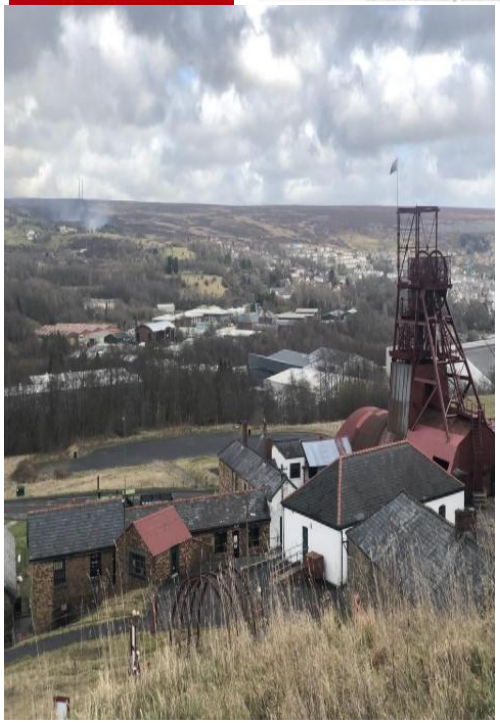
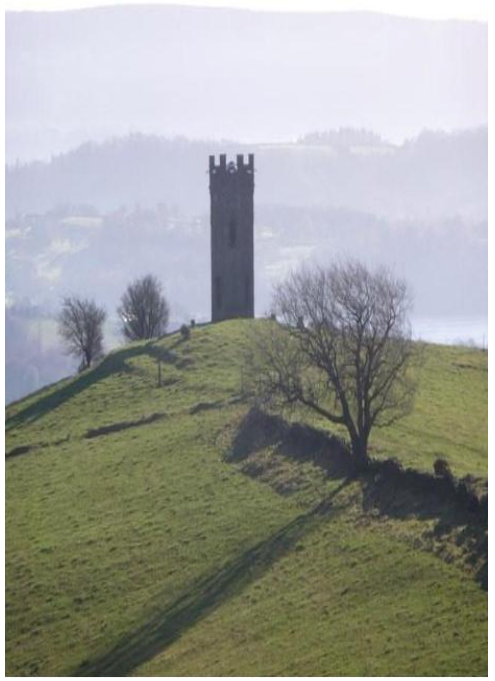


Torfaen NCN Plan 2026-29



NCN Executive Summary:

Torfaen NCN IMTP 2026-2029

The last 2 to 3 years have been a period of change across Wales as we transition from the well-established Neighbourhood Care Network (NCNs) Clusters, to implementing the Welsh Government's: Accelerated Cluster Development (ACD) programme. Historically, NCNs have been required to develop annual plans that reflect local issues across our communities and assessed against a range of evidence including for example, Population Needs Assessments. This plan is shaped by contributions from colleagues in health, social care and the Third Sector and is underpinned by the values of the Gwent Regional Partnership Board, placing people at the heart of everything we do as collaborative clusters, serving Torfaen.

Background Information:

Torfaen is currently established around 2 Neighbourhood Care Networks (NCNs), North and South, which work collaboratively to strive to improve primary care and community services within the local area. Previous priorities for 25/26 included:

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

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

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

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

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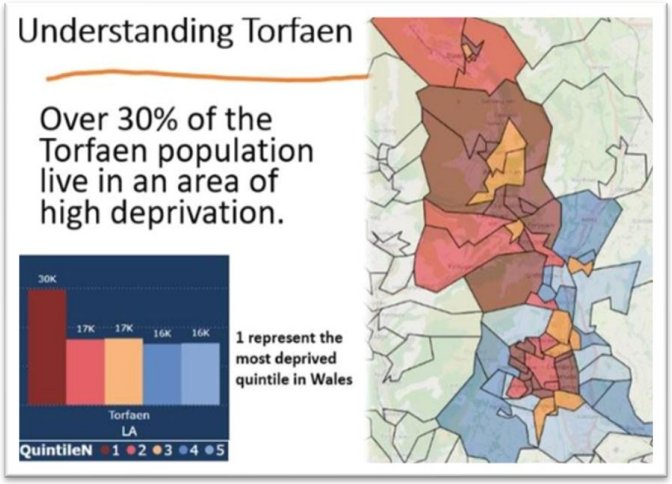
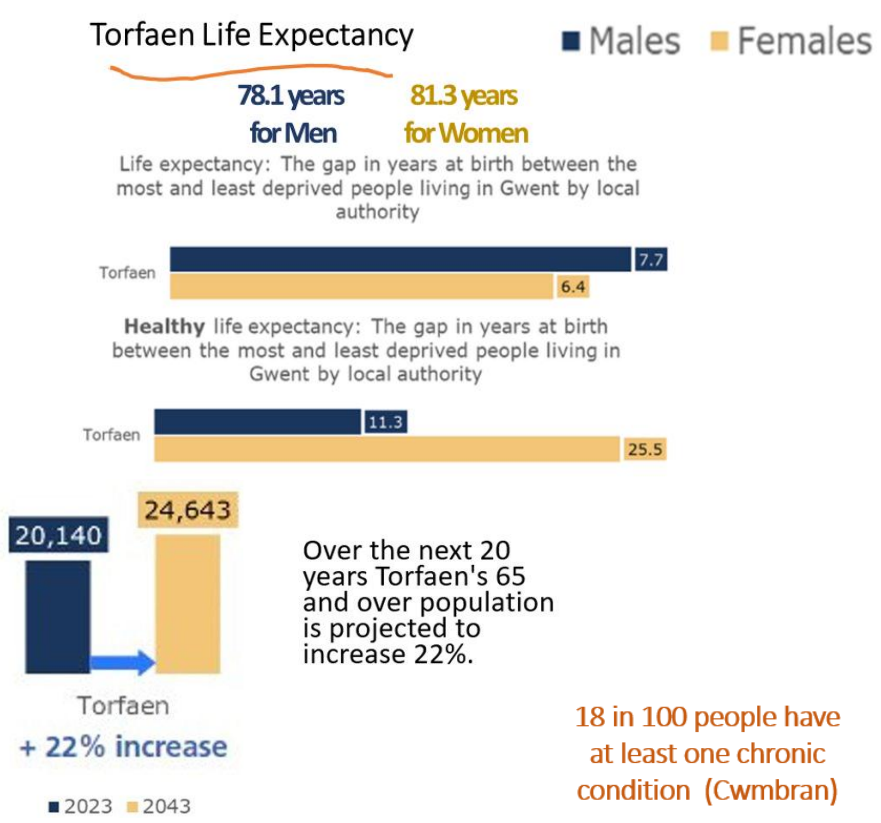
Torfaen NCN IMTP 2026-2029





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

Primary care data used as part of the WIMD in 2019 showed a recorded prevalence of chronic disease of 18% and a recorded prevalence of mental health conditions of 30% specifically in Cwmbran. Excessive drinking is a major health concern. In 2017/2018, 1,824 Torfaen residents per 100,000 were hospitalised for alcohol-related incidents. 78% of working-age adults in Torfaen are at an unhealthy weight. Torfaen has the highest percentage of loneliness among the five Local Authorities, with 20% of residents feeling lonely. This is 7.1% above the Welsh national average. We know that prolonged loneliness can lead to significant mental health problems, and physical effects such as a weakened immune system and increased inflammation in the body.

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

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

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

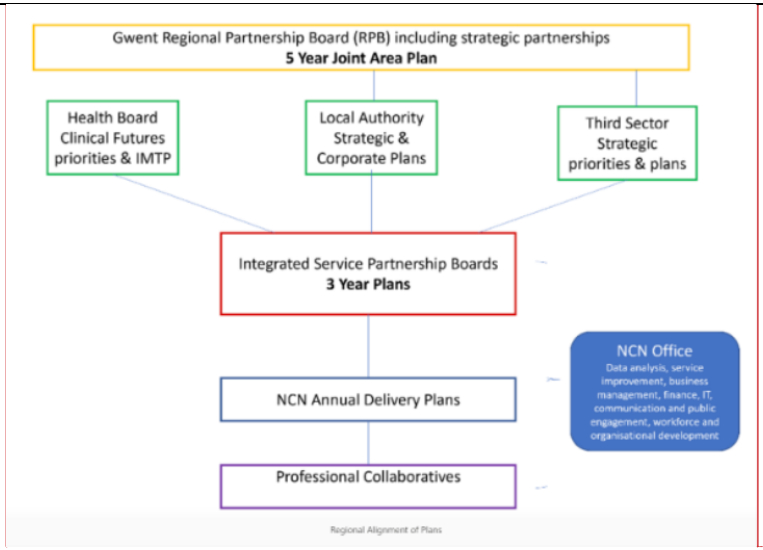
Strategic Partners:

Torfaen NCN IMTP 2026-2029

Strategic Context:

Torfaen's strategic direction is aligned with the RPB's Start Well, Live Well, Stay Well framework, ensuring that services are designed to support individuals across the life course. The NCNs aim to deliver place-based care, with a strong emphasis on prevention, early intervention, and co-production, ensuring services are responsive to local needs and delivered by a skilled, integrated workforce.

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



Regional Partnership Board (RPB)

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

Torfaen Integrated Services Partnership Board (ISPB)

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

Throughout 2025, the Blaenau Gwent and Torfaen (BGT) ISPB is preparing for the introduction of Place-Based Care (PBC), having been selected as the pilot localities for the new PBC operating model. The PBC operating model has to be more than a shuffling of the existing resources. It has to be more than additional 'partnership' meetings. And it has to be more than a growth in local services. It is a call to arms to do things differently. To think about data and insight differently; to plan services differently; to take decisions differently; and to direct investment differently.

Torfaen ISPB has rapidly matured through excellent engagement and collaboration. 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. Torfaen ISPB has a shared objective, aligning to the Marmot Principles, and delivering against national and local strategic drivers through:

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- 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

ISPB objectives:		ISPB priorities:
• 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	← Solutions, Improvement, Change → ← Intelligence for priorities & decision making →	• Third Sector as full partner • Integrated workforce for the future • Place Based Working • Redesigning services for older people • Ensure fit for purpose estate • Enhanced Financial scrutiny

Current services need to evolve to be able to sustain and improve. There is a necessity to change historical ways and patterns of working that no longer meet the needs of today's society and the needs of the future population, notwithstanding the changes to our service delivery and communication brought about by the covid pandemic. Torfaen NCNs are committed to evolving service delivery to meet current and future needs. This includes:

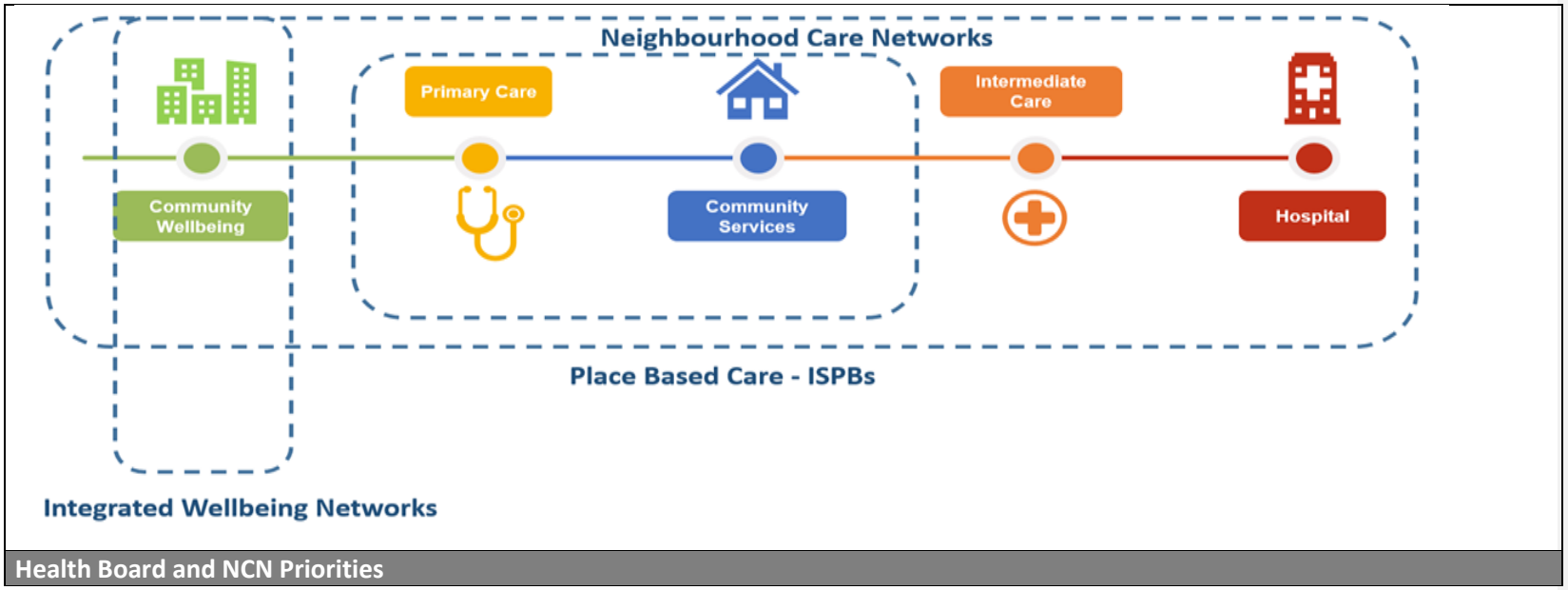
- Adapting to the growing demand for health and social care, we have an aging population, with patients living longer and with more complex needs, which intensifies the challenges faced by all sectors.
- Ensuring sustainability across all sectors in the short, medium, and longer term.
- Tackling health inequalities linked to socio-economic deprivation; closing gaps in life expectancy and healthy life expectancy
- Responding to demographic changes, including asylum seekers and refugee populations.
- Modernising the estate to support integrated, accessible services.

By embedding the strategic priorities of the ISPB and RPB into NCN planning, Torfaen is building a resilient, inclusive, and person-centered system of care that reflects the values of collaboration, prevention, and equity.

Collaborative (NCN) Clusters:

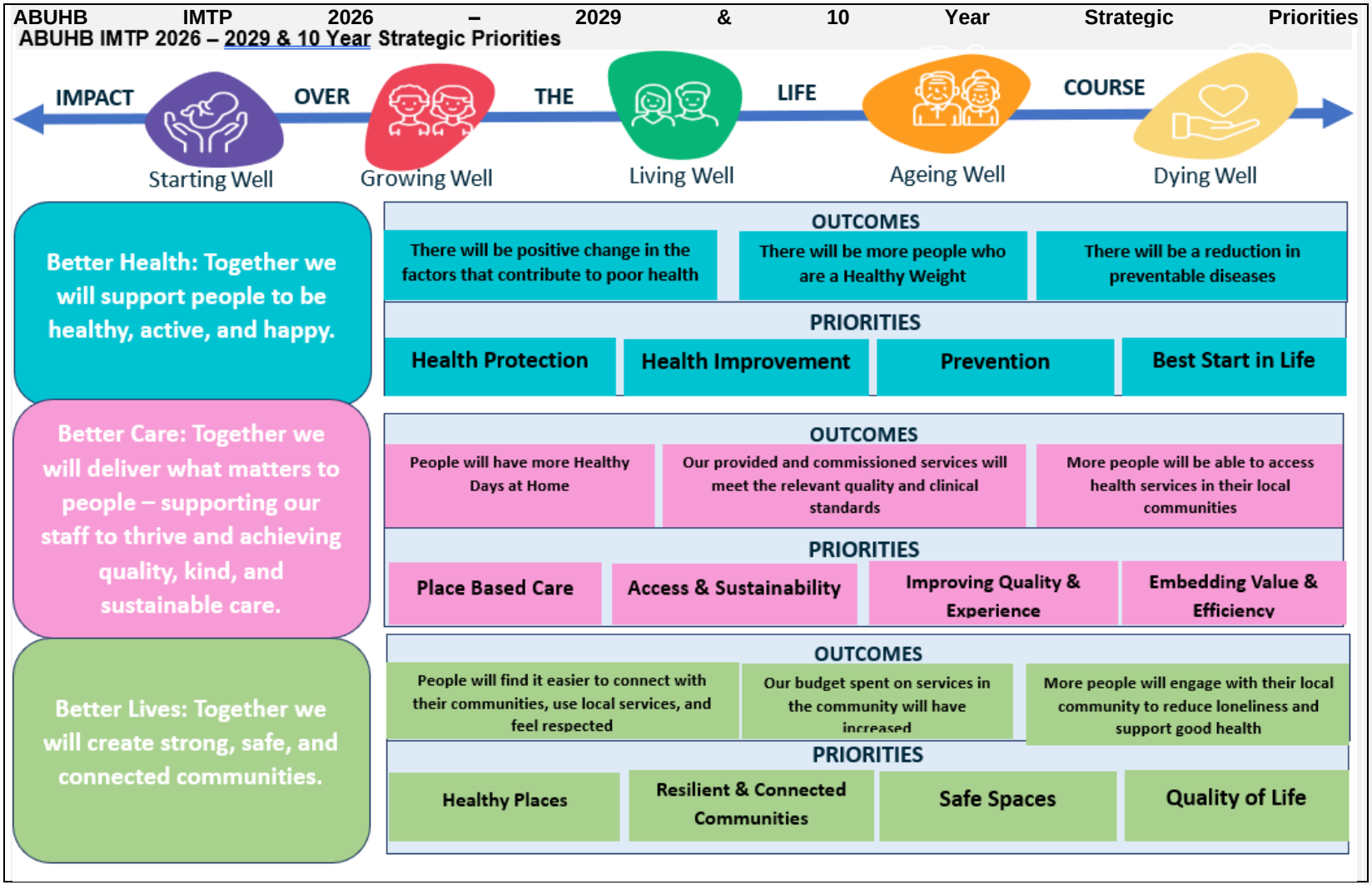
Neighbourhood Care Networks (NCNs) bring together local services across health, social care, and the Third Sector (including TVA) to plan and deliver tailored solutions that meet the needs of Torfaen residents at both individual and community levels. As a key component of the Integrated Strategic Partnership Board (ISPB), NCNs enable needs-based service delivery and help address health inequalities. The Integrated Wellbeing Network (IWN), closely linked to the ISPB, NCNs, and TVA, strengthens a community and place-based approach by gathering local intelligence, as reflected in this plan.

Torfaen NCN IMTP 2026-2029



Health Board and NCN Priorities

Torfaen NCN IMTP 2026-2029



Torfaen NCN IMTP 2026-2029

2025/26 Agreed NCN Priorities

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

Priority 1	To align the work of NCN and IWN to develop a more community orientated model of primary care through a deeper understanding of the community assets and local needs within the population particularly for socially vulnerable or marginalised groups. To support the development of Place Based Care
Priority 2	To ensure NCNs have good understanding of Integrated Wellbeing Networks (IWN) in order to utilise community assets such as community groups and voluntary organisations that help people maintain or develop social support networks. Coproduction of a 'social prescribing' model that connects people to activities, groups and services in their community addressing practical, social and emotional needs
Priority 3	To establish MDT working for people who have greater complexity and are most at risk of deterioration and adverse events such as hospitalisation. This MDT approach will require care coordination and committed involvement of reablement workers, specialist nursing teams, clinical pharmacists, CMHT, social workers, occupational therapist, housing and third sector organisations
Priority 4	To facilitate a collaborative approach in the delivery of diabetes prevention and CVD risk factor management to ensure that these programmes can be delivered systematically and at scale across NCNs
Priority 5	Establish high quality and equitable provision of supplementary/enhanced service across each NCN with an initial focus on IUD, minor surgery, substance misuse, homelessness and asylum seeker and refugees

Progress Made Against Agreed NCN Priorities within 2025/2026

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

Torfaen NCN IMTP 2026-2029

Priority 1	Progress to date: • Recruiting a Service Development Lead into the vacant post in Torfaen. This is an important first step in re-establishing the programme in the borough. • Focus on embedding the new lead into the borough and building effective working relationships with our partners. The new lead has spent time meeting with partner organisations to scope out the current landscape in the community and share our strategic vision. • These include regular discussions with partners across ABUHB, Torfaen Borough Council, community groups and TVA. • Torfaen NCN and the IWN continue to work collaboratively as part of a whole system approach to deliver on the 'A Healthier Wales's Strategy. • We have raised local awareness of community assets and 'community hubs' where people can access practical support. • Mapping work undertaken on link worker roles to avoid duplication • Behavioural Change Practitioners have been incorporated into the IWN team and aligned to the borough ensuring dedicated BCP's are able to build relations with key partners which allows them to effectively signpost and support those most at need. • BCP's are undertaking work with GP practices to help support vulnerable patients this winter. This involves proactively contacting patients with respiratory conditions to offer support such as the Help me Quit programme, vaccinations and warm homes advice.
Priority 2	Progress to date: • Early identification of opportunities for collaborative working with partners which has seen project plans being implemented, funding bids being agreed and plans being progressed into the next quarter. • Work is underway with local authority partners to provide practices in Torfaen with easy-to-use information on community wellbeing activities in the locality of each practice. • A project has been initiated to review the opening doors model across Torfaen to align it to the place-based care model and to classify hubs in line with the Welsh Government's community hub model. • Care Navigation – Practices refer to the NCN developed Care Navigation Padlet to signpost patients to community services • NCN funded Community Connectors 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. • Collaboration established with Public Health Team and ISPB partners to develop a Torfaen social prescribing model
Priority 3	Progress to date: • High Impact Individuals Multi-Disciplinary Team (MDT) is actively addressing the needs of complex and repeat individuals. Additional MDT models are under development via ISPBs. • Current MDT working being scoped with GP Practice to provide baseline from which to develop and share good practice. • Prospective PBC model and implementation plan is in development • Engaged with local authority to establish a single point of access 'Torfaen Connect' • Psychological Health Practitioners (PHP's) link people with health and social needs with third sector and community groups • Compassionate Future Care Planning provided in Primary Care through strong partnership working with CATCH, Palliative Care and St David's Hospice

Priority 4	Progress to date: • Offer of support from the Value Based Healthcare Team generated practice engagement at the Torfaen GMS Collaborative meeting on 13th November to improve uptake of ACR screening and foot checks for patients with T2DM. • Regular practice discussions demonstrate progress towards the GMS QI project on CVD prevention and delivery of the Hypertension Case Finding Local Enhanced Service Torfaen Place Based Care plans include a Health Coach that will provide behaviour change interventions for: • Patients in a pre-diabetic range i.e. the AWDPP intervention • Patients with a new diagnosis of hypertension • Patients on a hypertension register identified at high risk through the GMS QI project on CVD prevention Cardiovascular disease (CVD) prevention in people with high blood pressure | GOV.WALES Discussions held at Torfaen GMS Collaborative meeting, November 2025 to promote the All-Wales Diabetes Prevention Programme (AWDPP), led by Public Health Wales and funded via Welsh Government was introduced to primary care networks in 2022. The programme offers targeted support to people who are at an increased risk of type 2 diabetes, with the aim of preventing them from developing this condition. The programme sees dedicated, trained healthcare support workers, with oversight from dieticians, deliver a brief intervention to people who have had a blood test that shows that they are at an increased risk of type 2 diabetes. Aligned with the GMS Healthy Behaviours QI project, National Exercise Referral Service (NERS) presented in April 2025 NCN meeting to increase collaborative working with the NCN and partners. Through several NERS pathways that offer support to diabetes and cardiovascular disease, Torfaen health professionals improve patient access to: - Chronic condition prevention and management - 16-week pathway that includes Musculo Skeletal issues, mental health, weight management / diabetes, mild respiratory condition, referral from Rehabilitation. - Weekly Cardiac rehab circuit and Neuro@NERS Rehab gym sessions at Cwmbran Stadium - Behaviour change to embed positive physical activity habits, improving health and wellbeing
Priority 5	Progress to date: In alignment with national priorities and the principles of prudent healthcare, specifically to enhance the delivery and uptake of enhanced services targeted at vulnerable population groups. This includes collaborative service development initiatives focused on improving access, equity, and outcomes for individuals with complex needs, including those experiencing homelessness, substance misuse, or mental health challenges. Through strengthened cluster working, data-informed planning, and co-production with service users and third sector partners, we aim to reduce unwarranted variation and ensure that enhanced services are responsive, inclusive, and sustainable. Ongoing support and training for primary care teams, alongside robust monitoring and evaluation frameworks, will

	underpin continuous improvement and ensure alignment with the Welsh Government's strategic objectives for population health, care quality and well-being. To address this and drive improvement, we are working collaboratively within the NCN to implement targeted actions. These include engaging in structured discussions with practices to identify barriers and opportunities, securing appropriate funding to support initiatives, and strengthening community engagement through clear and consistent communication strategies. Collectively, these measures aim to enhance participation and ensure progress against the stated priority. Progress to date: • Held year on year discussions with relevant practices to provide Care Home DES, also aligning patients and practices to agreed care homes. • Ongoing discussions with contracting team to provide an ABUHB wide care home DES with the funding via GMS budget • "Vulnerable Groups" discussion with practices at NCN to improve access for homeless, asylum seekers, refugees, including presentations from PPV (post payment verification) to answer concerns with uncertainty around specifications for claiming. • Gender Identity ES discussions at NCN to improve uptake, i.e. inter practice referrals • Regular monitoring and discussions with practices around flu uptake, sharing good practice. The current uptake figures for the supplementary services are outlined in the attached appendix. Appendix..docx

Additional Priorities

- To deliver against priorities detailed with this year's action plan.
- To monitor Collaborative Cluster progress against the ACD Toolkit and annual self-reflection (maturity) process.
- To undertake annual evaluations of all funded schemes to ensure value for money, effectiveness and identify opportunities for reinvestment.
- Continue to address estate issues, agile working, and available accommodation space for both clinical and administration staff.
- Prevention programmes support and promote vaccine uptake
- CATCH positive evaluations to influence movement to core funding and equitable care to residents within care homes across ABUHB

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

- Sustainability, budgets, fixed term roles, Limited funding available inhibits large scale projects
- NCN budget is tied into valuable roles
- NCN funded projects that have been evaluated with successful outcomes are not progressed with core funding, prohibiting further NCN investment in innovation
- Financial pressure within practices, inflation impacting practice and uplifts do not cover rising costs
- Workforce retention and recruitment issues across the NCN
- Aging workforce/retirements pose a threat to future sustainability in the current models
- Issues with the recruitment of particular roles, such as GP Partners, practice nurses and advanced nurse practitioners
- Many practices are dependent upon locums which can be costly, and negotiation of services included is often required
- Dental Access and a practice closure (Dental Nova Cwmbran)
- Stability around NCN structure
- Regular high escalation levels in practice
- Educating patients to access appropriate services

Torfaen NCN IMTP 2026-2029

NCN Planning - 2026/2027		
Identified Quarterly Milestones Against Agreed NCN Priorities for 2026/2027		
Priority	**Defined Delivery Milestones**	
Priority 1 To align the work of NCN and IWN to develop a more community orientated model of primary care through a deeper understanding of the community assets and local needs within the population particularly for socially vulnerable or marginalised groups. To support the development of Place Based Care 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	**Q1 Continue of 25/26 progress** • IWN team to deliver behaviour change interventions focussed on agreed priorities for local communities including for socially vulnerable or inclusion health groups. • To work with communities to identify local issues and priorities to inform decision making and action by strengthening the skills, resources and abilities of communities, and the individual people within them, to be able to thrive. • 2 Behavioural Change Practitioners are now working within Torfaen. A mapping exercise is currently underway to identify areas with the highest levels of smoking prevalence, and we will align the BCP offer to areas of the borough with the highest need. We will identify suitable venues to host clinics with an increased number of clinics for those areas with the highest need.	**Q2 Continue in year priorities** • IWN lead to provide link between NCN and public health team work on health inclusion groups. • IWN to arrange community engagement events to help highlight community support available within the borough and to gain insight from the community that can inform future interventions • Extend the IWN's place-based approach across community wellbeing, integrated social care and health services. • Embed a culture of active signposting across Torfaen. • To bridge, link and coordinate well-being assets creating stronger, integrated support networks that enhance health, well-being and resilience of individuals and communities. Reduces social isolation and creates a cohesive and socially connected communities. • Explore the use of technology to support delivery of social prescribing and monitor activity and outcomes.
	Q3 Continue in year priorities • Continue ongoing work alongside partner organisations undertaking community hub mapping exercise. This will allow us to identify, connect and mobilise the existing strengths within a community that can be leveraged to enable communities to thrive. • IWN collaboratives to be aligned to the places identified under the placed based care model.	**Q4 Continue in year priorities** • Use evaluation findings to inform future service design. • Prioritise interventions that address identified population needs. **Secure Long-Term Sustainability** • Initiate discussions at ISPB level regarding funding options.

		Place Based Care Implementation Planning • Draft roadmap for service integration into mainstream provision. • Set timelines for phased delivery and resource allocation.
Priority 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	**Q1 Continue of 25/26 progress** • Scoping current MDT working within primary care and sharing good practice • High Impact Individuals Multi-Disciplinary Team (MDT) begins to develop a systematic way of identifying patient cohorts with likely complexity either through risk stratification (e.g. Electronic Frailty Index) and/or clinical impression (e.g. frequent attenders in general practice or when people discharge from hospital). • Progress ISPB Place Based Care and MDT model co-design	**Q2 Continue in year priorities** • Streamline current pathways of care to prepare for effective MDT and primary care referrals • Identify appropriate staffing to support effective data collection
	Q3 Continue in year priorities Key steps: • Map services in each 'place' and identify the practitioners and professionals that can provide proactive care for people with complex need who require personalised and co-ordinated multi-professional support.	**Q4 Continue in year priorities** • Implement an effective process for providing assurance to ISPB and other stakeholders • Encourage joint planning between GPs, community services, third sector organisations, and local authority teams. • Start to establish pathways into preventative services (e.g. assistive technology, home adaptations, falls prevention clinics) and pathways into urgent response services for patients in crisis or with acute exacerbations.

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	**Q1 Continue of 25/26 progress** • Encourage increased Torfaen GP practice engagement in Hypertension Case Finding Local Enhanced Service. • Collaborate with Public Health to deliver the Hypertension Case Finding Local Enhanced Service where there is no capacity at GP practice level. • Engage GP practices in a collaborative approach to the Healthy Behaviours QI project and the processes and pathways for systematic referral into local services and programme (e.g., Help Me Quit, National Exercise Referral Scheme, Community Weight Management) • Public Health Behavioural Change Practitioners offer support and interventions to individuals and groups in areas such as smoking cessation, diabetes prevention, cardiovascular disease and healthy weight management.	**Q2 Continue in year priorities** • Discuss and evaluate Healthy Behaviours QI project • Monitor delivery of All Wales Diabetes Prevention Programme, identifying good practice and addressing any gaps in service • To determine how the NCN Community Pharmacists can support QI projects in the reduction of diabetes and cardiovascular disease.
	Q3 Continue in year priorities • To scope the creation of 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.	**Q4 Continue in year priorities** • Create a 'Health 'Coach' role that will complete patient checks regarding populations at risk and complete a standardised 30-minute intervention session.
Priority 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	**Q1 Continue of 25/26 progress** • Map out the current provision of supplementary/enhanced services to fully understand activity levels and gaps in provision. • Discuss increasing equitable access to health inclusion groups including: -Develop culturally sensitive and accessible communication materials to	**Q2 Continue in year priorities** • Use population health data to identify vulnerable groups (e.g., people experiencing homelessness, asylum seekers, and substance misuse issues). • Align enhanced service specifications with cluster priorities and incentivise uptake through QI frameworks.

	-Employ link workers or community connectors to build trust and facilitate access -Extend hours or provide walk-in options to accommodate those with unstable living conditions or chaotic lifestyles.	• Monitor uptake and outcomes using robust data systems and share insights to drive improvement. • Involve service users and community representatives in designing and evaluating services. • Ensure feedback mechanisms are in place to adapt services based on lived experience.
	Q3 Continue in year priorities • Assess the level of latent capacity across the existing network of GMS providers and explore the potential for utilising this capacity for inter-practice referrals. • 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. • Work with the Primary Care Contracting Team to quantify the level of investment required to respond to the level of unmet need and gaps in provision e.g. minor surgery. • Identify enhanced service gaps and work with the wider NCN, ISPB and secondary care directorates to engage specialist services, local authority and third sector organisations (e.g. substance misuse, sexual health, community dental, optometry, BBV, housing and homelessness services) to build wrap-around support and an MDT approach for practices delivering the enhanced services for substance misuse, homelessness and asylum seekers and refugees.	**Q4 Continue in year priorities** • Prepare a proposal for the Enhanced Services Operational Group on the plan for investment in each GMS collaborative to improve equity of access.

Enablers required to deliver 2026/2027 quarterly milestones

- Permanent IWN/Sim Role for stability and continued progress
- Developing strong relationships with various stakeholders, i.e. ISPB and TVA
- Additional funding streams from TVA for COPD pilot project
- Extended funding opportunities via local authority
- Access to appropriate data streams, i.e. WIS,
- Increased maturity of the ISPB
- Core funding for NCN funded projects, i.e. CATCH

- Technology
- Professional Collaboratives working effectively together and continue to develop.
- Whilst the collaboratives are still in their infancy, they have successfully been able to utilise Population Needs Assessment data to identify service gaps and have subsequently undertaken improvement projects.
- Highly valued services in Torfaen NCNs
- Positive feedback from patients, practices, care homes, and district nursing
- Permanent Roles have been secured
- Staff completing further education, which enables them to perform more advanced clinical assessments and interventions, to release GP time
- Increased partnership working through ISPB
- Integrated working
- Engagement from key stakeholders
- Strong representation

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

- Permanent IWN/Sim Role for stability and continued progress
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Torfaen NCN IMTP 2026-2029

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

North Spend Plan Summary	2025/26	2026/27
Annual Budget	£ 337,402.00	£ 337,402.00
Top Slice: Advisers, Phlebotomy, Dementia Roadmap	£ 13,923.84	£ 14,330.31
Practice Based Pharmacists	£ 72,180.33	£ 74,341.71
Community Connectors	£ 65,448.00	£ 65,448.00
CATCH	£ 114,260.01	£ 118,871.19
PWPs	£ 64,183.63	£ 66,109.14
App Levy	£ 1,014.75	£ 1,045.19
Pay award	£ 4,877.73	£ -
Drop TL lewis accrual	£ -	
Med Equipment	£ -	£ -
HHI	£ -	£ -
Telephone Triage		£ -
Flu	£ -	
Staff training	£ -	
Laptop / IT / mysurgery	£ -	
Total Expenditure	£ 335,888.29	£ 340,145.53
Uncommitted Expenditure	£ 1,513.71	-£ 2,743.53
Check	£ -	£ -

South Spend Plan Summary	2025-26	2026-27
Annual Budget	£ 293,913.00	£ 293,913.00
Top Slice: Advisers, Phlebotomy, Dementia Roadmap	£ 12,212.76	£ 12,567.89
Practice Based Pharmacists	£ -	
Community Connectors	£ 65,448.00	£ 65,448.00
CATCH	£ 127,067.81	£ 130,849.35
PWPs	£ 71,353.65	£ 74,451.33
Pay award	£ 3,684.27	£ -
App levy	£ 162.57	£ 167.45
Jayex	£ 1,439.87	
HHI	£ 18,996.20	£ 7,685.45
	£ -	£ -
IT equipment	£ -	£ -
Flu	£ -	£ -
TM Lewis accrual dropped	-£ 1,560.00	
Total Expenditure	£ 298,805.13	£ 291,169.47
Uncommitted Expenditure	-£ 4,892.13	£ 2,743.53
Check	£ -	£ -

Torfaen NCN IMTP 2026-2029

Workforce Profile 2026/2027
Please outline your workforce profile for 2026/2027
There have been various challenges with the NCN budgets, we have had to absorb the annual NHS Wales pay awards for staff and therefore a few difficult commissioning decisions needed to be taken by the NCN Lead. In 2026/27 we are anticipating (at the time of writing), a small overspend. However, due to the fluidity of NCN budgets in respect of in-year slippage, especially from planned and unplanned absence, that we expect to be in a breakeven position on 31st March 2026. The monthly finance review of our budget will ensure increased governance and scrutiny.

Service	Brief Description	Risks, Challenges, Barriers
Placed Based Care – **See below additional workforce**	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.	• Estate • Staffing • Resource • Permanent contracts
Practice Based Pharmacists	Support practices with a pharmacist to alleviate pressures and increase medication reviews	• Uplift Costs
Psychological Health Practitioners	Reduce demand on GP appointments for low level psychological health concerns. Intervention provided to prevent crisis mode occurring.	• Staff Retention • Access/Care Closer to Home • Consistent Staff/Relationships • Uplift Costs
CATCH	Provide support for GP practices, with home visits for patients who are residents in nursing and residential care homes	• Core Funding • Staff Retention • Enhanced Service Coverage • Sickness
Community Connectors	Work with groups, activities, organisations and other stakeholders in the community to support, promote, collaborate and ensure community resilience.	• Uplifts in staff costs
District Nursing Team	Core community nursing services aligned with individual locality GP Practices	• Staff Retention • Rising and changing patient acuity • Mature workforce – partial retirements • Flexible working & succession planning • Lack of digital efficiency • Roll out of training programmes inhibited by staffing

Place Based Care Additional Workforce Profile

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- **We are in the early stages of mapping our workforce requirements for Place Based Care and this will be our priority in the forthcoming ISPB meetings**

NCN Planning 2027/2028 – 2028/2029

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

Priority		**2027/2028**	**2028/2029**
Priority 1	To align the work of NCN and IWN to develop a more community orientated model of primary care through a deeper understanding of the community assets and local needs within the population particularly for socially vulnerable or marginalised groups. To support the development of Place Based Care 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	• 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. • Establish IWN Collaborative sub/action groups to drive forward specific agendas and programmes in the areas e.g. ASB, community health events, Over 50's, social prescribing. • Strengthen the relationships between IWN/ NCN and the socially vulnerable groups by building on existing networks. • Facilitate relationships and networks between Primary Care MDT Teams and key stakeholders such as the local authority and anchor organisations. • Develop and formalise a Collaborative action plan to represent IWN/ NCN priorities, projects and actions identified to meet community need. • Strengthen the process of sharing and receiving information with the Collaboratives, NCN and wider partners. • Utilise local intelligence data and community insights to provide a place-based approach to service delivery and community support. • Explore the creation of a joint social prescribing framework, utilising leading sector specific software through a partnership approach between NCN, IWN, local authority partners and the community.	Develop and establish Collaboratives in each of the 4 'places' identified under the place-based care model in Torfaen. • Extend the IWN's place-based approach across community wellbeing, integrated social care and health services through enhanced links with the MDT's once established in Torfaen. • Continue effective partnership working with NCN networks, identifying gaps in provision and utilising NCN data to direct workstreams. **Expansion Strategy for Place-Based Care** Q1, Q2, Q3, Q4 • Finalise and commence implementation of the **expansion plan informed by 2027/28 evaluation findings**. • Scale up interventions that meet priority population needs across all four place-based areas. • Track performance metrics for expanded services. **Long-Term Sustainability** Q1, Q2, Q3, Q4

		• Manage the implementation and promotion of the social prescribing framework, through a coordinated communication plan. • Continue with the development of the Connect Torfaen website and the Wellbeing friends Facebook page, hand in hand with community hub development and asset mapping. Build capacity across IWN and NCN staff to develop and update partner organisations and the community using our online and social media presence. • Continue the development of 'hubs' in collaboration with the local authority and TVA, ensuring these assets can connect people with health and wellbeing resources, activities and other people to support their own wellbeing. **Expansion Strategy for Place-Based Care** Q1, Q2, Q3, Q4 • Finalise and begin implementing the expansion plan informed by evaluation findings. • Scale up interventions that address priority population needs across all four place-based areas. • Establish performance metrics for expanded services. **Long-Term Sustainability** Q1, Q2, Q3, Q4	
Priority 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,	• Set local strategy and operating model • Design and monitor an outcomes framework • Establish MDT working in each of the 4 places established in the PBC model • Cross reference the patient cohorts with the register of high-risk patients (i.e. 0.5%	**Strengthen Collaborative Working Across the NCN** • Facilitate regular multi-disciplinary meetings to share best practices and coordinate care. • Encourage joint planning between GPs, community services, third

	specialist nursing teams, clinical pharmacists, CMHT, social workers, occupational therapist, housing and third sector organisations	cohort) identified by the GP practice delivering the High-risk cohort supplementary service. • Employ/identify clinical leads and place-based care coordinators and a hub for patients identified through local intelligence functions or referred by local professionals. • Provide backfill or financial support to release GPs to participate in MDT meetings or align MDT meetings to GP practice undertaking enhanced care reviews and ongoing monitoring through the High-risk cohort supplementary service.	sector organisations, and local authority teams. • Embedding reliable teams that can work towards one strategy, one operating model and one culture for all decisions relating to the wellbeing system • Develop a shared care record across health and social care for the proactive care and MDT support for the identified cohort.
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	• Shared learning and best practice across NCN through QI meetings. • Evaluation of CVD/Diabetes/Hypertension/CKD intervention outcomes to date. • Health Coaches support the management of behavioural risk factors eg smoking cessation, vaccination uptake and healthy home initiatives. • Provide targeted clinical reviews and optimise prescribing for high-risk patients. • **Cardiovascular Risk QI** key learning and service improvements are shared and embedded in GP practice. • Explore joint working with Torfaen collaboratives (GMS, Optometry, Pharmacy, Nursing and Allied Health Professionals) to enhance this work, identify opportunities and widen the scope of patient care. • **Hypertension Case Finding and Community Engagement** promotes healthy behaviours and early detection by delivering screening in community settings such as libraries, community hubs and workplaces.	• Shared learning and best practice across NCN through QI meetings. • Evaluation of CVD/Diabetes/Hypertension/CKD intervention outcomes to date. • Collaborate with community partners and Health Coaches to deliver behaviour change coaching in a community setting. • Continued targeted clinical reviews and optimise prescribing for high-risk patients. • **Cardiovascular Risk Reduction QI -** Continue to support practices to review and optimise treatment for patients on hypertension registers. • Continue to facilitate peer learning and service improvements across practices and professional collaboratives. • **Hypertension Case Finding -** Monitor and evaluate impact of enhanced service for targeted screening in practices and in partnership with Public Health and IWN.

		• Collaboration with IWN and Public Health to widen the reach into the community. • Continued NCN participation in the **Diabetes Prevention Programme.** • Use data to identify at-risk patients and develop invitation plans for structured education and lifestyle programmes. • Review outcomes and adjust interventions to reduce progression from pre-diabetes. • **Chronic Kidney Disease (CKD) QI** – Practices have CKD risk profiling embedded as routine. Monitor the impact of practice to date.	• Continue to deliver community-based screening opportunities. • Continued NCN participation in the **Diabetes Prevention Programme**. • Use data to identify at-risk patients and develop invitation plans for structured education and lifestyle programmes. • **Chronic Kidney Disease (CKD) QI -**Continue to provide CKD risk profiling and monitor impact
Priority 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	• Provide training for primary care teams on trauma-informed care, safeguarding, and working with marginalised populations. • Review of the CATCH Care Home DES model to be discussed in conjunction with the NCN MDT working model.	• Offer enhanced services in community settings or through mobile clinics.

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 NCN Funding	Current Status	Comments	NCN Delivery Action Plan Please List activities or projects planned to commence during 2026/2027, as well as those ongoing from 2025/2026
					1	2	3	4					
Health Protection Services/ Building Community Resilience	Existing	Development of Health Prevention services in collaboration with the third sector, IWN and IAA, identifying social networks to help address the wider determinants of health	Flu programme will- Work in partnership with Local Education Authority Leads to jointly promote the importance uptake with parents and careers Programme to deliver vaccinations to all eligible cohort.	Prevention & Wellbeing Communication and Engagement Transformation and Vision for cluster	1			4			Ongoing GP cluster commitment to continue to 2024/25		
Health Protection Services	Existing	Dental - Development of Health Prevention services in collaboration with the third sector, IWN and IAA, identifying social networks to help address the wider determinants of health.	The NCN will liaise with ABUHB Community Dental Service and Dental collaborative, through our fully established Children and Young Adult Task and Finish Group, to explore opportunities of promoting the importance of Oral Hygiene and visiting the dentist.	Healthier Wales Population Health	1								
Building Community Resilience **Population Health**	New	Marmot Region	NCNs will support the Marmot Review which sets out a framework for action under two policy goals: to create an enabling society that maximizes individual and community potential; and to ensure social justice, health and sustainability are at the heart of all policies.	Healthier Wales Population Health Transformation and Vision for clusters Prevention and Wellbeing Communication and Engagement Mental Health and Emotional Wellbeing	1	2	3						
Care Closer to Home/Pathway re-design	Existing	Future service model for the development of sustainable Placed Based primary care services across both clusters	The NCN is undertaking work to profile timetables to enable Care Closer to Home in terms of delivering services for all our citizens and sustainable placed based care:	Supporting Social Care/Health Workforce Healthier Wales Population Health Prevention & Wellbeing Communication and Engagement Transformation and Vision for clusters				4					
Pathway Optimisation	Existing	The ongoing sustainability of all health and social care services on an operational footing level is paramount,	To support the NCN will undertake a mapping of services – both clinical and non-clinical to ensure that people with the right skills and experience work in an environment that is fit for purpose. Keeping a key focus on local population need and will include Immunisation and Vaccination, GMS sustainability and access, Psychological Wellbeing, Diabetes Prevention, CVD risk factor	Supporting Social Care/Health Workforce Healthier Wales Working alongside Social Care Population Health		2		4		NCN Funding			

Key: Alignment to NCN Agreed Priorities

2025-2027

1. To align the work of NCN and IWN to develop a more community orientated model of primary care through a deeper understanding of the community assets and local needs within the population particularly for socially vulnerable or marginalised groups. To support the development of Place Based Care

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

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

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

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

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			management, Obesity Pathway, Oral Health, Advanced Paramedic for home visiting/CRT/Care Home and FCP.	Prevention & Wellbeing Transformation and Vision for clusters Communication and Engagement								
Health Protection Services	New	Supporting the needs of the local population with the cost-of-living crisis	Work in partnership with IWN to use local intelligence of where funding should be directed to support with the cost-of-living crisis.	Supporting Social Care/Health Workforce Healthier Wales Working alongside Social Care Population Health Prevention & Wellbeing Communication and Engagement	1							
Accelerated Cluster Development	Existing	prioritise the establishment of Pan Cluster Groups	Continue to develop the ISPB priority actions with our partnership board landscape. To develop and strengthen the relationship with the Gwent Regional Partnership Board							WG Funding		
Health Protection Services	Existing	Diabetes Prevention Programme	Participation in the Diabetes Prevention Programme across both clusters for pre diabetic patients to be offered a brief intervention which includes lifestyle advice with the hope of reducing their HBA1c over the longer term to reduce or prevent the progression of diabetes	Population Health Healthier Wales Prevention & Wellbeing			3			NCN Funding		
Accelerated Cluster Development	Existing	Utilise NCN funding to innovate and test concepts relevant to our population needs which improve outcomes for all our residents.	To utilise NCN funding to innovate and test concepts which are relevant to our population needs and able to improve outcomes for all our residents, these include, SEM Scanners, assisted technology, locality based FCP programmes, reducing the impact of on the day demand. Developing exit strategies to enable proven concepts such as Psychological Wellbeing Practitioners and Practice Based Pharmacists to be core funded.	Prevention & Wellbeing Communication and Engagement Transformation and Vision for clusters Workforce & Organisational Development							Ongoing GP Cluster Commitment to continue to 25/26	
Health Protection Services	New	Seek to develop services that are high quality and equitably across the Borough for supplementary/enhanced services with an initial focus on IUD, minor surgery, substance misuse, homelessness and asylum seeker and refugees.	We will look to map our services to identify where the gaps are and work more collaboratively between our GMS partners to deliver services that are more equitable and, on a population, needs basis	Healthier Wales Population Health Prevention & Wellbeing				4				
Accelerated Cluster Development	Existing	Widening stakeholder attendance at NCN	Widening stakeholder attendance across our NCN to ensure full collaboration to meet population needs and maintain local voice. We will seek to implements our place based care strategy of a Happy Healthy Blaenau Gwent by creating a sustainable system of change through the integration of health and social care services, raising awareness of the benefits and opportunities for improving population outcomes through collaboration, strengthening partnership arrangements with the third sector and health colleagues such as the local authority, WAST, Direct care and other key partners to meet the specific health and wellbeing needs of our communities	Healthier Wales Working alongside Social Care Population Health NHS Recovery Supporting Social Care/Health Workforce Prevention & Wellbeing Transformation and Vision for clusters	1	2		4				

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				Workforce & Organisational Development								
Training and Education	Existing	Continue to support with training programmes for primary care settings	Continue to progress student support for university entry, as well as support the primary care academies with their onward programme and in turn support services with the academy placements of clinical roles within primary care settings. Continue with NCN Nurse model to support practices with nursing skills i.e., shingles, childhood immunisations, chronic disease management, wound care. Explore NCN nurse facilitator role to train and upskill general practice nurses this will include supporting the training and development of academy nurses and making the academy attractive to practices within the Blaenau Gwent area.	NHS Recovery Supporting Social Care/Health Workforce Healthier Wales Population Health Prevention & Wellbeing Transformation and Vision for clusters Workforce & Organisational Development								
Building Community Resistance **Population Health** **Health Protection Services** **Pathway Optimisation** **Care Closer to Home/Pathway re-design** **Estates Mapping** **Accelerated Cluster Development**	Existing	Happy Healthy Blaenau Gwent - establish a whole system approach to deliver place-based care where people can access a range of seamless care and support at or close to home, based on their unique needs and what matters to them	The NCN in partnership with our all our IWN partners will build community resilience through connections to increase social prescribing and community development in collaboration with the third sector. Align the work of the NCN and IWN to develop a more community orientated model of primary care through a deeper understanding of the community assets and local needs within the population, particularly for socially vulnerable or marginalised groups	Healthier Wales Population Health Transformation and Vision for clusters Prevention and Wellbeing Communication and Engagement Mental Health and Emotional Wellbeing	1	2		4				
Redesigning Community Services for Older People	Existing	Explore opportunities to deliver a sustainable community resource model.	Explore opportunities to deliver complex care closer to home through a sustainable community resource model which encompasses hospital @ home/step closer to home pathways , helping our residents to have their health and social care needs met as close to home as possible in a seamless and integrated way through models of care which reduce admission and long term care dependence, utilising a varied clinical skillset able to meet the demands of changing service needs and deliver on the D2RA pathways to provide preventative care and where needed a rapid response to prevent admission or, where admission is needed, the CRT Tyleri model will be available to provide a short clinical interventions prior to supporting individuals to be discharged to recover at home as quickly and safely as possible.									
Redesigning Community Services for Older People **Reablement Hospital Liaison OT**	Existing	Building on D2RA Project	Blaenau Gwent ISPB to align with the strategic priorities of the Health Board, Local authority and A Healthier Wales's vision of a whole system approach to health and social care, focussed on health and well-being and on preventing illness with access to a wide range of seamless community-based services.	NHS Recovery Supporting Social Care/Health Workforce Healthier Wales Population Health								
Redesigning Community Services for Older People	Existing		As part of the redesign of Frailty services we will review our existing hot clinic pathways and ensure that these are fit for purpose, providing rapid access clinics for older people to undertake assessment, diagnostics, and treatment on an ambulatory basis. CRT In-reach Model which brings alignment between health and social care services to support residents to remain in their usual place of residence for as long	Prevention & Wellbeing 24/7 model and Vision for clusters Workforce & Organisational Development					None, staff attending clinic will be from the core district nursing teams		Planned to commence when staffing levels improve	

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			as possible. Within YAB the locality team have supported and developed an additional staffing resource which will support a nurse led Tyleri Ward service. Part of the model includes direct admission and transfer pathways to support an 8 bedded CRT unit. Facilitate the introduction of the Graduated Care model across to supports seamless pathways from hospital to home utilising nurse led units to minimise the time being spent in hospital settings.									
Health Protection Services **Building Community Resilience**	/Existing	Building community resilience through connections to increased social prescribing and community development in collaboration with the third sector, Integrated Wellbeing Networks, Social Care and 3rd Sector	Increased social prescribing and community development in collaboration with the third sector, Integrated Wellbeing Networks, Social Care and 3rd Sector. Development of Wellbeing Friends (training for front line staff such as Care Navigators, DNs, CRT etc) improving access to and awareness of GDS, Optometry, Pharmacy and GMS services. Our focus is on building resilience through prevention and early interventions to enhance wellbeing and self-care, identifying social networks to help address the wider determinants of health such as Vaccination programmes, EPP mental health initiatives,	Working alongside Social Care Mental Health and Emotional Wellbeing Population Health Healthier Wales Prevention & Wellbeing Transformation and Vision for clusters Workforce & Organisational Development Data & Digital technology	1					NCN Funded	Ongoing GP cluster commitment to continue to 2024/25	
Accelerated Cluster Development	Existing	Practice Managers Forum will continue to innovate, transform, and provide new ways of working collaboratively across the NCN footprint.	Innovate, transform, and provide new ways of working collaboratively across the NCN footprint.	Healthier Wales Working alongside Social Care Population Health Prevention & Wellbeing Communication and Engagement Transformation and Vision for clusters			3		£3000		ongoing- as part of the collaborative cluster working 2025-26	
Accelerated Cluster Development	Existing	Utilising opportunities that technology can bring to increase access to services	The principles of the Primary Care Model for Wales to increase the digital offer around triage and signposting to ensure patients are seen by the right person at the right time in the right place. Working with Blaenau Gwent GP surgeries to increase numbers utilising technology to improve access to GMS services.	*NHS Recovery* *Supporting Social Care/Health Workforce* *Healthier Wales* *Working alongside Social Care* *Population Health* Prevention & Wellbeing Transformation and Vision for clusters Workforce & Organisational Development Development Data & Digital technology								

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Accelerated Cluster Development	Existing	Continue to progress with the ACD Programme	Develop and support both exit strategies and business cases to enable proven concepts to be transitioned over to core funding. Raising awareness of the benefits and opportunities for improving population outcomes through collaboration and strengthening partnership arrangements. Support with the Happy Healthy Blaenau Gwent strategy as a key priority across all professional collaboratives.	Healthier Wales Population Health NHS Recovery Supporting Social Care/Health Workforce Working alongside Social Care Prevention & Wellbeing Transformation and Vision for clusters Workforce & Organisational Development								
Estates Mapping	New/Existing	Utilising an assets-based approach to refine our Estates Strategy	Utilise an assets-based approach to refine our Estates Strategy around our four places – Tredegar, Ebbw Vale, Abertillery and Brynmawr, harnessing existing infrastructure to support integrated delivery on the ground.	NHS Recovery Supporting Social Care/Health Workforce Healthier Wales Population Health Prevention & Wellbeing 24/7 model Transformation and Vision for clusters Workforce & Organisational Development Data & Digital technology								
Staff wellbeing	Existing	Supporting our Health and Social Care staff within Blaenau Gwent staff within Primary and Community Care to feel valued, engaged with in a positive sense of wellbeing at work	The NCN is committed to providing wellbeing support to well deserving staff, offering a wellbeing space, but also to provide a warm personal welcome from the Blaenau Gwent Health and Social Care Team and well-being support and guidance.									

NCN Delivery Action Plan

Please List activities or projects planned to commence during 2026/2027, as well as those ongoing from 2025/2026

Appendix 1- Plan on a Page 2026/27

Torfaen Neighbourhood Care Networks (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 Multidisciplinary team (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 Cardiovascular disease (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 intrauterine devices, minor surgery, substance misuse, homelessness and asylum seeker and refugees.

Our Key Actions

Area of Focus 1:

- Work with communities to identify local issues and priorities to inform decision making and action by strengthening the skills, resources and abilities of communities, and the individual people within them, to be able to thrive.
- Identify, connect and mobilise the existing strengths within a community that can be leveraged to empower communities.
- Bridge, link and coordinate well-being assets creating stronger, integrated support networks that enhance health, well-being and resilience of individuals and communities.
- Understand the causes of health behaviour and create interventions to improve the health and well-being outcomes of individuals, groups, communities and the population.

Area of Focus 2:

- Scope and develop MDT models through partnership working.
- Progress Torfaen Integrated Service Partnership Board Place Based Care and MDT model co-design.

Area of Focus 3:

- Work with Public Health Behavioural Change Practitioners, Value Based Healthcare providing support in smoking cessation, diabetes prevention, cardiovascular health, and weight management.
- To scope the creation of a Chronic Disease Team across the NCN.
- Embed CVD Quality Improvement Programme with measurable outcomes.
- Implement Hypertension screening in practice and communities.

Area of Focus 4:

- Map out the current provision of supplementary/enhanced services to improve uptake , particularly people experiencing homelessness, asylum seekers, and substance misuse issues).
- Use appropriate datasets to establish areas of need.
- Continue to work with practices and the local community to improve vaccination uptake .
- Support proposal for Enhanced Services Operational Group that could provide further funding for improved access.

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

Enablers

- Placed Based Care
- Partnership Working
- Technology
- Skilled Workforce
- Financial Resource
- Fit for Purpose Estate
- Clinical Data

How will we know if we have made a difference?

Improve patient outcomes, increase access to services, stronger community partnerships