facilitate a collaborative approach in the delivery of diabetes prevention and CVD risk factor management to ensure that these programmes can be delivered systematically and at scale across NCNs
4. 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

## Our Key Actions

### Area of Focus 1:

- Working with the Integrated Wellbeing Network lead to implement the Living Well Strategy (LWS)
- Agree NCN level support for delivery via the LWS implementation plan
- Facilitate LWS consultation at NCN ISPB level
- Use data to assess effectiveness of the Wellbeing Link Advisor role & measure against previous baseline
- Work with GAVO & Public Health Team re impact of continued funding risk

### Area of Focus 2:

- Continue to fund (where available) South Multi-Disciplinary Team working to monitor impact & outcomes for the most 0.5% vulnerable population
- Identify options as necessary, to fund / grow the North Monmouthshire Multi-Disciplinary Team & continue to develop close links with the Rapid Frailty Response (RFR) team & Wellbeing Link Advisors etc.

### Area of Focus 3:

- South NCN level review of baseline data Healthy Living Project
- Aggregate practice level data re hypertensive patients treated to target – check data accuracy & process
- Discuss, share best practice, and consider adaptation of QI processes if applicable at collaborative level.
- Explore option re initiatives to benefit delivery of improved interventions in identified behaviours.

### Area of Focus 4:

- Monitor impact of digital innovations releasing capacity to increase up-take of Supplementary Services
- Engage contracting team to monitor progress re InterPractice Referral Agreement (LARC & Substance Misuse) & explore other options
- Respond to outcome of Health Inclusion Service report & support HIS nurse implementation if applicable
- Support proposal to the Enhanced (Supplementary) Services Operational Group re future investment to improve access.



## Enablers

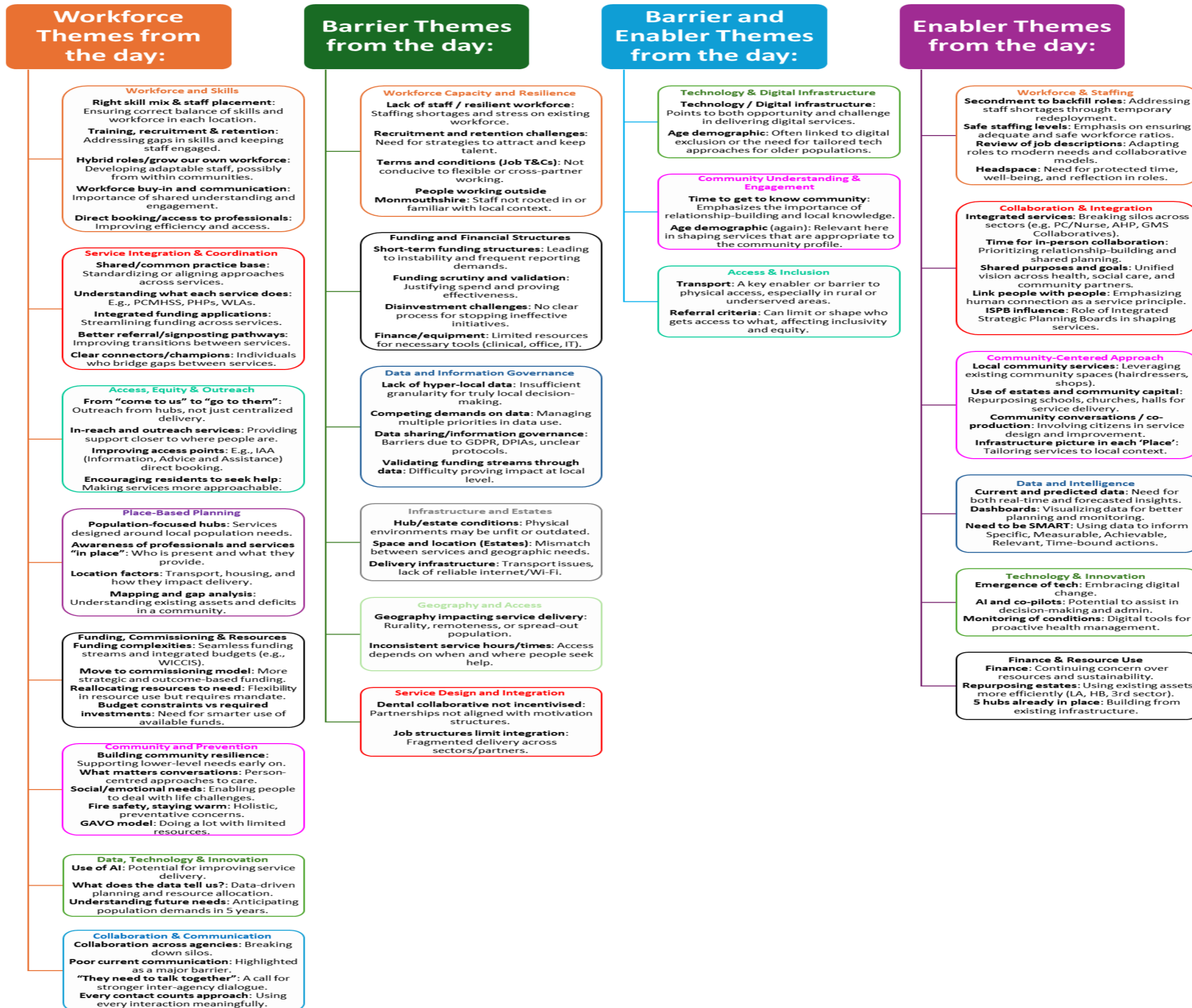
- Place-Based Population Needs Assessment (RPB)
- Integrated & Collaborative working across Partnerships
- Clinical benchmarked data re diabetes & CVD risk factors
- Supplementary Service mapping / gap analysis



## How will we know if we have made a difference?

Progress will be monitored via a range of primary & community level dashboards, NCN & Integrated Services Partnership Board reporting schedule

Appendix 2: ISPB Place-Based Care Workshop Outcomes



**Appendix 3: A Case Study – Wellbeing Link Advisors**

*GP Referral: I would like to refer this 65 year-old blind gentleman who is being taken advantage of by his neighbour. He has capacity and knows he has options but doesn't know how to access help. He relies on neighbours for shopping and pays what I consider to be over the odds to cover petrol, and he also pays for everyone (4 of them) to have breakfast when they go out. For instance, he's had to pay his neighbour £20 to get to the surgery to see me today and his neighbour charges him £10 to pick up his prescriptions. I'm not sure that Mr \* fulfils the criteria for a vulnerable adult, as he knows what he's doing, but he is most definitely being taken advantage of. He is also bored and would like to have more to do.*

The Wellbeing Link Advisor contacted the gentleman and liaised with the Coordinator of the Monmouthshire Car Scheme. A joint visit took place and the following topics were discussed: ♦ Social Isolation ♦ Lack of Independence ♦ Health Issues ♦ Financial Abuse Awareness ♦ Transport Issues, with information provided relating to available options: ♦ Monmouthshire Car Scheme ♦ Council Meals on Wheels Service ♦ Council Visual Impairment Team ♦ RNIB resources and Services ♦ Sight Cymru ♦ Befriending Service ♦ Local Lunch & Social Groups.

The gentleman was very pleased to learn about the local services and registered as a Car Scheme passenger. He was particularly keen to regain the ability to do his own food shopping, as he went without meals due to a lack of provisions. He mentioned a supermarket outside his area that he previously couldn't access and was also unable to receive deliveries from, as it falls outside their delivery zone therefore the Car Scheme Co-ordinator confirmed that this was something the service could assist with.

Additionally, the WLA agreed to provide further follow up by contacting the Visual Impairment Team, RNIB, Sight Cymru, and the Befriending Service on his behalf to explore other specific support options that could help improve his situation. The gentleman took the time to pass on this message, which was subsequently sent to the referring GP: **"Thank you so much for all you have done for me - you have made the world of difference to me already", with the GP response below: "That's wonderful news – this is the wellbeing links at its best! Thanks for your help, I hope he now has a good improvement in his quality of life. I think you offer a really amazing service for our patients".**

**Appendix 4: Supplementary Service Mapping Exercise to identify inequity and generate Collaborative level discussions:**

2025/26 Supplementary Services mapping exercise	Practice Name	NCN	Asylum Seeker	Homeless	Substance Misuse	Depo-Provera	Depo/Sayana Press	Contraceptive Implants (Nexplanon)	Contraceptive Implants (Nexplanon Non Registered Patients)	IUCD Registered	IUCD - Non registered	Minor surgery - Fee A & B	Minor surgery - Fee B Only	Minor Surgery non- Registered patients	
	Caldicot Medical	Monmouthshire South				Y		Y		Y	Y	Y	Y		
	Mount Pleasant	Monmouthshire South				Y	Y	Y		Y	Y	Y	Y		
	Vauxhall Practice	Monmouthshire South				Y		Y		Y	Y		Y		
	Town Gate	Monmouthshire South	Y			Y		Y		Y	Y		Y	Y	
	Castle Gate	Monmouthshire North	Y	Y	Y	Y	Y	Y		Y	Y	Y	Y		
	Dixton Surgery	Monmouthshire North	Y	Y	Y	Y		Y		Y	Y	Y	Y		
	Hereford Road	Monmouthshire North	Y		Y	Y	Y	Y		Y	Y	Y	Y		
	Old Station	Monmouthshire North	Y			Y	Y			Y		Y	Y		
	Usk Surgery	Monmouthshire North				Y				Y		Y	Y		
	Tudor Gate	Monmouthshire North	Y			Y		Y		Y		Y	Y		
	Wye Valley	Monmouthshire North				Y		Y		Y		Y	Y		