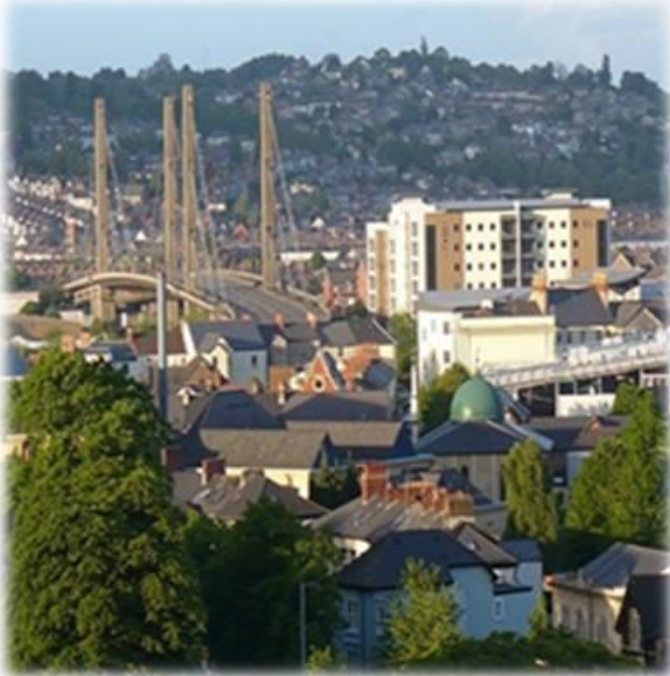


Newport Neighbourhood Care Network IMPT



NCN IMTP 2026-2029

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

Working as an NCN that incorporates General Medical (GPs), Dental and Optometric Practitioners, Pharmacists, Community Nursing, Allied Health Professionals (AHP), Integrated Wellbeing Network, Social Care and third sector organisations combine their detailed knowledge and expertise ensures care is better coordinated to assess population needs, identify service improvement priorities and develop local solutions to promote the wellbeing of individuals and communities.

This integrated medium term plan (IMTP) outlines the vision and priorities of Newport Neighbourhood Care Network (NCN) articulating how these will be achieved over the next three years.

Our NCN plans have developed over the last few years to adapt and meet the changing needs of our diverse and growing population. Regarded as the gateway to South Wales, Newport has a population of nearly 160,000 and is the second most diverse and densely populated unitary authority in Wales with communities rich in culture, tradition and language. Our NCN experiences significant contrast between wealth and deprivation with 23 of the 95 most deprived Lower Super Output Areas in Wales being in Newport, the highest proportion of any authority in the country, correlating with significant prevalence's of mental health illness in our communities. We exceed national averages of chronic health conditions including diabetes, cardiovascular, respiratory disease, have the highest homelessness rate in Wales and 14.5% of our population constitute of ethnic minorities.

Through the delivery of our NCN IMTP, we work to offer better care, better lives and better health and to meet the Quadruple Aims set out for Health and Social Care Systems in Wales. This will be achieved this in the context of the Primary Care Model for Wales.

NCN IMTP 2026-2029

About Newport

Newport is a multi-cultural city, with a population of 164,702 (as per GP registered individuals).

- Newport has the second highest proportion of population from Black, Asian and Minority Ethnic backgrounds in Wales, with 48 different languages spoken amongst 20 identified communities.
- It has been identified that there are 2340 households within Newport that do not speak English or Welsh as a main language.
- Newport has an ageing population, with a current over 65 years population of 27,510.
- Estimated ageing population projection to 37,241 by 2039
- Newport is facing a significant housing issue with high demand far outstripping supply, leading to a long waiting list for social housing and a rapid rise in homelessness and temporary accommodation use. Newport City Council have also recently announced that there are approximately 9000 individuals on the social housing waiting lists.
- The number of rough sleepers in Newport has been a significant concern, with recent figures showing a high count.
- Certain neighbourhoods are disproportionately affected by unemployment, low incomes, poor skill levels and crime and anti-social behaviour. According to Stats Wales data Pillgwenlly within the West ranks as number 39 in Wales most deprived areas and the Ringland area within the East is ranked as 70th.

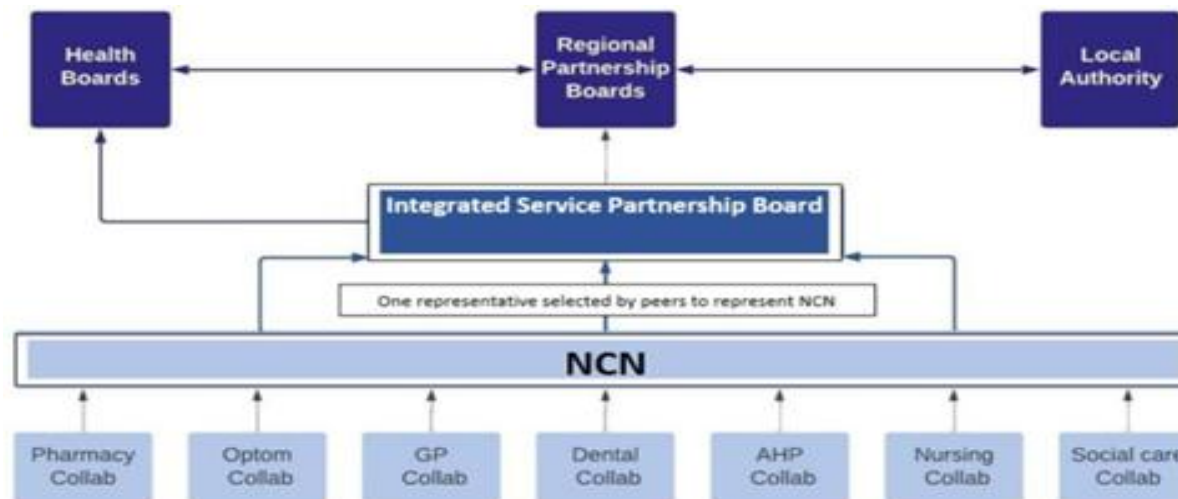


NCN IMTP 2026-2029

Governance and Reporting Across Strategic Partners:

Newport’s strategic direction is aligned with the Regional Partnership Board’s Start Well, Live Well, Stay Well framework.

The diagram below outlines the current governance and reporting framework providing opportunities for core resources to be optimised with partnership funding held in one place. This framework supports the opportunity, to realign 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:

- A Population Needs Assessment (PNA) is available and provides a joint assessment of the level of care & support needed across Gwent, including prevention, levels of service and emerging needs.

Evidence provided by the current PNA was used to support the priorities outlined within this 3-year plan with the 3 key RPB goals below applied across our NCN priorities:

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

The Newport ISPB is a sub-group of the RPB and a conduit for information sharing, decision making and providing direction over NCN delivery plan priorities.

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It enables key partner representatives to work together on strategic, long-term plans, to agree and develop priorities linked to, for example; the Social Services & Well-being of Future Generations Act, Strategic Programme for Primary Care, and A Healthier Wales. It facilitates a whole-system approach to improving health and wellbeing, integrating Health, Local Authority and Third Sector services thereby providing the best possible services to our residents. Newport ISPB has a shared objective, aligning to the Marmot Principles, and delivering against national and local strategic drivers through:

- Placed based care: Strengthening services with a key focus on prevention and early intervention, based on an evidence base and tailored to needs of residents, through a place-based approach
- Co-production: Designing and delivering effective, efficient services in partnership with residents and stakeholders
- Workforce quality: Ensuring Services are delivered by a capable, integrated workforce

<p>ISPB objectives:</p> <ul style="list-style-type: none"> • Deliver local implementation of RPB priorities • Coordinate available resources to meet population needs • Provide strategic direction • Support partnership working • Ensure plans reflect population health intelligence 	<p>← Solutions, Improvement, Change →</p> <p>← Intelligence for priorities & decision making →</p>	<p>ISPB priorities:</p> <ul style="list-style-type: none"> • Third Sector as full partner • Integrated workforce for the future • Place Based Working • Redesigning services for older people • Ensure fit for purpose estate • Enhanced Financial scrutiny
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Current services need to evolve to be able to sustain and improve. There is a necessity to change historical ways and patterns of working that no longer meet the needs of today's society and the needs of the future population, notwithstanding the changes to our service delivery and communication brought about by the covid pandemic. Newport NCN is dedicated to enhancing service delivery to meet current and future needs.

The consideration of the strategic priorities of the ISPB and RPB into NCN planning will ensure that Newport is able to offer a robust person-centered model of care that reflects the values of collaboration, prevention, and equity.

6 areas within Newport have been identified as 'places' within the city. Place based care will be multifaceted to be centered on the communities in each place. This will ensure that these 'places' are best equipped to design, develop and implement services that will improve communities within the defined place which will result in better outcomes for individuals.



Neighbourhood Care Network (NCN)

NCNs bring together all local services involved in health and care across a geographical area, to combine local expertise and knowledge these include:

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- General Medical (GPs),
- Dental and Optometric Practitioners
- Pharmacists,
- Community Nursing,
- Allied Health Professionals (AHP)
- Local Authority
- Third Sector Organisations
- Integrated Wellbeing Network

Functioning as an NCN ensures care is better coordinated to assess population needs and are a key component in identifying service improvement priorities and develop local solutions to promote the wellbeing of individuals and communities.

Newport is currently established around 2 Neighbourhood Care Networks (NCNs), East and West, with an ambition to improve and develop primary care and community services within the local communities.

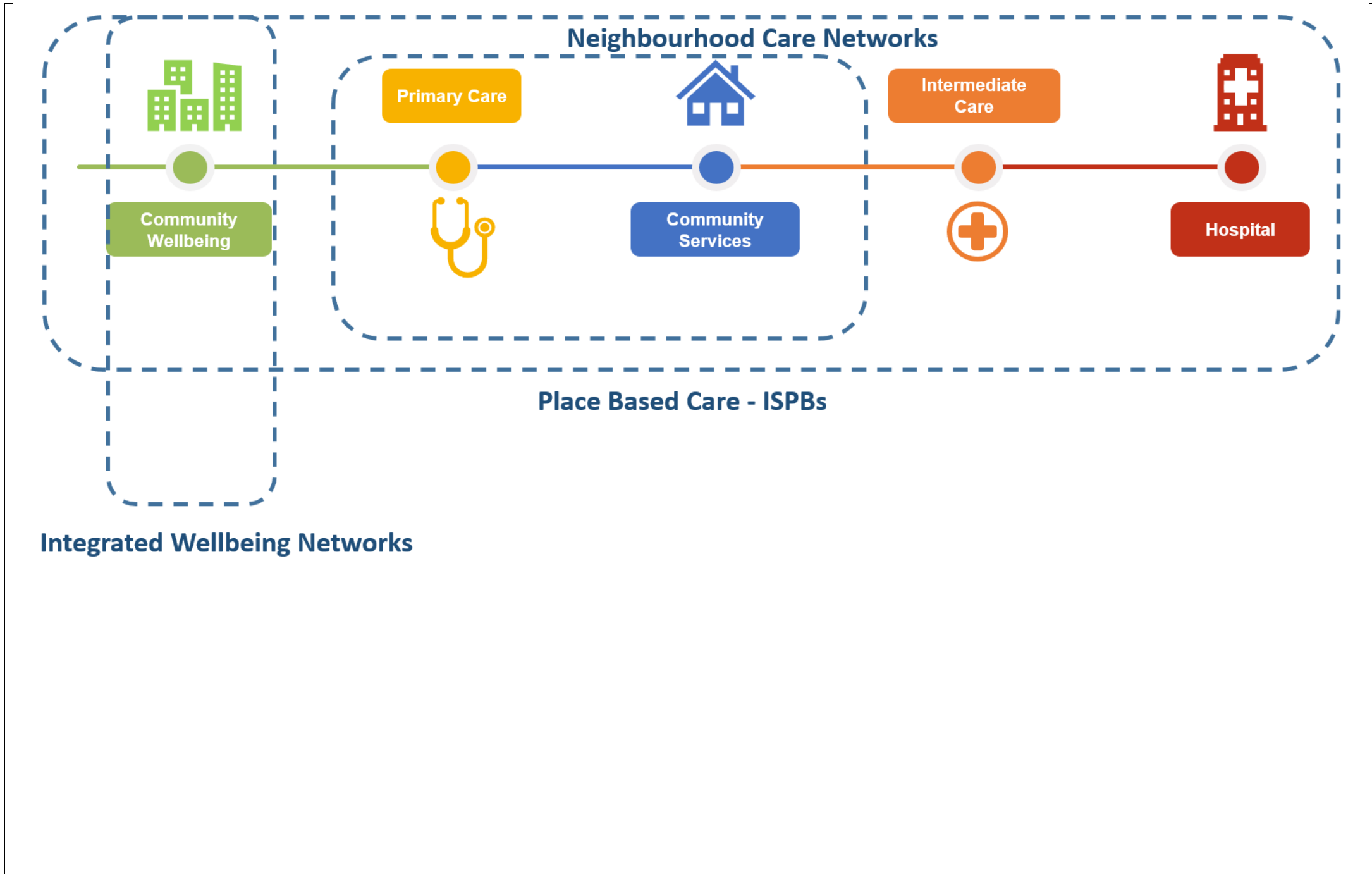
Professional Collaboratives

6 Professional collaboratives have been created as a result of Accelerated Cluster Development which is a key component of place-based care. Each of 6 collaboratives are represented at NCN meetings and help understand the local and regional needs of each service which then helps to inform planning. The professional collaboratives are made up of representation from:

- GMS
- Nursing
- Pharmacy
- Optometry
- Allied Health Professionals
- Dental

The Place-Based Care Continuum:

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Health Board and NCN Priorities

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



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

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

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

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

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

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

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Previous NCN Achievements Progress Made Against NCN Priorities within 2025/2026

Priority 1 Connecting people to non-medical activities, groups, and services in their community which can address their practical, social and emotional needs

- Strengthened relationships with Newport Integrated Wellbeing Network (IWN) to extend the IWN's place-based approach across community wellbeing and integrated social care and health services through enhanced links with MDT teams in Newport. As a result of collaborative engagement, funding was allocated to 'Kid Care 4 U which is a registered charity that aims to support families to acquire the skills and confidence they need to turn their potential into success at school, the workplace and beyond.
- NCN funding via the local authority Participatory Budgeting scheme; combined amount of £10k was gifted by the NCN to support local community groups in line with the identified NCN priorities such as mental health, dementia, women's health and wellbeing.
- The NCN provided support and funding for equipment in relation to Public Health 'Health Fayres' that were held 4 times throughout a 12-month period. All events were held within Mosques and community venues in order to engage with communities that recorded lower uptake in vaccinations and screening. The main aim of the events was to raise awareness of accessing support for:
 - *Coronary vascular disease*
 - *Hepatitis screening and advice,*
 - *General health advice,*
 - *Flu & Covid 19 adult vaccinations,*
 - *Childhood immunisations & vaccinations information,*
 - *National screening programmes for breast, bowel and cervical cancer as well as aortic aneurysm*
- Worked in collaboration with IWN and the local authority in the Implementation Community Connector roles in Ringland & Bellevue Medical Practices supporting individuals to connect to social groups, maximise their income, access carer support and received general signposting to support services. The NCN and IWN use asset-based approaches to create accessible community resources that support integrated care. These resources are shaped by the aspirations of the community, allowing health, social care and third sector services to be delivered in informal, familiar settings. The approach focuses on the social, economic, and environmental factors that contribute to poor health and wellbeing. By using a strength-based model, previously separate services are brought together to collaborate and develop solutions that focus on what matters most to individuals, their families and communities. Through a shared understanding the NCN, IWN and PBC Team have strengthened collaboration with third sector and community organisations to deliver early intervention, prevention and chronic disease management with a focus on diabetes, CVD, mental health and social prescribing through community connectors.
- RIF and NCN funding have been invested to commence implementation of the NFSP which has enabled Community Connectors to be allocated to Bellevue and Ringland Medical Practices.
- A snapshot of Ringland Q2 data shows us that the Community Connector assisted 58 individuals with mainly anxiety, financial worries, carer strain and housing issues. Feedback from the individuals supported includes: -
 - *"You have been absolutely amazing. I didn't know this sort of help existed. Some people struggle more than me and they are left with nothing. Thank you so much for everything*
 - *"We are desperate, and you are helping us, thank you" –*
 - *"Not many people know how to help me, people don't help each other anymore. You have made me very happy, I'm grateful. Thank you"*
 - *"I feel better, feel lighter and I tell no one my business. It's strange my head feels better. You don't know how you are helping me*Integrated care approaches were developed aligned to IWN priorities to ensure that the most can be achieved from shared resources to enable individuals to have good quality of lives and cope with adversity.

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Collaboration in shaping long term preventative services is ongoing utilising community assets to improve access, engagement and social connectedness so that individuals are encouraged to participate in rewarding activities that improve wellbeing and have the support needed to address wider determinants that negatively impact health.

- The 19 Hills Health and Wellbeing Centre opened in January 2025 with £29m Welsh Government investment. The primary objective of the Health and Wellbeing Centre is to develop an integrated model of support offering care closer to home and service delivery to address health inequalities in the local population. The centre currently offers:

General Medical Services: Offered by Ringland Medical Practice and Park Surgery.

Community Dental Services and General Dental Services (provided by Ringland Dental Practice)

ABUHB Community Services: including Family and Therapy Services, Audiology, AAA Screening, Diabetic Retinopathy, Mental Health Support Services

The aim of the Centre is to address the holistic needs of the community by promoting wellness, supporting the management of health conditions, and emphasising the co-production of health and social care services. It provides opportunities for the integration of primary care and public health, free space for wellbeing activities delivered by community groups. A schedule of regular planned wellbeing activities had been developed up until April 2026 which include:

- Menopause and Cancer Café
- Self-Care Week
- Breastfeeding and parenting Groups
- MDT Wellbeing Clinics
- Wellbeing Book Clubs
- Department of Works and Pensions pop up surgeries
- Public Christmas Event
- New Year New You Event
- Diabetes focussed event

A Community Involvement Officer has been employed at 19 Hills Health & Wellbeing Centre until April 2026, to develop the community activities in conjunction with the IWN team, to ensure that services and community groups are aligned to provide wrap around care and support.

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- Behavioural Change Practitioners (previously Help Me Quit practitioners) have been employed within Public Health Wales who 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 MDT working for people with complex needs who are most at risk of deterioration or adverse events

- As an NCN, Newport has long recognised the value of MDT and multi sector working to deliver collaborative joint care planning for individuals with complex conditions so that when needs escalate, shared plans are agreed that ultimately improves outcomes whilst optimising the use of finite health and care resources. Introduced in Newport West GP Practices in 2019, the virtual ward model set the innovative landscape for developing holistic, patient-centred assessment; multidisciplinary partnership working between GPs, other primary care professionals, social care and third sector colleagues. Utilising RIF and NCN funding, a Placed Based Care Service has been established to further develop the virtual ward model which consists of a hub team of Clinical Nurse Leads, OT, Pharmacists and Coordinators who work in in the spirit of a shared endeavour with GP Practices, primary, community, social care, the independent and third sector services to promote a collective intent to align resources that deliver a pragmatic and integrated health and wellbeing model attuned to the diverse needs of population groups in Newport particularly those living and/or at risk of developing complex needs, long term conditions and frailty so they are empowered to proactively manage their own health rather than being passive recipients of services.

Achievements so far include: -

- Strengthening of established MDT team meetings in GP Practices to enhance care for complex patients and ease GMS pressures, the Newport Place Based Care Service continues to move and expand at pace.
- Multidisciplinary coordination: the team coordinates care for complex patients, acting as a central hub for communication between different professionals involved in a patient's care.
- Multidisciplinary placed based partnership development that meets the needs of individuals and communities in Newport particularly vulnerable and marginalised groups so that use of community assets that support individuals access to health and wellbeing resources is maximised. In 25/26, 1,446 stakeholders attended MDT meetings
- MDT meetings occur in every GP Practice where individuals with complex, long-term conditions, frailty, poor mental health are the primary beneficiaries from receiving patient centred shared care planning that includes biopsychosocial influences that construct ill health. Through collaboration the individual receives holistic coordinated care that addresses their needs, improves their outcome and reduces risks of decline. In 24/25 2,986 individuals were support by the PBC Service and 310 MDTs held
- Proactive and anticipatory care planning for individuals who have historically received uncoordinated ad hoc care due to the complexity of their conditions
- Wellbeing Clinics are held to address social, economic and environmental factors that overlap ill health so that individuals receive the appropriate support to improve their ADL's and social connectedness.
- Reduced strain on GMS, NHS & LA resource by ensuring the individual receives the right care closer to home that is more preventative, cost-effective and productive therefore reducing reliance on GP, secondary care and statutory services.
- Building on the principles outlined in the Primary Care Model for Wales and the quadruple aims of "A Healthier Wales", Newport NCN continues to work collaboratively with Primary, Community, Social Care, third sector and external providers to maximise all opportunities to achieve place based seamless multi-professional and/or cross sector responses as close to home as possible for individuals to avoid crisis and escalation of their care needs, where feasible.

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- Secured community space (West Market Street) to deliver PBC Clinics that provide a multifaceted, preventative patient centred approach that also addresses biological, social and environmental factors that construct ill health for high risk stratified individuals with 3+ NCDs
- The District Nursing service and National Exercise Referral Scheme worked in collaboration to identify housebound bariatric patients that would benefit from light exercise sessions within their own home in an attempt to reduce Body Mass Index (BMI).

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

- Regular monitoring and discussions with practices around the flu vaccination uptake, sharing good practice and up to date uptake figures
- There is ongoing work to determine how low GMS uptake in particular areas can be increased either through inter practice agreements or support from community services. This will provide equity of services within the city and ensure better health and care are provided locally. The consideration of vulnerable groups will be of high importance to ensure that appropriate health care is available to all citizens of Newport.

As of April 2025, Public Health Wales data identifies that with Newport there are:

- 402 individuals registered as asylum/refugees
- 819 individuals classed as homeless/owed a duty of care under the Housing Act.
- Of the 819, 25 are registered as rough sleepers
- 172 individuals recognised a Roma gypsy/traveller community.
- 83 registered sex workers.

Newport is one of three designated dispersal areas in Wales; support was given to the Health Inclusion Service (HIS) and local authority in the health registration process of the resettlement of asylum seekers and refugees.

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

- Sustainability risks within teams due to budget restraints.
- Risk to staff retainment due to fixed term contracts.
- NCN budget is predominately allocated to the Place Based Care team which increases as staff uplifts are awarded.
- NCN funded proven projects remain within NCN budgets rather than reallocated to health board core funding
- Aging workforce and increased work life balance opportunities resulting in reduced working patterns pose a risk in stability
- Some difficulties with the recruitment of roles, such as GP Partners
- NCN structure recently destabilised
- Public messages of additional services still appear to be unclear such as the use of the Common Aliment Scheme and community pharmacy interventions, i.e. Test and Treat.
- Estates are an issue to further utilise and expand community services, i.e., HIS Team do not have allocated clinic space other than in external organisational buildings. GMS practices are full to capacity which hinders their ability to provide additional services and roles.
- Access to patient systems used by partners such as WICCIS to avoid silo working and duplication.

Proposed Milestone for Agreed Priorities for 2026/2027

Priority 1 Connecting people to non-medical activities, groups, and services in their community which can address their practical, social and emotional needs

NCN IMTP 2026-2029

End of Year Objectives	
<ul style="list-style-type: none"> • To have an active culture of signposting amongst health and wellbeing services within Newport • To have a system in place to support the delivery of social prescribing and monitor activity and outcomes. 	
Priority 2 Reducing premature mortality and morbidity through prevention and management of diabetes and cardiovascular risk factors	
<p>Q1.</p> <ul style="list-style-type: none"> • Gather and understand the local community intelligence that exist and where gaps exist. • Understand the mapping exercise undertaken by the ISPB of community assets/Link Workers across aligned 6 places. • Continued development of ‘Your Newport, Your Wellbeing’ • Commence implementation a social prescribing referral system • Work with IWN and GAVO to develop a small grants scheme 	<p>Q2.</p> <ul style="list-style-type: none"> • Align Your Newport, Your Wellbeing Link Workers to the identified 6 places. • Review of investment to align existing community resources to bridge gaps in service provision. • Implementation of a social prescribing referral system pilot
<p>Q3.</p> <ul style="list-style-type: none"> • Continue the social prescribing communication system pilot 	<p>Q4.</p> <ul style="list-style-type: none"> • Evaluate the social communication pilot and complete the rollout into year2
End of Year Objectives	
<ul style="list-style-type: none"> • Behavioural Change practitioner embedded in community teams. • Health Coach that will be able to support practices with hypertension • NCN response to the rising demand of long-term conditions 	

NCN IMTP 2026-2029

- Have a defined understanding of the role of primary care dietetics in the reduction of diabetes
- Complete a mapping exercise with each professional collaborative to determine what support can be offered in regards to diabetes and CKD.

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

- Q1.**
- The current 'Place Based Care' team within Newport is to be relaunched with a rebranded name to avoid confusion with the wider place-based care concept
 - Service criteria, roles and responsibilities to be redefined to provide clarity and understanding of the future direction of the service.
 - Define 'complex need' criteria to ensure that this cohort of patients are not overlooked whilst moving focus to the rising risk population.
 - Continue to develop and refine the evaluation strategy for the work of the place-based care team
 - Connect the dedicated Newport HIS Nurse to the PBC team

- Q2.**
- A review of the NCN Pharmacy Provision (East) will be undertaken to provide a clear explanation of roles and availability to understand if a place-based approach that Newport West has adopted within this professional cohort could be mirrored to allow for uniformity across the city

- Q3.**
- Expand the professional input within the MDT meetings such as social services and Health Inclusion Service presence.
 - MDT Coordinators to strengthen working processes with the Health Inclusion Service with a focus on outreach work.
 - Align MDT Coordinators to identified areas in line with place-based care

- Q4.**
- Further understand the processes and procedures of partners that impact directly upon outcomes and decisions of the place-based care team, such as the local authority's First Contact referral process

- End of Year Objectives**
- Rebranded new identify of the Newport PBC service
 - Stronger relationships with other health board services and partners

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

- Q1.**
- Identify service gaps that exist within the local supplementary/enhanced services across Newport.

- Q2.**
- Support inter-practice service agreements with GP practices in the NCN.

Q3.

Q4.

NCN IMTP 2026-2029

<ul style="list-style-type: none"> • Facilitate stronger relationships with GMS and the High Intensity Services to ensure that continued specific individual care and medication is identified and provided. 	
End of Year Objectives <ul style="list-style-type: none"> • Agreed hub and spoke model for LES/DES services where gaps have been identified exist. 	
Enablers required to deliver 2026/2027 quarterly milestones	Challenges, risks and barriers to successful delivery of agreed milestones within 2026/2027
<ul style="list-style-type: none"> • Additional IWN roles and continued progress. • Developing strong relationships with various stakeholders, i.e., ISPB and GAVO. • Extended funding opportunities via local authority. • Access to appropriate data streams to avoid duplication. • Core funding for NCN funded projects, i.e., Psychological Health Practitioners. • Professional Collaboratives working effectively together and continue to develop. • Positive feedback from patients, practices, care homes, and district nursing • Temporary positions within teams permanently secured Place Based Care Team • Staff completing further education, which enables them to perform more advanced clinical assessments and interventions, to release GP time • Increased partnership working through ISPB • Improved integrated working and understanding of partners working processes. • Engagement from key stakeholders • Relevant representation at meetings such as MDT’s • Alignment of MDT coordinators as a place-based approach. 	<ul style="list-style-type: none"> • Sustainability risks within teams due to budget restraints. • Risk to staff retainment due to fixed term contracts. • Inability to shift service/projects to release resource to invest. • NCN budget is predominately allocated to the Place Based Care team which increases as staff uplifts are awarded. • NCN funded proven projects remain within NCN budgets rather than reallocated to health board core funding. • Financial pressure within practices, inflation impacting practice and uplifts do not cover rising costs • Aging workforce and increased work life balance opportunities resulting in reduced working patterns pose a risk in stability • Some difficulties with the recruitment of roles, such as GP Partners • NCN structure recently destabilised • Educating patients to access appropriate services such as the Common Aliment Scheme and medical pharmacy interventions. • Estates are an issue to further utilise and expand community services, i.e., HIS Team do not have allocated clinic space other than in external organisational buildings. • Access to patient systems used by partners such as WICCIS to avoid silo working and duplication.
Finance Profile 2026/2027 The Health Board are required to deliver a breakeven financial plan for the 2026 – 2029 IMTP, please outline your breakeven Financial Profile for 2026/2027	

NCN IMTP 2026-2029

East Spend Plan Summary	2026/27
Annual Budget	495,903
Top Slice: Advisers, Phlebotomy, Dementia Roadmap	£19,415
Practice Based Pharmacists	£177,118
B4 Coordinator	£40,155
MDTs (based on 2 pm)	£40,800
PHPs (based on 4wte)	£175,926
Hub Team Lead	£58,790
Other	£0
Total Expenditure	£512,205
Forecast position	(£16,302)

West Spend Plan Summary	2025/26
Annual Budget	£538,077
Top Slice: Advisers, Phlebotomy, Dementia Roadmap	£20,334
Practice Based Pharmacists	£199,784
PHPs (based on 4wte)	£183,751
Team Lead & Occupational There	£14,698
Clinical Nurse Lead	£64,116
MDTs	£33,600
AccuRx / e-consult	£25,094
Accruals	
Link	£0
Other Non Pay	£0
Total Expenditure	£541,377
Forecast position	(£3,300)

NCN IMTP 2026-2029

The NCN budgets are largely devoted to the work of the place-based care model, this remains under consent review and any funding that becomes available will be reinvested as required.

In order to balance the financial budget and ensure that all funding is relevant to the NCN priorities, there are a number of options being discussed.

Workforce Profile 2026/2027

Please outline your workforce profile for 2026/2027

The current workforce profile is as follows:

Service	Roles	Brief Description	Risks, Challenges, Barriers
Place Based Care	<ul style="list-style-type: none"> • Clinical Lead Nurses • PBC Clinical Pharmacists • Occupational Therapist • MDT Coordinators • Link Worker 	To provide health and social care support within the community and addressing local need. The goal is to keep people healthy and at home by offering services closer to where they live, supported by multi-agency teams that connect community members and local services.	<ul style="list-style-type: none"> • Budget • Staff Uplift costs • Fixed Term Contracts • Estates • Service duplication
Pharmacy	Practice-Based Pharmacists	Alignment of Community NCN Pharmacists with PBC team, exploring how their professional skills can be utilised in reducing chronic conditions via intervention and medicine management.	<ul style="list-style-type: none"> • Pan Gwent model • Budget • Difference in NCN models • Staff Uplift costs
Mental Health	Psychological Health Practitioners (PHPs)	Reduce demand on GP appointments for low level psychological health concerns. Intervention provided to prevent crisis mode occurring.	<ul style="list-style-type: none"> • Staff turnover • Budget

Intended Additional Workforce Profile for 2026/27 and beyond

The ISPB has designed a Place Based Care model which splits Newport into 6 "places" which require targeted interventions to support individuals and communities in Newport to improve their health, wellbeing and resilience whilst also addressing socio-economic challenges that construct ill health and lead to poor outcomes and systemic differences that currently exist. This cannot be achieved without appropriate investment to secure a dedicated workforce to deliver the model. Whilst the ISPB will continue to develop place-based partnerships to share resources and the NCN will continue to maximise all funding opportunities to recruit into the roles desperately needed, permanent recurring funding is required to deliver a robust person-centred Place Based Care model.

NCN IMTP 2026-2029

The current Place Based Care Team deliver MDT working for complex patients registered with Newport GP Practices, holistic clinical nurse lead and OT person centred interventions and support rising risk cohorts to prevent deteriorations. The current workforce is insufficient to meet the levels of need that exist in Newport. Permanent funding is therefore required to increase the workforce in alignment with ISPB and NCN plans to deliver holistic patient centred care that is underpinned on addressing wider factors that influence health. Current demand is continuously outstripping PBC Service capacity despite the team working proactively to share workload and utilise all available pathways for alternative support. Increasing the workforce will enable the team to work far more up stream delivering preventative care and interventions that prevents deterioration and reduces GMS, Primary Care and Secondary Care demands. Therefore, the following roles have been identified as required in the future going forward and will be captured within the costed model as there are insufficient funds within the NCN budgets.

Additional Occupational Health Therapist x 1wte	Better Care-Place Based Care	£60,068
New Pharmacy Technician x 1wte	Better Care-Place Based Care	£68,448
New Chronic Conditions Nurse x 1wte	Better Care-Place Based Care	£60,068
Additional Link Worker x 4wte	Better Care-Place Based Care	£177,420
New Social Prescriber x4wte	Better Care-Place Based Care	£241,098
New Community Involvement Officer x 2wte	Better Care-Place Based Care	£80,336
New Business Officer x 1wte	Better Care-Place Based Care	£32,127
New Paramedic x 1wte	Better Care-Place Based Care	£62,277
New Physiotherapist x 1wte	Better Care-Place Based Care	£62,277

NCN IMTP 2026-2029

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

Priority	2027/2028	2028/2029
Priority 1 Connecting people to non-medical activities, groups, and services in their community which can address their practical, social and emotional needs	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.	Continue effective partnership working with NCN networks, identifying gaps in provision and utilising NCN data to direct workstreams.
	Continue the development of ‘hubs’ in collaboration with the local authority and third sector, such as West Market Street, Alway, Gaer, St Julians, 19 Hills, ensuring these assets can connect people with health and wellbeing resources, activities and other people to support their own wellbeing.	.
Priority 2 Reducing premature mortality and morbidity through prevention and management of diabetes and cardiovascular risk factors	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.	Establish a chronic disease team across the NCN that will specialise in the management of long-term health conditions, such as diabetes, diet, heart disease, and asthma, by providing proactive care, patient education, and collaborative treatment planning within the multidisciplinary place-based care team. The role will conduct annual reviews, manage medication, monitor symptoms, and help patients with lifestyle changes to improve their quality of life and wellbeing.
	BCP’s to 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. The aim is to ensure that key health messages reach a broad audience, particularly those at heightened risk with respiratory illnesses. Content will focus on: <ul style="list-style-type: none"> • Encouraging uptake of the Help Me Quit smoking cessation programme 	

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	<ul style="list-style-type: none"> • Promoting the importance of winter vaccinations for respiratory health and encouraging eligible individuals to take up the offer of seasonal vaccinations • Signposting individuals to relevant support services, including Warm Homes initiatives and local well-being resources 	
<p>Priority 3 MDT working for people with complex needs who are most at risk of deterioration or adverse events</p>	<p>Support the work of the MDT teams in diabetes prevention by developing community-based support to promote and encourage healthy behaviours and support mechanisms in partnership with third sector organisations such as Diabetes UK, e.g., Peer Support Groups, Food Control.</p>	
<p>Priority 4 Equity of access to supplementary/enhanced services across Gwent</p>	<p>Continue to monitor supplementary and enhanced services across Newport</p>	

Title	New or Existing project	Brief Description	Results/Benefits expected by end Mar 2027	Strategic alignment against ABUHB and NCN Priorities	Areas of Focus				Budget	Funding Source	Current Status	Comments
					1	2	3	4				
Building Community Resistance Population Health Health Protection Services Pathway Optimisation Care Closer to Home/Pathway re-design Estates Mapping Accelerated Cluster Development	Existing	Establish a whole system approach to deliver place-based care where individuals can access a range of seamless care and support at or close to home, based on their unique needs and what matters to them	In partnership with IWN and third sector partners we will build community resilience through collaborative approaches and connections to increase social prescribing and community development Align the work of the NCN and IWN to develop a more community orientated model of primary care through a deeper understanding of the community assets, gaps in provision and local community needs within the population, particularly for socially vulnerable or marginalised groups. Behavioural Change Practitioners and Link Worker roles will be key enablers	Healthier Wales Population Health Transformation and Vision for clusters Prevention and Wellbeing Communication and Engagement Mental Health and Emotional Wellbeing	1	2			£25,074	NCN IWN	In Development	
Building Community Resistance Population Health Health Protection Services Care Closer to Home/Pathway re-design Accelerated Cluster Development	Existing	Continue to promote signposting to the most appropriate groups and activities to the Newport wellbeing offer	Staff will engage people in conversations about what matters to them and provide information to signpost them to services, groups and activities, using local knowledge or directories MECC training undertaken.	Healthier Wales Population Health NHS Recovery Supporting Social Care/Health Workforce Prevention & Wellbeing	1	2				N/A		
Accelerated Cluster Development Building Community Resistance Population Health	Existing	Continue to progress with the ACD Programme	Develop and support both exit strategies and business cases to enable proven concepts to be transitioned over to core funding. Raising awareness of the benefits for improving population outcomes through collaboration and strengthening partnership arrangements.	Healthier Wales Population Health NHS Recovery Supporting Social Care/Health		2	3			N/A		

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<p>Health Protection Services</p> <p>Pathway Optimisation</p> <p>Care Closer to Home/Pathway re-design</p>			<p>Continue with the Place Based Care model as a key priority across all professional collaboratives.</p>	<p>Workforce</p> <p>Working alongside Social Care</p> <p>Prevention & Wellbeing</p> <p>Transformation and Vision for clusters</p> <p>Workforce & Organisational Development</p>									
<p>Building Community Resistance</p> <p>Population Health</p> <p>Health Protection Services</p> <p>Pathway Optimisation</p> <p>Care Closer to Home/Pathway re-design</p> <p>Accelerated Cluster Development</p>	<p>Existing</p>	<p>To continue to develop the 6 Professional Collaboratives to create a subgroup of professionals that feed into the NCN Management team.</p>	<p>To have identified support from the professional collaboratives in regard to the NCN priorities. To have identified project assistance/funding from the professional collaboratives in line with NCN priorities.</p>	<p>Healthier Wales</p> <p>Population Health</p> <p>NHS Recovery</p> <p>Supporting Social Care/Health Workforce</p> <p>Working alongside Social Care</p> <p>Prevention & Wellbeing</p> <p>Transformation and Vision for clusters</p> <p>Workforce & Organisational Development</p>	<p>1</p>	<p>2</p>				<p>N/A</p>	<p>Ongoing</p>		<p>No payments allocated to collaboratives to attend and participate</p>
<p>Building Community Resistance</p> <p>Population Health</p> <p>Health Protection Services</p> <p>Pathway Optimisation</p> <p>Care Closer to Home/Pathway re-design</p>	<p>Existing</p>	<p>Continue to embed, expand and resign the Newport Place Based Care team</p>	<p>Additional roles and expertise offered to meet population need and ensure sustainability within workforces. Work in collaboration with High Intensity Service, IWN and Local Authority. Service criteria, roles and responsibilities to be redefined.</p>	<p>Healthier Wales</p> <p>Population Health</p> <p>NHS Recovery</p> <p>Supporting Social Care/Health Workforce</p> <p>Prevention & Wellbeing</p>	<p>1</p>	<p>2</p>		<p>4</p>		<p>NCN RIF</p>	<p>Ongoing</p>		<p>Funding for additional roles is yet to be determined</p>

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Building Community Resistance Population Health Health Protection Services Pathway Optimisation Care Closer to Home/Pathway re-design	New	Explore the use of technology such as an electronic social prescribing system to support place-based care.	Extend IWN's place-based approach across community wellbeing, integrated social care and health services through enhance links with MDT teams and Support delivery of social prescribing and monitor activity and outcomes to avoid duplication.	Healthier Wales Population Health NHS Recovery Supporting Social Care/Health Workforce Prevention & Wellbeing	1	2			£23,350	NCN	In Development	Full invest cost. Phased approach in implementation
Building Community Resistance Population Health Health Protection Services Pathway Optimisation Care Closer to Home/Pathway re-design Accelerated Cluster Development	New	To determine how the NCN Community Pharmacists can support QI projects in the reduction of cardiovascular disease, diabetes and chronic long-term conditions.	Extend the support to the Long-Term Conditions team of the Community Pharmacist in the reduction of cardiovascular disease. Ensure GP practice engagement in the All-Wales Diabetes Prevention Programme to enable equitable delivery across all NCN for the estimated 18,000 people in a pre-diabetic range	Healthier Wales Population Health NHS Recovery Supporting Social Care/Health Workforce Prevention & Wellbeing		2	3		East £ West PBC 2.4wte £167,668	NCN	In Development	Is this just the PBC?
LES & Enhanced Services Place Based Care Population Health	Existing	Unmet Population Health Needs	Assess the residual level of unmet need across the GMS collaborative and facilitate discussions about how gaps in provision and unmet need can be addressed. Identify where inter practice agreements can be created to deliver services on behalf of surrounding practices., in particular services in relation to women's health such as IUD's but also minor surgery, substance misuse, homelessness and asylum seekers	Healthier Wales Population Health NHS Recovery Supporting Social Care/Health Workforce Prevention & Wellbeing				4		N/A	Ongoing	Welsh Government/Contr actual
Building Community Resistance Population Health Health Protection Services Pathway Optimisation	New	High Intensity Service	Support MDT processes with Newport GPs that provide the enhanced services with the dedicated HIS Nurse, HIS Psychologist and local authority to support patients with housing.	Healthier Wales Population Health NHS Recovery Supporting Social Care/Health				4		N/A	n Development	

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<p>Care Closer to Home/Pathway re-design</p> <p>Estates Mapping</p> <p>Accelerated Cluster Development</p>				<p>Workforce</p> <p>Prevention & Wellbeing</p>								
<p>Building Community Resistance</p> <p>Population Health</p> <p>Health Protection Services</p> <p>Pathway Optimisation</p> <p>Care Closer to Home/Pathway re-design</p> <p>Estates Mapping</p> <p>Accelerated Cluster Development</p>	Existing	Health Hub Promotion	To continue to promote 19 Hills Health and Wellbeing Centre as a health hub which offers a variety of health and wellbeing services for women.	<p>Healthier Wales</p> <p>Population Health</p> <p>NHS Recovery</p> <p>Supporting Social Care/Health Workforce</p> <p>Prevention & Wellbeing</p>	1	2		4		IWN	Ongoing	
<p>Building Community Resistance</p> <p>Population Health</p> <p>Health Protection Services</p> <p>Pathway Optimisation</p> <p>Care Closer to Home/Pathway re-design</p> <p>Estates Mapping</p> <p>Accelerated Cluster Development</p>	Existing	To continue to support the Vaccinations & Screening programmes targeting the most vulnerable groups utilising data informed screening to monitor uptake.	To increase the uptake of vaccinations and screening within community settings. Continue to collaborate with local authority and educational services in regard to the uptake of 2- to 3-year-olds	<p>Healthier Wales</p> <p>Population Health</p> <p>NHS Recovery</p> <p>Supporting Social Care/Health Workforce</p> <p>Prevention & Wellbeing</p>	1			4		N/A	Ongoing	Contractual element of the GMS contact
<p>Estate Mapping</p> <p>Building Community Resistance</p> <p>Population Health</p> <p>Health Protection Services</p> <p>Pathway Optimisation</p> <p>Care Closer to Home</p>	Existing	To continue to address estate issues within GMS and community service provision.	<p>Continued efforts will be given to supporting the planning of future service developments in the neighbourhood network. This will include ensuring that services and facilities for the neighbourhood meet the needs of the local population in the context of the finite resources available.</p> <p>Collaboration will be maintained with local NCN and</p>	<p>Healthier Wales</p> <p>Population Health</p> <p>NHS Recovery</p> <p>Supporting Social Care/Health Workforce</p> <p>Prevention & Wellbeing</p>								

NCN Areas of Focus

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

1. Social Prescribing & Integrated Wellbeing Network

- Promote active signposting utilising MECC principles
- Integrate community based roles such as Link Workers, Behavioural Change Practitioners and Social Prescribers in to the Place Based Care Team
- Map and develop community assets such as community groups and activities
- Support the transition to place based working and investment in workforce capacity

2. MDT Working

- Continue to deliver integrated person centred care via the MDT concept
- Embed additional roles into MDT practice to ensure a well-rounded person centred approach
- Work collaboratively with Social Care and Third Sector partners to avoid duplication of work

3. Diabetes & Cardiovascular Disease

- Explore how NCN Pharmacists can support the Hypertension Care Finding and CVD QI projects
- Identify and agree an optimal approach for patients with a new diagnosis of hypertension
- Explore the role of Primary Care Dietetics in the reduction of Diabetes
- Scope roles such as Health Coaches and Long Term Conditions professionals

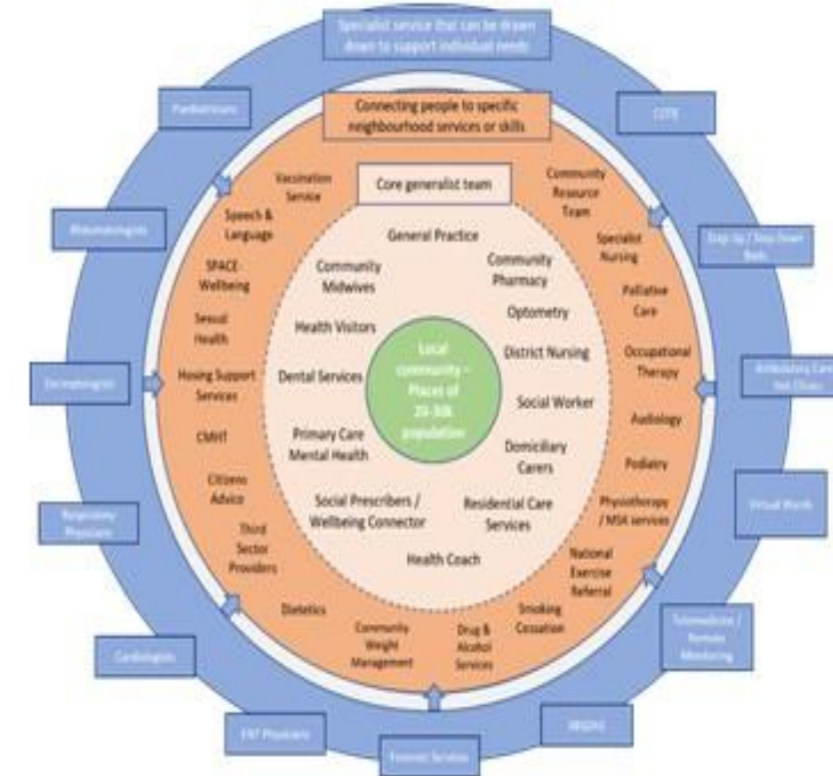
4. Enhanced Services

- Identify service gaps that exist within the local supplementary/enhanced services across Newport
- Support inter-practice service agreements with GP practices in the NCN
- Facilitate stronger relationships with GMS and the High Intensity Services to ensure that continued specific individual care and medication is identified and provided



Enablers

*Integrated Neighbourhood Teams
Skilled & confident workforce
Compassionate and inclusive culture
Balancing rights & responsibilities
ethos
Fit for purpose facilities & premises
Digital technology*



How will we know if we have made a difference?

Improved Patient Outcomes

Stronger Community Partnerships

Increased Access to Services