

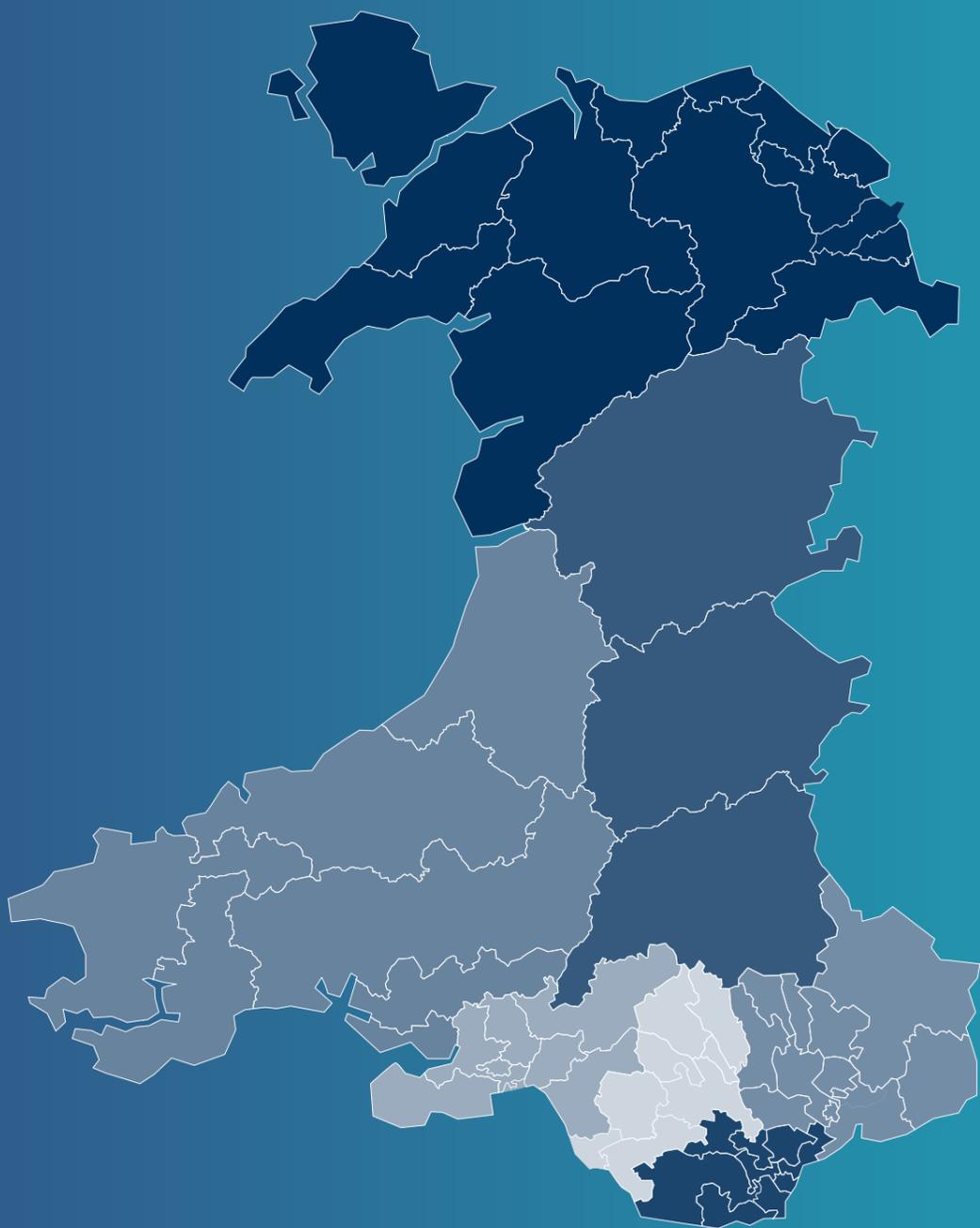


Aneurin Bevan University Health Board (ABUHB)





Aneurin Bevan University Health Board (ABUHB)



Interactive elements explained



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Aneurin Bevan
University Health Board

Lloyd Hambridge
Divisional Director

Primary Care, Community Services,
and Complex and Long Term Care

Welcome to the 2025 edition of the Aneurin Bevan University Health Board (ABUHB) Neighbourhood Care Networks (NCNs), our local terminology for clusters, report. Since the last publication in 2019, we have continued to evolve and adapt to meet the ever-changing needs of our communities for now and future generations.

Our NCNs remain at the heart of our strategy to deliver integrated, patient-centered, place-based care across Gwent. Bringing together a diverse range of health and social care professionals, third sector organisations and community groups, including General Practitioners (GPs), Dental and Optometric Practitioners, Pharmacists, Community Nurses, Allied Health Professionals (AHPs), and social care professionals.

By working collaboratively, the NCNs are ensuring that care is better coordinated, more efficient, and tailored to the unique needs of each community.

Over the past few years, we have faced unprecedented challenges, particularly associated with the impact of global COVID-19 pandemic and widening health inequalities. Our NCNs have been instrumental in our response, providing vital support and services to our population.

This report highlights the achievements and progress of our NCNs, showcasing the dedication and hard work of our teams.



The report also outlines the alignment of NCNs to our future plans and priorities as we strive to improve health outcomes and promote the wellbeing of individuals and communities across Aneurin Bevan University Health Board.

These future goals include:

- **Delivering Place-Based Care:** developing a place-based care approach, tailoring our services to the specific needs and characteristics of our communities.
- **Implementing Value-Based Health and Care:** prioritising outcomes that matter most to patients and striving to deliver high-quality care that maximises value by improving health outcomes and patient experiences, while ensuring efficient use of resources.
- **Promoting Preventative Health:** focusing on preventative health measures, including health education, early intervention, and community-based initiatives.

- **Strengthening Workforce Development:** supporting the professional development of our workforce, ensuring they have the skills and resources needed to deliver high-quality care.
- **Sustainability and Resilience:** building a sustainable and resilient health system that can adapt to future challenges and continue to provide high-quality care.
- **Embracing Digital Health:** investment in digital health technologies to improve access to care, enhance patient engagement, and streamline service delivery.
- **Expanding Integrated Care:** further integrate health and social care services, ensuring seamless and coordinated care for all individuals, particularly those with complex needs.
- **Enhancing Community Engagement:** working closely with our communities to understand their needs and preferences, ensuring that our services are responsive and culturally appropriate.

Blaenau Gwent Integrated Service Partnership Board (ISPB)

Who are we?

Blaenau Gwent is a county borough in South East Wales, it borders the areas of Monmouthshire and Torfaen to the East, Caerphilly to the West and Powys to the North.

It is the smallest Borough across Gwent covering a geographical area of 109 km² (42.08 square miles), serving an approximate population of 71,852 covering the 4 main towns of Ebbw Vale, Tredegar in the West, Brynmawr and Abertillery in the East.

ISPB Chairs: Esther Phillpott (ABUHB) & Alyson Hoskins (BGBC)
Membership consists of representation from ABUHB, BGBC, Third Sector

Residents receive out of hospital/general health and social care from independent contractors, local authority and third sector. It has 2 Neighbourhood Care Networks (NCN) areas, East and West, whose purpose is to work across sectors including both public and third sectors to develop and support sustainable services on a local footprint. Across Blaenau Gwent the independent contractors comprise of 10 GP practices, 28 community pharmacies, 10 dental practices 9 optometry practices.

Local authority services comprise of:

Children Services – Information Advice and Assistance Team, 3 locality-based teams, a 14 plus team, the Placement team, a Supporting Change Team, a My Support Team, a Family Time Team and a Disability Team.
Adult Services – Information Advice and Assistance Team.

Community Services

- 6 Libraries
- 14 Post Offices
- 22 Primary Schools
2 Secondary Schools
- 10 Local Nature Reserves
- 1 x National Cycle Route
- 17 x Children's Play Areas
- 1 x Sports Centre
- 14 x Outdoor Sports Facilities

What are we working on?

A Healthier Wales sets a target of a fully integrated health and social care system, with a key focus on a strengths based and self-care approach with the movement of care from hospital into the community. The role of the Blaenau Gwent Integrated Services Partnership Board (ISPB) is to act as an enabler for embedding a whole system approach that integrates health, local authority and voluntary sector services, and is facilitated by collaboration and consultation.

Within the ISPB there is an underpinning intent to improve services and the care that residents receive through working in a more efficient and effective way, this is endorsed through the Marmot regional Framework for Action, the Social Services and Wellbeing Act requirements and the Transforming Primary Care model through the development of place based working across organisations and structures to enable our greatest asset, our workforce, to focus on empowering communities to be resilient and take ownership of their health wellbeing, removing pressures from our systems through redesigning of services.

Over the next 12 -18 months the focus will be specifically on older people, supporting early intervention/ prevention and prudent healthcare to help strengthen the community response for integrated service delivery.

CASE STUDY

2–3-year-old Influenza vaccination programme – Through our Improving Outcomes Through Earlier Intervention task and finish group we were able to expand our flu programme for the 2–3-year-old across all our pre school and nursery settings.

What are the key achievements?

- Reinstatement and good representation of the ISPB
- We have worked together collaboratively with stakeholders to develop our shared vision of creating a more prosperous Blaenau Gwent through our place-based care strategy of a “Happy Healthy Blaenau Gwent”.
- We have developed an aligned Integrated Blaenau Gwent Plan which builds upon the plans of the Blaenau Gwent ABUHB & East and West Cluster, BGBC’s Corporate/Business plans and priorities, supporting alignment across organisations.
- Development of task and finish groups to support individual key priorities for example Improving Outcomes Through Earlier Intervention (Dental & Immunisation) that has been key in supporting the 2–3-year-old flu programme in Blaenau Gwent.

What have we learnt?

- Through our ISPB we have been able to provide system leadership to enable collaboration between partner organisations across health social care and third sector to identify and meet the needs of the local population.
- Through our parentship working we have been able to truly understand the population needs and align our key priorities across health, social and third sector organisations.
- Develop a joined-up place-based approach to management of estates aligned to local service models.
- Better progress against task and finish groups that were agreed when the priorities were set, not all have been established e.g., estates and mapping.

What is next?

Continue to work with partners to implement our vision for a “Happy Healthy Blaenau Gwent” as above.

Including links to IMTP

Blaenau Gwent ISPB will focus on the RPB emerging priorities whilst aligning to the ABUHB IMTP and the Cluster annual plans for a whole system approach.

The framework will set out actions 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. Central to the review is the recognition that disadvantage starts before birth and accumulates throughout life.

This is reflected in the 8 policy objectives below:

1. Giving every child the best start in life
2. Enabling all children, young people and adults to maximize their capabilities and have control over their lives
3. Creating fair employment and good work for all
4. Ensuring a healthy standard of living for all
5. Creating and developing sustainable places and communities
6. Strengthening the role and impact of ill-health prevention
7. Tackle racism, discrimination, and their outcomes
8. Pursue environmental sustainability and health equity together

Blaenau Gwent ISPB
(East & West)

Blaenau Gwent NCN (East & West)

Who are we?

Blaenau Gwent Borough is the smallest local authority in Gwent, with a geographical area of 109 km² (42.08 square miles), serving an approximate population of 71,852 covering the 4 main towns of Ebbw Vale, Tredegar, Brynmawr and Abertillery.

Esther Phillpott – Head of Service
Aimee Clement-Rees – Assistant Head of Service
Claire Evans – Network & Community Services Manager
Victoria Price – Network & Community Services Manager
Joanne Bradley – Network Support Officer

Across Blaenau Gwent independent contractors comprise of:

- 10 GP practices, 3 managed by the Health Board from 1st March 2025
- 10 Dental Practices
- 24 Community Pharmacies
- 9 optometry practices

Community Services

- 6 Libraries
- 14 Post Offices
- 22 Primary Schools
2 Secondary Schools
- 10 Local Nature Reserves
- 1 x National Cycle Route
- 17 x Children's Play Areas
- 1 x Sports Centre
- 14 x Outdoor Sports Facilities

What are we working on?

The priorities and actions we have set will remain the same with the added key component of delivering our place-based care strategy aligned to the key areas of focus for NCNs.

As part of our annual plan for 24-25 and 25-26 we aim to align our strategic priorities for the ABUHB IMTP:

1. Every child has the best start in life
2. Getting it right for children and young adults
3. Adults in Gwent live healthy and age well
4. Older adults are supported to live well and independently
5. Dying well as part of life



Blaenau Gwent NCN (East & West)

Cluster/NCN Lead

Blaenau Gwent East
 Dr. Isolde Shore-Nye Isolde.
 Shore-Nye2@wales.nhs.uk

Blaenau Gwent West
 Dr. Simon Donovan Simon.
 Donovan2@wales.nhs.uk

CASE STUDY

In 2024 Blaenau Gwent East and West cluster invested in an Advanced Paramedic Practitioner (APP) Hospital Avoidance Project – APPHAP.

The project involved APPs 9 who rotate in and out of the Blaenau Gwent Locality providing support to all 10 practices across the borough for a home visiting service with acute house calls.

The APP will work across Blaenau Gwent offering a community-based service to aid home visiting to those patients who may require admission but could be suitable for Community Resource Team/Rapid Response (CRT/RR) input. By utilising this service, will enable earlier assessment and referral into CRT/RR. Although we are still in the early stages of the project the feedback has been extremely positive.

GMS Feedback

January 2025

'All APP's I have dealt with so far seem very competent, helpful, friendly and approachable'

February 2025

'Thank you so much... all members of the team have been very professional and have generally fitted in well to our team... Excellent, I have found their note taking comprehensive and am very satisfied with the service'

What are the key achievements?

Achievements delivered by the NCNs in Blaenau Gwent for 24/25:

- The 2024-25 influenza vaccination campaign for 2- and 3-year-olds was extended to all childcare providers and education settings across Blaenau Gwent. The NCN working in partnership with the ABUHB Immunisation service delivered the programme across a total of 45 settings during the month of September.
- The NCN have successfully implemented and delivered a First Contact Physiotherapy Service across the West Cluster of Blaenau Gwent. The service is designed to maximise benefits for patients with musculoskeletal conditions.
- The NCN have Successfully implemented the Advanced Paramedic Practitioner – Hospital Admission Avoidance Project across the both clusters. APP are specialised and autonomous clinicians APPs provide advanced clinical assessment skills, diagnosis, treatment and referral of patients using a medical/management model of care. The aim of the initiative is to allow early assessment and appropriate conveyance to hospital, where required, but optimising the use of alternative primary care and community services to mitigate the pressure on the wider care systems. The APPs undertake home visits (including care homes) working collaboratively with GPs, Community Resource Team - Rapid Response, District Nurses teams to deliver care. APPs have increased access to the medicines formulary, supported by Patient Group Directives, to treat a range of acute presentations.
- Introduced a new service in Blaenau Gwent West to deliver a pharmacy service to housebound patients. The NCN Pharmacist has been carrying out in-home reviews, the aim is by targeting this group of patients who often only receive reactive care we will be able to identify those at most risk, make appropriate medication change suggestions to the practices, reduce waste and medications harms / risks.
- We have continued to support the needs of the local population in terms of the cost-of-living crisis, the NCN provided funding to support the Aneurin Leisure Fit and Fed Programme which is a programme provides food and nutrition education, physical activity, enrichment sessions and healthy meals to children during the school summer holidays.
- The NCN, in partnership with the Integrated Wellbeing Network (IWN), has launched an online map that will connect the people of Blaenau Gwent to everything that is within the local area to support mental and physical well-being. Communities can use the map to find groups, services and organisations in the local area.
- The Blaenau Gwent Locality Team and NCN Leads have fully supported the opening of the Bevan Health and Wellbeing Centre in Tredegar.
- As part of the NCN Protected Learning sessions, a Winter planning event took place which was organised and delivered by the Blaenau Gwent Locality Team. The event focused on supporting our collaboratives with the significant pressures we know are faced during winter periods and had representatives from services across health, social and third sector who can assist with sustainability, admission avoidance and / or early discharge.

Aneurin Bevan University Health Board (ABUHB)



Blaenau Gwent NCN (East & West)

Cluster/NCN Lead

Blaenau Gwent East

Dr. Isolde Shore-Nye
Isolde.Shore-Nye2@wales.nhs.uk

Blaenau Gwent West

Dr. Simon Donovan
Simon.Donovan2@wales.nhs.uk

- A roadshow of staff wellbeing events was delivered. They were designed collaboratively with the Mental Health and Learning Disabilities Division. The events offered a warm and personable welcome, relaxation area, creative tables, dog therapy, wellbeing information and raffle prizes donated by local businesses. A total of 173 staff in the area benefitted from the staff wellbeing pop ups.
- A calendar of Community wellbeing events has been delivered based on population needs. There have been 4 events delivered this financial year to date. Topics have included mental health, best start in life and childhood immunisations.
- The NCN team were approached by Tredegar Town Council to host Health and Wellbeing workshops as part of Tredegar Comprehensive Schools Immersion Day. The Blaenau Gwent Locality Team hosted over 100 pupils through 5 workshops that focused on young people taking ownership for their own health and wellbeing.
- The Civica system for call scheduling was piloted within the Community Resource Team. It has replaced a paper diary and improved staff safety by utilising the check in and check out function for home visits.
- Successful roll out of the All-Wales Diabetes Prevention Programme across both clusters where patients, in the pre-diabetic stage, are offered a brief in intervention which includes lifestyle advice with the hope of reducing their HBA1c over the longer term to reduce or prevent the progression of diabetes.
- Fully established a Children and Young Adult Task and Finish Group to improve outcomes through early intervention with a key focus on dental and immunisation.
- Blaenau Gwent West NCN participated in the SPPC Peer Review with Cwm Taff Health Board.
- In order to deliver on the vision of creating a Happy Healthy Blaenau Gwent Service, we have been working in partnership to not only develop a model of care that will be right for the people of Blaenau Gwent but also the success of the project is reliant on engagement of all partners. This proposed model has had full support and endorsement from the ISPB, recognising that there is a drive to deliver A Healthier Wales.

What have we learnt?

Blaenau Gwent sees a significant gap in healthy life expectancy between the wealthiest and poorest in our communities which means we see a high number of patients with multiple health needs accessing our services.

As NCNs we are fully committed to help achieve better outcomes for our service users by building resilient communities and embedding a person-centred approach to service provision and supporting citizens and their families to take ownership of their health and wellbeing needs through prevention, self-care and early intervention to deliver the change communities need.

Our key achievements demonstrates that as an NCN are striving to meet the needs of the population we serve, through our drive of true partnership working we have been able to take a distributed leadership approach ensuring full engagement from all partners to provide the highest quality services for the population of Blaenau Gwent.

Key Reflections / Challenges in 2024/25

Finance	Impact of reduced budgets and pay awards has caused fluctuations beyond our control making it difficult to commit to long-term planning or test new initiative.
Workforce retention, recruitment & resilience	Lack of staffing to support the delivery of our priorities. Uncertainty around workforce capacity, fluctuation in staffing levels and inability to recruit and retain clinical staff, impacting significantly on ability to forward plan activities.
Increasing deprivation levels	Our population is characterised by large pockets of health inequalities, linked to social-economic deprivation and the current financial crisis which further impacts these areas. Demand for health and social care is growing and continues to grow. The ageing population is living longer with more complex needs, increasing the pressure on an already challenged social care, health and third sector.
Cost of living pressures	Continued impact on people's mental health & wellbeing leading to a growing demand for support locally.
Estates	While it is noted that estates across some areas of the locality are improving there are still a significant amount that are not fit for purpose to deliver place-based care. Lack of capacity and buildings fit for purpose means we are unable to support opportunities to reduce service demands.
Bureaucracy	Lengthy corporate processes often hinder our ability to deliver key priorities in a timely manner.

What is next?

For 2025/26 we will aim to align to the key areas of focus set out for NCNs by developing a 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.



This will be delivered through our 'Happy, Healthy Blaenau Gwent' placed based care strategy. 'Happy Healthy Blaenau Gwent' is our locally driven project, it is our vision for Blaenau Gwent to be a considerate and caring locality, working in a collaborative approach to support people's health and wellbeing.

Our aim is to build more resilient communities so that our citizens can be empowered to directly access community assets across Blaenau Gwent to support their health and wellbeing. The Happy Healthy Blaenau Gwent framework aligns to the Welsh Government National Framework for Social Prescribing.

The core objectives in this framework will be interpreted at a local level in Blaenau Gwent to provide the driving force for the programme.

We want to:

- Empower people who look after themselves and each other
- Build stronger and more resilient communities together
- Work collaboratively with all our partners to deliver high quality and equitable services for now and the future

This vision is validated by the strategic direction set out in The National Primary Care Programme, A Healthier Wales and Prosperity for All setting out strategic ambitions for increasing workforce sustainability and utilising the third sector to meet the increasing demands upon our core services.

Transformation funding has provided the opportunity to progress this vision through embedding a Happy Healthy Blaenau Gwent model of care to support our place-based strategy.

Through embedding MDT principles, we can deliver appropriate care to people with long terms conditions and support the management of demand for our services collectively across social care and health. Our IWN partners will be instrumental in delivery of this model of care to ensure NCNs have an understanding of the community assets such as community groups and voluntary organisations that help people maintain or develop social support networks and improve outcomes for our residents.

Caerphilly Integrated Service Partnership Board (ISPB)

Who are we?

Caerphilly Borough lies at the heart of both the South Wales Valleys and the Cardiff Capital Region and covers a large geographical area of 278 km² (107 square miles). It is approximately just over 18.6 miles long and nearly 11 miles wide and runs from the Brecon Beacons National Park in the north, to Cardiff and Newport in the south. It is bordered to the north by Merthyr Tydfil, the west by Rhondda Cynon Taf, and to the east by Blaenau Gwent and Torfaen local authorities.

Its health board boundaries are Cwm Taf Health Board and Cardiff & Vale University Health Board. It has a resident population of approximately 181,731 (Mid-Year 2020 Stats Wales). The General Practitioner (GP) registered population is higher than the residency at 187,000 people registered who receive out of hospital/general health and social care from Aneurin Bevan University Health Board (ABUHB), independent contractors, local authority and third sector.

ISPB Chairs: Eira Turner (ABUHB) & Jo Williams (CCBC)
Membership consists of representation from ABUHB, CCBC, GAVO, PHW

Across Caerphilly there are key independent contractors that are integral to our health and social care system, comprising of; 20 GP Practices, 43 community pharmacies, 25 dental practices and 17 Optometry practices. There are 25 residential / nursing homes, 93 schools (Primary & Secondary), 39 community centers and 18 libraries. A snapshot shows that Caerphilly currently has 14 providers who give domiciliary care within the borough.

What are we working on?

Caerphilly ISPB agreed the marmot principles as a framework to assure we are working in the right direction to meet the need of our population as well as addressing inequalities across the borough. Our priorities are:

- Early years and best start in life
- Mental Health & Wellbeing
- Community Resilience (Including preventative workstreams)
- Workforce (Sustainability, wellbeing, training etc.)
- Implementation of NCN Development Programme
- Digital technologies



Caerphilly ISPB
(East, North & South)

CASE STUDY

Experience, quality and safety – Improved collaborative / Integrated planning on provision of service to ensure experience of intervention for citizens are effective and sustainable both now, and into the future.

Research, innovation, improvement and value – Engage and support with all aspects across respective employing organizations, bringing together teams to facilitate and support transformation of service delivery.

What are the key achievements?

- Building and enhancing working relationships across partners
- Partnership and collaborative working
- Implementation of Participatory Budgeting

What have we learnt?

- Provides an integrated leadership across the system involving NCNs, Health Board, Local Authority, Housing and Third Sector.
- Partnership working avoids duplication and clarifies pathways for the public.

- Partnership and collaborative working allows a combined discussion around sharing of knowledge, expertise and resources which enhances care delivery, access and utilisation of facilities/estate across the Borough.
- Align / agree commissioning arrangements.
- Creating opportunities for pooled budgets and combined bids and joint spend.
- Provides a partnership-based detail assessment of need.
- Understanding professional assessment of service gaps, barriers and opportunities.
- Enhanced coverage of Integrated Wellbeing Network (IWN) across the Borough.
- Further progressed development of an integrated workforce plan.

What is next?

Continue:

- To work with partners to establish wrap-around health and wellbeing services
- Partnership working in relation to estate prioritization and rationalisation
- Use of preventative, early opportunity and self-management approaches
- Use of multidisciplinary teams to undertake active signposting
- Use prudent pathways to improve planned care
- Recruit, train and educate our workforce to meet population need

Caerphilly NCN (East, North & South)

Who are we?

Caerphilly Borough covers a large geographical area of 278km (107 Square miles) and borders with two other health board providers i.e Cwm Taf Health Board and Cardiff & Vale University Health Boards well as three other LA areas within Gwent (Blaenau Gwent, Newport & Torfaen).

Eira Turner: Head of Service
Jonathan Lewis: Network & Community Services Manager
Clair Roper: Network & Community Services Manager
Neirin Rees: Service Improvement Manager
Mari Burland: Network Support Officer
Stella Montgomery: Network Support Officer

Caerphilly has a resident population of approximately 176,831 (Mid-Year 2021 Stats Wales) with a General Practitioner (GP) registered population higher than the residency at 187,000 people. Registered patients receive out of hospital health and social care from independent contractors, local authority and third sector organisations.

Across Caerphilly independent contractors comprise of 20 GP practices, 43 community pharmacies, 25 dental practices and 17 optometry practices.

What are we working on?

The top strategic priorities highlighted in the Caerphilly NCN Plan were:

1. Early years & Best start in life
2. Mental Health & Wellbeing
3. Community Resilience



Caerphilly NCNs (East, North & South)

Cluster/NCN Lead

Caerphilly East:

Jackie Reynolds
 Jackie.Reynolds@wales.nhs.uk

Caerphilly North

Heather Griffiths
 Heather.Griffiths4@wales.nhs.uk

Caerphilly South

Alun Edwards
 Alun.Edwards@wales.nhs.uk

CASE STUDY

In 2024 the biggest new investment from the NCN budgets was to invest in GP practice aligned community wellbeing connector roles. This was undertaken in collaboration with our Local Authority partners.

The Community Wellbeing Connectors work with residents identifying appropriate solutions to their complex needs, building on the legacy and relationships developed to date, whilst moving to a fresh approach to building resilient communities.

The impact of this approach has already delivered an improved experience for individuals within Caerphilly borough as shown by example below.

Referred by his GP, a widower struggling with new health issues impacting mobility and breathing, expressed a desire to re-engage with his love of sport and socializing, albeit at a slower pace.

He also felt overwhelmed by daily tasks. With his permission, the Wellbeing Connector provided information on local groups (Veteran's Hub, luncheon group), private home support providers (gardening, cleaning, shopping), and referred him for an OT/Care & Repair assessment for home modifications (shower seat, rails). Information on Telecare (key safe, pendant) was also provided. The patient was grateful, feeling safer and more independent.

What are the key achievements?

Some of the achievements delivered by the NCNs in Caerphilly are:

- Increasing Community Wellbeing Connectors and embedding them in GP practices and communities.
- Extended Interval Prescribing - GMS and Pharmacy collaboratives working in partnership.
- MDT Coordinator / MDT Meetings - Supporting ABUHB Apprenticeship Programme.
- Staff Wellbeing – The Zen Den.
- Professional collaborative implementation –Nursing, Optometry, GMS, AHP, Dental and Pharmacy.
- Collaborative localised programmes i.e. Optometry have tripled the referrals to Help me Quit and presented at NCN Event, Pharmacy Extended Interval Prescribing.
- Diabetic Prevention Programme – Roll out across Caerphilly.
- Participatory budgeting supported 8 health & wellbeing projects in Upper Rhymney Valley – chosen by local residents.
- Optometry Collaborative have embedded smoking cessation into routine eye examinations. This has resulted in 300% increase in referrals to Help Me Quit.
- Recent pilot supporting flu vaccination uptake in Caerphilly North for Children aged 2-3 in preschool & nursery settings.
- NCN Investment into 3rd Sector Mental Health counselling support.
- Psychological Health Practitioners working within all GP Practice Settings.
- Community Wellbeing Connectors employed and embedded within all Caerphilly GP Practices through good partnership working with Caerphilly Local Authority.
- Place Based Care / Hub Development through improved site/room utilisation increased the offer of a boarder range of services at a local level. (Eg. Respiratory, diabetic, falls, audiology services etc.)
- First contact physiotherapy – Aligned to all GP practices improving access to MSK assessment within community.
- IWN in partnership with wellbeing connectors, nature wellbeing coordinator and Ty Bryn Surgery held a wellbeing pop-up and the Coed Cefn-Pwll-du Park Run.
- Participatory Budgeting awarded Funding to 8 wellbeing projects in Caerphilly North agreed via a citizens participation panel.
- Pan-Caerphilly event centered on theme of prevention bringing together an array of health, social care and third-sector professionals to provide valuable insight into preventative health and wellbeing strategies and initiatives to focus on ways to enhance outcomes for the local population.

Have you received any awards or recognition you would like to share?

3 Staff Recognition Awards in 2024, received high commendation and recognition at the ABUHB Staff awards:

- Population Health & Wellbeing Award – Caerphilly IWN
- Green Healthcare Award – Mari Burland Highly
- Employee Health & Wellbeing Award – Stella Montgomery

Establishment of Professional Collaboratives Across Caerphilly. Leading with Gwent-Wide Optometry Collaborative the successes of which include Help Me Quit. Recognising the impact, Optometry Wales are looking to roll out this initiative across Wales.



Caerphilly NCNs (East, North & South)

Cluster/NCN Lead

Caerphilly East:

Jackie Reynolds
Jackie.Reynolds@wales.nhs.uk

Caerphilly North

Heather Griffiths
Heather.Griffiths4@wales.nhs.uk

Caerphilly South

Alun Edwards
Alun.Edwards@wales.nhs.uk

What have we learnt?

As highlighted in our key achievements, partnerships and collaborative efforts have enabled us to improve service delivery and better meet the health and wellbeing needs of the population.

Other examples include:

- Good working relationships across the Core NCN membership.
- Strong focus on sustainability of core clinical services.
- Strong focus on innovation/development of services.
- Committed NCN Leadership and Support Team.
- Committed and good relationships with IWN.
- Clear direction via the NCN plan on a page of what the priorities are and how these can be delivered via integrated/collaborative working.
- NCN provides a conduit for two-way partnership working.
- Development of place-based care models and hubs across health and social care to support sustainable services for the local population.

What could have been done differently

Through continuous monitoring and review, and utilisation of Plan Do Study Act (PDSA) cycles as necessary, we have aimed to maximise all resources and investments available to NCNs and their partners.

However, we have recognised many weaknesses and threats to NCN delivery such as:

- NCN budgets are committed recurrently which limits opportunities for new innovation.

- Annual variability of funding (e.g. sickness, recruitment and retention).
- Organisational and silo working creates barriers to integration.
- Sustainable challenges within the primary care workforce in some areas.
- Increasing staff costs impacting on service provision alongside financial pressures faced by independent contractors due to National Insurance contributions.
- Unable to transition effective NCN models to core budgets limiting future investment.

What is next?

Building resilient communities:

To align the work of NCNs and Integrated Wellbeing networks 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.

Encouraging collaborative working with focus on enhanced services:

To improve equity of access to enhanced/supplementary services across independent contractors and developing a multiprofessional approach for Inclusion Health services.

Prevention and management of long-term conditions:

To reduce premature mortality and morbidity through prevention and management of diabetes and cardiovascular risk factors.



Including links to IMTP

As a Health Board the priority areas for the Primary Care and Community Services Division over the period 2025/26 will be to progress and deliver on the following areas:

- Long Term Conditions – Management & Prevention
- Access & Sustainability
- Redesigning of Older Persons Services
- NCN Development & Partnerships

To achieve actions for above priority areas it will be essential to ensure that all the underpinning enablers are effective. These include:

- Quality & Patient Safety
- Workforce, Staff Wellbeing and Culture
- Communication and Engagement
- Financial Management
- Fit For Purpose Estate
- Digital Technologies
- Value Innovation and Research

Monmouthshire Integrated Service Partnership Board (ISPB)

Who are we?

Monmouthshire holds a strategic position between key centres in South East Wales, South West of England and the Midlands; the main settlements located at Abergavenny, Chepstow, Monmouth, Caldicot and Usk. Monmouthshire's distinctive settlement pattern arises from its historic market towns and villages; approximately half of the population live in rural and semi-rural areas. The county contains good quality agricultural and farming land and is generally regarded as prosperous, offering good quality lives for its residents. Data revealed pockets of deprivation across Monmouthshire, especially in Abergavenny, Monmouth and Caldicot, made starker when compared with least deprived areas in the same towns.

The county stretches from the Gwent Levels coastline (South), the uplands of Bannau Brycheiniog (Brecon Beacons) National Park (North), to the picturesque river of the Wye Valley, an Area of Outstanding Natural Beauty (East). Monmouthshire borders England to the East, Newport and Torfaen to the West and Powys to the North.

Good road networks connect Monmouthshire to Cardiff, Newport and Bristol via two Severn Bridges and since the removal of the Severn Tolls, more people are taking advantage of these links to commute out of Monmouthshire for employment opportunities.

- Cluster Services (GP/other contractors/community services)

There are a number of services represented that enable the working of the ISPB and the wide range of priorities. This is primarily relates to Integrated Health & Social Care Services including: therapies, social work, community nursing, carers, commissioning, mental health, learning disabilities, respite, third sector, children and young people services and primary care services including.

Chief Officer, MCC (Chair)
Head of Service – Monmouthshire, ABUHB (Co-Chair)
Head of Service - Monmouthshire, MCC
Divisional Director, Primary Care & Community Division, ABUHB
Health, Social Care and Wellbeing Partnership Lead, GAVO
Group Manager for Mental Health & Learning Disabilities, MCC
Assistant Head of Service, Monmouthshire, ABUHB
Network and Community Services Manager, ABUHB
ACD Service Improvement Manager / Network & Community Support Officer, ABUHB
Integrated Service Managers
Integrated Wellbeing Network Lead, MCC

Health, Social Care and Wellbeing Partnership Lead, GAVO
Finance Director, ABUHB
Senior Nurse, OAMH, ABUHB
Monmouthshire NCN Collaborative Cluster Leads (North and South)
Finance rep, MCC
Head of Children's Services, MCC
Head of Podiatry and Orthotics & AHP Professional Collaborative lead, ABUHB
Mental Health & Learning Disabilities Divisional Director, ABUHB
Consultant Public Health, ABUHB (Ad-Hoc)
Decision Support Analyst, Finance, ABUHB
Business Partner Accountant, ABUHB
Workforce & Development, ABUHB



Monmouthshire ISPB
(North & South)

CASE STUDY

'Community Conversations (CC)' takes place in Abergavenny, Usk, Monmouth and Chepstow. Community Conversations provides local community and voluntary groups opportunities to collaborate and identify how to meet local needs. Usk CC demonstrates how partnership with District Nurses, GAVO and community / voluntary groups can plug gaps in services e.g.; Mind Monmouthshire, the Rural Support Centre and Health Board are exploring how to support rural communities etc. with opportunities for health board staff to partner with GAVO and Monmouthshire County Council in Abergavenny, Monmouth and Chepstow.

What are we working on?

ISPB IMTP priorities:

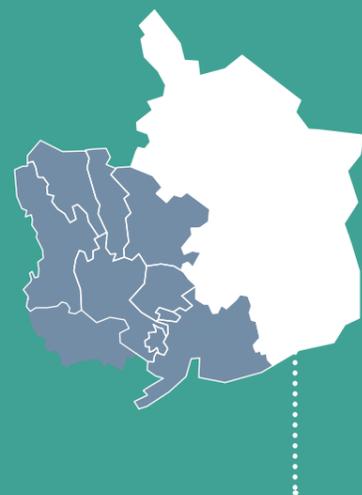
- Developing workforce strategy.
- Supporting early intervention and prevention across partner organisations.
- Partnership working to understand whole system (health, socialcare and third sector) pressures and identify opportunities to support integrated services teams in Monmouthshire e.g. Expansion of South Rapid Medical (Frailty) Service into the North.
- Identifying pressures in supporting children and young people and their families or carers in finding solutions.
- Developing cross-partner communications/ engagement to build bridges and overcome differences in operational language and working etc.
- Maximising opportunities for partnership working across health and social care estate.
- Increasing financial governance and transparency – working together to provide governance and oversight of the Section 33 Agreement, and funding streams linked to the ISPB and Project Group.
- Taking forward the Accelerated Cluster Development (ACD)/Pan-Cluster Planning Group (PCPG) national initiatives, linked to ABUHB primary care (Neighbourhood Care Network with quarterly reporting at ISPB).

The ISPB is strategically aligned with the following local/national policies/ themes/programmes:

- **SPPC:** Strategic Programme for Primary Care e.g. Empowering People, Providing Care Closer to Home, Local Integrated Care
- **PBCC:** Placed Based Care Areas of Focus: 1. Building resilient communities, 2. Creating solid foundations across primary care and community services, 3. Building integrated teams in every "place", 4. Working collaboratively on prevention programmes and enhanced services, 5. Enhancing intermediate care and secondary care interface
- **RPB:** Regional Partnership Board 3 overarching aims: Start Well, Live Well, Stay Well
- **NCN/ Accelerated (Collaborative) Cluster Development:** National programme to accelerate cluster progress against toolkit
- **PCmFW / AHW:** Primary Care Model for Wales / A Healthier Wales
- **RSfOP:** Redesigning Services for Older and/or Frail People

The ISPB also:

- Provides the local footprint for the tactical delivery of the Regional Partnership Board's (RPB) Area Plan
- Coordinates the use of available resources across the partnership to meet local needs
- Commissions service and develop agreements to support partnership working
- Utilises intelligence from Clusters (NCNs) to ensure plans reflect population need, supports actions to address issues raised, provide strategic direction to inform development of respective cluster plans.



Monmouthshire ISPB
(North & South)

Key achievements

Monmouthshire ISPB has implemented quarterly exception process, which enables project leads to report successes and escalate potential risk in terms of ability to deliver on agreed priorities. This helps partners understand issues relating to service pressures and receive support where necessary.

In December 2024, the ISPB introduced a GAVO led Project Sub-Group, with a remit of monitoring a £200,000 dementia related, recurrent budget, and look at funding options which may support new schemes.

A key achievement is opening Assistive Technology rooms in Chepstow Community Hospital and recently in Monnow Vale. We are scoping options to replicate this elsewhere in Monmouthshire.

Integrated Services Health&Social Care – Rapid Medical (Frailty) Service

Our Integrated teams provide people with necessary care and/or treatment; either at home, or as close to home as possible, promoting personal independence via collaborative working. Services have demonstrated their value through reducing avoidable hospital attendances, providing safe alternate pathways of care, and minimised hospital stays by facilitating early and safe discharge.

Neighbourhood Care Networks (NCNs/Clusters – linked to Accelerated Cluster Development)

Representatives of individual Professional Collaboratives come together to assess the wider health and wellbeing needs of their population (typically between 25,000 and 100,000 people) and rely on the Regional Partnership Board's, Population Needs Assessment (RPBNA), to underpin NCN (annual) cluster plans.

There are two Monmouthshire NCNs (North and South) with a collaborative professional network featuring GPs, dentists, optometrists, pharmacists, mental health practitioners, integrated services staff including: district nurses, social workers, therapists, direct care staff, midwives, dieticians, specialist nurses, psychological health and wellbeing links coordinators, housing representatives and Third Sector colleagues.

Accelerated Cluster Development - Professional Collaboratives (linked to NCNs)

The mechanism by which, GMS, Dental practices, Community Pharmacies, Optometry practices, Community Nurses, Allied Health Professions, Social Services and others come together within their profession/specific groups. The cluster footprint supports the wider NCN in considering the RPBNA and identify local solutions based upon localised knowledge and expertise.

Third Sector

The Gwent Association of Voluntary Organisations (GAVO) is affiliated to the Wales Council for Voluntary Action and an active member of Third Sector Support Wales. GAVO's 2022-25 strategic plan details how it is an active member of the new Gwent Public Service Board Framework and supporting structures, in-line with the Wellbeing of Future Generations (Wales) 2015 legislation. GAVO continues to support the ISPB and NCN Clusters, ensuring the voice of local communities are represented. For a number of years the ISPB and NCNs have been closely linked to GAVO's vast network of support, this is reflected in our plans.

Learnings

Positives

Quarterly exception/progress reports provides awareness of barriers/risks in the delivery of plans, the Project Sub-Group has removed the operational element from the ISPB.

The ISPB retains an equal focus on needs assessments and changing needs of communities. Working with the RPB to align the PNA and Population Wellbeing Assessments (Wellbeing of Future Generations Act); avoiding duplication, promoting collaboration and joint working in response to local need.

Could have done differently

Implementing a Project Sub-Group sooner would have reduced demand on ISPB time, allowing greater focus on progressing strategic workstreams.

Including links to IMTP

As with the current 3 year ISPB IMTP, the board remains cognisant of Regional Partnership Board, Health Board, Local Authority and GAVO priorities, when agreeing new 3 year IMTP.

The ISPB recognises its role as sub-group of ABUHB in terms of the Accelerated Cluster Development Programme and has adopted Health Board IMTP priorities within its own strategic plan e.g. redesign of older people's pathway work aligns with ISPB's 'whole-system' priority, acknowledging most frail/elderly population; ensuring we have a workforce fit for the future.

What is next?

Future priorities

Focus on delivering year 2 priorities from ISPB plan. Towards the end of each reporting year, consider emerging themes for the following year, e.g., 8 Marmot Principles, assessed against current partnership service framework.

Continuing prevention agenda, looking at links between established community-based support, including Community Conversations on a place-based basis, and proposed new wellbeing centre in Osbaston, Monmouth.

Further development relating to the 'in-take' reablement pathway within our Integrated Services.

Monmouthshire NCN (North & South)

Who are we?

Personnel

Monmouthshire North & South NCN Clusters are supported by two Clinical Leads (GPs), Network Manager, ACD Service Improvement Manager and Support Officer. The NCNs hold relatively small budgets with a combined total of circa £500,000, which enables to test new services based on identified need and agreed priorities.

Dr Harries is NCN Lead North with many years experience as both NCN Lead, and GP based in Monmouth Town. Dr Holtam is South NCN Lead and is instrumental in implementing new projects and schemes in response to identified local need. Both NCNs have representation from a range of services including: GP practices, community nursing, Integrated Health and Social Care, primary / adult and older adult mental health, third sector, housing, weight management, Monmouthshire County Council, allied health professionals, community pharmacy, dental, optometry, public health Wales, carers and child / family services.

Geography

North Monmouthshire, according to the Regional Partnership Board's annual plan, is mainly rural area, with the South considered semi-rural.

Services within the cluster (GP/other contractors/community services).

Monmouthshire NCNs consists of a network of 12 GP Practices, 2 Integrated Health and Social Care teams, Third Sector colleagues and others, serving a population of around 104,000 (c. 55,000 North & 49,000 South). The North NCN has 7 GP practices with 5 in the South.

What are we working on?

Top strategic priorities

Building resilient communities: Our continued aim is working in partnership to ensure people in and around Monmouthshire (circa 14,000 residing across the border registered with a Monmouthshire GP), can be involved in the large network of community support on a place-based basis.

However, as with previous plans, we continue to recognise the significance of working together as a collection of collaboratives, to understand needs of people within our key 'places', and use it to shape our services in an integrated way, to meet those needs across a vast geographical area.

Monmouthshire has well documented challenges relating to its growing, older population and high levels of demand across primary, community and social services, due to people living longer with long-term conditions. Recognising the need to avoid people being admitted to hospital where possible as we know 'deconditioning' in older people has a significant impact. We share this as a priority with the ISPB and continue working with GAVO as a whole.

Wellbeing Network: NCNs continue building community resilience through connections with GAVO and Integrated Wellbeing Networks. By increasing knowledge and understanding the needs of people and communities in Monmouthshire, supporting early intervention and prevention and initiatives such as Community Conversations and Wellbeing Information Hub development.

Accelerated Cluster Development Programme: Place-Based Care delivered by Professional Collaboratives and Clusters, aligned with GAVO etc. Professional Collaboratives are mechanisms by which, GMS practices, Dental practices, Community Pharmacies, Optometry practices, Community Nurses, Allied Health Professions and in Monmouthshire, Third Sector (GAVO), come together across cluster footprints and towns, to identify local solutions together.

Link to relevant plans

The work of the NCNs is strategically linked to a range of national policies and guidance as referenced below

SPPC: Strategic Programme for Primary Care e.g.; Empowering People, Providing Care Closer to Home, Local Integrated Care

RPB: Regional Partnership Board 3 overarching aims: Start Well, Live Well, Stay Well

ISPB: Integrated Services Partnership Board priorities

PCMfW / AHW: Primary Care Model for Wales / A Healthier Wales

CASE STUDY

The S.M.A.R.T. project: "Working as a cluster ensures care is better co-ordinated to promote the wellbeing of individuals and communities." Introduces the South Monmouthshire Agile Response Team (S.M.A.R.T.) project, a programme of MDT meetings and 'holistic' reviews in GMS, helping protect our most vulnerable older people by identifying as early as possible, any potential harm such as risk of falling or other vulnerabilities that might need support, therefore avoiding hospital attendance.

The MDT review process takes into account psychological, mental, physical and social factors, rather than just the symptoms of an illness, and identifies potential support based on individual need from medical, social and third sector perspective. 2025/26 plans to introduce a robust dataset which will demonstrate the effectiveness of this, and other MDT models in place across the Health Board footprint.

What are the key achievements?

Have you received any awards or recognition you would like to share?

- Dr Rowena Christmas, GP Wye Valley Practice and chair of the Royal College of General Practitioners (RCGP) in Wales, awarded MBE for services to General Practice.
- Robert Denman, Governor of HM Prison Usk and Prescoed, awarded Officer of the Order of the British Empire (OBE) in recognition of outstanding public service.
- Dr Sarah Neville, GP partner, Tudor Gate Surgery appointed post of Associate Dean for GP training for Aneurin Bevan University Health Board and South Powys.

- Monmouthshire Integrated Team chosen for The Chair's Award in the Health Board annual Staff Recognition Awards.
- Dr Jaideep Kitson, Consultant Physician and Assistant Medical Director, won Award for Leadership in the Health Board annual Staff Recognition Awards.
- Monnow Vale Health and Social Facility Ward Manager, Kelly Windebank, nominated for a Hospital Award.
- Jane Bevan, Chepstow Outpatients Co-ordinator awarded Certificate of Recognition.
- Mount Pleasant GP and South NCN Lead, Dr Holtam Nominated For GP of the year award.
- Monmouthshire has two Secure Estates, Usk and Prescoed – one of which is to become centre of excellence for older prisoner care.



Monmouthshire (North & South)

Cluster/NCN Lead

Monmouth North:

Dr Brian Harries
Brian.Harries2@wales.nhs.uk

Monmouth South:

Dr Annabelle Holtam
annabelle.holtam@wales.nhs.uk



Monmouthshire (North & South)

Cluster Lead

Monmouth North:

Dr Brian Harries
Brian.Harries2@wales.nhs.uk

Monmouth South:

Dr Annabelle Holtam
annabelle.holtam@wales.nhs.uk

What have we learnt?

What went well:

- **Continued investment in schemes linked to enhancing Primary Care response, building capacity and resilience:**
- **Practice Based Pharmacists (North)** – creating GP capacity with localised expertise.
- **Practice Manager lead (North & South)** – co-ordination of both clusters, creating efficiencies and sharing good practice etc.
- **GP led Safeguarding Forum (North & South)** – shared expertise and knowledge across GMS.
- **Wellbeing Link Advisor Service (North & South)** – responding to the social determinants of ill-health.
- **Psychological Health Practitioners (North)** – localised access to mental health assessment/ support.
- **Annual Winter Planning:** Bringing together primary, community, social services and third sector to plan for anticipated service pressures, and needs of our most vulnerable people.
- **ACD programme ‘Spotlight’** reporting helps identify service risk and need. ACD aimed at bringing collaborative groups to the same level of maturity.
- **Immunisation uptake:** Data confirms that Monmouthshire GP practices performed excellently when benchmarked against Gwent practices. Continue to strive to meet 75% national target in all cohorts each season.
- October 2024 snapshot of Covid vaccinations confirmed Monmouthshire, 47.6%, had the highest uptake in ABUHB. Monmouthshire also highest uptake in Care Home residents in ABUHB, 78.8%.

What could have been done differently

- Progressing Accelerated Cluster Development programme, understanding professional roles and continued uncertainty around the permanency of the program and funding.
- Continued pressure on primary and community services from increased population and new housing developments acknowledged.
- Financial risk: Uncertainty due to Government’s increase in National Insurance contributions 2024/25 – regular discussions held at Cluster contract meetings to monitor impact on recruitment and retention across primary care contractors.
- Potential risk to cluster funded projects due to impact of NHS pay awards.
- Continued impact on people’s mental health & wellbeing has led to growing demand for support locally, measured via our jointly funded Wellbeing Link Advisors and Psychological Health Practitioners. Data tell us that number of contacts for WLA service has more than doubled in last 12 months meaning increased impact from rising costs on people in Monmouthshire.
- Lack of available finance for new service developments, initiatives and opportunities aimed at reducing pressure.
- Potential fragility around some collaboratives and capacity to mature at the same rate as others – lack of incentive/ contractual recognition/ administrative support/ often senior representation with conflicting priorities (especially Allied Health Professionals).

What is next?

Building resilient communities:

Align work of NCNs and Integrated Wellbeing Networks to develop a more community orientated model of primary care through deeper understanding of community assets and local needs within the population, particularly for socially vulnerable or marginalised groups.

Ensure NCNs have good understanding of Integrated Wellbeing Networks in order to utilise community assets, community groups and voluntary organisations, that help people maintain or develop social support networks.

Building integrated neighbourhood teams in every “place”

Establish MDT working for people with greater complexity, most at risk of deterioration, and adverse events such as hospitalisation. This MDT approach requires care coordination and committed involvement of reablement workers, specialist nursing teams, clinical pharmacists, CMHT, social workers, occupational therapists, housing and third sector organisations.

Working collaboratively on prevention programmes and enhanced services

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

Continue promoting our ‘social prescribing’ model connecting people to activities, groups, and services in their community which address their practical, social and emotional needs.

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

Newport Integrated Service Partnership Board (ISPB)

Who are we?

The Newport ISPB is jointly chaired by the Health Board and Newport City Council. In addition to NCN Leads and Health Board representation it involves a range of partners including Housing, Social Care and Third Sector.

Newport is a multi-cultural city, with a population of 164,702 (as per GP registered individuals), this exceeds the projected population data from Stats Wales by 5 years, it was anticipated that this figure would not be met until 2028. 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.

In relation to Inclusion health groups, there is a growing homeless and rough sleeper population. The registered number of rough sleepers within the city has risen from 21 in January 2021 to 47 in January 2023. The recent Ukrainian refugee resettlement has further increased the number of refugees in the Newport area in addition to asylum seekers that are granted leave to remain and settle in the area.

Newport has an ageing population, with a current over 65 years population of 27,510. Estimated ageing population projection to 37,241 by 2039.

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 10 in Wales most deprived areas and the Ringland area within the East is ranked as 69th. Newport City Council have also recently announced that there are approximately 9,000 individuals on the social housing waiting lists.

Services within the cluster (GP/other contractors/community services)

- 17 GP Practices
- 16 Dental practices
- 13 Optometrists
- 27 Community Pharmacies
- Third Sector Services (All Listings - Your Newport, Your Wellbeing)

What are we working on?

- Local delivery of RPB priorities
- Collaboration and partnership working
- Ensuring plans reflect population need
- Place Based Care
- Redesigning services for older people
- Whole system approach to healthy eating
- Increasing the uptake of childhood Immunisations
- Engagement with vulnerable groups

What is next?

Future priorities

- Childhood vaccinations including the potential for pop-up clinics as part of Newport City Council asset revitalisation
- Whole System Approach to Healthy Weight Management and specific pilot for cost-of-living support, through the Community Food Partnerships, with a sub group established for the Food Poverty Action Plan.
- Further advancement of Place Based Care including an enhanced Social Prescribing model
- Redesigning Service for Older People including opportunities for step-up/step-down care following Spring Gardens and Parklands consultation and outcomes
- Engagement with Inclusion Health group in the design of a multi-agency model of support
- Community "Hubs" and Newport City Council asset revitalisation – opportunities for partnership working and collaboration particularly a central hub for Inclusion Health groups



Newport ISPB

Newport NCN (East)

Who are we?

In Newport, there are two NCNs serving a population of approximately 164,702 people. It is a city of two halves, where the most affluent meet the most deprived. There are over 48 different languages spoken here amongst 20 different communities. Newport has the second highest proportion of population from a BME background in Wales and is an asylum seeker dispersal area.

Newport East NCN team: Leah MacDonald, Louise Williams, Nicola Cook, Kate Hopkins, Daniel Kendall and Maxine Spoke at Victoria House/ 19 Hills Health & Wellbeing Centre, Newport.

There are nine GP practices which operate in the Newport East Cluster area:

- Beechwood Primary Care Centre
- Lliswerry Medical Centre
- Park Surgery
- Ringland Health Centre
- The Rugby Surgery
- Underwood Health Centre
- Richmond Clinic
- Isca Medical Centre
- St Julians Medical Centre

Services within the cluster (GP/other contractors/ community services)

- 9 GP Practices
- 7 Dental practices
- 7 Optometrists
- 15 Community Pharmacies

What are we working on?

Building Resilient Communities

Creating place-based care models and preventative approaches to service delivery in order to help improve the resilience of local communities.

Place-based care is a method of delivering care that focuses on the resources available in a specific area to improve health and reduce health inequalities via:

- Collaboration
- Shared resources
- Local design
- Targeted interventions
- Efficient use of resources

Place-based care can lead to positive outcomes, such as: fewer visits to accident and emergency, reduced waiting times for health assessments, higher satisfaction with the support received, and improved value for money.

Building resilient communities involves developing the capacity of individuals and communities to respond to emergencies and other challenges. Some strategies for building resilience include:

- Empowering communities
- Improving access to services
- Involving vulnerable groups
- Improving employment skills
- Developing social networks
- Supporting mental health
- Learning new things
- Being aware of biases

What are the key achievements?

19 Hills Health & Wellbeing Centre

The £28million health and wellbeing development is due for handover to the health board on 28th November 2024. There will be a phased approach to services being provided from the building between January and March 2025. The services that will be available are:

- Ringland Medical Practice
- Park Surgery
- Community Dental Services
- General Dental Services
- Mental Health Support Services
- Podiatry
- Speech & Language Therapy
- Health Visiting
- School Nursing
- Sexual Health
- Lymphedema
- Child and Family Psychology
- District Nursing
- Audiology
- Memory Assessment
- Child and Adolescent Mental Health Services
- Dietetics
- Weight Management
- Looked After Children

Sustainability

To continue to strive to create a sustainable health and social care workforce that will be able to meet the needs of the population in the immediate term and for the foreseeable future.

Continue to support and fund statutory and non-statutory services, to reduce the impact on GP time for example:

- Psychological Health Practitioners
- NCN Practice Based Pharmacists
- Link Workers

Accelerated Cluster Development

Professional Collaboratives (PCs) are networks of professionals with common expertise and skills who work collectively to assess the needs of the population.

- Paediatric Recovery from Illness
- Adferiad
- Community Liver Clinic
- Community Wellbeing groups

The aim of the centre is to:

- Ensure healthcare services are provided from high quality, fit for purpose buildings
- Bring healthcare professionals, third sector and other providers under one roof to ensure, a coordinated approach to health and wellbeing.

Aneurin Bevan University Health Board, together with Newport City Council and our third sector partners, the Health and Wellbeing Centre will form part of a vibrant community hub which will be available to Newport East residents



Newport NCN (East)

Cluster/NCN Lead

Newport East:
Dr Graeme Yule
Graeme.Yule2@wales.nhs.uk

What is next?

Workforce

- Strengthen the existing workforce to ensure business continuity. Fostering employee engagement by developing and supporting employees and transferring knowledge through Continuing Professional Development. Identifying any gaps and actively looking to recruit to extended roles to bolster the existing workforce.
- If additional funding were to be made available to the NCN then staff resources could be increased within the placed based care team. Including links to IMTP.

Place Based Care

- The place-based care model will continue to be the overarching vehicle of driving and delivering NCN priorities within Newport. The NCN will continue to work in partnerships that are collaborative arrangements between organisations responsible for arranging and delivering health and care services and others with a role in improving health and wellbeing. The Newport Placed Based Care model will continue to identify roles that will compliment and strengthen the multi-disciplinary team process.
- To continue with the multi-disciplinary team model that people who have greater complexity and are most at risk of deterioration and adverse events, such as hospitalisation, to live safe, independent and fulfilled lives. This multi-disciplinary team approach will require care coordination and committed involvement of Reablement workers, Specialist Nursing teams, Clinical Pharmacists, Community Mental Health Team, Social workers, Occupational Therapists, Housing and Third sector organisations.

Newport Area v Places

- A Newport Estates Strategy has been created that provides a footprint of neighbourhoods within the city. This will provide a basis in identifying the correct balance between structures that enable the NCN to plan effective and efficient care for the local population whilst enabling the delivery of person-centred care to meet the needs of individuals within the context of their local community.
- Collaborative work is required with the Integrated Services Partnership Board (ISPB) going forward in terms of availability of data sets to improve preventative risk stratification and case identification to prioritise people with, for example, moderate or severe frailty. By analysing and linking unplanned care data sets it would then be possible to identify cohorts who could have been supported earlier in the community through proactive multi-professional support.

Social Prescribing/Community Connector

- To strengthen the multidisciplinary team via additional and varied roles. The role of a community connector has been identified as a link role that will be employed by Newport City Council and will sit within the Information, Assistance and Advice. They provide face to face appointments and will deliver a person-centred approach to empower patients to recognise their own needs, strengths and personal assets. The community connector will also act as the conduit in connecting patients with their own communities for support with their personal health and wellbeing. A Service Level Agreement has been created outlining the purpose and objectives of the role and a paper has been submitted to seek funding to allow a Community Connector pilot with Bellevue Surgery and Ringland Surgery.

Integrated Wellbeing Network

- Work closely with the Integrated Wellbeing Network and Gwent Association Voluntary Organisation (GAVO) and align priorities to improve wellbeing, supporting them to alter unhealthy behaviours and increase their resistance to disease.
- Work collaboratively with Integrated Wellbeing Network regarding Heritage & Health to promote collaboration within diverse communities in Newport to improve both understanding and access to health services and community support including community screenings, vaccinations and raise awareness of preventative health and wellbeing support. Diabetes, Dementia and women's health has been identified as priorities. In addition to delivering peer to peer workshops for Diabetes, Dementia and Women's Health, a need has been identified from community engagement to also provide to support to improve ground level resilience by:
 - o Training community leaders & interested individuals on Make Every Contact Count (MECC), Five Ways to Wellbeing, First Aid, Connect 5 & Screening, nutrition skills for life to deliver healthy lifestyle changes to their communities.
 - o Upskilling unpaid carers –such as training in basic life support particularly those caring for disabled children and other generic
- Work will continue to Identify and develop community-based 'centres' for well-being resources in the community.
- Ensure that community-based 'centres' can connect people with health and wellbeing resources, activities and other people/citizens to support their own wellbeing.
- To align the work of NCNs and Integrated Wellbeing Network to develop a deeper understanding of a community orientated model of primary care through community assets and local needs within the population, particularly for socially vulnerable or marginalised groups.
- To ensure NCNs have a good understanding of Integrated Wellbeing Networks in order to utilise community assets such as community groups and voluntary organisations that help people maintain or develop social support networks.
- To co-produce a 'social prescribing' model that connects people to activities, groups, and services in their community which can address their practical, social and emotional needs.

Prevention Programmes and Enhanced Services

- To establish high quality and equitable provision of supplementary/enhanced service across each NCN with an initial focus on intrauterine device (IUD), minor surgery, substance misuse, homelessness and asylum seeker and refugees.

To facilitate a collaborative approach in the prevention and management diabetes and wider cardiovascular disease (CVD) risk factors (including hypertension) to ensure that these programmes can be delivered systematically and at scale across NCNs.

Chronic Conditions

To continue to monitor local rates of chronic conditions via the Population Needs Analysis data. Diabetes in adults has increased by 40% to 212,716 in 2021/22. Newport has the highest prevalence of 8.7% which is the highest in Wales and thus diabetes has been determined as one of the divisions key priorities. Aiming to reduce the number of adults living with diabetes.

Mental Health

To continue to support the local population mental health issues and reduce the demand upon General Medical Services (GMS) in this area.

Professional Collaboratives

To provide professional leadership for collaboration or working at scale to create greater stability and to deliver contracted services more efficiently and effectively.

Population Communication & Engagement

To continue to engage with the population in relation to health and wellbeing.



Newport NCN (East)

Cluster/NCN Lead

Newport East:

Dr Graeme Yule

Graeme.Yule2@wales.nhs.uk

Newport NCN (West)

Who are we?

In Newport, there are two NCNs serving a population of approximately 164,702 people. It is a city of two halves, where the most affluent meet the most deprived. There are over 48 different languages spoken here amongst 20 different communities. Newport has the second highest proportion of population from a BME background in Wales and is an asylum seeker dispersal area.

There are 7 GP practices which operate in the Newport West Cluster area:

- Malpas Brook Health Centre
- Westfield Clinic
- The Rogerstone Practice
- Bryngwyn Surgery
- St David's Clinic
- Bellevue Surgery
- St Paul's Clinic

Services within the cluster (GP/other contractors/ community services)

- 7 GP Practices
- 9 Dental practices
- 5 Optometrists
- 12 Community Pharmacies

What are we working on?

Building Resilient Communities

Creating place-based care models and preventative approaches to service delivery in order to help improve the resilience of local communities.

Place-based care is a method of delivering care that focuses on the resources available in a specific area to improve health and reduce health inequalities via:

- Collaboration
- Shared resources
- Local design
- Targeted interventions
- Efficient use of resources

Place-based care can lead to positive outcomes, such as: fewer visits to accident and emergency, reduced waiting times for health assessments, higher satisfaction with the support received, and improved value for money.

Building resilient communities involves developing the capacity of individuals and communities to respond to emergencies and other challenges.

Case Studies for Place Based Care

There are a number of case studies available that show how the Place Based Care team and overall approach has been supporting people with complex needs.

Some strategies for building resilience include:

- Empowering communities
- Improving access to services
- Involving vulnerable groups
- Improving employment skills
- Developing social networks
- Supporting mental health
- Learning new things
- Being aware of biases

Sustainability

To continue to strive to create a sustainable health and social care workforce that will be able to meet the needs of the population in the immediate term and for the foreseeable future.

Continue to support and fund statutory and non-statutory services, to reduce the impact on GP time for example:

- Psychological Health Practitioners
- NCN Practice Based Pharmacists
- Link Workers

Professional collaboratives

To continue the development of professional collaboratives to strengthen multi-professional involvement in the design and implementation of new roles and models of care delivery.



Newport NCN (West)

Cluster/NCN Lead

Newport West:

Susan Thomas
Susan.Thomas30@wales.nhs.uk

Priority area of focus – NCNs/IWNs	What we intend to achieve in the next 2 years
MDT working for people with complex needs, including (but not exclusively) people with moderate or severe frailty	To enable people with complex needs to live safe, independent and fulfilled lives at home and minimise their risk of adverse events due to their illness or social circumstances, including avoidable hospital attendances and admissions which often result in deconditioning and irreversible loss of functional and physical ability.
Premature morbidity and mortality from diabetes and cardiovascular risk factors	To enable people to reduce their risk of premature mortality from cardiovascular disease through hypertension case finding, optimising blood pressure management, preventing onset of diabetes and reduce the risk of macrovascular and microvascular complications in people with a diagnosis of type 2 diabetes.
Connecting people to non-medical activities, groups, and services in their community	To improve mental and physical wellbeing by connecting people to non-medical services, groups and activities in their local community which offer emotional support, social connections, opportunities to become more active or provide practical assistance for causes of poor health such as housing, unemployment, relationship or financial problems.
Equitable access to enhanced or supplementary services	To ensure people have high quality and equitable access to supplementary/enhanced services with an initial focus on IUCD fitting, minor surgery, substance misuse, homelessness, asylum seeker and refugees.
Behaviour change support	To ensure people have timely access to individual, group and self-directed behaviour change support at a scale that is likely to achieve population impact.
Community engagement and capacity building	To mobilise and enhance community assets and empower people to lead initiatives that enhance social support networks and community resilience.

What are the key achievements?

Community Engagement – Health Fayres

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 in the and community venues in Newport West, in order to engage with communities that recorded lower uptake in vaccinations and screening.

The main focus of the events was:

- Coronary vascular disease
- Hepatitis screening and advice
- General health advice
- Flu & Covid 19 vaccinations
- Childhood vaccinations
- Screening programmes

Place Based Care

- The place-based care model will continue to be the overarching vehicle of driving and delivering NCN priorities within Newport. The NCN will continue to work in partnerships that are collaborative arrangements between organisations responsible for arranging and delivering health and care services and others with a role in improving health and wellbeing. The Newport Placed Based Care model will continue to identify roles that will compliment and strengthen the multi-disciplinary team process.
- To continue with the multi-disciplinary team model that people who have greater complexity and are most at risk of deterioration and adverse events, such as hospitalisation, to live safe, independent and fulfilled lives. This multi-disciplinary team approach will require care coordination and committed involvement of Reablement workers, Specialist Nursing teams, Clinical Pharmacists, Community Mental Health Team, Social workers, Occupational Therapists, Housing and Third sector organisations



Newport NCN (West)

Cluster/NCN Lead

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Susan.Thomas30@wales.nhs.uk

What is next?

Workforce

- Strengthen the existing workforce to ensure business continuity. Fostering employee engagement by developing and supporting employees and transferring knowledge through Continuing Professional Development. Identifying any gaps and actively looking to recruit to extended roles to bolster the existing workforce.
- If additional funding were to be made available to the NCN then staff resources could be increased within the placed based care team. Including links to IMTP

Facilities and Estates

- A Newport Estates Strategy has been created that provides a footprint of neighbourhoods within the city. This will provide a basis in identifying the correct balance between structures that enable the NCN to plan effective and efficient care for the local population whilst enabling the delivery of person-centred care to meet the needs of individuals within the context of their local community.

Data and Intelligence

- Collaborative work is required with the Integrated Services Partnership Board (ISPB) going forward in terms of availability of data to improve risk stratification and case identification to prioritise people with, for example, moderate or severe frailty. By analysing and linking unplanned care data sets it would then be possible to identify cohorts who could have been supported earlier in the community through proactive multi-professional support.

Social Prescribing/Community Connector

- Strengthen multidisciplinary team worker through additional link worker roles. The role of a Community Connector has been identified as a link worker role that will be employed by Newport City Council and will sit within the Information, Assistance and Advice. They provide face to face appointments and will deliver a person-centred approach to empower patients to recognise their own needs, strengths and personal assets. The Community Connector will also act as the conduit in connecting patients with their own communities for support with their personal health and wellbeing. A Service Level Agreement has been created outlining the purpose and objectives of the role and a paper has been submitted to seek funding to allow a Community Connector pilot with Bellevue Surgery and Ringland Surgery.

Integrated Wellbeing Network

- Work closely with the Integrated Wellbeing Network and Gwent Association Voluntary Organisation (GAVO) and align priorities to improve wellbeing, supporting them to alter unhealthy behaviours and increase their resistance to disease.
- Work collaboratively with Integrated Wellbeing Network regarding Heritage & Health to promote collaboration within diverse communities in Newport to improve both understanding and access to health services and community support including community screenings, vaccinations and raise awareness of preventative health and wellbeing support. Diabetes, dementia and women’s health has been identified as priorities. In addition to delivering peer to peer workshops for these health issues, a need has been identified from community engagement Cluster/NCN Lead to also provide to support for community resilience by:
 - o Training community leaders & interested individuals on Make Every Contact Count (MECC), Five Ways to Wellbeing, First Aid, Connect 5 & Screening, nutrition skills for life to deliver healthy lifestyle changes to their communities
 - o Upskilling unpaid carers –such as training in basic life support particularly those caring for disabled children and other generic

- Work will continue to Identify and develop community-based ‘centres’ for well-being resources in the community.
- Ensure that community-based ‘hubs’ can connect people with health and wellbeing resources, activities and other people to support their own wellbeing.
- Align the work of NCNs and Integrated Wellbeing Network to develop a deeper understanding of a community orientated model of primary care through community assets and local needs within the population, particularly for socially vulnerable or marginalised groups.
- Ensure NCNs have a good understanding of Integrated Wellbeing Networks in order to utilise community assets such as community groups and voluntary organisations that help people maintain or develop social support networks.
- Co-produce a ‘social prescribing’ model that connects people to activities, groups, and services in their community which can address their practical, social and emotional needs.

Prevention Programmes and Enhanced Services

- To establish high quality and equitable provision of supplementary/enhanced service across each NCN with an initial focus on intrauterine device (IUD), minor surgery, substance misuse, homelessness and asylum seeker and refugees.
- To facilitate a collaborative approach in the prevention and management diabetes and wider cardiovascular disease (CVD) risk factors (including hypertension) to ensure that these programmes can be delivered systematically and at scale across NCNs.

Chronic Conditions

To continue to monitor local rates of chronic conditions via the Population Needs Analysis data. Diabetes in adults has increased by 40% to 212,716 in 2021/22. Newport has the highest a prevalence of 8.7% which is the highest in Wales and thus diabetes has been determined as one of the divisions key priorities. Aiming to reduce the number of adults living with diabetes.

Mental Health

To continue to support the local population mental health issues and reduce the demand upon General Medical Services (GMS) in this area.

Professional Collaboratives

To provide professional leadership for collaboration or working at scale to create greater stability and to deliver contracted services more efficiently and effectively.

Population Communication & Engagement

To continue to engage with the population in relation to health and wellbeing.

Torfaen Integrated Service Partnership Board (ISPB)

Who are we?

The Torfaen ISPB is jointly chaired by the Health Board and Local Authority.

- Since the transformation of the approach from TIP into ISPB, the key success factor has been the breadth of knowledge of partners involved and harnessing this to drive an overall position of system improvement for the residents of Torfaen. This has been achieved through ensuring partners are all actively engaged in setting the vision in workshops during meetings and having a range of programmes that utilises experience of partners – for example, tackling our frequent attenders to ED has drawn in colleagues from WAST, Police, Third Sector, Health and Social Care.
- The partnership would benefit from delegated funding to mobilise programmes of work at pace; as the partnership is committed to embedding a place based care approach. It is sometimes challenging to bid into funding streams which advocate for a regional approach.
- Torfaen ISPB consists of key partners who play a significant role in the successful functioning of the health and social care system within the borough, since re-establishing in 2023 the focus of the ISPB has primarily been weighted towards the adult part of the system and partners in attendance reflect this. The partnership is serviced by colleagues from Primary Care, Therapies, Public Health, Adult Social Care, Community Regeneration (which includes Libraries and Community Centres), WAST, Housing Associations, Police, Torfaen Voluntary Alliance (TVA) and Citizens Advice Bureau.
- Following success within the adult system, the ISPB is rolling out the approach to Children and Young people and in March 2025 will be undertaking a workshop to agree areas of work for the forthcoming financial year. This is an area of priority for the partnership, as Torfaen has the highest population of looked after children per 10,000 in Europe. The workshop aims to bring together colleagues already linked to the ISPB and attract new specialist input for Health Visiting, School Nursing, Education and Youth Services.

Torfaen is located in the south-east of Wales and borders the city of Newport to the south, the county of Monmouthshire to the east and the county boroughs of Caerphilly and Blaenau-Gwent to the west and northwest. Torfaen has an area of 126km² and is the 3rd smallest borough in Wales with a population of around 92,300.

Geographically the area runs from the Heads of the Valleys in the north to the M4 corridor in the south and there are three main settlements along the way - Blaenavon, Pontypool and Cwmbran. Torfaen is the most easterly of the industrial valleys of South Wales with the settlements in the north and middle of the borough originally established to exploit the abundant non-renewable charcoal, coal and iron resources in the area. As those heavy industries declined over the past 100 years, so did the prosperity of those areas.

Today the World Heritage Site town of Blaenavon has around 6,000 population and is furthest north in the Borough. Blaenavon is famous for the Big Pit coal mining museum and Europe's best preserved 18th century ironworks.

The former industrial town of Pontypool with its traditional indoor and outdoor market is the next largest settlement located in the heart of the borough, and including the various communities that surround it, has a population of around 37,100.

In the south of the borough, Cwmbran is unique in being the only New Town in Wales, being designated in 1949 and was designed as a distinctive, progressive and modern town offering new opportunities for its residents. Much of the southern parts of the county borough are now urbanised around Cwmbran, which has the largest population of each of the three settlement areas with around 48,700. Cwmbran Shopping Centre attracts the largest number of shopping visitors with 17 million customers a year from the wider area of Gwent and the M4 corridor.

What are we working on?

The Torfaen ISPB priorities are:

- Ensuring full engagement of the third sector
- Integrated workforce for the future
- Place Based Working
- Redesigning services for older people
- Ensure fit for purpose estate
- Enhanced financial scrutiny across the system

What are the key achievements?

Torfaen ISPB aims to:

- Understand the population needs including key priorities.
- Understand professional assessment of service pathway gaps, barriers and opportunities articulated by clusters/ professional collaboratives and local authority services.
- Development of an aligned ISPB delivery plan that pulls together the priorities across the system.
- Provide system leadership which enables collaboration between partner organisations across health and social care to identify and meet the needs of the local population.
- Undertake integrated planning based on detailed assessment of needs and operational plans which set common ambitions between partners for integrated service delivery, service developments.

and opportunities for delivery of integrated community-based care to Torfaen residents.

- Support and influence the development an Integrated Workforce Plan which reflects both the local sustainability of services and the ambitions of Torfaen.
- Based on need, jointly commission a suite of services from organisations that can deliver innovative, outcomes-based services, based upon need as identified within the Integrated Torfaen Plan.
- To enable delivery of services to realise the objectives and actions outlined in the Integrated Torfaen Plan. This will include the selection of information based on existing data to create the framework for the ISPB and provide a baseline for monitoring in programmes of work.
- To create a culture which motivates all partners within Torfaen use an innovative approach and intelligence to drive continuous improvements in the provision of integrated services.
- To identify, monitor and seek assurance that actions are in place to mitigate risks to partnership working and the delivery of the priorities outlined in the plan.

The partnership has been successful in overseeing the development and implementation of;

- Integrated Reablement redesign – ensuring that at the point of accessing social care from either the community or from a hospital discharge reablement rather than a long term service is offered/trialed, reducing dependency on long term service provision and creating capacity in the domiciliary care market.
- Revised IAA approach within TCBC and wholesale review of communities approach to reprofile 'community' as the offer.
- Torfaen approach to reducing Pathway of Care Delays in line with Care Action Committee targets Priority 1 on total delays, assessment delays and days delayed.

Linked to this, Housing colleagues have provided a pathway for support for patients who would potentially delay with a housing issue.

- Establishing a working group to review high intensity users and establishing alternative arrangements to presentation at ED.
- Transport project for the North of the Borough to support residents to access health services
- Housing project with CAB, linking post-code data on patients with a respiratory condition to housing associations to tackle fuel poverty and property condition.



Torfaen ISPB (North & South)



Torfaen ISPB (North & South)

The key achievements have been:

Early Intervention and Prevention through Place Based Care

- Integrated Community Reablement Service
- Blaenavon Resource Centre
- Wesley Street Family Resource Centre

Maximising our Assets

- Gwent House, Cwmbran Town Centre
- County Hospital Redesign

Sustainability of our Community Services

- Children's service – in terms of locality care provision and Welsh Government ambition around eliminating profit in care
- Older Adult Service Redesign – in terms of a graduated approach from Information, Advice and Assistance through to prevention and early intervention and long-term specialist care
- Mental Health pathways – stepped model of care from mental wellbeing through to specialist mental health service

Integrated Wellbeing Networks

- Building resilience and capacity with community
- Mapping and networking community assets
- Creating a network of neighbourhood "hubs" where people can access support, activities and groups
- Maintaining the Torfaen Connect directory of wellbeing service

What is next?

Priorities going forward are to:

- Review and recruit to the Integrated Wellbeing Network Lead role to further develop the programme.
- Expand on our CRT unit support within the community, working collaboratively in community settings.
- Ensure that services have the flexibility to meet individual needs
- Improve access to specialist expertise.
- Provide a positive experience for patients and carers.
- Ensure a supportive working environment and career development opportunities for our staff, creating a culture that motivates.



Torfaen NCN (North & South)

Who are we?

Eryl is the NCN Lead for Torfaen with an area of responsibility for Family and Therapies and Women's Health. In her years as NCN Lead, Eryl has led a care home alignment that has transformed care home residents' care and increased cluster collaboration by creating the Torfaen Pharmacy and Practice Pharmacist Network. With a pharmacy background, Eryl is Lead Prescribing Advisor for the ABUHB Medicines Management team. She is member of both the All Wales Prescribing Advisory Group and the Pharmacy Delivering a Healthier Wales Delivery Group.

The Torfaen Locality Team includes: **Head of Service**
Assistant Head of Service, Network & Community Manager,
Service Improvement Manager, Business Support Officer

Torfaen has a population of 98,300 people. 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.

There are 11 GP practices which operate in the Torfaen area:

- Blaenavon Medical Practice
- Oak Street Surgery
- New Chapel Street
- Cwmbran Village/ Llanymaenan Surgery
- Clark Avenue Surgery
- Nant Dowlais Health Centre
- Panteg Health Centre
- Trosnant Lodge
- Abersychan Group Practice
- Pontypool Medical Centre

Services within the cluster (GP/other contractors/ community services)

- 11 GP Practices
- 13 Dental practices
- 11 Optometrists
- 21 Community Pharmacies

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 aims to provide a more integrated place-based care system involving primary care, community and wellbeing services offering co-ordinated care, closer to home with collaboration of professional skills across multi-disciplinary teams.

Torfaen has increased collaborative working across the NCN aiming to strengthen community resilience, respond to population need, and deliver patient-centred care through its 3 key workstreams:

1. Prevention, Wellbeing and Self-care
2. Access and Sustainability
3. Integrated Primary and Community Care

What are we working on?

Top 3 priorities for Torfaen north and South NCNs in 2024/25

1. Sustainability of services across the NCN

- CATCH providing support for GP practices.
- Gwent House and Trevethin estates to support additional services and reduce demand in practice.
- Cluster Pharmacist improving medicines safety.
- Engagement with Medicines Management team to address and improve outlier prescribing.
- Psychological Health Practitioners (PHP's) providing access to mental health advice and support within GP practices.
- Luton Model rollout and promotion of extended prescription intervals.
- Continue to identify services, technology and innovation to help aid access and sustainability for General Practice and community services such as AccuRx and Choose Pharmacy platform.
- Continue improvement and equitable provision of Enhanced Services.

2. Accelerated Cluster Development - Professional Collaboratives and Multidisciplinary Working

- Capture the knowledge and experience of the NCN, ISPB and, once appointed, IWN team to map service provision, identify gaps and develop community orientated solutions and networks using community assets according to population need.

- Professional Collaboratives inform NCN decision making.
- Care Navigation signposting to local services to ensure the right care at the right time at practice level to be cascaded via ISPB and professional collaboratives.
- Reducing health inequalities CVD Outreach in - Torfaen ISPB project.
- Community Pharmacy Independent Prescribing clinic GP practice booking system pilot.
- Robust governance arrangements for NCN funding, SLAs and evaluation of services.

3. Building Resilient Communities

- Local needs analysis to identify priorities and develop effective solutions.
- Promoting referral and increasing access to specialist roles in the community such as Palliative Care services, Diabetic and Respiratory Specialist Nurses.
- Community Connectors link individuals with local groups, activities and organisations to support physical and mental wellbeing.
- Highlighting preventative services to keep citizens well including influenza immunization, childhood immunisation, smoking cessation services, weight management services and exercise referral schemes.



Torfaen NCN (North & South)

Cluster/NCN Lead

Torfaen

Eryl Smeethe
Eryl.Smeethe@wales.nhs.uk

CASE STUDY

Our Healthy Homes Initiative involves working with GP practices in the area to identify patients who may benefit from intervention provided by Care & Repair.

We contact patients and invite them to reach out to Care & Repair who will undertake a face-to-face assessment to identify how they might benefit from the service.

The scheme offers fully funded home adaptations to elderly patients in need of support to reduce the risk of falls and help them remain safe, warm, secure and happily independent in their own homes. Since the inception of this scheme, almost 900 people have benefitted from minor home adaptations and over £230,000 in welfare benefits that have been identified and subsequently claimed for.

Aneurin Bevan University Health Board (ABUHB)



Torfaen NCN (North & South)

Cluster/NCN Lead

Torfaen
Eryl Smeethe
Eryl.Smeethe@wales.nhs.uk

What are the key achievements?

Members of the Torfaen NCNs have received the following recognition and award in the last year.

- Dr Esther Okafor of Panteg Health Centre won GP of the Year at the South Wales Argus Health & Care Awards 2024.
- Layanson Pharmacy won Pharmacy of the year at the South Wales Argus Health & Care Awards 2024.
- Torfaen North district nursing team in Blaenavon received a nomination by a patient or relative for the Health Board's recognition awards.
- Panteg Health Centre staff received a Certificate of Recognition Patient Choice Award at the Staff Recognition Award 2024.

The team at Trevethin Health Centre were finalists for the Health & Wellbeing award at the South Wales Argus Health & Care Awards 2024.

What have we learnt?

The Torfaen CATCH team support GP practices throughout Torfaen by undertaking home visits and comprehensive geriatric assessments for care home residents.

The benefits of the CATCH Nurse clinical assessment include:

- Increased time to provide a holistic assessment for each patient with diagnostics.
- Identification of new clinical or medication issues.
- Time to discuss future case wishes with patients and their families.
- Time to support and advice care home staff on best practice.

Throughout the year, the CATCH team have become further imbedded in service provision in the area, strengthening relationships with both patients and our partner organisations.

- Highly valued service in Torfaen.
- 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.
- Supporting care homes with the Care Home Directed Enhanced Service to ensure equity of provision across Torfaen.

What could have been done differently

There are 3 ongoing challenges:

1. Budget

- Limited NCN budgets prevents large scale projects.
- NCN budget is committed on a recurrent basis.
- NCN funded projects that have been well evaluated have not been transitioned to core funding which limits opportunities for investment in new initiatives.
- Financial pressure on independent contractors due to inflation pressures and pay uplifts.

2. Sustainability

- Workforce retention and recruitment issues across primary care and community teams.
- Aging workforce and retirements pose a threat to the sustainability of current models
- Issues with the recruitment of particular roles, such as GP partners, practice nurses and advanced nurse practitioners
- Dental access and a GDS practice closure
- Regular high escalation levels within GMS practice
- Patient awareness of appropriate services

3. Accelerated Cluster Development – Professional Collaboratives

- Moving beyond the transition phase into full development and understand roles and responsibilities proves challenging at times.
- Early stages of maturity.
- Limited representation where engagement is non-contractual.
- Membership of the professional collaboratives is mostly senior staff and there is a need for more widespread engagement.
- Lack of optometry lead in South Torfaen.
- Regular venues to secure collaborative meetings.

Including links to IMTP

As a Health Board the priority areas for the Primary Care and Community Services Division over the period 2025/26 will be to progress and deliver on the following areas:

- Long Term Conditions – Management & Prevention
- Access & Sustainability
- Redesigning of Older Persons Services
- NCN Development & Partnerships

What is next?

The NCNs priorities are to:

- Improve the health and wellbeing of the local population and reduce health inequalities.
- Support sustainability of independent contractors
- Enable people to stay well and lead healthier lives for longer.
- Reduce health inequalities.
- Establish MDT working for people who have greater complexity and are most at risk of deterioration and adverse events such as hospitalisation.