

Social Services & Well-being Act

Population Needs Assessment Gwent Region Report



Greater Gwent Health, Social Care &
Well-being Partnership

Partneriaeth Lles, Iechyd a Gofal
Cymdeithasol Gwent Fwyaf

Index

1	Foreword	5
2	Introduction	6
3	Outcome Priorities	12
4	Demography	12
5	Section 1	
	■ Engagement	18
	Core Themes	
	■ Children and Young People	28
	■ Older People	34
	■ Health & Physical Disabled People	39
	■ People with Learning Disabilities and Autism Spectrum Disorders	46
	■ Mental Health	52
	■ Sensory Impairment	59
	■ Carers who need support	65
	■ Violence against women, domestic abuse and sexual violence.	69
6	Section 2	
	■ Service Mapping	74
	■ Health and Social Care Integration	76
	■ Joint Commissioning & Pooled Budgets	77
	■ Preventative Services	79
	■ Information Advice and Assistance (IAA)	82
	■ User led services and the Third Sector	83
	■ Workforce Development	84
	■ Links to national groups	85
	■ Advocacy	85
	■ Transitions	87
	■ National Outcome Framework	87
	■ Equality Impact Assessment	88
	■ Links to Well-being of Future Generations Act	88
	■ Secure estates	89
	■ Safeguarding and links to regional groups	89
7	Next steps & Joint Area Plan	91
	■ Appendix	97

Working in Partnership



Bwrdd Iechyd
Aneurin Bevan
Health Board



How to view this Population Needs Assessment (PNA)

‘What it is and what it is not!’

- 1 The PNA is not an exhaustive list of graphical data but includes appendices where further data is included.
- 2 The PNA will include links to other supporting information such as the local Well-being Assessments required under the Well-being of Future Generations Act - we do not want to duplicate large sections of information in the PNA which is included in other documents.
- 3 The PNA uses a national toolkit developed by Welsh Local Government Association (WLGA) and Social Services Improvement Agency (SSIA).
- 4 The PNA will not include or reference every data source available - as it will simply be too large, but we will use the Social Services and Well-being Act data catalogue developed by Data Unit Wales as a starting point.
- 5 The PNA is based on the views of citizens and providers, and co-production is a core design principle. Citizens and providers helped identify the priority outcomes under each core theme.
- 6 The PNA will use the latest research. The PNA is not adopting a ‘blank canvas’ approach as there are a number of previously completed, and current, needs assessments and market position statements that include useful intelligence. Also, national reports such as NHS Adverse Childhood Experiences provide invaluable data that the PNA will incorporate, but not replicate.
- 7 The core theme chapters will read as executive summaries and highlight regional priorities and also high level partnerships and services that can support the agenda.
- 8 The core theme chapters will also include a list of suggested actions to be included in the underpinning joint Area Plan required following the publication of the PNA – again this list is not exhaustive but a starting point and will be developed further when producing the joint Area Plan.
- 9 The PNA is the first of its kind and will set the direction of travel for health and social care services - it is the ‘shop window’ in terms of priorities and next steps - and more detailed analysis, mapping of services and actions will be set out in the joint Area Plan required by April 2018.

Foreword

The Gwent Health Social Care and Well-being Partnership is pleased to publish the region’s first Social Services and Well-being Act Population Needs Assessment which will be central to promoting Well-being, supporting people at the earliest opportunity to maintain their independence and to help people to better help themselves.

We are living in a time of enduring austerity and the priorities that we identify and work in partnership to deliver, will also need to ensure that services are sustainable now and in the future. This needs assessment presents not only the level of need across the region, but also provides the region’s response to the identified need as well as proposing the next steps required to meet those needs. The Gwent Regional Partnership will now translate words into action through good partnership working and shared goals and aspirations.

Finally, to ensure this needs assessment will have the desired impact we need to engage with our citizens and we are pleased that so many people and partners have taken part in our pre-engagement and consultation activities to help us identify what matters most. We believe that engagement is not a process but a culture, and we will continue to engage every step along the way through our various panels and existing partner agency groups.

Phil Robson Chair of the Gwent Regional Partnership Board
Interim Vice Chair of Aneurin Bevan University Health Board

Chair of Citizen Panel

The Gwent Citizen’s Panel were very pleased to receive a presentation on the Population Needs Assessment in July 2016. This was welcome confirmation that service needs and priorities were being taken very seriously. It also provided a level of understanding of the assessments that allowed panel members to go back to groups in their localities and broadcast the assessments for completion.

My own linked group, Caerphilly Over 50s Forum, spent some time discussing the PNA at our Steering Group and we were able to submit a comprehensive assessment covering all aspects where we felt the older person’s interests and priorities were important. We recognised the size of the task in reaching out to collect the data but were very pleased to take part in the process. A quote from our meeting: “This is hard work - let’s hope they are listening.”

Chris Hodson
Chair, Citizen’s Panel

INTRODUCTION

What is the Population Needs Assessment Report?

The Social Services and Well-being Act (Act), in Part 2, section 14, requires that local authorities and local health boards must jointly carry out an assessment of the needs for care and support, and the support needs of carers in the local authority areas. Care and support is in relation to people known to Social Services but we also need to recognise that there are a large number of people who are supported through preventative services and initial research has estimated that this could be approximately 1 in 5 people. A population needs assessment report should comprise two sections:

Section 1: The assessment of need

Local authorities and Local Health Boards must jointly assess:

- the extent to which there are people in the area of assessment who need care and support
- the extent to which there are carers in the area of assessment who need support
- the extent to which there are people whose needs for care and support (or, in the case of carers, support) are not being met

The PNA report must include specific core themes dealing with:

- children and young people
- older people
- health / physical disabilities
- learning disability/autism
- mental health
- sensory impairment
- carers who need support; and
- violence against women, domestic abuse and sexual violence.

Section 2: The range and level of services required

Local authorities and Local Health Boards must jointly assess:

- the range and level of services required to meet the care and support needs of the population and the support needs of carers
- the range and level of services required to prevent needs arising or escalating; and
- the actions required to provide these services through the medium of Welsh.

Under the Social Services and Well-being Act, the 5 local authorities within the Aneurin Bevan University Health Board (ABUHB) footprint - Blaenau Gwent, Caerphilly, Monmouthshire, Newport and Torfaen - must form a partnership arrangement with the ABUHB and produce a single combined population needs assessment report (PNA).

In addition the PNA must:

- Be produced once per local government electoral cycle and across the ABUHB footprint
- Contain the population assessment for each of the local authority areas but also combine these assessments to produce a single regional assessment of the needs of the people in the whole of the Local Health Board's area
- Include an assessment of the range and level of services required to meet those needs
- Demonstrate clearly the extent to which the core themes are concentrated or diffused across the partnership
- Keep population assessment reports under review and revise them if required.

The first population assessment will be published in April 2017 and the **Leadership Group (via the regional Transformation team)**, which is the executive officer group that reports to the Regional Partnership Board (RPB) will co-ordinate this work. **The RPB will act as a joint committee to oversee the process.**

Definition of Well-being

It is recognised that the PNA will need to link to Well-being Assessments required under the Well-being of Future Generations Act. Although the definition of well-being is slightly different in each Act, there are synergies to gain, and duplication to avoid by linking the assessments.

Section 2 of Part 1 of the Act provides a clear definition of well-being that applies to:

- a) People who need care and support; and
- b) Carers who need support.

Reference to well-being in the Act means the well-being of a person who needs care and support and carers who need support in relation to any of the following aspects:

- a) Physical and mental health and emotional well-being
- b) Protection from abuse and neglect
- c) Education, training and recreation
- d) Domestic, family and personal relationships
- e) Contribution made to society
- f) Securing rights and entitlements
- g) Social and economic well-being
- h) Suitability of living accommodation.

In relation to a child, “well-being” also includes:

- a) Physical, intellectual, emotional social and behavioural development
- b) “welfare” as that word is interpreted for the purposes of the Children Act 1989.

In relation to an adult, “well-being” also includes:

- a) Control over day to day life
- b) Participation in work.

An overarching Well-being 'duty' on LA's to seek to promote the Well-being of people who need care and support



Regional Partnership Board

As set out in the Partnership Arrangements (Wales) Regulations 2015 local authorities and local health boards are required to establish Regional Partnership Boards (RPB) to manage and develop services to secure strategic planning and partnership working; and to ensure effective services, and care and support are in place to best meet the needs of their respective population.

The objectives of the Regional Partnership Boards are to ensure the partnership bodies work effectively together to:

- Respond to the population assessment carried out in accordance with section 14 of the Act, and
- Develop, publish and implement the Area Plans for each region covered as required under section 14A of the Act
- Ensure the partnership bodies provide sufficient resources for the partnership arrangements, in accordance with their powers under section 167 of the Act
- Promote the establishment of pooled funds where appropriate.

Regional Partnership Boards (RPB) will also need to prioritise the integration of services in relation to:

- Older people with complex needs and long term conditions, including dementia.
- People with learning disabilities.
- Carers, including young carers.
- Integrated Family Support Services.
- Children with complex needs due to disability or illness.

Governance

The Regional Partnership Board (RPB) has considered a governance structure and partnership arrangements with existing groups that are well placed to lead on specific core themes across the PNA e.g. South East Wales Violence against Women, Domestic Abuse and Sexual Violence Board, Dementia Board, Carers Partnership Board, Mental Health and Learning Disability Local Partnership Board. The RPB will also explore partnership arrangements with wider regional groups such as local authority Public Service Boards – especially in relation to links to the Well-being of Future Generations Act - Gwent Area Planning Board for Substance Misuse, Gwent Welfare Reform Partnership, In One Place Programme and Housing Associations, as well as both Adult and Children’s regional safeguarding boards.

Area Plan

Each local authority and health board are required to prepare and publish a plan setting out the range and level of services they propose to provide, or arrange to be provided, in response to the population needs assessment. Area plans must include the specific services planned in response to each core theme identified in the population assessment.

As part of this, Area Plans must include:

- the actions partners will take in relation to the priority areas of integration for Regional Partnership Boards;
- the instances and details of pooled funds to be established in response to the population assessment;
- how services will be procured or arranged to be delivered, including by alternative delivery models;
- details of the preventative services that will be provided or arranged;
- actions being taken in relation to the provision of information, advice and assistance services; and
- actions required to deliver services through the medium of Welsh.

The first Area Plans must be published by 1 April 2018 and the RPB will ensure links between the Area Plan and the local authority Well-being Plans required under the Well-being of Future Generations Act to facilitate collaborative working between the 2 legislative duties and avoid duplication. Links to local authority Corporate Improvement Plans and ABUHB Intermediate Medium Term Plans will also be established, as well as alignment to the Neighbourhood Care Network plans in each of the GP cluster areas of which there are 12 in the Gwent region. The RPB will also work closely with Housing Associations in the region - recognising the key role they play in achieving well-being of tenants - and ensure an alignment to their delivery plans.

Links to strategies

Included in each core theme chapter is a link to key strategies. The list is not exhaustive but is representative of the key strategic drivers, and a comprehensive cross referencing will be completed when developing the Area Plans. However, links to wider legislation such as the Well-being of Future Generations (Wales) Act 2015, Housing (Wales) Act 2014 and the local housing strategies of Housing Associations, Violence against Women, Domestic Abuse and Sexual Violence Act 2015, Working Together To Reduce Harm (The Substance Misuse Strategy for Wales 2008 - 2018), Welsh Adverse Childhood Experiences (ACE) Study, Ageing Well in Wales the Strategy for Older People in Wales (2013/23) have been referenced whilst developing the draft PNA.

Links to Well-being of Future Generations Act

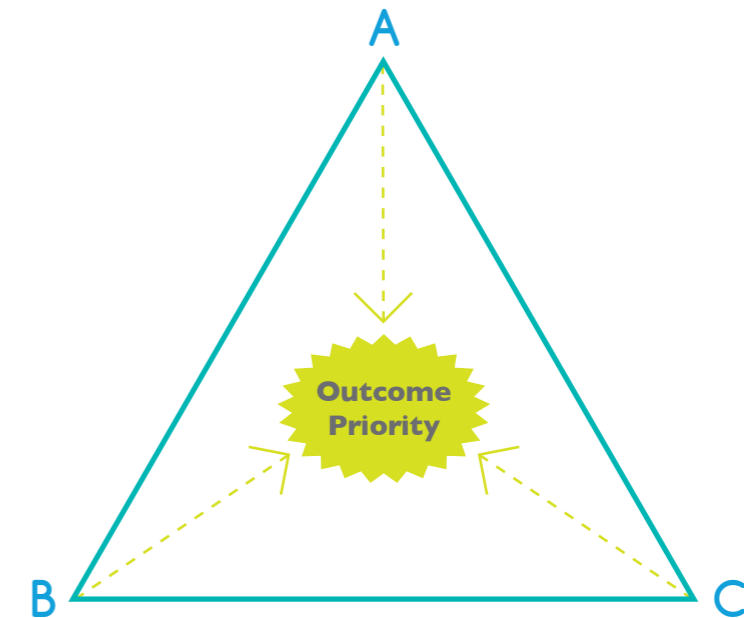
The Social Services and Well-being Act (the Act) shares similar principles with a number of national strategies and legislation. However, the Act shares almost identical principles with the Well-being of Future Generations Act with the main difference between the acts being the time frame: the PNA under the Act covers a 3-5 year period based on electoral cycle and the Well-being Assessment under the WFG Act covers a suggested period of 20-30 years.

Social Services and Well-being Act Principles	Sustainable Principles: Well-being of Future Generations
Services will promote the prevention of escalating need and the right help is available at the right time	Prevention: How acting to prevent problems occurring or getting worse
Partnership and co-operation drives service delivery	Collaboration: how acting in collaboration with any other person or any other part of an organisation could help meet Well-being objectives Integration: Consider how the proposals will impact on Well-being objectives, Well-being goals, other objectives or those of other public bodies
People are at the heart of the new system by giving them an equal say in the support they receive	Involvement: The importance of involving people with an interest in achieving the Well-being goals, and ensuring that those people reflect the diversity of local communities.
The Act supports people who have care and support needs to achieve well-being	Long term: the importance of balancing short- term needs with the need to safeguard the ability to also meet long - term needs

A task and finish group was established in Newport and led by Director for People to explore synergies across both acts. The group has identified and explored opportunities to align both population assessments, reduce duplication and identify areas of joint working/collaboration. The learning from the task and finish group has been used to design the methodology across the region; and also shared with Welsh Government. The analysis has also laid foundations for aligning the joint Area Plan and local Well-being Plans required under subsequent acts.

Social Services and Well-being Act Prioritisation Matrix 'Triangulation'

It is important that priorities are identified through sound reasoning and clear evidence which also delivers the Welsh Government's direction for public services at a local level. However, it is paramount that priorities reflect the local needs of communities and are identified through effective engagement and co-production with local people. To ensure all factors are considered, a 'Prioritisation Matrix' has been developed based on the 3 factors and we call this 'triangulating the priorities.'



- A Engagement - what have people told us?**
Needs identified by vulnerable groups, providers and wider population.
- B Data trends - What has the data told us?**
Is the data curve moving in an adverse direction and will it exacerbate or reach a critical level without intervention?
- C National policy and strategies - What are we expected to deliver?**
Are the outcome priorities representative of national drivers and is funding provided through national funding streams?

Following the identification of outcomes a 'Partnership working and resources test' is applied to ascertain if the outcomes require multi-agency input and would the outcome be achieved without intervention or resources? If the outcome cannot be achieved within existing resources/partnership working it is included as priority outcome.

Outcome Priorities

The outcomes identified through the engagement with citizens, practitioners, partners and confirmed through consultation and use of the prioritization matrix.

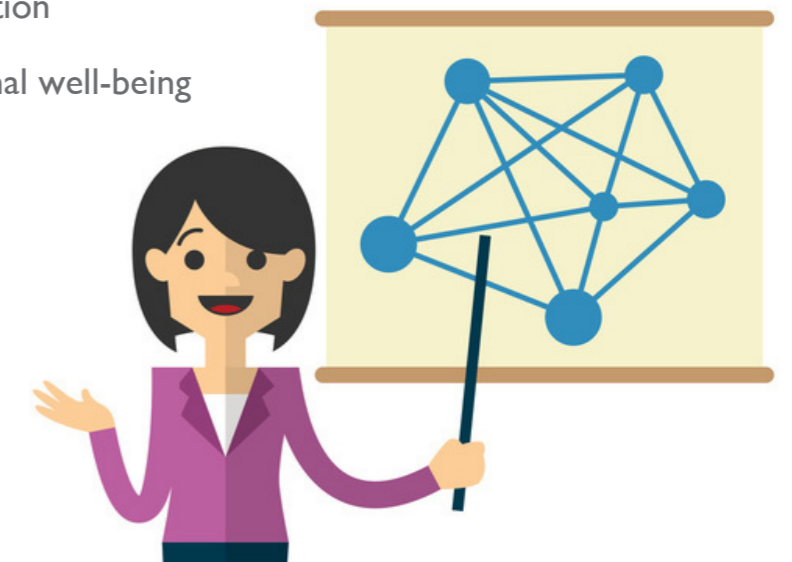
Core Theme	Outcome Priority
Children & Young People	<ul style="list-style-type: none"> To improve outcomes for children and young people with complex needs through earlier intervention, community based support and placements closer to home. To ensure good mental health and emotional well-being for children young people through effective partnership working.
Older People	<ul style="list-style-type: none"> To improve emotional well-being for older people by reducing loneliness and social isolation with earlier intervention and community resilience. To improve outcomes for people living with dementia and their carers. Appropriate housing and accommodation for older people.
Health & physical disabled people	<ul style="list-style-type: none"> To support disabled people through an all age approach to live independently in appropriate accommodation and access community based services, including transport. To help people reduce the risk of poor health and well-being through earlier intervention and community support.
People with Learning Disabilities and Autism Spectrum Disorders	<ul style="list-style-type: none"> To support people with learning disabilities to live independently with access to early intervention services in the community; and greater public awareness and understanding of people with learning disabilities needs. To provide more timely diagnosis of Autistic Spectrum Disorder and access to support services and information and advice.
Mental Health	<ul style="list-style-type: none"> Increased understanding and awareness of mental health amongst the public to reduce stigma and help people to seek support earlier. To improve emotional well-being and mental health for adults and children through early intervention and community support.
Sensory Impairment	<ul style="list-style-type: none"> Ensure people are supported through access to accurate information, assistance and 'rehabilitation' where required. Improve emotional well-being especially through peer to peer support.

Core Theme	Outcome Priority
Carers who need support	<ul style="list-style-type: none"> Support carers to care through flexible respite, access to accurate information, peer to peer support and effective care planning. Improve well-being of young carers and young adult carers through an increased public understanding.
Violence against women domestic abuse and sexual violence	<ul style="list-style-type: none"> Provide earlier intervention and safeguarding arrangements to potential victims through 'Ask and Act'. Safeguard victims, including men, through effective partnership support.

Cross-cutting priorities

A number of priorities were identified that cut across the core themes above and will require a multi-agency approach:

- Loneliness and social isolation
- Mental health and emotional well-being
- Support for carers
- Peer to peer advocacy
- Earlier support and community intervention



Demography - What does Gwent look like?

Greater 'Gwent' is a term used to reflect the five local authority areas: Blaenau Gwent, Caerphilly, Monmouthshire, Newport and Torfaen. Gwent benefits from following the same geographic footprint as the Aneurin Bevan University Health Board. Demographics of Gwent are varied and include rural countryside areas, urban centres and the most easterly of the south Wales valleys.

Blaenau Gwent is situated in the valleys of south east Wales and covers approximately 10,900 hectares with a population of **69,674**. The area has accessible green spaces and close community working but it is an area with high levels of unemployment and a high percentage of people who are dependent on benefits.

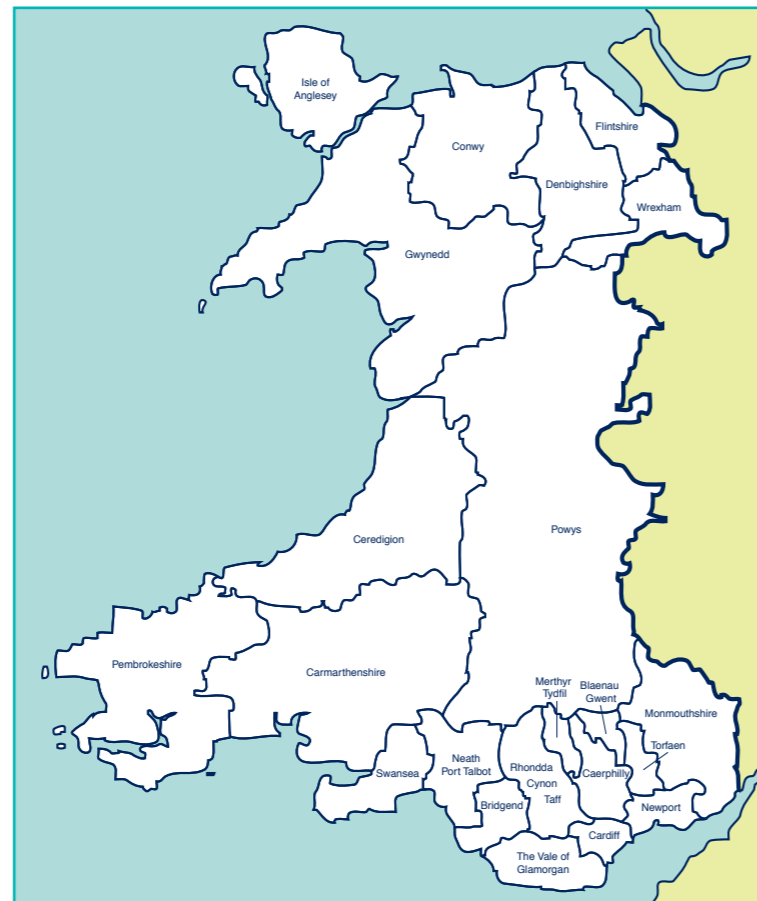
Caerphilly has the largest population in Gwent of **179,941**. People are widely dispersed amongst fifty small towns and villages with the main settlements largely reflecting the area's rich coal mining heritage. Caerphilly has an expanding economy and benefits through good transport links to Cardiff but there are significant levels of unemployment and poor health.

Monmouthshire is classed as a 'semi-rural accessible area'. There are four major towns, with a total population of **92,336**. Monmouthshire has the lowest level of unemployment in Gwent: however there are pockets of deprivation as evidenced in north Abergavenny.

Newport City is the third largest urban centre in Wales with a population of **146,841**. The city has the second largest number of people from minority ethnic communities of all the Welsh counties (after Cardiff) and has continued to increase since 2009 when the figure was estimated at **6.6%** of the population.

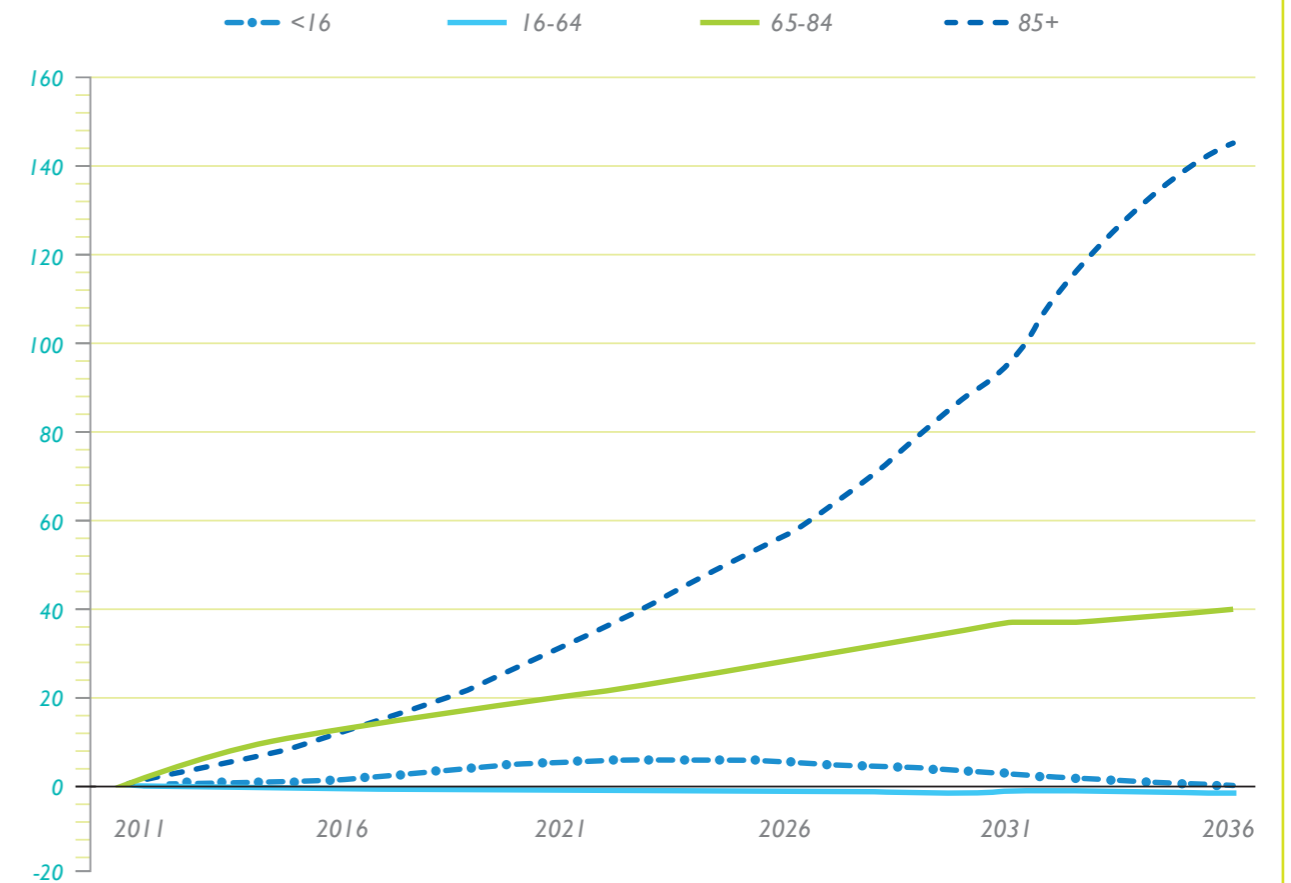
Torfaen is the most easterly of the south Wales urbanised valleys with a population of **91,609**. There are three urban centres: Pontypool, Blaenavon, and Cwmbran. The largest number of traveller caravans was recorded in Torfaen during the January 2016 Bi-annual Gypsy and Traveller count with a total of sixty-one, which was **41%** of the Gwent total.

Each local authority is required to produce a Well-being Assessment (WBA) under the Well-being of Future Generations Act and a link to the assessments will be included in the appendix as this PNA does not seek to replicate the more detailed local demography required in each of the individual WBAs.



Population projections by age group, percentage change since 2011, Aneurin Bevan UHB, 2011-2036

Produced by Public Health Wales Observatory, using 2011 - based population projections (WG)



Key Points

- The population is projected to increase by 4.1% from around 577,100 in 2011 to 601,000 in 2036. The greatest increase will be seen in Newport with an estimated 17.3% increase (145,800 to 170,900), Caerphilly 2%, Torfaen 1.1%. Blaenau Gwent will have an estimated population decrease of - 6.6% and Monmouthshire -1.3%. The Blaenau Gwent decrease is the largest estimated decrease across the population in Wales.
- There are significant increases projected for the over 65 years of age population when an estimated 1 in 4 people (26%) will be aged 65 or older - which is broadly similar to Wales.
- By 2036, it is estimated that the number of people aged 85 and over will increase by 147% (from around 13,000 in 2011 to 32,000 in 2036).



Section 1

ABUHB population key data

- In 2014, around 1 in 5 residents were aged over 65 years (19%), 6 in every 10 (62%) were of working age (16 to 64 years) and nearly 1 in 5 (19%) were aged under 16.
- The population aged under 16 has decreased by 2,700 (1%) between 2005 and 2014, from 114,100 to 108,300.
- There has been a significant decrease in the under 75 mortality rate of 17.1% and 17.4% for males and females respectively (a greater improvement than Wales). This demonstrates the positive impacts and significant improvements that a range of services, activities and targeted programmes have made to reduce mortality rates.
- The general fertility rate is broadly similar to that of Wales - but there are differences in the general fertility rates across ABUHB which will impact on the planning of maternity and child services - particularly for Newport and Monmouthshire.



Welsh Language

The Welsh language strategic framework 'More than just words' aims to improve frontline health and social services provision for Welsh speakers, their families and carers. In keeping with the principles in the framework, the regional planning systems will include reference to the linguistic profile of local communities and ensure this is reflected in service delivery.

A detailed Welsh language community profile has been completed by local Public Service Boards (PSBs) for inclusion in the local Well-being Assessment in each area, and this PNA does not duplicate the information. This PNA will use the profile to effectively identify the actions required to deliver the range and level of services identified as necessary through the medium of Welsh.



The development of the joint Area Plan will set out the key actions required to ensure people needing care and support services can access support through the medium of Welsh. We have already taken steps by ensuring assessments - proportionate and/or care and support planning - include the 'active offer' to converse through the medium of Welsh and is asked at the first point of contact within local authorities (this extends to social services and IAA front doors; and will also include integrated assessment (IA) stages). We will also work with workforce development colleagues to ensure sufficient Welsh language support is available across health and social care.

Engagement - a culture not a process

What people have told us

Engagement is central to the development of this PNA and critical to ensuring the identified needs are reflective of local communities. We need to identify the issues important to citizens as well as ensuring people are equipped to promote their own Well-being.

A considerable emphasis has been placed on engagement and the views of citizens as we want this PNA to be owned by citizens and bring about the change required to promote Well-being.

Under the Act a regional Citizens' Panel and a regional 'Value-Based' Provider Forum have been established and they have been engaged to ensure citizen and provider views are central to this PNA.

How engagement is central to the PNA - Our Procedure

Regional Partnership Boards must establish and publicise a procedure for obtaining people's views on the PNA. Our procedure is set out below.

1 Identify the citizens: 'Who we have engaged with'

i. People Accessing Care and Support Services

We recognise that engagement must take place with **people, including children**, who have experience of **using care and support services**, the parents of children who have care and support needs, and carers. Under the Act there is a requirement for individual local authorities to undertake a qualitative questionnaire with people who are supported by social services and across the region 10,000 questionnaires were posted to citizens between September and November 2016. It is too early to include a complete analysis of the questionnaire feedback from across Gwent in this PNA but information will be used to produce the underpinning joint Area Plan.

However, a basic overview is as follows:

- Nearly 10,000 questionnaires were distributed across Gwent.
- The return from adults was over 30% in each local authority.
- The return from children was much lower and below 20% across the region.
- A large percentage of adults felt they were treated with respect and 83% were happy with the support they received but a smaller percentage felt part of their community.
- Large numbers of carers felt part of the decisions involving loved ones they cared for but a smaller number felt they can sometimes do the things that matter most to them.
- A large percentage of children felt they live in home with people where they are happy and feel safe.

ii. Focussed work with minority groups

We have also engaged the views of those who would otherwise be hard to reach and marginalised including minority groups such as homeless people and travellers. We have used existing mechanisms to engage with vulnerable groups such as those set out below.

- Looked After Children and young carers
- People in secure estates and their families
- Homeless people
- Lesbian Gay Bisexual Transgender (LGBT) community
- Black Minority Ethnic groups
- Military veterans
- Asylum seekers and refugees



iii. Use of existing networks and groups

We recognise that there are numerous established groups and networks that are best placed to provide views of citizens. As part of this PNA we have also engaged with youth forums, 50 plus forums, parenting forums, citizen panels, carers groups and learning disability groups.

Wider population in partnership with Well-being Assessments

We have linked closely with partners developing local Well-being assessment under the Well-being of Future Generations Act and have included questions in relation to care and support needs in wider engagement events.

2 Engage with providers & third sector organisations

We have developed a regional 'Value-Based' Provider Forum to ensure the views of local partners are central to the work of the Regional Partnership Board. We will engage with the third and private sectors to ensure the solutions required to deliver the PNA priorities can be achieved. Third and private sector organisations may be able to help identify people who are not known to local authorities or Local Health Boards; but have unmet care and support need(s). As part of the consultation we organised 2 regional workshops to engage with the third sector and providers.

3 Be clear on what we ask people

In relation to health and social care needs the 3 questions posed were

- i. What do you feel are your greatest needs?
- ii. How can we help you to improve your Well-being?
- iii. What services are needed?

4 Summarise

We have undertaken engagement activities with a number of people through citizen panels, provider forums, young people and older people forums. We have also worked in partnership with colleagues undertaking Well-being Assessments under the Well-being of Future Generations Act.

5 Set out how information has been reflected in the assessment - What people told us and what we will do.

Throughout the PNA we have highlighted the comments of citizens to ensure their views are central to the development of the core theme situational analysis and response analysis. We have also set out clearly in this PNA: what people told us and what we will do.

6 Feedback from existing groups and established engagement mechanisms

Supporting People

The Supporting People programmes across the region have undertaken a Gwent Needs Mapping Exercise (GNME) which has collected information on individuals presenting to homelessness services, social workers, probation officers and other relevant services in the local area. The GNME form is distributed to agencies working with vulnerable people and during 2015 /2016 a total of 4940 GNME returns were received from across the five Gwent local authorities; an increase of over a thousand returns compared to the previous reporting period. The Supporting People teams continue to raise the profile of the GNME form to organisations and almost a quarter of those completing the GNME appear to have a diagnosed mental health condition.

Local Supporting People teams also used different methods to engage with service users within their locality and some teams held events and others engaged directly by meeting service users at their own project. Service users were able to comment on the support they have received and it is clear to see the positive impact that floating support services and accommodation based services have on their well-being and quality of life. Suggestions to improve services were also received and this will further drive service developments across the region.

Supporting People also organise an annual needs planning event. Stakeholders are invited to attend giving their views and thoughts on services provided locally and regionally; and information from these events helps to inform the understanding of unmet needs and at the priorities identified at the latest event were:

- People with mental health issues
- People over 55 years
- Young People aged 16 to 24 years

The data continues to reflect that people are presenting to services with the same predominant needs as in previous years; this year mental health appears as either a lead or secondary need in every local authority, with older people aged 55+ being the prevailing lead need in Monmouthshire and Torfaen.



Veterans

A veteran is defined as: “anyone who has served for at least one day in the Armed Forces (Regular or Reserve), as well as Merchant Navy seafarers and fishermen who have served in a vessel that was operated to facilitate military operations by the Armed Forces.” There is no routine source of information on military veterans in Wales, so the number resident in Wales is unknown. Studies identify that most veterans in general view their time in the Services as a positive experience and do not suffer adverse health effects as a result of the time they have served.

However, for a minority, adverse physical and mental health outcomes can be substantial and can be compounded by other factors – such as financial and welfare problems. Key health issues facing the veteran population relate to common mental health problems (but also include Post traumatic Stress Disorder (PTSD)) and substance misuse – including excess alcohol consumption and to a much lesser extent - use of illegal drugs. In addition, time in the Services has been identified to be associated with musculoskeletal disorders for some veterans.

Other issues that studies have identified as being of importance to veterans include:

- Accessing suitable housing and preventing homelessness.
- Supporting veterans into employment.
- Accessing appropriate financial advice and information about relevant benefits.
- Accessing health and support services.
- Supporting veterans who have been in the criminal justice system.
- Loneliness and isolation.
- Ready access to services to ensure early identification and treatment (physical & mental health).
- Supporting a veterans wider family.

Research suggests that most people ‘do not suffer with mental health difficulties even after serving in highly challenging environments’. However, some veterans face serious mental health issues.

The most common problems experienced by veterans (and by the general population) are:

- depression
- anxiety
- alcohol abuse (13%)

Probable PTSD affects about 4% of veterans. Each year, about 0.1% of all regular service leavers are discharged for mental health reasons. Each Health Board in Wales has appointed an experienced clinician as a Veteran Therapist (VT) with an interest or experience of military (mental) health problems. The VT will accept referrals from health care staff, GPs, veteran charities and self-referrals from ex-service personnel. The service in ABUHB is based in Pontypool. The primary aim of Veterans’ NHS Wales is to improve the mental health and well-being of veterans with a service related mental health problem. The secondary aim is to achieve this through the development of

sustainable, accessible and effective services that meet the needs of veterans with mental health and well-being difficulties who live in Wales. A 2016 report from ‘Forces in Mind’ provides the findings from a review of the mental and related health needs of veterans and family members in Wales.

The report identified that a lot of good work had been developed in Wales in recent years to better meet the mental and related health needs of veterans and their family members, however the report also identified areas where it was felt additional work was needed to be undertaken to meet the needs of veterans.

Including:

- A need for a strategic focus and co-ordination in terms of planning/commissioning of services for veterans - both generalist and specialist - across sectors and regions.
- A need to ensure consistency and implementation across Wales of the Armed Forces Forums and Champions.
- A need to ensure the long-term sustainability of/capacity within services.
- A need to establish effective local multi-agency partnerships to improve assessment and referral pathways.
- Meeting the needs of veterans with highly complex needs particularly those with dual diagnosis (mental health and substance misuse) and those involved in the criminal justice system.
- To meet the unmet need among veterans and families, with more prevention, identification and early intervention needed within generalist/mainstream services to prevent pressure on crisis services.
- To recognise and appropriately cater for the practical, social and emotional support needs of the families of veterans with mental health problems including safeguarding issues particularly around domestic violence and the long-term well-being of children;

A Welsh Government report from 2014 ‘Improving Access to Substance Misuse Treatment for Veterans’ identified that Substance Misuse Area Planning Boards lead on local collaborative planning, commissioning and delivery for services to ensure that the needs of veterans are met. A 2011 report from Public Health Wales on ‘Veterans’ health care needs assessment of specialist rehabilitation services in Wales’ identified a range of recommendations to support veterans with respect to their physical health and disability with regards to specialist rehabilitation service provision.

Gypsy Travellers

The 2011 Census showed the following people identified as Gypsy/Traveller or Irish Traveller (this excludes Roma).

Gypsy Travellers

■ Newport	84	(0.06%)	■ Caerphilly	31	(0.02%)
■ Blaenau Gwent	72	(0.10%)	■ Monmouthshire	6	(0.01%)
■ Torfaen	155	(0.17%)	■ Wales	2785	(0.09%)

However, it is likely that many households would not have completed the census – both because they were living on ‘unauthorised sites’ or encampments and as such did not appear on official records or because of a mistrust of the purpose of the census. Where people did receive forms potential lower than average literacy levels may have meant that some households would not have completed them, and where they were completed some households would have chosen not to identify as Gypsies/ Travellers or Irish Travellers.

The largest Gypsy & Traveller (G&T) population is in Torfaen, however Nantyglo in Blaenau- Gwent also has a large population, many now living in ‘bricks and mortar’ in close proximity to a long established site. Newport also has a significant G&T population in unofficial sites around the periphery of the city centre and Newport is very often the unofficial unauthorised site for travellers in transit heading east/west from Ireland to England.

Issues facing Gypsies and Travellers

The Gypsy and Traveller population face poorer health outcomes when compared to the general population:

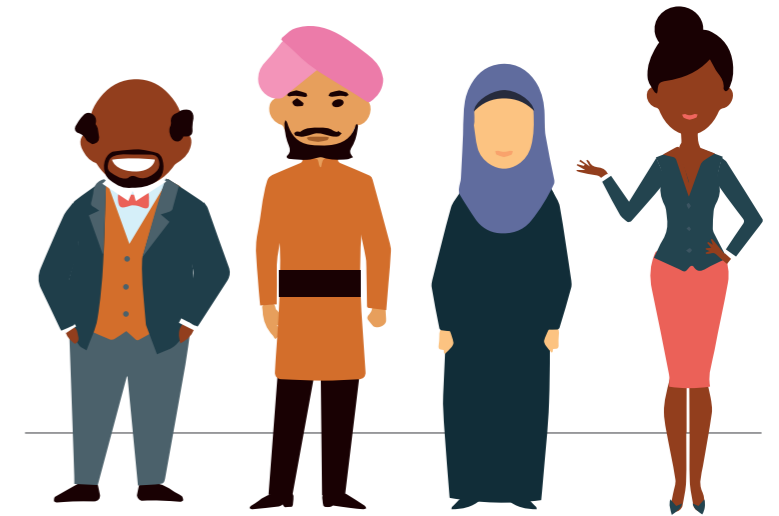
- Infant mortality rates are up to five times higher among this minority group when compared to the national rate.
- The immunisation rates among Travellers children are low compared with the rest of the population. Some suggest that GPs are reluctant to register Travellers as they are of no fixed abode, meaning they cannot be counted towards targets and therefore remuneration.
- There is a high accident rate among the Traveller and Gypsy population, which is directly related to the hazardous conditions on many Traveller sites - particularly as sites are often close to motorways or major roads, refuse tips, sewage work, railways or industrialized areas. Health and safety standards are often poor.
- Travellers have lower levels of breastfeeding.
- There is also a higher prevalence of many medical conditions when compared to the general population, including miscarriage rate, respiratory problems, arthritis, cardiovascular disease, depression and maternal death rates.
- Alcohol consumption is often used as a coping strategy, and drug use among Traveller young people is widely reported and feared by Traveller elders.
- Cultural beliefs include considering that health problems (particularly those perceived as shameful, such as poor mental health or substance misuse) should be dealt with by household members or kept within the extended family unit
- Travellers also face challenges in accessing services either due to the location of the sites (or due to transient nature of being in an area). Not having access to transport (particularly related to women who often cannot drive) to reach services is another reason for low use of services as well as low levels of health literacy of what services they are entitled to use or how to access them.

Generally the communities have low expectations in regard to their health and life expectancy. Studies have repeatedly shown that Travellers often live in extremely unhealthy conditions, while at the same time using health services much less often than the rest of the population.

Black Minority Ethnic (BME) groups

The 2011 Census shows the following percentages classed as BME populations in each local authority compared to Wales.

BME Groups	
Blaenau Gwent	1.5%
Caerphilly	1.6%
Monmouthshire	1.9%
Newport	10.1%
Torfaen	2.0%
Wales	4.4%



Public Health Wales have found that ethnicity is an important issue because, as well as having specific needs relating to language and culture, persons from ethnic minority backgrounds are more likely to come from low income families, suffer poorer living conditions and gain lower levels of educational qualifications. In addition, certain ethnic groups have higher rates of some health conditions. For example, South Asian and Caribbean-descended populations have a substantially higher risk of diabetes; Bangladeshi-descended populations are more likely to avoid alcohol but to smoke and sickle cell anaemia is an inherited blood disorder, which mainly affects people of African or Caribbean origin. Raising the Standard: Race Equality Action Plan for Adult Mental Health Services aims to promote race equality in the design and delivery of mental health services in order to reduce the health inequalities experienced by some ethnic groups.

Asylum Seekers, Refugees & Migrants

Until 2001, relatively low numbers of asylum seekers and refugees decided to settle in Wales compared to some parts of the UK. The numbers of asylum seekers and refugees increased when Wales became a dispersal area. The number of asylum applications in 2016 has seen an increase of 8% compared to the year before. Service provision to refugees and people seeking asylum by non-government organisations (NGOs) has decreased significantly in recent years. This has an adverse impact on people’s health and Well-being. No recourse to public funds and safeguarding issues such as honour based violence and trafficking are key emerging themes for service providers. For service users the lack of, or limited access to information and tenancy support appear to be the key emerging themes

Various reports acknowledge that data collection systems for the number of migrants have weaknesses, which puts limitations on their reliability. There is no agreed definition for ‘migrants’ which further exacerbates reliable data collection.

The 2011 census found that the top ten countries of origin of people born outside the UK, in order of highest numbers first were: Pakistan, India, Bangladesh, Poland, Philippines, Germany, South Africa, Nigeria, Italy and Zimbabwe. Feedback from Education and Social Services indicate that people from Roma background have very specific needs in addition to those of the general new-migrant population.

Good communication with migrants is essential. Determining the language and suitability of format (e.g. written, audio, face to face, telephone) and support available, such as advocacy and interpretation are critical elements to ensure effective communication. This will in turn benefit budgets and customer care as it contributes to determining the appropriate service. In addition, other issues highlighted for both migrants and asylum seekers include the need for more advocacy and floating support for migrants, lack of a strategic approach to information and service provision for new migrants and lack of coordination between services for migrants, asylum seekers and refugees.

Lesbian Gay Bisexual Transgender (LGBT) community

The public health white paper 'Healthy Lives, Healthy People' identified poor mental health, sexually transmitted infections (STIs), problematic drug and alcohol use and smoking as the top public health issues facing the UK.

All of these disproportionately affect LGBT populations:

- Illicit drug use amongst LGB people is at least 8 times higher than in the general population
- Around 25% of LGB people indicate a level of alcohol dependency
- Nearly half of LGBT individuals smoke, compared with a quarter of their heterosexual peers
- Lesbian, gay and bisexual people are at higher risk of mental disorder, suicidal ideation, substance misuse and deliberate self-harm
- 41% of trans people reported attempting suicide compared to 1.6% of the general population



People in secure estates and their families

HMP Usk/Prescoed is situated in Monmouthshire and social care staff support inmates in line with the Act. ABUHB also provide primary healthcare services to offenders in HMP Usk/Prescoed, in partnership with the National Offender Management Service (NOMS). In addition to the prison population it is likely that ex-offenders will require additional care and support to prevent needs arising, particularly those who misuse drugs and/or alcohol or have mental health problems.

A recent 'Prison Health Needs Assessment in Wales' report was published by Public Health Wales and highlighted a number of key areas to address:

- Access to healthcare facilities
- Mental health and healthcare
- Substance Misuse including smoking
- Oral health
- Infections disease
- Support following release

Children and young people in contact with the Youth Justice System

Children and young people in contact with the youth justice system can have more health and well-being needs than other children of their age. They have often missed out on early attention to these needs. They frequently face a range of other, often entrenched, difficulties, including school exclusion, fragmented family relationships, bereavement, unstable living conditions, and poor or harmful parenting that might be linked to parental poverty, substance misuse and mental health problems. Many of the children and young people in contact with the youth justice system in Gwent may also be known to children's social care and be among those children and young people who are not in education, employment or training.

For vulnerable children and young people, including those in contact with the youth justice system, well-being is about strengthening the protective factors in their life and improving their resilience to the risk factors and setbacks that feature so largely and are likely to have a continuing adverse impact on their long-term development. Well-being is also about children feeling secure about their personal identity and culture. Due attention to their health and well-being needs should help reduce health inequalities and reduce the risk of re-offending by young people.

Across the region the Youth Offending Service (YOS) & partners are:

- Developing a health pathway in partnership with ABUHB for young people involved/in contact with the youth justice system.
- Testing the Youth Justice Board (YJB) Enhanced Case Management - a therapeutic approach towards addressing a child's offending behaviour
- Identifying, screening and responding to Speech, Language & Communication Needs (SLCN) via the provision of a dedicated Gwent YOS Speech & Language Therapist.
- Commissioning a Substance Misuse Service for Children and Young People within Gwent.

Children & Young People

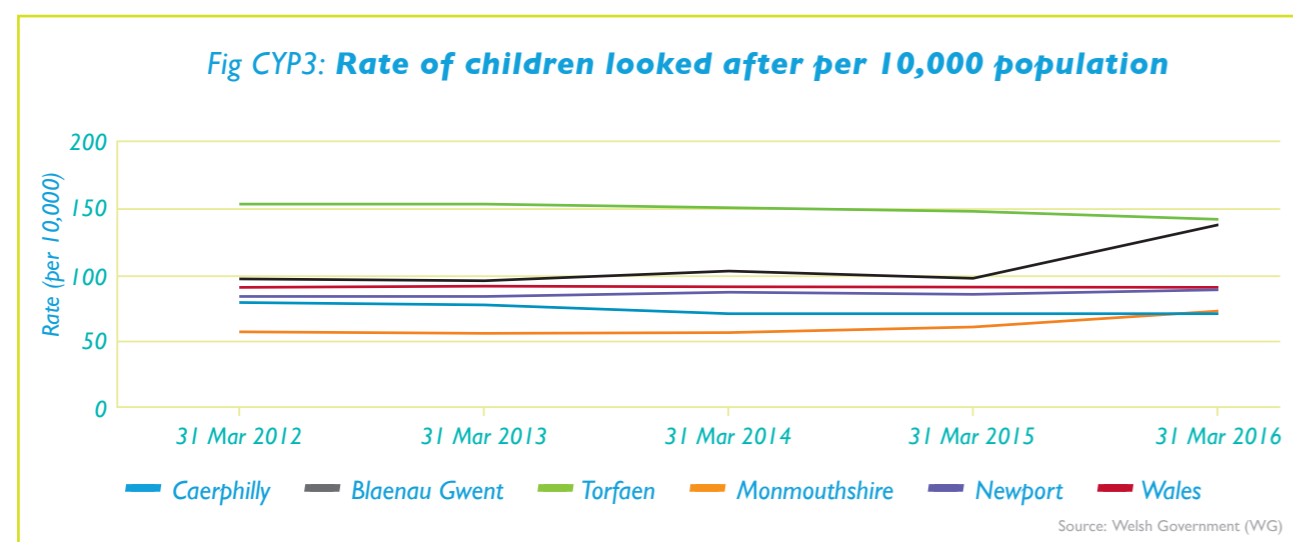
A demography and population profile for individual local authorities is included in the 5 local Well-being Assessments. An abbreviated demography is included in section 1 of this PNA which also includes the population projection for the region. For the purpose of this PNA 'Children and Young People' are defined as people aged up to the age of 18 years and who are receiving care and support services.

The priority outcomes identified through engagement with citizens, partners and use of the prioritisation matrix; and subsequently confirmed through consultation are:

1. To improve outcomes for children and young people with complex needs through earlier intervention, community based support and placements closer to home.
2. To ensure good mental health and emotional well-being for children young people through effective partnership working.

So what does the data show us?

A comprehensive situational analysis is included in the appendix, but a representative sample of need is set out in the chart(s) below.



	Caerphilly	Blaenau Gwent	Torfaen	Monmouthshire	Newport	Wales
31 Mar 2012	78	96	152	56	83	90
31 Mar 2013	77	96	153	55	84	91
31 Mar 2014	71	102	152	56	86	91
31 Mar 2015	70	98	150	60	86	89
31 Mar 2016	72	139	142	73	88	90

Source: Welsh Government (WG)

Figure CYP3 shows the rate of looked after children per 10,000 population aged under 18 across the Gwent region over the period 2012 to 2016. Blaenau Gwent saw the highest increase over the period, while the biggest decreases was in Caerphilly and Torfaen over the period. The rate has remained at a near constant for Wales over the period 2012 to 2016.

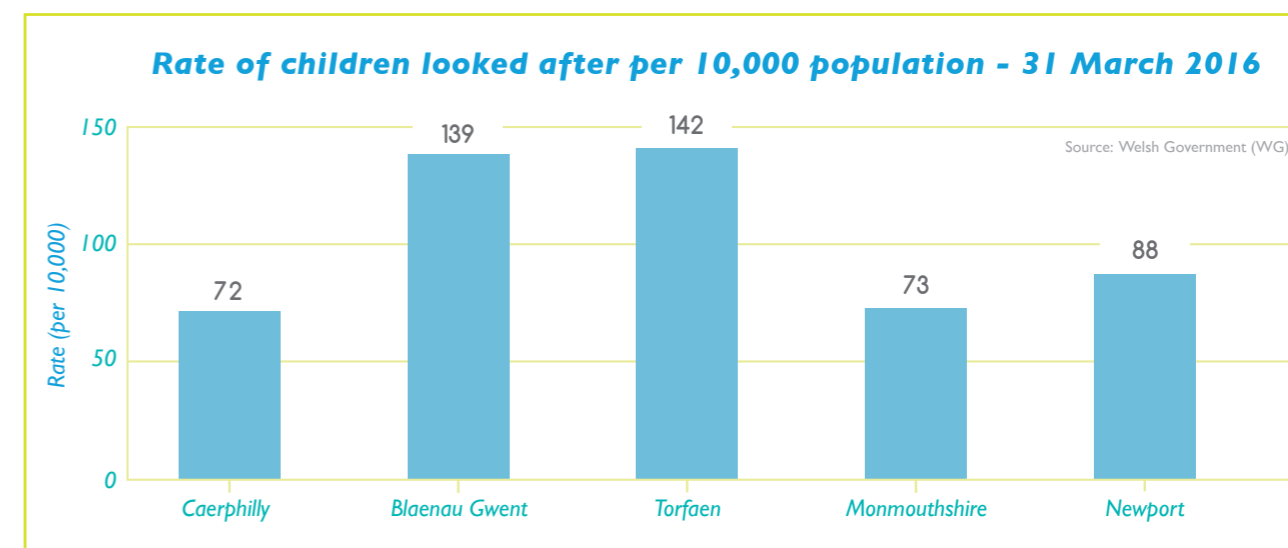


Figure CYP4 shows the rate of children looked after per 10,000 population aged under 18 years on 31 March 2016 across the Gwent region. This ranged from 72 per 10,000 population in Caerphilly to 142 per 10,000 population in Torfaen. This compares with 90 per 10,000 population for Wales on 31 March 2016.

What do we know?

The reason(s) why a child becomes looked after varies, but in nearly every case children will have been through a traumatic or difficult life experience which can result in instability, distress, poor emotional and physical health, or lack of social and educational development. Overall, looked after children do not enjoy the same positive advantages, experiences and outcomes as other children. Occasionally children are placed out of the county to ensure their well-being is protected and their outcomes met. For some children with complex health needs, suitable provision of support is sometimes only available out of their county. Out of county placements can be very costly to local authorities and generally the single largest expenditure to social care budgets; and in some cases the expected outcomes for children placed away from their homes are not always met as well as was originally intended.

It is therefore recognised that children and families benefit from services being delivered as close to home as possible to maintain essential and important connections with support networks, and other local services. It is also recognised that for some young people, the required support may be located out of their local area, as the specialised provision is not available, but it can mean that they may become isolated from their professional and social networks. This practice is not in line with the Welsh Government priority of keeping young people in Wales and close to home if appropriate.

A small number of children, mainly disabled children, receive NHS Continuing Healthcare funding. These young people present with complex needs and are in receipt of significant packages of care, usually out of county as appropriate provision is not often available within the Gwent region.

What are we doing?

A regional **Children & Families Partnership Board (CFPB)** has been established with representation from across health, social care and education. There is no set definition for children with complex needs at a regional level, but the CFPB has defined this group of children and young people (CYP) as:

1. CYP who have experienced complex trauma (often challenging teenagers with complex attachment difficulties).
2. CYP with ASD/Learning Disability and challenging behaviours.
3. CYP with Physical Disabilities and complex health needs.

The CFPB has identified the following areas of collaboration:

- integrate systems, assessments and planning for children with complex needs, where a multi-agency timely response would produce better well-being outcomes for the children, young people and their families/carers
- prevent escalation of complexity and related crisis
- plan and develop (commission) a responsive and integrated range of well-being, care, support and accommodation services to meet the well-being outcomes for C&YP with Complex needs and their families/carers
- achieve a consistent regional decision making process for Continuing Care

Following a gap analysis in emotional well-being and mental health services project (completed 2015) relevant partners have been, or are in the process of developing a number of services including:

- Neurodevelopmental Service (ASD/ADHD)
- Enhanced Early Intervention in Psychosis (14-25 Age Group),
- Specialist CAMHS Crisis Responses: Enhanced Crisis Outreach Team, Extended Eating Disorder Service, Extended Emergency Liaison Service and Dialectical Behaviour Therapy Service
- Psychological service for developmental trauma and attachment difficulties
- Development of Integrated Services for Children with Additional Needs (ISCAN) based on a hub and spoke model of service delivery in ABUHB children's centres to support children and young people with disabilities and their families/carers

Case Study

In 2015, Caerphilly Children's Services volunteered to be the lead testing area to pilot a new model of joint assessment and planning, based on recognized best practice and a Multi-agency Assessment and Planning Group for Children with Complex Needs was established. The main drivers for improving practice are early intervention and the continued feedback from families who would welcome a joined up approach and the production of a single plan. Funding from Intermediate Care Fund 2016 (ICF) was granted to pilot a new integrated assessment and planning model.

In relation to the CFPB priorities, an external consultancy has been commissioned to undertake research on steps that local authorities, Aneurin Bevan University Health Board and partner agencies should take to help prevent the escalation of complex needs. The research is focused on three main areas:

- **How best to address the increasing number of looked after children being placed in independent out-of-region residential care.**
- **Over time help to safely reduce the number of looked after children who experience a combination of placement breakdown, an escalation of need, and placement in independent out-of-region provision.**
- **Consider how support for children and young people on the edge of care (in danger of becoming looked-after) could operate effectively and safely to prevent such children and young people requiring statutory care.**

Research is also being undertaken in the Development of Accommodation and Support for Care Leavers with Complex Needs and the objectives of this work are to: develop an integrated plan to support a regional approach to delivering accommodation and support services for young people in care or leaving care post 16 years of age; outline new and innovative ways of delivering accommodation and support services to this vulnerable group, reducing the over-reliance on the private sector in ensuring that the needs of these young people are met in the longer-term and; research and propose evidenced based regional opportunities of alternative accommodation solutions to CYP who have experienced complex trauma.

Flying Start and **Families First** are preventative programmes which aim to give children the best start in life, reduce the escalation of needs and support families to ensure a child's well-being. A recent health **Adverse Childhood Experience (ACE)** study highlights that children who experience 4 adverse experiences are 3 times more likely to suffer from poor mental health in later life. The RPB are considering how ACEs can be reduced through a collective approach across health and social care and through a place based approach such as 'Care Closer to Home' (see section 2). There are a number of other support services available through the third sector as well as core public local authority and health services.

“Being in care can be tough but we can help others by sharing our experiences so that they know there is someone who understands what they are going through.”

Youth Forum Member

What we will do:

- **We will explore a peer to peer**
- **Support groups for young people**

Actions and next steps

Prevention and Early Intervention including Information, Advice and Assistance (IAA):

There is a need to develop joint assessment, planning and commissioning for children with varying needs where a multi-agency response would produce better outcomes.

This way of working will help deliver:

- A focus on prevention of crises and support at an earlier point in their development.
- Support nearer to their own community
- A focus on meeting children's needs in a more integrated way and jointly commissioned across health and social care

There are 4 key early intervention anti-poverty programmes funded across Wales: Communities First, Families First, Flying Start and Supporting People (Communities First is being phased out but some provision will remain). Welsh Government are currently exploring consistent assessment principles, consistent workforce training and joint commissioning opportunities across the programmes, and the region will explore similar approaches. Information, Advice and Assistance (IAA) will also direct families to appropriate resources and support; and Family Information Services are key partners at the 'front door' in each local authority to 'signpost' to effective support. In line with ABUHB's 'Care Closer to Home', there is an opportunity to explore place-based approaches and preventative services (see section 2 for further details).

Commissioning, Pooled Budgets and Health & Social Care Integration:

We will need to ensure that funding is re-directed to provide lower levels of intervention, to support children sooner and to prevent avoidable or unnecessary out of county placements. We will need to make use of the Intermediate Care Funding (ICF) across the region and as highlighted, an external consultancy are researching appropriate models to reduce escalation of need, including a review of out of county placements and the potential to re-design local services to meet future needs.

Under part 9 of the Act there is a requirement to set out and agree plans for health and social care integration for children with complex needs due to disability or illness; and it is anticipated that the externally commissioned review will bring forward recommendations to facilitate greater integration.

Also, under Part 9 of the Act there is a requirement to ensure joint commissioning of Integrated Family Support Teams, and this will now fall under the governance arrangements of the Regional Partnership Board. Heads of Children Services are currently exploring and developing regional fostering arrangements across the region.



Advocacy & Voice of the child

We will ensure the views of children are considered in all planning arrangements and ensure that advocacy provision is available throughout the region for children and young people. A single regional advocacy contract is being developed by Heads of Children Services and we will work closely with current advocacy providers to determine good practice and identify any gaps in service provision. Through our third sector partners we will also aim to increase informal advocacy and explore the roles of social enterprises and community groups in this area.

Links to key strategies:

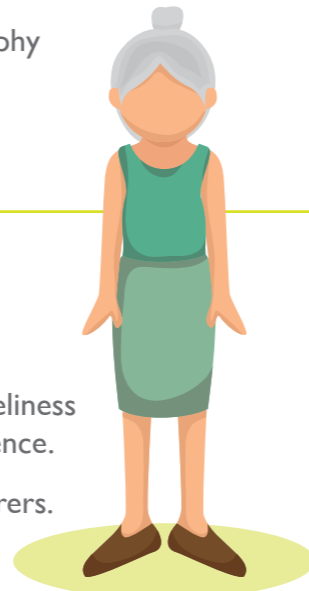
- Regional Partnership Board Statement of Intent Children with Complex Needs
- NHS Adverse Childhood Experiences (ACE)

Summary and what we will deliver through the joint Area Plan:

- Support Children and Family Partnership Board's review of local arrangements for children with complex needs and delivery of work programme with a focus on Looked After Children.
- Consistent models of practice and alignment of Welsh Government's early intervention and preventative programmes.
- Develop and deliver a regional ACE action plan with a focus on earlier intervention and mental health support for children and young people through community based assets.

Older People

A demography and population profile for individual local authorities is included in the 5 local Well-being Assessments. An abbreviated demography is included in section I of this PNA which also includes the population projection for the region. For the purpose of this PNA Older People are categorized as being over the age of 55 years.



The priority outcomes identified through engagement with citizens, partners and use of the prioritisation matrix; and subsequently confirmed through consultation are:

1. To improve emotional well-being for older people by reducing loneliness and social isolation with earlier intervention and community resilience.
2. To improve outcomes for people living with dementia and their carers.
3. Appropriate housing and accommodation for older people.

So what does the data show us?

A comprehensive situational analysis is included in the appendix, but a representative sample of need is set out in the chart(s) below.

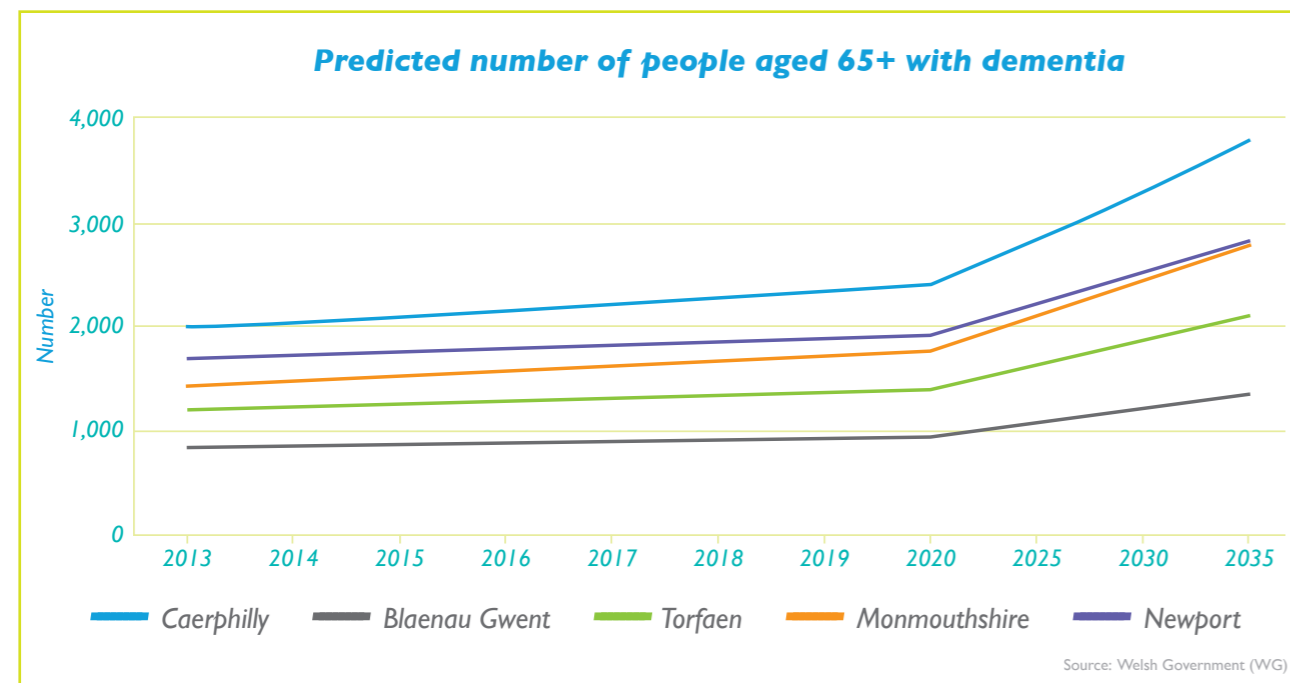
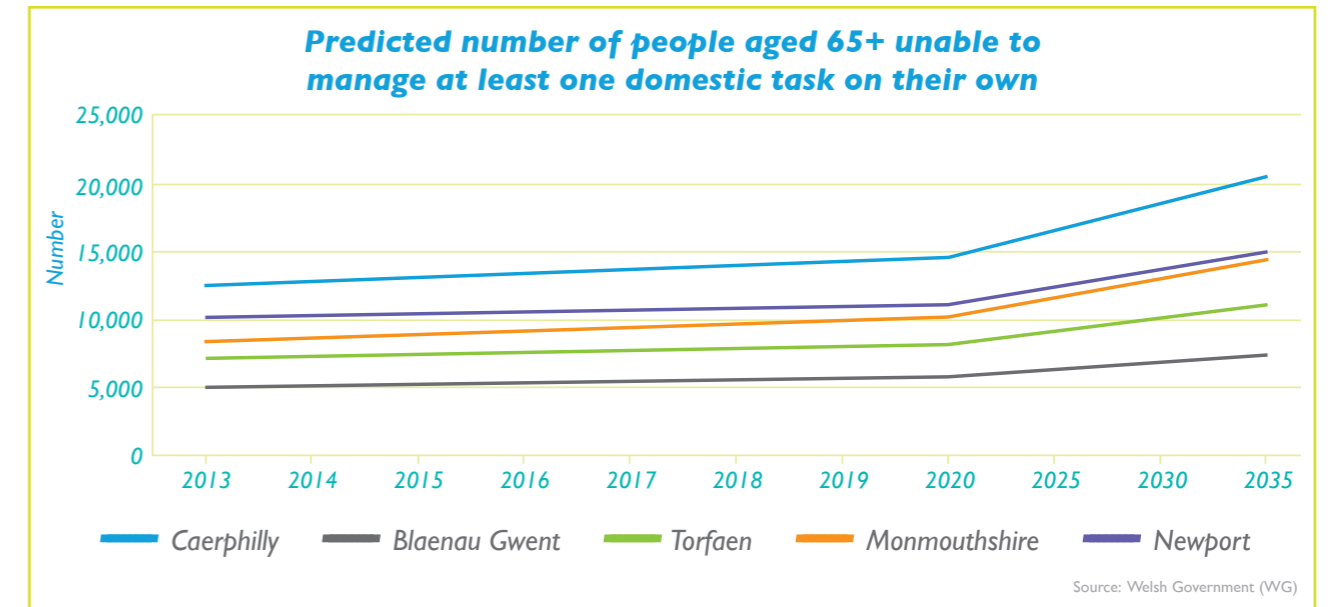


Figure OPI shows the predicted number of people aged 65 years or older with dementia over the period 2013 to 2035. It shows that across all local authority areas in the Gwent region an increase in the number of people living with dementia is predicted. The increases range from 62.1% in Blaenau Gwent to 97.1% in Monmouthshire over the period 2013 to 2035.

Figure OP2 shows the predicted number of people aged 65 years or older who are unable to manage at least one domestic task on their own over the period 2013 to 2035. It shows that all local authority areas across the Gwent region are predicted to see an increase. The predicted increases range from 44.9% in Blaenau Gwent to 71.6% in Monmouthshire.



What do we know?

We know from Office National Statistics data that the number of people aged over 85 in UK has doubled in the past three decades and by 2030, one in five people will be over 65. The demographic and financial pressures are well known and form the context of the whole system transformation that is required. Wales already has a higher proportion of people over 85 than other parts of the UK, so the need for change is more significant, as the **percentage of 85 year old's is set to increase by 90% by 2030** and a growth of 30-44% of people living with dementia.

“When I was diagnosed with dementia I became depressed and didn’t leave my home, but the best thing that happened to me is that I met another person living with dementia who understood what I was going through. I am now very active thanks to her.”

Dementia Friendly Cafe Member

What we will do:

- **Develop a new peer to peer service for people newly diagnosed with dementia to link with people who also have a diagnosis.**

What are we doing?

The Aneurin Bevan University Health Board (ABUHB) and the five Gwent local authorities have well established arrangements for aligning, planning and delivery across the care pathway including specialist care through to community support. The **Gwent Frailty programme** has taken this forward with the aim of building capacity within community settings to reduce demand on health and social care resources, particularly acute and institutional care. This is a multi-agency approach and one that we aim to build on to address the well-being needs and aspirations of our older citizens as well as reduce delayed transfers of care.

There are well established **Community Resource Teams (CRTs)** in each of the five boroughs and are planning to increase capacity and capability, utilising the Intermediate Care Fund for 2016/17. The Frailty programme recognises need for risk stratification to ensure resources are targeted to prevent deterioration and we are working with GP teams to develop suitable tools and systems.

More recently ABUHB have undertaken **“Care Closer to Home”** development workshops in each local authority to identify opportunities to align and integrate services around GP cluster areas (Neighbourhood Care Networks). As part of the workshops a mapping exercise of support services was undertaken and the findings are to be used as the basis of service development and delivery in the next period.

Case Study

Pre-engagement workshops undertaken with the regional citizen panel, provider forum and leadership group identified person centered support, where people are listened to, with earlier intervention and community resilience. Newport City Council and ABUHB Primary Care have committed Primary Care and ICF funding to the **Newport Older Person’s Pathway**. This project involves risk stratification of over 75s and the provision of targeted support through Age Cymru employed Care Facilitators. Older people that are identified as ‘at risk’ through the risk stratification tool are offered a home visit to develop a ‘Stay Well Plan’ that will help them to maintain their independence.

Actions and next steps

Preventative and Early Intervention including Information, Advice and Assistance (IAA):

- Reduce social isolation and loneliness through community connectors, social prescribing, volunteer activity and schemes such as ABUHB ChaT scheme.
- Develop ‘Dementia Friendly Communities’ further.
- Wider integration of a ‘team around the person and their supporters’ and place based approach on Neighbourhood Care Network (NCN) footprints, linked to the ‘Care Closer to Home Strategy’; and to make use of community hubs to focus on keeping people independent and well in the community.
- Supporting Anticipatory Care Planning, so that people’s needs and wishes can be taken forward, even in times of crisis. We anticipate this would reduce unplanned hospital admissions for those who would prefer to remain at home or within a care home setting to receive treatment.
- Develop new ways of engaging with people, especially in partnership with third sector to provide information, including the national DEWIS Citizen Portal, as well as social media and other forms of communication to promote easy access to support.

- Academic studies and evaluations undertaken as part of The Big Lottery Fund have demonstrated that volunteering can have a positive effect on a range of aspects of individual well-being, including: happiness, life satisfaction, self-esteem, sense of control over life, improved physical health and alleviating depression. We will encourage volunteering working in partnership with third sector partners and support the rollout of the new ‘Ffrind I mi’ volunteering programme launched by ABUHB.



Commissioning, Pooled Budgets and Health Social Care Integration:

We already have a level of service integration and collaboration through the Gwent Frailty service and integrated Boards for Carers, Dementia, Learning Disability & Mental Health services, but recognise that we need to extend this to cover:

1 Improved partnership processes

- Gwent already has several well established integrated services for older people and we will build on this solid foundation using the new integrated assessments to ensure that there is a holistic approach to individuals that supports independence and reduces hospital admissions. The role of case co-ordinator will be established so that older people with complex needs will have a single point of contact, who is able to cross professional and organisational boundaries to find solutions to meet a wider range of individual needs.

Workforce Development

- Front line services should be delivered by experienced professionals, who are able to triage and problem solve. Individual local services have been developed in each of the 5 localities that supports this approach, with demand being pro-actively managed, through effective risk management and sign-posting to alternative services. There will be a need for all health and social care workers to have a knowledge of older people’s issues.

2 Flexible and responsive services

- We will take forward wider consideration of extended and 24/7 working, with some key services being re-designed to meet this requirement. We already provide most Frailty services 365 days per year and we can build on this to create an integrated health and social care service that better meets the expectations of older people with complex needs and take forward good medication support into evenings and weekend, linking to hospitals.

3 Commissioning and pooled budgets

3 Commissioning and pooled budgets

- We will facilitate domiciliary care that is planned and developed with providers on a place based approach to be sustainable and outcome focused. This has begun with an in depth review of domiciliary care during 2016/17 the findings of which will be considered and implemented during 2017/18. We will develop the working relationships with Registered Social Landlords (RSL's) established through the 'In One Place' project to ensure there is an alignment to the review of domiciliary care on a place based approach.
- We will take forward a 'better life' programme and resilience models to support care homes in giving sustainable, high quality and consistent care to support well-being.
- We will support care homes to better manage older people with complex needs to reduce unplanned admissions to hospitals. This will also mean developing a much more integrated approach to commissioning care home provision with the establishment of a pooled fund by April 2018.

Case Study: New models Blaenau Gwent

There are some examples of community groups, social enterprises and cooperatives developing in the region. In Blaenau Gwent a community group has grown out of the dementia friendly community implementation group. The group - Blaenau Gwent friends of dementia - have raised funding to help people living with dementia access community groups and ensure their voices are heard. We need to promote this practice further and will work with our social valued based service providers to begin to articulate and pilot how new models of service might look in future.

Direct payments are used across Wales to deliver social care and this promotes independence. However, their use is varied. Their use is to be encouraged, building on the achievements to date, so that people are more empowered to design their own solutions when they have eligible care needs.

Links to key strategies:

- Regional Partnership Board Statement of Intent
- Ageing Well in Wales
- Care Council for Wales National Priorities
- Strategy for Older People 2013/23 refresh

Summary and what we will deliver through the joint Area Plan:

- Develop place based approach 'Care Closer to Home' including consistent delivery of community connectors across the region to reduce social isolation.
- Further develop 'Dementia Friendly Communities'
- Develop domiciliary care joint commissioning process with National Commissioning Board and linked to Care Standards Social Improvement Wales 'Above and Beyond' Report and the 'Care and Support at Home' Strategic Plan currently being developed by Care Council for Wales.

Health & Physical Disabled People

A demography and population profile for individual local authorities is included in the 5 local Well-being Assessments. An abbreviated demography is included in section 1 of this PNA which also includes the population projection for the region.

This chapter will consider the health needs of people requiring care and support AND the needs of Disabled People in the context of the 'social model of disability.'



The priority outcomes identified through engagement with citizens, partners and use of the prioritisation matrix; and subsequently confirmed through consultation are:

1. To support disabled people through an all age approach to live independently in appropriate accommodation and access community based services, including transport.
2. To help people reduce the risk of poor health and well-being through earlier intervention and community support.

So what does the data show us?

A comprehensive situational analysis is included in the appendix, but a representative sample of need is set out in the chart(s) below.

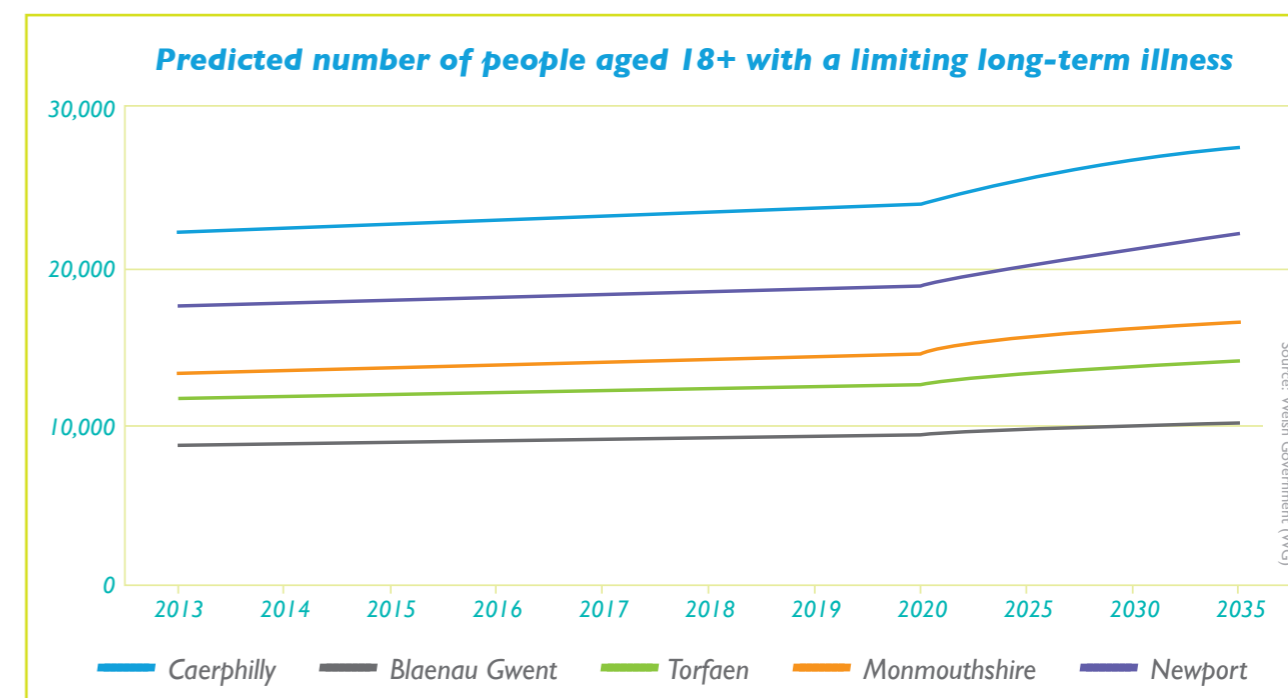


Figure PHI shows the predicted number of people aged 18 years or older with a limiting long term illness over the period 2013 to 2035. It shows that all local authority areas across the Gwent region are predicted to see an increase in the number. The predicted increases range from 14.1% in Blaenau Gwent to 25.1% in Newport.

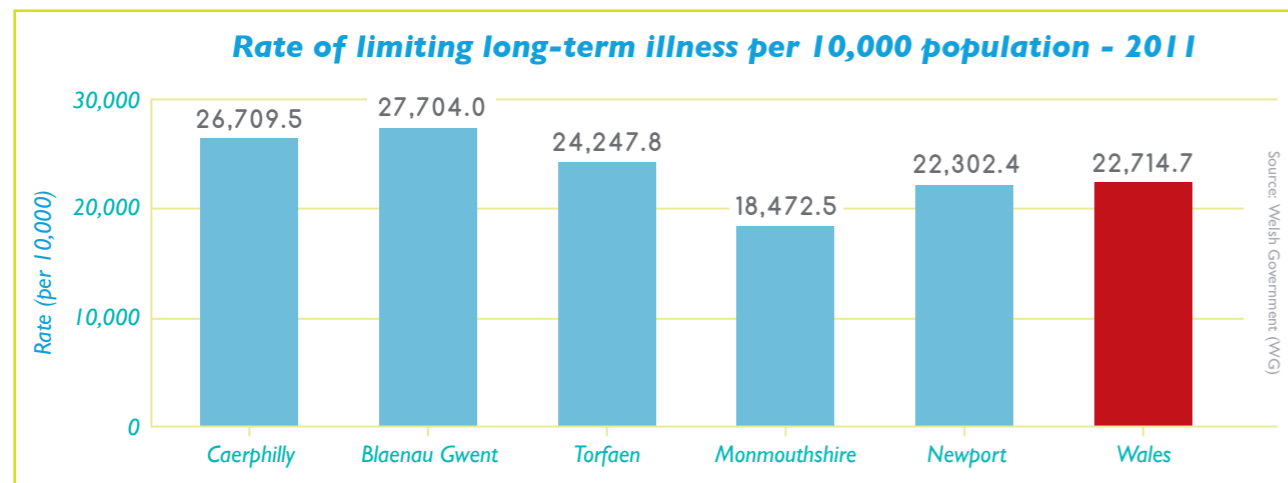


Figure PH2 shows the rate of limiting long-term illness per 10,000 population in 2011. Across the Gwent region the rate ranged from 18,472.5 per 100,000 population in Monmouthshire to 27,704.0 per 100,000 in Blaenau Gwent.

What do we know?

Physical Disability - Facts & Figures (Disability in the United Kingdom 2016):

- There are around 11.9 million disabled people in the UK. Almost 1 in 5 people (19%) in the UK have a disability; this figure has remained relatively constant over time (12.2 million in 2012/13). There are more disabled women than men in the UK.
- People living in Wales (26%) are more likely to have a limiting long-standing illness or disability than other regions of Great Britain.
- It is estimated that the number of older disabled people is likely to increase by around 40% between 2002 and 2022, if age related disability rates remain constant.
- In 2014/15, the most common impairments that disabled people had were: mobility (57%), stamina/breathing/fatigue (38%), dexterity (28%) and mental health (16%). Some people had more than one impairment but were asked.
- 19% of households that include a disabled person live in relative income poverty (below 60% of median income), compared to 14% of households without a disabled person. Disabled people pay on average £550 per month on extra costs related to their disability.
- Transport is the largest concern for disabled people in their local area. Pavement/road maintenance, access, and frequency of public transport are the biggest issues.
- The annual cost of bringing up a disabled child is 3 times greater than that of bringing up a non-disabled child and 40% of disabled children in the UK live in poverty. This accounts for around 320,000 disabled children, and almost a third of those are classified as living in 'severe poverty'.
- Overall, 1 in 10 adults in Britain experience depression at any one time. Around 1 in 20 people at any one time experience major or 'clinical' depression. The World Health Organisation has predicted that depression will be the leading cause of disability by 2020. Mental ill health and learning disabilities in particular are anticipated to grow.
- The distribution of disabled people is fairly evenly spread across the UK but Wales (24%) and a few other regions in England have a higher rate of disability compared to the UK as a whole (19%).
- In the UK, people from white ethnic groups are almost twice as likely as those from non-white ethnic groups to have a limiting long-standing illness or disability (20% compared with 11%).

The Gwent area has a mixture of affluent and deprived areas. This is reflected in the wide range of lifestyle patterns and health outcomes in differing local authorities in the Gwent area.

Disability

The original 1995 Act definition of disability is 'a physical or mental impairment which has substantial and long-term adverse effects on ability to carry out normal day to day activities'. However, across the region we will adopt the social model of disability which in that disability is caused by the way society is organised, rather than by a person's impairment or difference. It looks at ways of removing barriers that restrict life choices for disabled people. When barriers are removed, disabled people can be independent and equal in society, with choice and control over their own lives. Many people with physical and sensory impairments live completely independently, however disability can sometimes necessitate increased need for informal help and health care and long-term care needs and costs. Although not an inevitable consequence of ageing, increasing age is commonly associated with increasing disability and loss of independence, with functional impairments such as loss of mobility, sight and hearing.

The term physical/sensory disability covers visual, hearing and physical impairments; the register of Physical/Sensory Disability is compiled from local authority registers of physically or sensory disabled people in Wales aged 18 years or over. Registration is voluntary and not all people with disabilities choose to register. The registers are therefore not a reliable guide to the prevalence of physical and sensory disability in the population. The prevalence of disability rises with age in general and with an increasingly older population it is expected that the number of people living with a disability in Gwent will increase in the coming years.



Overall health

Overall the health status of the population across Gwent is slightly worse to Wales in terms of general health status – with 22% of people describing their health status as being fair or poor compared to Wales (19%). 17% of the Gwent population identified that their day-to-day activities were limited because of health problem or disability lasting (or expected to last) at least 12 months - this is compared to a Wales figure of 15%, although there is wide variation across the Gwent area - 12% in Monmouthshire and 22% in Blaenau Gwent. This variation can be clearly linked to deprivation. Across Gwent 52% of adults reported currently being treated for an illness (Wales 50%) with 21% of adults currently being treated for high blood pressure (Wales 20%), 15% for a respiratory illness (Wales 14%), 14% for arthritis (Wales 12%), 14% for a mental illness (Wales 13%), and 9% for diabetes (Wales 7%).

Tobacco use (Smoking)

Smoking remains a major cause of premature death in Wales. Smoking and passive smoking has been linked to a range of serious illnesses including cancers and heart disease. Across Gwent 21% of adults aged over 16 smoked compared to 19% across Wales. This varies significantly across Gwent with 17% in Monmouthshire and 26% in Blaenau Gwent. Across all Gwent areas - the smoking prevalence for females is lower than males - the lowest smoking prevalence being 13% in females in Monmouthshire.

Alcohol

Alcohol is a major cause of death and illness in Wales with around 1,500 deaths attributable to alcohol each year (1 in 20 of all deaths). Across Wales consumption of alcohol has slightly decreased and adults under 45 now drink less. Whilst this decrease is good news, it masks persistent or increased drinking in over 45 year olds.

40% of adults across Gwent reported drinking above the guidelines on at least one day in the past week, including 25% who reported drinking more than twice the daily guidelines (sometimes termed binge drinking) - this is broadly comparable with data across Wales. Again there is variation across Gwent with 46% of adults in Monmouthshire drinking above the guidelines and 35% in Torfaen.



Substance Misuse

Gwent treatment data for 2012/13 reported that 1,746 adults were being assessed for drug misuse. Public Health Wales undertook a capture-recapture study designed to provide an estimate of prevalence of problematic drug use (injecting drug use or long duration or regular use of heroin, other opioids, cocaine and crack cocaine). It estimated that the prevalence rate to be 1% of the population. Using the ONS mid-2012 population estimates for Gwent (i.e. 468,281 over 16 year olds) this equates to between 4,682-5,151 problematic drug users. More information is included in the Gwent Substance Misuse Area Planning Board Needs Assessment included in the appendix.

Healthy eating, physical activity and weight

A healthy, balanced diet is an essential component of healthy living. A balanced diet combined with physical activity helps to regulate body weight and contributes to good health. Maintaining a healthy body weight also reduces the risk of health problems such as diabetes, coronary heart disease, stroke and some cancers. Regular physical activity is an essential part of healthy living. A lack of physical activity is among the leading causes of avoidable illness and premature death.

Across Gwent 29% of adults reported meeting the guidelines of eating five or more portions of fruit and vegetables the previous day - this is lower than the Wales figure of 32%. This figure varied from 26% in Caerphilly and Blaenau Gwent to 35% in Monmouthshire. In Wales 59% of adults were classified as overweight or obese. There is significant variation across the Gwent area with 53% overweight or obese in Monmouthshire and 63% in Caerphilly - with an overall figure across Gwent of 61%.

Across Wales 58% of adults reported being physically active (doing at least 150 minutes of moderate intensity physical activity in blocks of 10 minutes or more in the previous week), and 30% reported being inactive (active for less than 30 minutes in the previous week). In Gwent these figures are 55% and 34% - showing that across Gwent people are less active.



What are we doing?

Full economic and social participation of disabled people is essential in creating a smart, sustainable and inclusive economy. Accessing services and support to maintain independent living are essential including the availability of transport services particularly in rural areas. **Community connectors and social prescribers** are in local areas providing information, advice and assistance to help people connect with their community, access support and promote Well-being. Support to enable people to maintain employment when living with an illness or disability (mental or physical) is a key issue, and signposting to support services is developing across the region.

There are a wide range of programmes available for people to live healthy lifestyles including support for: alcohol and substance misuse, stopping smoking and weight management including physical activity and healthy eating – many schemes are delivered by **Housing Associations** and the third sector. **Healthy Schools** is an initiative that develops a whole school approach within a common national framework. Local Healthy Schools schemes encourage schools to ensure that pupils are involved in the planning and implementation of actions and some examples are fruit tuck shops run by pupils, playground buddy schemes and school nutrition action groups. Actions taken by health promoting schools depend on the wants and needs of pupils which emerge through the consultation process, and pupils are instrumental in planning and delivering those actions.

Case Study: Third Sector & Five Ways to Well-being

Gwent Five Ways to Well-being Network aims to support professionals to promote and protect the mental health and well-being of the population. The Five Ways to Well-being are a Well-being equivalent of 'five fruit and vegetables a day'. **Community Health Champions** are people who can really make a difference to the health of their friends, family, neighbours and work colleagues by passing on information and inspiring them to take steps to look after their health; and in Gwent the third sector are key to the programme in terms of its delivery.

Living in an accessible home is known to improve a person's independence, reduce housing adaptation costs and reduce admissions to residential care facilities. **Care & Repair** provides advice and practical support to vulnerable older and disabled people who wish to undertake repairs, improvements or adaptations to their homes, so as to enable them to remain there in independence and security for as long as they wish.

Intermediate Care Fund is a grant totalling £60m across Wales and is being used to support people to maintain their independence and remain in their own home. The fund helps health boards and partners in local authorities, housing and the voluntary and independent sectors work together to support: frail and older people, those with a learning disability or complex need and those with autism. ICF helps avoid unnecessary admissions to hospital or residential care and delays when someone is due to be discharged from hospital.

The **Gwent Substance Misuse Area Planning Board (APB)** is a regional partnership that provides advice and support to responsible authorities in order to plan, commission and monitor delivery of high quality treatment and prevention services that are based on the needs of substance misusers, families and communities. The APB currently discharges an annual regional Substance Misuse Action Fund (SMAF) budget of £4.4m on behalf of the 5 local authorities to provide adult and young person's drug, alcohol and family support services within the region.

Case Study: Living Well Living Longer

The Aneurin Bevan University Health Board's Living Well Living Longer programme is the first of its kind in Wales, and will start in **Blaenau Gwent** to identify those at the greatest risk of developing cardiovascular disease and invite them for a short health check at venues across the borough. Men in Blaenau Gwent have among the lowest life expectancy in England and Wales according to official statistics.

“We need up-to-date information which is easy to understand so we know what is good and bad for us.”

50 plus Member

What we will do:

- Continue to develop the DEWIS website to provide people with current information.

Actions and next steps

Prevention and Early Intervention including Information, Advice and Assistance (IAA):

- Continue to provide good **public health information, advice and assistance** especially through 5 ways to Well-being and support people to lead and maintain a healthy lifestyle; and support people to 'self-manage' their illness or disability and have more control over their life.
- We will continue to develop DEWIS website.
- Ensure consistent delivery of community connectors and social prescribers across the region to encourage people to fully participate in their local community to prevent social isolation/loneliness; and where appropriate maintain employment and access appropriate welfare benefits.

Commissioning, Pooled Budgets & Health and Social Care Integration:

- Implement '**Care Closer to Home**' strategy to support families and individuals to enable people to live independently in their own homes and communities; and to prevent escalation of need and crisis.

- Explore joint commissioning opportunities between **Intermediate Care Fund, Registered Social Landlords and Supporting People programme** to maximise capacity within the Community.
- The region will continue to support and engage in the Integrated Health and Social Care Collaborative Commissioning Programme and the National Framework for Residential Care Home Placement for People with Learning Disabilities and People with Mental Health Problems (under 65).

Links to key strategies:

- Local Well-being Assessments in each local authority area
- Regional Mental Health & Learning Disability Strategy

Summary and what we will deliver through the joint Area Plan:

- Implement 'Care Closer to Home' Strategy
- Align with 5 local Well-being Assessments required under Well-being of Future Generations Act and explore joint action planning for wider detriments to health

People with Learning Disabilities and Autism Spectrum Disorders

A demography and population profile for individual local authorities is included in the 5 local Well-being Assessments. An abbreviated demography is included in section 1 of this PNA which also includes the population projection for the region.

The priority outcomes identified through engagement with citizens, partners and use of the prioritisation matrix; and subsequently confirmed through consultation are:

1. To support people with learning disabilities to live independently with access to early intervention services in the community; and greater public awareness and understanding of people with learning disabilities needs.
2. To provide more timely diagnosis of Autistic Spectrum Disorder and access to support services and information and advice.

So what does the data show us?

A comprehensive situational analysis is included in the appendix, but a representative sample of need is set out in the chart(s) below.

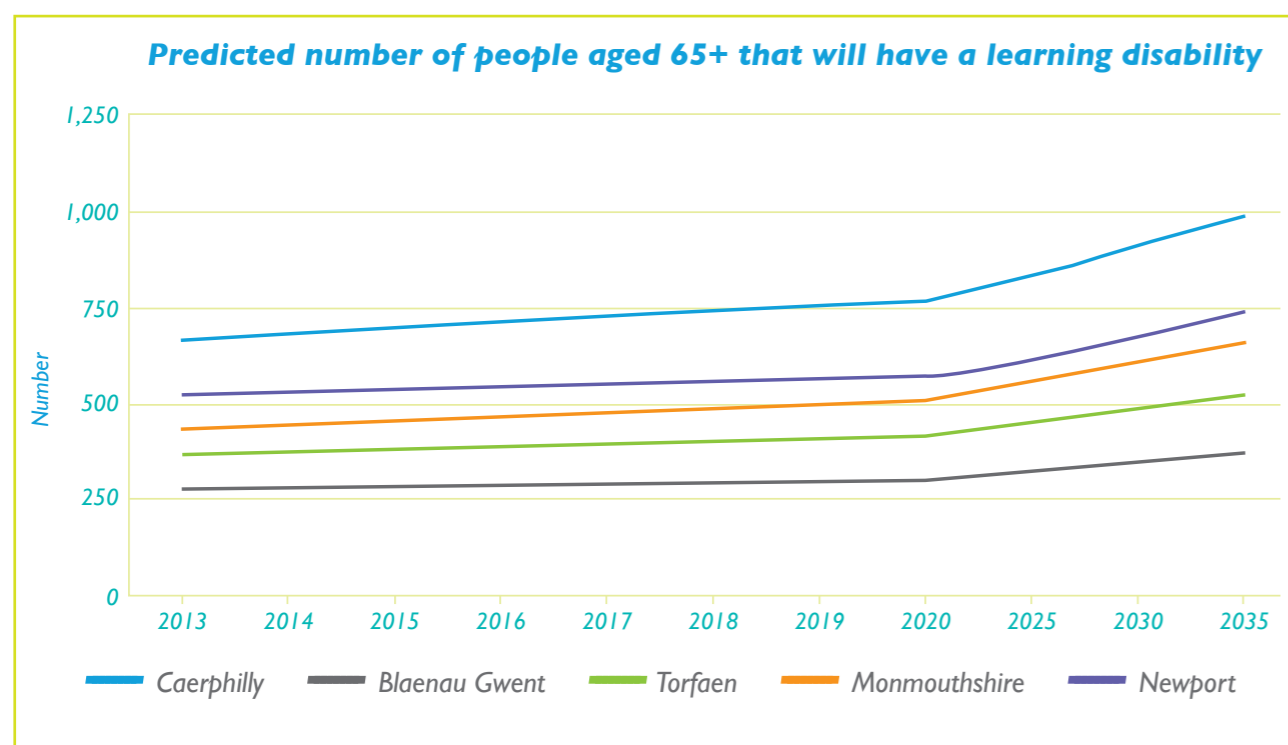


Figure LD1 shows the predicted number of people aged 65 years or older that will have a learning disability over the period 2013 to 2035. All local authority areas across the region are predicted to see an increase in the number. The predicted increases range from 35.4% in Blaenau Gwent to 54.5% in Monmouthshire.

What do we know? – Learning Disabilities

It is estimated that 2 to 3% of the population are living with a learning disability and the Department of Health defines a 'learning disability' as a 'significantly reduced ability to understand new or complex information, to learn new skills' and a 'reduced ability to cope independently which starts before adulthood with lasting effects on development' (Valuing People, 2001).

Learning Disability - Facts & Figures (Disability in the United Kingdom 2016):

- Approximately 1.5 million people in the UK have a learning disability. Over 1 million adults aged over 20, and over 410,000 children aged up to 19 years old have a learning disability.
- 29,000 adults with a learning disability live with parents aged 70 or over, many of whom are too old or frail to continue in their caring role. In only 25% of these cases have a Local Authority planned alternative housing.
- Less than 20% of people with a learning disability work, but at least 65% of people with a learning disability want to work. Of those people with a learning disability that do work, most work part time and are low paid.
- People with a learning disability are 58 times more likely to die aged under 50 than other people. And 4 times as many people with a learning disability die of preventable causes compared to people in the general population.
- People with a learning disability are 10 times more likely to have serious sight problems and 6 out of 10 people with a learning disability need to wear glasses.

A learning disability can be mild, moderate or severe:

- Mild learning disabilities - most people can lead normal lives but that they may need assistance in handling difficult situations.
- Moderate learning disabilities - people generally attend to the basic tasks of life but more complex activities, such as using money, usually require support within a special residential environment.
- Severe learning disabilities - people are able to look after themselves with careful supervision.
- Those diagnosed with profound and multiple learning disabilities (PMLD) have more than one disability, with the main disability being learning difficulties. They are likely to have difficulty in communicating, have mental health disorders and need carer support to assist with daily functions such as washing, dressing and eating.

Some people with a mild learning disability can communicate easily but take a bit longer than usual to learn new skills. Others may not be able to communicate at all and have more than one disability. A learning disability is not the same as a learning difficulty or mental illness. Some children with learning disabilities grow up to be quite independent, while others need help with everyday tasks, such as washing or getting dressed. A diagnosis of a profound and multiple learning disability (PMLD) is used when a child has more than one disability, with the most significant being a learning disability. Many children diagnosed with PMLD will also have a sensory or physical disability, complex health needs, or mental health difficulties and need a carer to help them with most areas of everyday life, such as eating, washing etc.

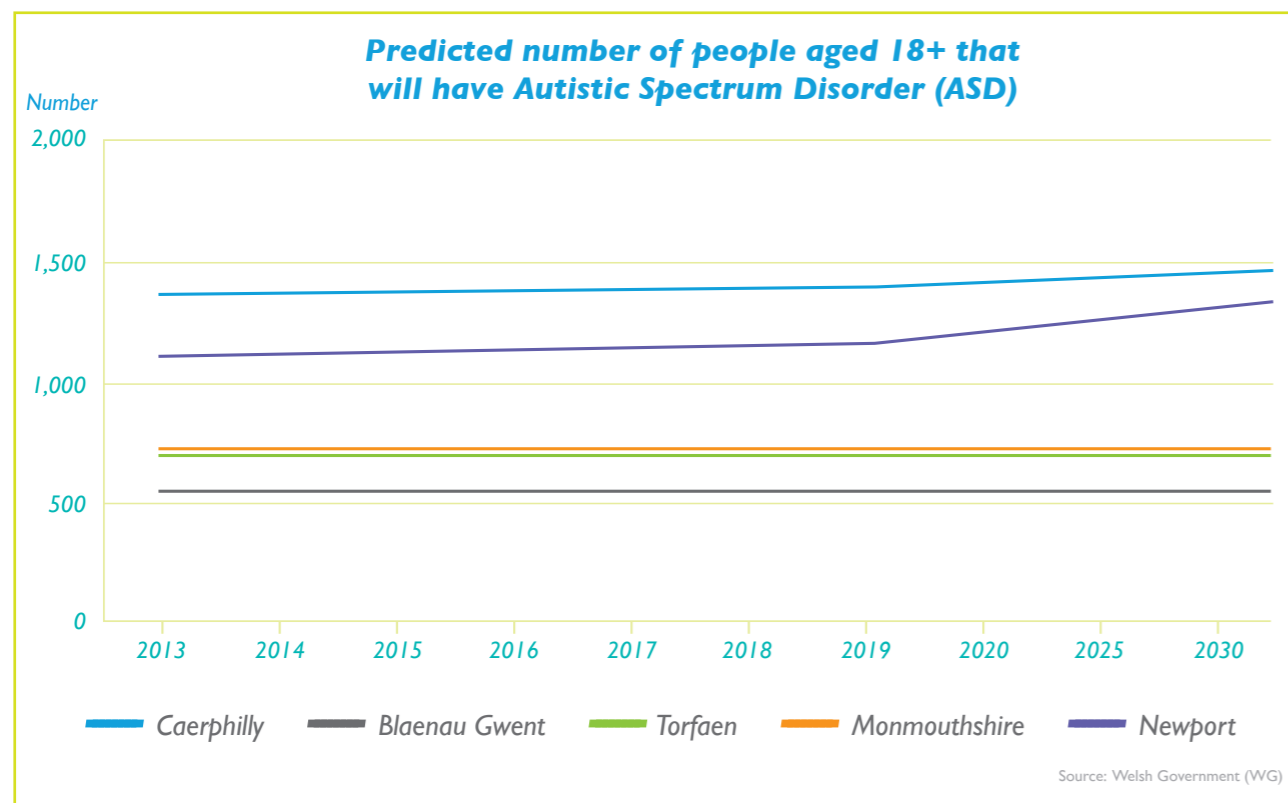


Figure LD4 shows the predicted number of people aged 18+ that will have Autistic Spectrum Disorder (ASD) over the period 2013 to 2035. Across local authorities in the Gwent region, with the exception of Blaenau Gwent, all local authority areas are predicted to see an increase in the number. Across the remaining local authority areas in the Gwent region predicted increases range from 2.1% in Monmouthshire to 17.7% in Newport.

What do we know? Autistic Spectrum Disorder (ASD)

Autism spectrum disorder is defined as 'persistent difficulties with social communication and social interaction' and 'restricted and repetitive patterns of behaviours, activities or interests' present since early childhood, to the extent that these 'limit and impair everyday functioning' (Diagnostic and Statistical Manual, fifth edition).

Facts and Figures

- It is estimated that 1 in every 100 people in the UK have an Autistic Spectrum Disorder (ASD).
- ASD is a lifelong condition and affects people from all backgrounds.
- All individuals with an ASD have impairments in the same three areas (i) social interaction (ii) social imagination (iii) social communication; but sensory impairment and mental health issues are also factors.
- Many people with an ASD have not been diagnosed, and therefore may not realise they have the condition. This is especially true for adults.

Autism is a lifelong condition which is neither a learning disability nor a mental health issue. It is crucial to increase diagnosis rates, effective planning and training available to the public sector, third sector and members of the public. An early ASD diagnosis will enable parents to understand their child's needs and to seek appropriate support in their caring role. Many people with autism are not identified or diagnosed during childhood but may be helped by having access to assessment services as adults. Children, young people and adults with autism and their carers will have different support needs according to their age and abilities. Adults with autism can experience anxiety and social isolation, have difficulties in education, problems in finding/sustaining employment and difficulties in establishing/maintaining social relationships/friendships.

An early ASD diagnosis will enable parents to understand their child's needs and to seek appropriate support in their caring role. Many people with autism are not identified or diagnosed during childhood but may be helped by having access to assessment services as adults. Children, young people and adults with autism and their carers will have different support needs according to their age and abilities. Adults with autism can experience anxiety and social isolation, have difficulties in education, problems in finding/sustaining employment and difficulties in establishing/maintaining social relationships/friendships.

What are we doing?

A regional Mental Health and Learning Disability Partnership Board oversees the delivery of the Gwent Strategy for Adults with a Learning Disability 2012/17 (the strategy is currently being reviewed). The purpose of the strategy is to provide a clear strategic direction regarding the future planning and delivery of services for adults with a learning disability who live within, or have services commissioned across the region. It describes the core principles that are fundamental to service provision and outlines the key issues that need to be addressed to deliver high quality, safe and cost effective services.

The objectives of the strategy for people with a learning disability are to:

- Have more choice and control over their life.
- Have choice regarding how they spend their time and where they live and who they live with.
- Have better health outcomes and appropriate access to healthcare.
- Have smooth, planned and effective transition from child to adult services
- Receive timely and appropriate support for families/carers of people with a learning disability
- Receive support and proactive interventions that promote social and emotional well-being.
- Access the range of appropriate specialist health and social care services in a timely manner.
- Receive a co-ordinated, safe and timely service and appropriate support to plan for the future.
- Receive clear information regarding generic and specialist learning disability services.

A robust mapping of services and community support has been undertaken by **Supporting People (SP) Teams** across the region. Supporting People teams have also prioritised people with learning disability through the regional SP Plan. The In One Place Programme is a collaborative programme that was launched in 2014 to improve the provision of accommodation to those with complex health and social care needs within the Gwent region. The **In One Place Programme** brings together the Aneurin Bevan University Health Board, the five local authorities and eight housing associations.

Case Studies:

Torfaen are currently developing a local Learning Disability strategy to: develop ways of preventing the need for longer term care, greater involvement of adults in all aspects of care and support, flexible, personalised and alternative models of care, and a social care workforce that has the necessary knowledge and skills.

Caerphilly People First have received adult safeguarding training through the Adult Safeguarding Board and developed a specific training programme for people with learning disabilities, and have also identified people with learning disabilities to train as champions and deliver safeguarding training amongst their peers.

Autism

Wales was the first country in the UK to take a national approach to autism, originally publishing a Strategic Action Plan in 2008. Welsh Government refreshed the plan in November 2016 and it sets out the Welsh Government's ambitions for both raising awareness of autism and ensuring public services work together to deliver effective care and support services for adults and children with autism.

The revised Strategic Action Plan sets out three priority areas for action, based on what was highlighted:

- Timely access to assessment and diagnosis – a standardised assessment pathway with a new 26 week waiting time from referral to first assessment appointment has been established. There will also be improvements to adult's diagnostic services through the National Integrated Autism Service.
- Support to overcome everyday barriers in education/training, employment and accessing services.
- Identify gaps in information, advice and training. Across the region Welsh Government and local partners will build on the 'Learning with Autism' programme for primary schools and develop new resources for education settings. There will also be a focus on training for primary care and mental health professionals, people working in leisure services, and employers in general.

An independent evaluation of the national Autistic Strategic Action Plan undertaken in 2012 reported that the strategy had a positive impact on people and families, as well as professionals. There have been increased rates of identification as well as increased rates of diagnosis. There has also been improved support for children and young people in education, as well as improvement in transition services.

"We want to live in our own homes and feel listened to and want more face to face chats."

Access for All member

What we will do:

- **Ensure workforce are trained and skilled to undertake 'what matters most' conversations.**

Actions and next steps

Prevention and Early Intervention including Information, Advice and Assistance (IAA):

- Continue to increase the profile and awareness of ASD and promote use of materials available through national ASD website www.asdinfo.wales.co.uk. The website includes information and resources for people with autism, families, carers and professionals. The quality of the national resources has been recognised internationally and Welsh Government has been approached by a number of countries for permission to use the materials.
- Align Supporting People provision with local community connectors to ensure people are aware of support services and signposted to community provision.

Commissioning, Pooled Budgets and Health & Social Care Integration:

- Review current strategy for Adults with a Learning Disability with an emphasis on integrated planning to improve outcomes, integrated service delivery and reduce inequalities across the Boroughs and; joint commissioning priorities to inform commissioning of services.
- Develop a co-ordinating group and a local ASD lead to oversee development of improved services and link to a national ASD co-ordinator.
- Support and implement new National Integrated Autism Service. Since April 2016, Welsh Government have funded the development of new specialist teams in every region, providing adult diagnostic services. The service also support the improvements in children's diagnosis, treatment and support services through the 'Together for Children and Young People' programme. The service will also provide wider support and advice for children and adults, as well as their families or carers. It will also provide training and support for professionals.
- Explore joint commissioning opportunities between Intermediate Care Fund and Supporting People programme for people with learning disabilities to maximise capacity within the Community, including greater awareness of ASD and invest in further resource materials to raise awareness of autism and provide training resources across professional groups.
- The region will continue to support and engage in the Integrated Health and Social Care Collaborative Commissioning Programme and the National Framework for Residential Care Home Placement for People with Learning Disabilities and People with Mental Health Problems (under 65).

Links to key strategies:

- Regional Supporting People Plan
- National Autistic Spectrum Disorder (ASD) Strategic Action Plan.

Summary and what we will deliver through the joint Area Plan:

- Support Mental Health and Learning Disability Partnership Board review Gwent Strategy for Adults with a Learning Disability 2012/17 and set out key regional commissioning and integration actions.
- Local implementation of Welsh Strategic Action Plan including development of new Integrated Autism Service.

Mental Health

A demography and population profile for individual local authorities is included in the 5 local Well-being Assessments. An abbreviated demography is included in section 1 of this PNA which also includes the population projection for the region. For the purpose of this PNA children and young people are categorized as up to the age of 18 years and receiving care and support services.

The priority outcomes identified through engagement with citizens, partners and use of the prioritisation matrix; and subsequently confirmed through consultation are:

1. Increased understanding and awareness of mental health amongst the public to reduce stigma and help people to seek support earlier.
2. To improve emotional well-being and mental health for adults and children through early intervention and community support.

So what does the data show us?

A comprehensive situational analysis is included in the appendix, but a representative sample of need is set out in the chart(s) below.

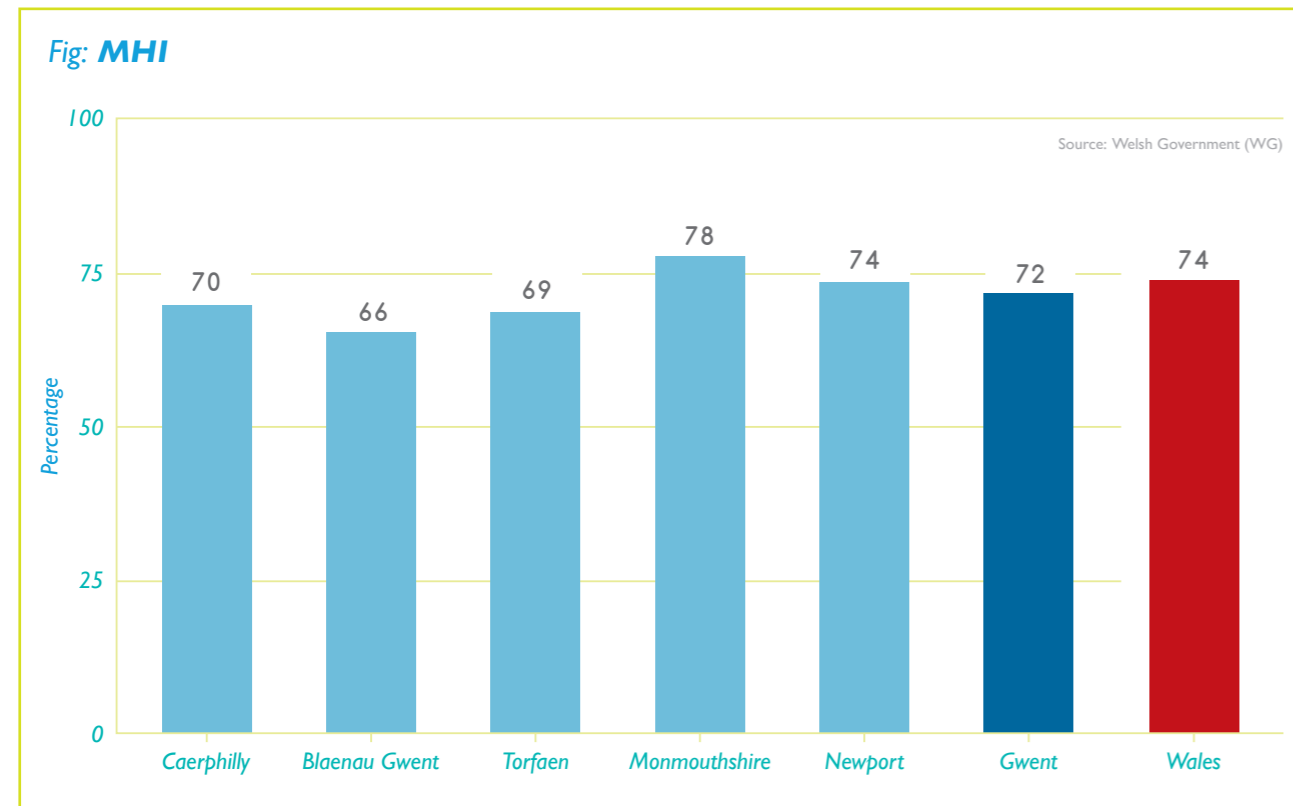
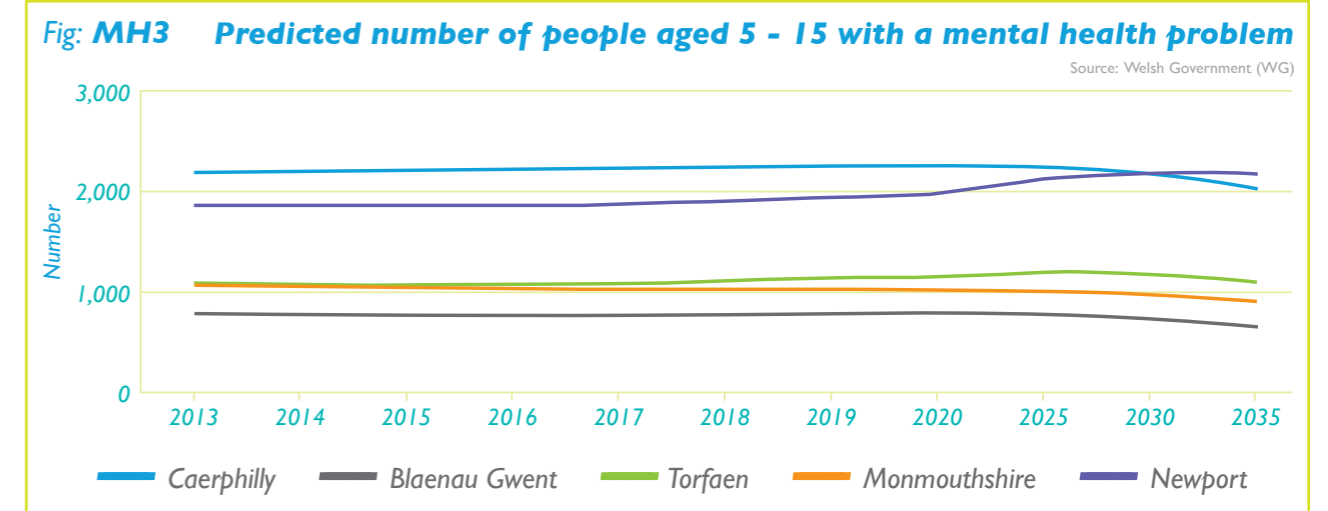


Figure MHI shows the percentage of people aged 16 years or older free from a common mental disorder in 2013-2014. The percentage ranged from 66% in Blaenau Gwent to 78% in Monmouthshire. This compares with 72% of people aged 16 years or older free from a common mental disorder for Gwent and 74% for Wales.

Figure MH3 shows the predicted number of people aged 5 - 15 with a mental health problem over the period 2013 to 2035. Across the local authority areas in the Gwent region both Torfaen and Newport are predicted to see increases of 0.4% and 16.6% in the number of people aged 5 - 15 with a mental health problem. The other local authority areas are all predicted to see decreases over the same period.



Fact and figures for mental health and mental illness across Wales? (Welsh Government)

- 1 in 4 adults experiences mental health problems or illness at some point during their lifetime.
- 1 in 6 of us will be experiencing symptoms at any one time.
- 2 in 100 people will have a severe mental illness such as schizophrenia or bipolar disorder.
- 1 in 10 children between the ages of 5 and 16 has a mental health problem and many more have behavioural issues.
- Approximately 50% of people who go on to have serious mental health problems will have symptoms by the time they are 14 and many at a much younger age.
- Between 1 in 10 and 1 in 15 new mothers experiences post-natal depression.
- 1 in 14 people over 65 and 1 in 6 over the age of 80 will be affected by dementia.
- 9 in 10 prisoners have a diagnosable mental health and/or substance misuse problem.

What do we know?

Positive mental health is a key factor for good health and relevant to the whole population. In 2007 the World Health Organisation stated that there is no health without mental health, which means that public mental health is integral to all public health work. Statistics show that one in four of the adult population have a life chance of experiencing mental ill health. Mental illness is the largest single cause of disability with 22.8% being attributable to mental illness, compared with 16.2% for cardiovascular disease and 15.9% for cancer. This is forecast to increase by 7.8% by 2030 (WHO, 2008). Self-reported surveys show that 13% of adults in Wales report having a mental illness (Welsh Health Survey 2015). Mental illness can have multiple impacts upon society including poor educational attainment, increased substance misuse as well as increased anti-social behaviour and crime. There are also large economic costs of mental illness, with the estimated overall cost of mental health problems in the UK being over £110 billion in 2006/07, representing 7.7% of GDP. Care and treatment of mental disorders account for over 10% of total NHS expenditure.

Over the last 4 years there has been over 100% increase in referrals to Children and Adolescent Mental Health Service (CAMHS). Many of the children and young people who are then assessed do not need highly specialist interventions, but add to the waiting times for those children who do need such support.

Suicide is a tragedy for all concerned and is a cause of distress for many people - the individual, family, friends, professionals and the community at large. It is estimated that for every person who dies through suicide at least six others are significantly and directly affected. Many others may be indirectly affected. Losing someone through suicide can be particularly traumatic and difficult to cope with; its impacts are psychological, spiritual and economic. There is no single reason why someone may try to take their own life. It is best understood by looking at each person's life and circumstances. However certain factors or problems may make suicide more likely. Previous self-harm is a key risk factor. Mental illness, misusing drugs or alcohol or having a close relative who has died from suicide may increase risk. Life events like losing your home, job or the end of a relationship can also increase the risk of suicide or self-harm.

Many people may have thoughts of suicide because of distressing events; about 19 people in every 100 will have these thoughts at some point in their life. Only a very small number of those who harm themselves or who think about suicide will actually die in this way. Suicide is about three times more common in men than women. This may be because men tend to use different methods to those used by women. Women are much more likely than men to be admitted to hospital as a result of self-harm. The number and rate of suicide in the general population in Wales rose between 2009 and 2013. The rise was found in males only. Suicide is one of the three leading causes of death in the most economically productive age group (15-44 years); and during the period 2010 – 2012 it accounted for almost one in five deaths in males aged 15 to 24 years (the second leading cause of death in this age group) and just over one in ten deaths amongst women of that age. Each year in Wales between 300 and 350 people die from suicide. This is about three times the number killed in road accidents. Overall - Gwent has one of the lowest suicide rates in Wales – 10.4 per 100,000 population.

What are we doing?

Responding to mental illness is not the sole responsibility of any one organisation, the challenge is one shared across all partners and there is increasing recognition that the wider issues that affect health and well-being (housing, education, employment) sit with equal importance alongside clinical diagnosis and treatment.

Where people live has an impact on their psychological well-being, both positively and negatively. At the local level, health, social care and third sector organisations have already committed to working as one to address the challenge.



A regional Mental Health and Learning Disability Partnership Board has been developed to:

- Oversee the delivery of the Gwent Mental Health and Learning Disability Strategies
- Oversee the delivery of the **'Together for Mental Health'** strategy and other relevant Mental Health and Learning Disability strategies such as **'Together for Children and Young People'**, **'Talk to Me 2'** and the **'ASD Strategic Action Plan'**.
- Map existing services, planning and commissioning arrangements and strategic arrangements across partner organisations.
- Develop a strategic vision for improving mental health and learning disability and best use of resources across partner organisations.
- Agree the strategic and operational issues of joint working in relation to mental health and learning disability.
- Identify key strategic national and local issues requiring a collaborative approach in order that the benefit to service users and carers is maximised.
- Agree multi-agency strategies and the contribution of stakeholder agencies taking into account other partnership arrangements both within the area and nationally.

A regional 'Together for Mental Health' delivery plan is being developed and will set out the actions to progress Welsh Government national priorities at a local and regional level.

The delivery plan sets out regional actions across 11 priority areas and will build on the delivery of the current regional Together for Mental Health in Gwent and South Powys 2012-2017 strategy.

Case Studies: ABUHB and Newport

A **review of the commissioning of Adult Mental Health Third Sector Services across Gwent** took place during early part of 2016 and one service model and tender was identified. All Local Authorities in Gwent commission mental health services from the Third Sector, however at the time of the tender exercise only NCC were in a position to commission alongside ABUHB. However, all the other four authorities have been kept updated and it is hoped that they will also align their funding to the new service delivery areas when their contracts end in March 2017. The new service model areas reflect the priorities identified via a public and provider consultation process and are: Advocacy, Counselling, Skills, Training and Community Well Being (Drop ins/centres/hubs) and Information and advice.

The Gwent Five Ways to Well-being virtual network includes over 250 individuals from a range of statutory and third sector organisations trained on **'The Five Ways to Well-being'** an evidence-based set of actions developed by the New Economics Foundation. We are developing support across the region to intervene earlier and for targeted groups such as veterans who have been in the armed forces and who may have experienced the trauma of battle - this will need to be coupled with specialist therapeutic help to recover when they return to their communities. This help should be delivered by a combination of statutory and voluntary sector organisations.

Support for individuals with substance misuse problems are planned and commissioned on behalf of the Gwent area by an Area Planning Board where the needs of those with a co-occurring mental health and substance misuse issue are responded to, and it is key not to duplicate efforts.

Case Studies: Torfaen Social Prescribers

More and more, greater importance is being placed on the need for support services based in the community, which people can access to improve low levels of poor mental health and well-being. Community Connectors funded through the Intermediate Care Fund and Torfaen Social Prescribers based in GP surgeries help link people to local groups in the community to avoid isolation and to keep healthy and active.

Previous reviews of specialist Child and Adolescent Mental Health Services (CAMHS) in Wales have identified that the service is under more pressure than ever before, but does not have the capacity to meet demand. **'Together for Children and Young People' (T4CYP)** was launched by the Minister for Health and Social Services on 26th February 2015. Led by the NHS in Wales, this multi-agency service improvement programme is aimed at improving the emotional and mental health services provided for children and young people in Wales.

A continued emphasis on emotional, mental health and well-being is essential so that services can identify early on where there may be additional need for support. This is very important to prevent young people requiring the services of specialist CAMHS. The **Skills for Living Service** in Gwent, supported by local authority and health board funding focusses on the mental health needs of looked after children, recognising the significant additional risks faced by this group.

Case Studies: Caerphilly

The **'Road to Well-being'** (R2W) programme has been developed which provides universally accessible psycho-educational classes and information resources to help people manage stress and improve mental well-being. The R2W programme is co-delivered with the Communities First Mental Health Workers in Caerphilly County Borough Council. The re-commissioning of the third sector provision, and subsequent contract award to the Growing Spaces consortium, will also extend the Foundation Tier provision aimed at improving mental well-being and resilience.

An Action Learning Set has developed a **"Whole Person, Whole Life Approach to Crisis and Recovery"**. The key component of the new model is likely to include a 24/7 single point of access; mental health support for first responders; acute in-patient provision; crisis, home treatment and liaison; crisis housing; sanctuary homes; host families and housing and tenancy support. All of the above are being developed within the context of resilient communities and recovery orientated services that prevent crisis.

Mental Health First Aid (MHFA) started in Australia in 2000, with the aim of increasing mental health literacy among the general community. The idea of MHFA is that people should be taught how to perform basic 'first aid' for those exhibiting signs of mental health distress, just as they are commonly taught first aid for physical problems. It is available to increase knowledge, reduce stigma and increase supportive reactions in terms of mental health. MHFA educational courses are available in Gwent for anyone who wishes to help to identify, understand and help a person who may be developing a mental health issue. It teaches people how to recognise the signs and symptoms of common mental health issues, provide help on a first aid basis and effectively guide someone towards the right support.

"I see many pupils in my school with self-image issues and low self-esteem and we need greater support in our local communities."

Headteacher

What we will do: Explore how the Youth Mental Health First Aid training can be delivered across the children's workforce.

In Wales 'Talk to Me 2' is the Welsh Government's strategy on suicide and self-harm prevention (2015/20) and includes measures to develop individual resilience across the life course, and build population resilience and social connectedness within communities. This five-year action plan aims to raise awareness of suicide and self-harm and help people understand that it is often preventable.

The plan is aimed mainly at people who are at highest risk. It has six objectives:

- 1.** Further improve awareness, knowledge and understanding of suicide and self-harm amongst the public, individuals who frequently come in to contact with people at risk of suicide and self-harm and professionals in Wales.
- 2.** To deliver appropriate responses to personal crises, early intervention and management of suicide and self-harm.
- 3.** Information and support for those bereaved or affected by suicide and self-harm.
- 4.** Support the media in responsible reporting and portrayal of suicide and suicidal behaviour.
- 5.** Reduce access to the means of suicide.
- 6.** Continue to promote and support learning, information and monitoring systems and research to improve our understanding of suicide and self-harm in Wales and guide action.

Actions and next steps

Prevention and Early Intervention including Information, Advice and Assistance (IAA):

We will continue to develop the Community Connector and the Social Prescriber model across the region and ensure a consistent regional approach through **'Together for Mental Health Delivery Plan'**. Key to this will be linking through to the ABUHB 'Care Closer to Home' model and a place based approach. We will also build on the 'Five Ways to Well-being' and ensure accurate information, advice and assistance is provided through our IAA services and DEWIS.

Commissioning, Pooled Budgets and Health Social Care Integration:

- Regional requirements for commissioned services will be identified through **'Together for Mental Health Delivery Plan'**. We will also consider a number of reviews across the Gwent area undertaken by Health Inspectorate Wales.
- The Intermediate Care Fund will also be aligned to support the agenda across both adult and children services as well as aligning to other existing funding, such as Supporting People, to maximise resources
- We will also use ABUHB's 'Care Closer to Home' and Integrated Medium Term Plan (IMTP) to coordinate community support services to ensure consistency and avoid duplication.
- The Regional Joint Commissioning Group is currently reviewing the third sector contributions across health and social care; and the review will consider the community support required to support mental health agenda such as befriending.
- The region will continue to support and engage in the Integrated Health and Social Care Collaborative Commissioning Programme and the National Framework for Residential Care Home Placement for People with Learning Disabilities and People with Mental Health Problems (under 65).

Links to key strategies:

- Welsh Government (2012) Together for mental health - A Strategy for Mental Health and Well-being in Wales <http://gov.wales/docs/dhss/publications/121031tmhfinalen.pdf#>
- Welsh Government (2015) Talk to me 2 - Suicide and Self Harm Prevention Strategy for Wales 2015-2020 <http://gov.wales/docs/dhss/publications/150716strategyen.pdf>
- National Together for Mental Health Delivery Action Plan
- Together for Mental Health Gwent
- ABUHB Integrated Medium Term Plan (IMTP)

Summary and what we will deliver through the joint Area Plan:

- Review and align regional strategies to Together for Mental Health Delivery plan
- Coordination of consistent community based services such as community connectors / social prescribers
- Multi agency place based models which include wider partners such as Housing Associations, employment support and community programmes
- Accurate Information, Advice and Assistance through DEWIS and Five Ways to Well-being

Sensory Impairment

A demography and population profile for individual local authorities is included in the 5 local Well-being Assessments. An abbreviated demography is included in section 1 of this PNA which also includes the population projection for the region. For the purpose of this PNA sensory impairment refers to people with either visual or hearing impairments or both - the extent of those impairments will vary from person to person.

The priority outcomes identified through engagement with citizens, partners and use of the prioritisation matrix; and subsequently confirmed through consultation are:

1. Ensure people are supported through access to accurate information, assistance and 'rehabilitation' where required.
2. Improve emotional well-being especially through peer to peer support.

So what does the data show us?

A comprehensive situational analysis is included in the appendix, but a representative sample of regional emerging areas are set out in the chart(s) below.

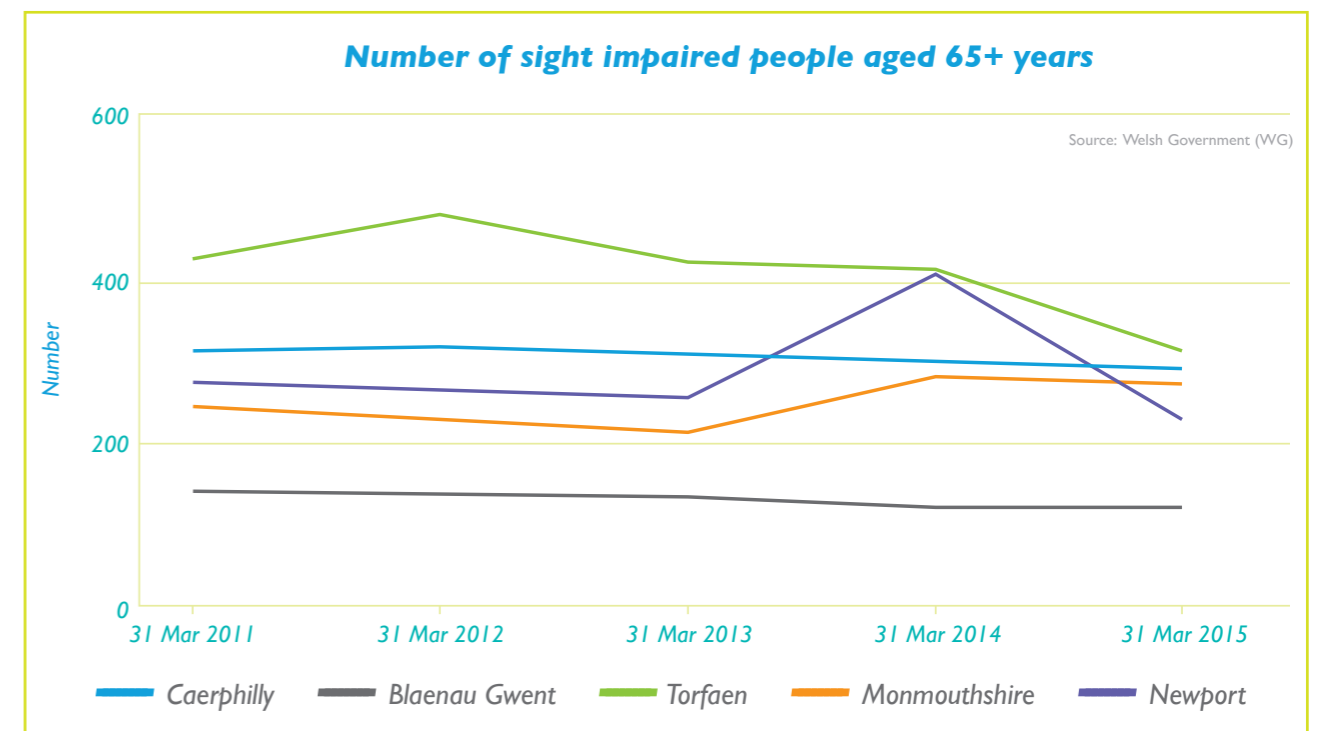


Figure above shows the number of sight impaired people aged 65 years or older over the period 31 March 2011 to 31 March 2015. Across the local authority areas in the Gwent region, Monmouthshire has seen an increase of 14.1% in the number over the period, from 241 at 31 March 2011 to 273 at 31 March 2015. The other local authority areas across the Gwent region all saw decreases which ranged from 6.5% in Caerphilly to 27% in Torfaen over the same period.

What do we know?

There are an estimated 106,000 people in Wales living with sight loss and broad figures suggest that 1 in 10 people over 65 will have some form of sight loss to different degrees, 1 in 3 over 80 and 1 in 2 over the age of 90. Figures are estimated to double by 2050 because of the aging demographic and 75% of all sight loss occurs in people aged 65 and over. There are currently around 3500 people in Gwent that are registered as sight impaired but most of the data capture of sensory impairment is poor because many people with sight loss do not appear on severely sight impaired (SSI) (previously known as 'blind') or sight impaired (SI) (previously known as 'partially sighted') registers for many reasons. People who are hard to reach generally fail to register (evidence shows that people from some ethnicities are 6 times more likely to experience sight loss but are less likely to engage; and people with learning disability are 10 times more likely to have sight loss but are rarely diagnosed). Some people simply don't wish to confirm a diagnosis and some people choose not to be registered because they are concerned with the stigma in relation to jobs etc (also there may be a significant number of people who perhaps fear that they shouldn't be driving, and therefore don't go to the optometrist/GP as they fear licence removal). Sight is the primary conduit through which our brains absorb information but 43% of people who lose their sight will suffer significant and debilitating depression. Health indices demonstrate a reduction in positive outcomes, and well-being is heavily compromised post diagnosis.

It is estimated that the numbers of people registered as SSI or SI will increase as there is a direct relationship to an increasing older population, however new treatments have emerged over recent years for some causes of sight loss which are related to age and so we may see a slower rate of increase or a plateauing of those with sight loss. It is generally accepted within the sight loss community that there are at least 5 times as many people with uncorrected sight loss than are 'registered' on local authority registers. RNIB estimate there are 28,000 people in Gwent with sight loss. National studies conducted by the Centre for Disability Research at Lancaster University suggests that an estimated 579,000 adults with learning disabilities (including 122,000 known to the statutory services) have refractive error (blurred vision).

Hearing loss

In terms of hearing loss 'Action on Hearing Loss' estimate 1 in 6 people have hearing loss or tinnitus (530,000 in Wales and 1 in 3 over the age of 80). Both sight and hearing loss are prevalent in the older population and it is likely that up to 70% of those with sight loss have a hearing loss too. Obviously some of those people will have a hearing aid that effectively mitigates the loss, although it is true that a hearing aid doesn't provide the same level of support as, say, spectacles would if someone was simply short-sighted or long-sighted.

Information provided by public services should be accessible to people who are deaf or have hearing loss and a planning approach should be embedded where all information intended for people who are deaf or have hearing loss is fully accessible and so available in British Sign Language and, if in video form, subtitled. Residential care home staff should be supported to identify people who are deaf or have hearing loss and to ensure that they are appropriately supported. 70% of 70 year olds have a hearing loss but evidence shows that the numbers of people identified in Care Homes as needing hearing support is much lower, leading to many people being left out of activities and social interaction. The Commissioner for Older People in Wales has recently published a report with some guidance for care homes which should be implemented to improve care. The increasing older population is leading to higher demand on services like audiology and the ABUHB audiology team have already worked with third sector partners to develop volunteer based hearing services, now being provided in-house as a core part of the audiology delivery. The team is working with stakeholders on future developments of service including consideration of primary care audiologists, following on from successful pilots elsewhere in Wales.

Health and social care services for people who are deaf or have hearing loss should be shaped and designed in collaboration with service users and third sector. People who are deaf or have a hearing loss should as part of their pathway after diagnosis, or on first contact with social care, be offered the opportunity to register (local authorities have a statutory duty to offer to register people who are deaf or have hearing loss).

Teams supporting people with mental health issues or dementia need greater awareness of the specific communication needs of people who are deaf or have a hearing loss, given the high prevalence and co-morbidity rates. Supporting improved communication in most cases can lead to better health outcomes for other conditions and support in a more robust manner and the right of deaf people to engage in prudent healthcare discussions about their own care.

Action on hearing loss reporting estimated that there are 105,000 people across Gwent with hearing loss using 2014 StatsWales estimates.

Other information highlighted:

- More than 70% of over 70 years-old and 40% of over 50 years-old have some kind of hearing loss.
- Around one in every 10 UK adults has tinnitus. This increases to 25-30% of over 70 years-old.
- For some people their tinnitus is so severe that it has a dramatic impact on their quality of life, leading to extreme anxiety and depression.
- People with hearing loss are too often unable to communicate with friends and family, colleagues and health professionals. This can result in them withdrawing from social situations and becoming isolated.
- Research shows that hearing loss doubles the risk of developing depression and increases the risk of anxiety and other mental health problems.
- There is also strong evidence that mild hearing loss doubles the risk of developing dementia, with moderate hearing loss leading to three times the risk, and severe hearing loss five times the risk.
- People who are severely or profoundly deaf are four times more likely to be unemployed than the general population. Someone who develops hearing loss can lose their job and struggle to get another one.

Evidence suggests that the timely provision of hearing aids can reduce these risks and improve quality of life.

Other reports evidence a number of key messages:

- In the 2012 Action on Hearing Loss report 'Life Support' it was found that communication needs are not taken into account in the systems used to determine an individual's social care budget in a third of local authorities (33%) in Wales. They also found that three-quarters (75%) of local authorities in Wales did not provide a text phone number or special telephone service for people with hearing loss. The report also found that a quarter did not provide advocacy support for people with hearing loss.
- Action on Hearing Loss Cymru in 2015 used the experiences of people with sensory loss who have used housing services in Wales, to develop best practice guidance which recommends that housing services should provide deaf awareness training for housing staff, install and maintain hearing loops in accommodation, and consider the effects of background noise when allocating tenancies.
- A 2015 report found that people with hearing loss in Wales face serious barriers to employment due to employer attitudes and inadequate support in the workplace. The report also found that some Job Centre staff did not provide specialist support for people with hearing loss and were unaware of their communication needs.
- In 2013, Wales became the first country in the UK to develop guidance on communication and information in GPs and hospitals for people with sensory loss.

What are we doing?

Both Social Services and ABUHB provide services and support to people with sensory loss. There is also support services in the third sector and 'Sight Cymru' work across the region. The Low Vision Service Wales (LVSU) was founded in 2004 with the aim of providing a more accessible low vision service for the population of Wales:

- The LVSU is delivered by optometrists, dispensing opticians and ophthalmic medical practitioners who have undergone further training in the speciality of low vision with Cardiff University and funded by Welsh Government as an enhanced primary eye care service.
- Free at point of contact for the service user, any low vision aids are provided on a long term loan basis and recycled when no longer required.
- The establishment of the service resulted in the number of low vision assessments performed in Wales increasing. Waiting times to access a low vision service decreased from 6 months to 2 months for the majority of people and journey time decreased for 80% of people.
- Year on year the numbers of patients accessing the LVSU has increased, with 8049 LVSU assessments being performed between April 2015 and April 2016 (WG, 2016).
- By 2015, the LVSU had completely replaced all secondary care based low vision services in Wales. The LVSU now has 184 practitioners working from 202 practices across Wales to deliver the service. 20% of low vision assessments performed are done so within the patient's own home (WG, 2016).
- The LVSU assessment is a holistic assessment where the practitioner discusses the difficulties caused by the vision impairment and works with the patient to set goals and identify solutions, these may be in an optical or non-optical form.
- Practitioners work very closely with Social Services and the voluntary sector to ensure that patients receive support to remain as independent as possible.
- The LVSU continues to evolve. Current work is being done to identify patients who are at risk of depression, and future work will look more closely at identifying those patients with dual sensory loss.

"I felt so much better for talking to another person who has gone through the same problems as me."

Member of Sight Loss Support Group

What we will do: Continue to support peer to peer groups.

Case Studies: Sight Cymru, Blaenau Gwent

A peer support group for people with Visual Impairment and their carers was established in 2014 and facilitated by Sight Cymru. In 2016, some members expressed an interest in taking on responsibility for the group. This led to the formation of a committee drawn from amongst users of the group and it has since become officially constituted, opened a bank account and is being supported to source suitable funding to continue its work. This move towards self-sustainability was vital and the sense of purpose afforded to group members by being able to take ownership and decide direction is invaluable. One of the most valuable aspects of the group has been the mutual support given and received by the various members. An example of this can be found in relation to one particular older lady, who was new to having a visual impairment and consequently experiencing depression and isolation. She was encouraged to attend the group and ended up in conversation with a younger man who had been living with sight loss for a number of years. His positive attitude and encouragement resulted in the lady later stating to a Sight Cymru staff member that she felt "so much better" for having spoken with this man. The group is currently moving to an even larger venue, in order to accommodate a further increase in numbers, a fact which serves to highlight just how many people can potentially be reached by this type of informal yet essential support.

Actions and next steps

Prevention and Early Intervention including Information, Advice and Assistance (IAA):

- People can, and do, adjust to loss of sight and continue leading independent and fulfilling lives. The key to such adjustment is sufficient accessible information and timely, effective rehabilitation. DEWIS is being developed across the region to improve information and will include functions to help people with sensory impairment. Over 50% of sight loss is avoidable.
- Mutual and peer to peer support amongst people living with a visual impairment has proven to be successful in user led groups developed across the region - see case study above - and further development of similar models will need to be supported across the region to help empower and enable citizens.
- Typically, sight-loss conditions deteriorate and people need access to rehabilitation officers to help them adjust to their condition and living safely in their homes, and other preventative services. Research shows positive impacts in functional vision and a correlation on improved mental health and well-being by early intervention rehabilitation for the Vision Impaired. With only 1 in 4 people with sight loss of working age being in employment, there is an economic driver to ensuring high levels of independence too.
- For people with sight loss, access to specialist habilitation/rehabilitation is vital to maximise independence and ensure quality of life. It also has a considerable beneficial impact on those living with or caring for someone with sight loss, people who otherwise are at risk of mental health issues themselves. Ensuring people understand their sight conditions and are able to take up clinical solutions and have access to other services are fundamental to their ongoing capacity to cope. Rehabilitation provides not only a functional enabling resource for the person with sight loss, but also delivers understanding to carers and

family members. Rehabilitation for the Vision Impaired is not re-ablement which implies recovery from disability and is often limited to 6 weeks. It should be viewed in the context of preventing falls, burns, injuries and decline in mental or physical health as well as the ability to promote independent living, ongoing education and social development.

- With so many of those losing their sight being elderly: hearing impairment, dementia and frailty are frequently experienced simultaneously, and continuing sight degeneration compounds impacts. As circumstances change, further access to provision should be enabled, and clear accessible services should be a priority. It is therefore essential that people receive timely access to provision although at present, there are no statutory guidelines around the time it takes for each local authority to contact people post referral.

Commissioning, Pooled Budgets & Health and Social Care Integration:

It is well recognised that there is a need to reduce the time people are on waiting lists and to provide earlier interventions to prevent people reaching crisis. A principle of the commissioning process should include guidance on ensuring a sufficient number of Rehabilitation Officers for Visual Impairments (ROVIs) per head of the population, and the quality and timeliness of the service. In this respect, the benchmarking good practice guidance around rehabilitation for the vision impaired provides a sustainable standard.

An Adult Sight Loss Pathway has been developed, including the requirement that those people moving through the hospital setting should see an Eye Clinic Liaison Officer, and that all people with sight loss greater than 6/60 should be assessed by a Rehabilitation Officer. The Adult UK Sight Loss pathway sets out a defined pathway across health and social care and provides an important tool for enabling and streamlining the requirements under Act; it encourages more effective partnership working and a smooth transition for the person with sight loss.

The critical role of the eye clinic liaison service is recognised within the pathway as a first point of contact in the hospital setting. The requirement within the Act to offer advice and information is frequently provided by these specialists although funding for these roles is uncertain. Through the joint regional commissioning group guidance and adoption of the ASL pathway will be considered across the region.

Links to key strategies

- Welsh Government/NHS Wales Together for Health - Eye health Care Delivery Plan for 2013-2018.
- Wales Vision Strategy Implementation Plan 2014 - 2018.

Summary and what we will deliver through the joint Area Plan

- Use good practice and effective pathways to develop regional commissioning principles.
- Ensure accurate, accessible and timely Information, Advice and Assistance through DEWIS and other means.
- Work in partnership with third sector to identify new models to support rehabilitation process and supply of low vision tools.

Carers who need support

A demography and population profile for individual local authorities is included in the 5 local Well-being Assessments. An abbreviated demography is included in section 1 of this PNA which also includes the population projection for the region. For the purpose of this PNA a Young Carer is defined as a person under 18 who provides or intends to provide care for another person, and a carer is defined as a person who provides or intends to provide care for an adult or a disabled child (but paid carers are excluded). This is a major change to the previous definition - in that carers no longer have to establish that they are also 'providing or intending to provide 'a substantial amount of care on a regular basis'.

The priority outcomes identified through engagement with citizens, partners and use of the prioritisation matrix; and subsequently confirmed through consultation are:

1. Support carers to care through flexible respite, access to accurate information, peer to peer support and effective care planning.
2. Improve well-being of young carers & young adult carers through an increased public understanding.

What does the data show us?

A comprehensive situational analysis is included in the appendix, but a representative sample of need is set out in the chart(s) below.

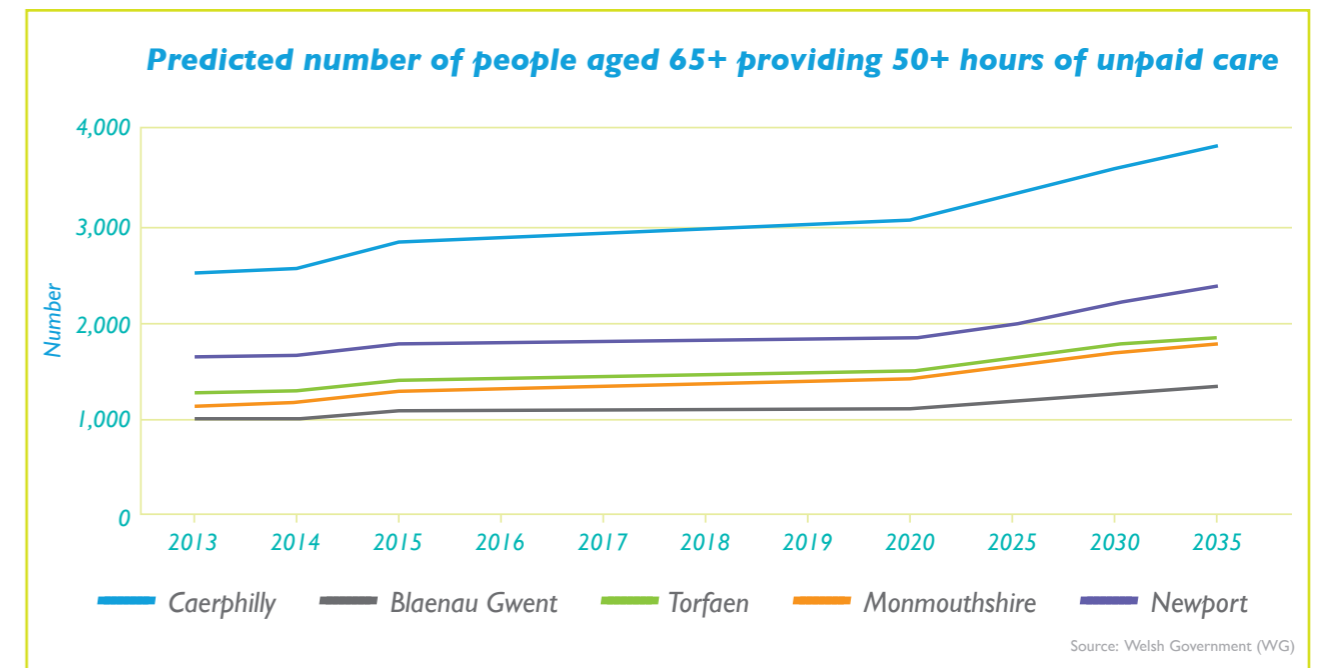


Figure above shows the predicted number of people aged 65 years or older providing 50 hours or more of unpaid care over the period 2013 to 2035. All local authority areas across the Gwent region are predicted to see an increase in the number. The predicted increases range from 35.6% in Blaenau Gwent to 58.9% in Monmouthshire over the period.

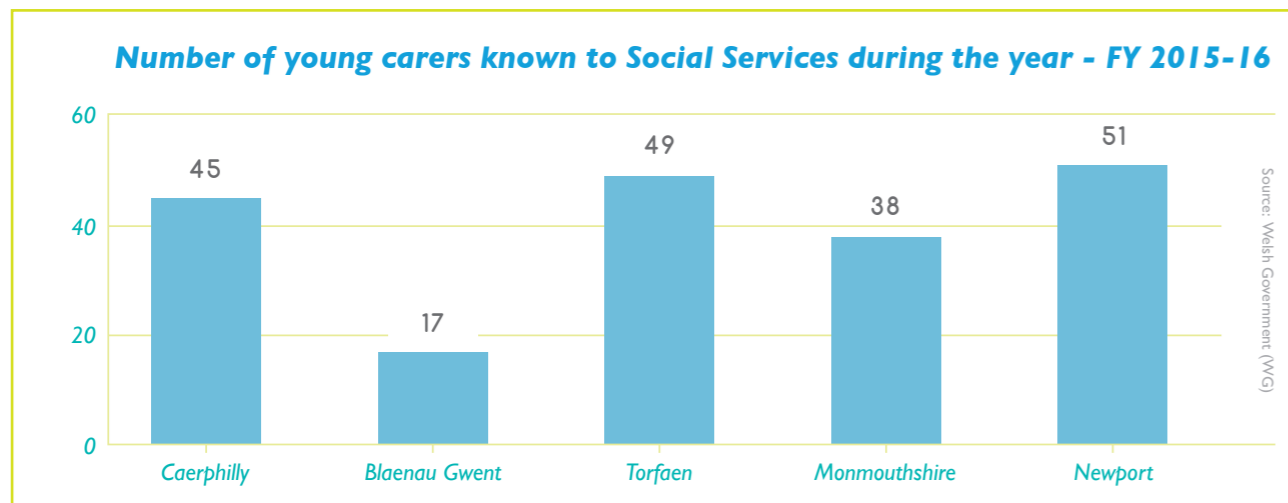


Figure above shows the number of young carers known to Social Services during the year 2015-16. It shows that the number ranged from 17 in Blaenau Gwent to 57 in Newport.

What do we know?

There is likely to be an increase in the number of carers as a result of predicted increase in population. There are an estimated 356,000 adult carers in Wales today and 90,000 carers spend over 50 hours a week on their caring responsibilities and currently provide over 70% of community care. It is estimated that carers and families provide 96% of the care in Wales, supported by communities, volunteers and care and support services; and save the social economy of Wales £3.5 billion each year. Yet the decision to care can mean a commitment to future poverty, and, for young carers, temporary or permanent delay in pursuing further education and training opportunities. Many give up an income, future employment prospects and pension rights to become a carer. The Social Services and Well-being (SSWB) Act recognises the key role played by carers, giving them the rights to support which are equivalent to the rights of those they care for. Section 14 of the Act places a joint requirement on local authorities and Health Boards to work together to assess carers. Too often people do not recognise themselves as carers and do not wish to receive support from statutory services. There is a need to increase awareness of the SSWB Act and eligibility or entitlement to support in order to enhance opportunities for the early identification of carers and to provide the necessary information and advice to carers to enable them to make informed choices.

“I can help other people in my position and tell them what works and where to get help.”

Young Carer, Youth Forum Member

What we will do:
Continue to support groups for young carers to help each other.

What are we doing?

Following the implementation of the Carers Strategy (Wales) Measure in 2012 a multi-agency regional Carers Programme Board was set up to steer, implement and monitor actions and progress. Following the repeal of the Measure and provision of transitional funding to action the SSWB Act

requirements, as they apply to carers, the multi-agency Carers Programme Board continued to drive progress. The Carers Board is Chaired by an Aneurin Bevan University Health Board (ABUHB) Independent Member. The Board objectives are: strengthening of the partnership approach at a local level; creation of opportunities to enable the third sector to fully participate in delivery; plan and deliver the increased responsibilities for ABUHB and local authorities; embed the practice of mainstreaming the carers' needs so that it is common practice. The Carers Board, through the Board Chair, will report directly to the Regional Partnership Board. The Carers Board has developed and is implementing a work programme based on identified carer support and service gaps.

The work programme for 2016/17 & 2017/18 is targeting the following areas:

- Advocacy support,
- Support to young adult carers and transition arrangements,
- Mental health and well-being support for carers of all ages,
- Continued and effective information/advice/signposting and
- Ongoing staff training.

The Carers Board has established ongoing links with various carer forums across the region in order to ensure effective involvement of carers in the work of the Board. Work to map current service provision has enabled the identification of service gaps, for example advocacy for carers. It should be noted that the Dementia Board has also completed a mapping of respite services for carers. Also, through the Care Closer to Home strategy we have mapped out existing partners and services.

Case Studies: Dementia Friendly Cafe, Monmouthshire

Dementia Friendly Cafés are organised by Alzheimer's Society across the region and provide an opportunity for people living with dementia and their carers to come together to receive information, advice and share their views with professionals. The cafés also provide an opportunity to take part in fun activities and carers to share their feelings amongst peers. One carer remarked how she was finding very difficult and was 'ready to throw the towel in' but it was the other carers at the café who provided practical advice and emotional support to help her remain positive.

Action Plan & Next Steps

Preventative and Early Intervention including Information, Advice & Assistance (IAA):

- The Welsh Government has stressed the importance of information and advice at every stage of the care and support process and section 17 of the Act outlines the duty to make available a service to provide adults in need and carers with information about care and support. A national information portal (Dewis) has been developed and will provide a database of service information for citizens (including carers). This will be a useful tool in facilitating links to local information.
- A targeted approach will continue within health services to ensure systems to identify and support carers more effectively, including staff who are carers.
- Engaging with informal community networks, via the 'community connector' roles in order to identify carers at the earliest opportunity and sign post to support services and peer to peer groups.

Commissioning, Pooled Budgets and Health Social Care Integration

Through consistent commissioning across ABUHB and local authorities we will establish consistent practices through the following key elements.

- Future delivery of sustainable staff training to ensure that carer awareness is included within partner's core business, making use of an all Wales awareness raising e-learning tool, which will be accessible to all organisations.
- Section 24 of the Act requires that carers must be fully involved in their assessments and makes clear that the duty to assess applies regardless of the authority's view of the level of the carer's needs for support, or their financial situation.
- 'What Matters' conversations will be undertaken with carers to ascertain what is important to help them to care.
- We will also explore how medicines prompting can be better delivered through region wide, community based service models.
- Respite services are consistently highlighted by carers as a pivotal support need but there are some instances where currently commissioned support is underused. This can be because the service provision is based on a 'one size fits all' approach and thus does not reflect the type of respite service required as well as a lack of carer feedback to inform necessary changes to commissioned services. We will seek to expand more befriending volunteering opportunities with a view to providing flexible respite and link this to the review of third sector commissioned services currently being undertaken by the Joint Regional Commissioning Group.
- It is anticipated that the implementation of the Care Closer to Home Strategy will also increase the networks of support for carers at a community level.

Advocacy

Arrangements are being discussed at Carers Programme Board meeting in late 2016 and will be included in the Area Plan development.

Links to key strategies

- Regional Partnership Board Statement of Intent
- Regional Dementia Strategy

Summary and what we will deliver through the joint Area Plan.

- Coordination of consistent community based services such as community connectors/ social prescribers to identify and support carers
- Review of medical prompting to better support carers
- Accurate Information, Advice and Assistance through DEWIS and Five Ways to Well-being
- Review of and align third sector commissioning principles to support befriending for carers requiring support
- Ensure that the implementation of the 'Care Closer to Home' strategy increases the community level support for carers
- Consistent commissioning across health and social care to ensure equitable, region wide and effective models of carer support, including flexible respite.

Violence against women, domestic abuse and sexual violence

A demography and population profile for individual local authorities is included in the 5 local Well-being Assessments. An abbreviated demography is included in section 1 of this PNA which also includes the population projection for the region. For the purpose of this PNA we subscribe to the definitions of domestic abuse as set out in the Violence against Women, Domestic Abuse & Sexual Violence (Wales) 2015 Act.

The priority outcomes identified through engagement with citizens, partners and use of the prioritisation matrix; and subsequently confirmed through consultation are:

1. Provide earlier intervention and safeguarding arrangements to potential victims through 'Ask and Act'.
2. Safeguard victims, including men, through effective partnership support.

So what does the data show us?

A comprehensive situational analysis is included in the appendix, but a representative sample of need is set out in the chart(s) below.

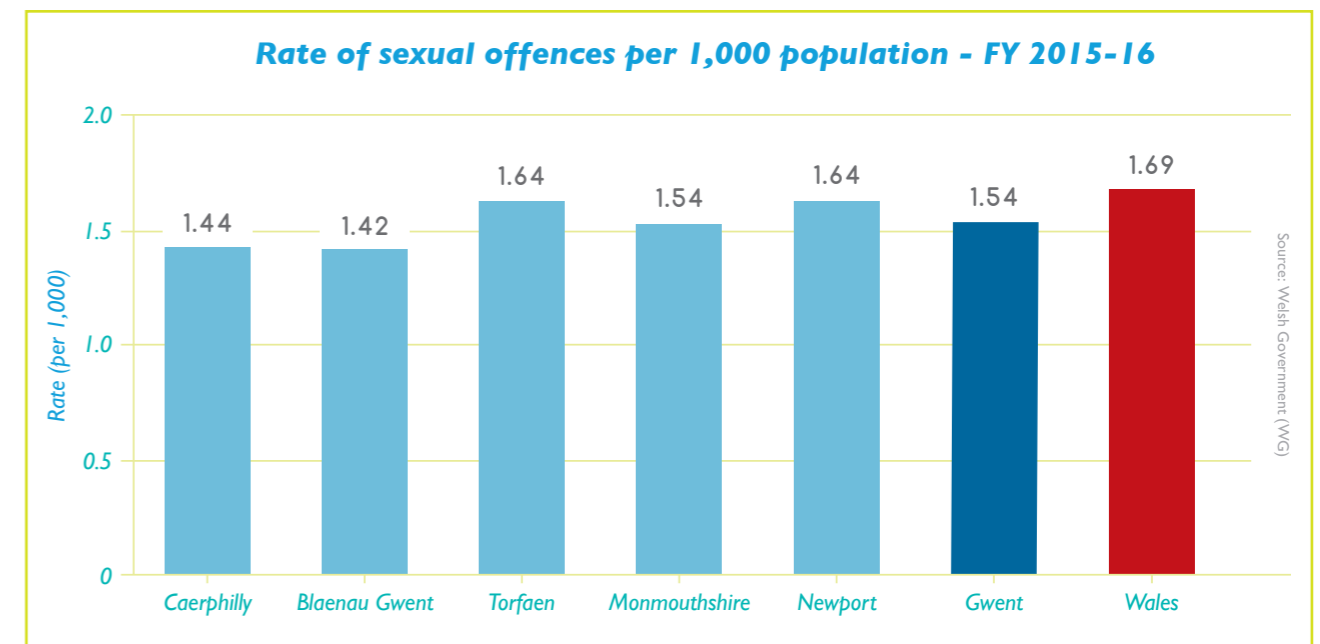
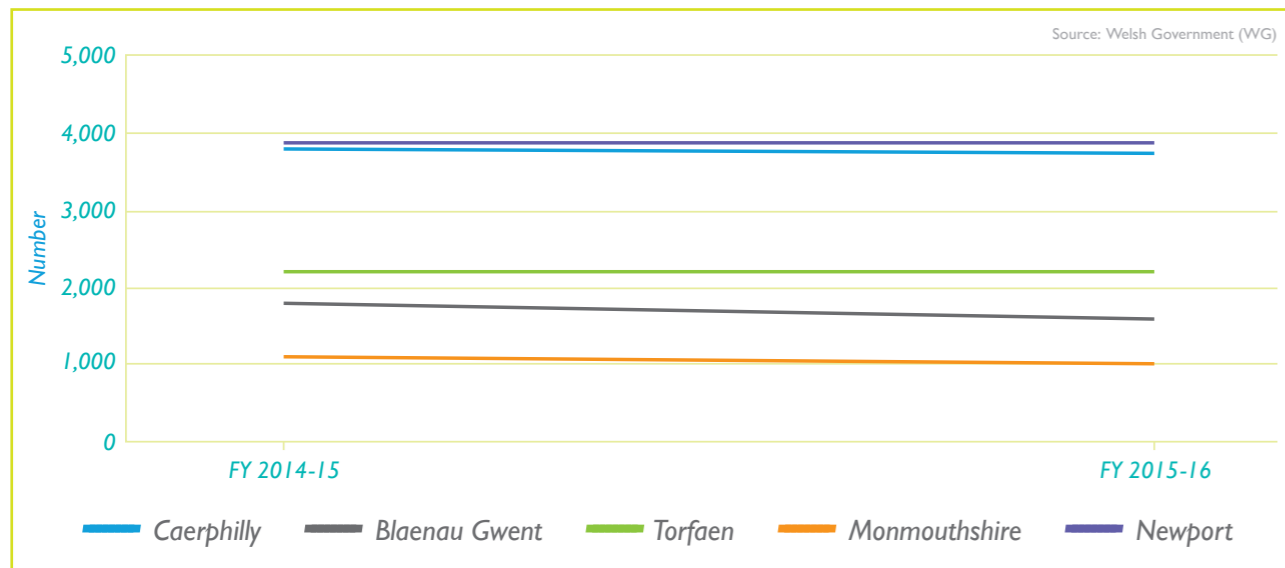


Figure VI shows the rate of sexual offences per 1,000 population in 2015-16 across the Gwent region. The rate ranged from 1.42 per 1,000 population in Blaenau Gwent to 1.64 per 1,000 population in both Torfaen and Newport. This compares with 1.54 per 1,000 population for Gwent and 1.69 per 1,000 population for Wales.



	Caerphilly	Blaenau Gwent	Torfaen	Monmouthshire	Newport
FY 2014-15	3,805	1,778	2,192	1,059	3,882
FY 2015-16	3,782	1,595	2,223	973	3,920

Figure V2 shows the number of recorded incidents of domestic abuse and discussions between Gwent Police, ABUHB and local authorities [(Domestic Abuse Conference Call (DACC))] over the period 2014-15 to 2015-16. Blaenau Gwent, Caerphilly and Monmouthshire have seen a decrease with Blaenau Gwent and Monmouthshire showing the largest decreases of 10.3% and 9.2% respectively; and Caerphilly 0.6% reduction. Newport and Torfaen have seen a small increase over the period of 0.1% and 1.4% respectively.

What do we know?

The Violence against Women, Domestic Abuse & Sexual Violence (Wales) 2015 Act was passed in April 2015 and aims to improve the Public Sector response by providing the strategic focus to improve the arrangements for the prevention, protection and support for individuals affected by such violence and abuse.

This new Act is set within the wider legislative context of the Well-Being of Future Generations (Wales) Act 2015 and the Social Services and Well-being (Wales) Act 2014; and provides a unique opportunity to embed VAWDASV as a priority in determining the well-being of Wales.

What are we doing?

There are two established processes used to manage and support the VAWDASV agenda:

- **Domestic Abuse Conference call (DACC)** - Gwent Police hold a daily conference call in all five local authority areas. DACC was established following an evaluation of a pilot in

Newport and found the benefits to be: early intervention and opportunities to make victims safer; fast and effective information sharing; shared responsibility and accountability; early identification of risk. An overview of DACC highlights considerable numbers with over **12000 incidents in both 2014/15 and 2015/16**; but early analysis has shown a **28% drop in repeat victims** and good evidence to show improved safety and well-being of victims and their families, and at the same time, effectively manage offenders. The DACC process is currently being reviewed in order to ensure a consistent approach across the region.

- A **multi-agency risk assessment conference (MARAC)** is a meeting where information is shared on the highest risk domestic abuse cases between representatives of local police, probation, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs) and other specialists from the statutory and voluntary sectors. After sharing all relevant information about a victim, representatives discuss options for increasing safety for the victim, and turn these options into a co-ordinated action plan. The primary focus of the MARAC is to safeguard the adult victim. An overview of MARAC in Gwent again presents considerable numbers with **978 MARAC completed 2014/15, 726 completed 2015/16** (This reduction is more around process issues than a reduction in high risk victims). The MARAC will also make links with other fora to safeguard children and manage the behaviour of the perpetrator. At the heart of a MARAC is the working assumption that no single agency or individual can see the complete picture of the life of a victim, but all may have insights that are crucial to their safety. The victim does not attend the meeting but is represented by an IDVA who speaks on their behalf.

Building on the Pan Gwent Domestic Abuse Forum a **South East Wales Violence against Women, Domestic Abuse and Sexual Violence (VAWDASV) Partnership Board** has been established to provide the governance vehicle for the regional partnership for related services. The Board parallels the South East Wales Safeguarding Children's Board and Gwent Adults Safeguarding Board. All three Boards will link together to provide a framework of safeguarding governance and will ensure that communication links exist with strategic multi-agency partnerships working across the region including the Regional Partnership Board (RPB). The VAWDASV Board will provide senior leadership bringing together agencies to work together in a joined up way and to ensure the best possible services are provided to protect and support victims and prevent crime. Where there are gaps in service or shortcomings in performance the Board will bring together the key agencies to prioritise and address issues.

The term 'Violence against Women' incorporates all forms of violence against women; honour based violence, forced marriage, female genital mutilation (FGM), trafficking, sexual violence and exploitation and domestic abuse. The term 'Violence against Women' refers to the disproportionate experience of women to such forms of abuse. Whilst it is important that this is acknowledged and communicated, it does not mean that the violence and abuse directed towards men or perpetrated by women is neglected. The work of the VAWDASV Board is concerned with all forms of violence against women, domestic abuse and sexual violence as it affects all citizens.

The VAWDASV Wales Act (2015) introduces requirements for Welsh Ministers to prepare and publish a National Strategy for VAWDASV and for relevant authorities to publish joint local/regional strategies. The South East Wales region was chosen as a pilot site across Wales and are currently undertaking a comprehensive needs assessment that will provide the required information to inform the development of a strategic plan and a set of priorities that will ensure consistency and efficacy

Section 2

across the region with a common shared model of service delivery. The regional strategic plan will be drafted by April 2017 and will enable alignment to Welsh Government National Strategy which was published in November 2016. The Regional VAWDASV Partnership Board will provide the governance vehicle and will develop, approve and monitor the regional strategy as required under the Violence Against Women, Domestic Abuse and Sexual Violence (VAWDASV) Act (Wales) 2015.

Actions and next steps

Prevention & Early Intervention including Information, Advice & Assistance (IAA)

‘Ask & Act’ is the Welsh Government policy of targeted enquiry to be practised across the public service for VAWDASV. The **South East Wales local authorities have been selected as one of two early adopter sites in Wales for ‘Ask and Act’** to develop and implement processes ahead of national roll out next year. Identifying abuse and/or violence at an early stage can be an effective measure in preventing an escalation in severity and frequency, and can assist to ensure appropriate and timely support is provided.

The aims ‘Ask and Act’ are:

- to begin to create a culture across the public service where addressing VAWDASV is an accepted area of business and where disclosure is expected, supported, accepted and facilitated;
- to increase identification of those experiencing VAWDASV;
- to pro-actively engage with those who are vulnerable and hidden, at the earliest opportunity, rather than only reactively engaging with those who are in crisis or at imminent risk of serious harm;
- to offer referrals and interventions for those identified which provide specialist support based on the risk and need of the service user; and
- to improve the response to those who experience.

Commissioning, Pooled Budgets and Health & Social Care Integration

The VAWDASV Board have commissioned Welsh Women’s Aid to undertake a regional needs assessment which is due to be completed by April 2017. The needs assessment and corresponding regional strategy that follows will set the direction of strategic services in terms of; partnership working; potential joint working models and processes. The Area Plan which will follow this PNA will use the VAWDASV needs assessment and regional strategy as the basis for forward planning.

Links to key strategies

- South East Wales Regional Violence against Women, Domestic Abuse and Sexual Violence Strategy 2017 - 21.

Summary and what we will deliver through the joint Area Plan

- Implementation of ‘Ask and Act’ as part of Welsh Government pilot.
- Strategic alignment with VAWDASV Board, needs assessment and strategic plan.

Service Mapping

Under each core theme set out in section 1 there is a high level assessment of the range and level of services required to meet the care and support needs of citizens; and the support needs of carers: 'What are we doing section'. The list of current and planned activity is not exhaustive, but it is relevant to the emerging priority area under each core theme.

We recognise that the DEWIS website www.dewis.wales may be better placed to provide an up to date directory that is self-managed in terms of content and therefore will remain current. The DEWIS website is continually being updated across the region and across Wales; and the regional team supports this activity and partners to upload their information. The RPB will provide overall oversight to ensure that DEWIS is populated and publicised to all partners.

As highlighted in Part 2, Section 14 of Social Services and Well-being Act codes of practice, citizens and social care workforce must be engaged in the process of identifying the range and level of services necessary. Service mapping data has been included in appendices and some services have uploaded their data to DEWIS. It would not be prudent to include a comprehensive list of services and compilation of directories within the appendix of this PNA. However, where the service mapping relates to the priority outcomes, we have included specific service mapping work - for example Monmouthshire mapped the IAA entry points across the borough.

In parallel to the development of this PNA, the ABUHB are developing an overarching 'Care Closer to Home' strategy for the effective and sustainable integration of care, centred on GP cluster models [Neighbourhood Care Networks (NCNs)]. As a key part of the strategy development process, five individual workshops were organised across individual local authorities and partners were asked to map and identify existing community based services and resources.

The Region's **Supporting People** teams have undertaken further scrutiny and mapping of the services provided across various client groups and this continues to be undertaken as part of the Gwent Regional Collaborative Committee (RCC) work plan. This mapping and reviewing of services will enable further opportunities for regional service remodelling and development. The RCC has prioritised 'People with Mental Health Issues' and 'Young People with Support Needs (16-24)/Young People who are Care Leavers' through 2016/17 work plan. Specific gaps in services for these client categories will be highlighted through the continued review process and will provide an opportunity to develop services that continue to meet future needs of these client groups and to commission services if gaps are identified.

The following two client categories are still prioritised as part of the RCC work plan:

- **People with Learning Disabilities** - during 2015 a task and finish group identified a set of principles with regard to delivery of services to this client group which were agreed with all five Social Services Departments across all Gwent Local Authorities. Regular reports are provided to the RCC to provide updates of local progress against the principles.
- **Older Persons Services** - Services provided to older people were prioritised for scrutiny by the Gwent RCC and this prioritisation has helped to ensure that work has continued to be undertaken locally to advance the recommendations made in the Aylward Review 2010.

A more focussed and detailed mapping of services and partners organisations will be undertaken when developing the joint Area Plan. This will enable the RPB to directly map services and link them to the identified regional priorities. For the wider mapping of services we will work closely with the Public Service Boards (PSBs) as they develop their Well-being Plans. DEWIS will also be further enhanced and developed to include the wider community based services and partner organisations. Where possible the DEWIS database will be a resource for service provision and support down to individual ward level.

What we will deliver through the joint Area Plan:

- 1. Continue to build on existing service mapping through the 'Care Closer to Home' strategy, Supporting People agenda and link specifically to priorities identified therein.**
- 2. Further develop and enhance the DEWIS website so it becomes the primary directory of resources for the region.**
- 3. Work with PSBs to ensure wider service mapping is integrated with that of Health and social care as an important step towards the creation of a public service response at community level.**

Health & Social Care Integration

The PNA is a key driver for change and is required to set out the extent to which the needs identified in relation to the core themes should be met by providing services in partnership between the Local Health Board and the local authorities within the region. Under each core theme a high level description is provided which highlights those key areas for integration.

Under Part 9 of the Act which covers Partnership Arrangements, Welsh Government through the Regional Partnership Board (RPB) has prioritised the integration of services in relation to:

- Older people with complex needs and long term conditions, including dementia.
- People with learning disabilities.
- Carers, including young carers.
- Integrated Family Support Services.
- Children with complex needs due to disability or illness.

There are already well established and developed areas of integration which are supported by current strategic partnerships across the identified groups, and further details of existing arrangements and areas for development are included in the RPB's joint statements of strategic intent for older people, children with complex needs and carers. Integration of services for people with learning disabilities is well established in key areas such as accommodation via the 'In One Place' partnership which is a partnership between all 9 Registered Social Landlords in the region, the local authorities and the Health Board. Also the 'Supporting People' priorities outlined above will also be aligned to support the regional imperatives under Part 9 where appropriate.

The RPB will determine the most appropriate structures for ensuring the provision of these integrated services. This could include the establishment of management or operational groups, or a redefining of existing partnership groups, as well as integrated teams for specific service areas. Partnership agreements will be developed for new partnership arrangements which may or may not require a delegation of functions, as set out in Part 9 of the Act.

The RPB has determined that a 'place based approach' to care and support is the key to operational service delivery that will enable health and social care resources to be better aligned to meet different local and individual needs. We are aware that many localities have significant but often very different social and economic challenges which mean that a 'one size fits all' approach is neither appropriate nor sustainable. As highlighted in ABUHB's 'Care Closer to Home' strategy and as described above, a place based approach has been adopted by the region which is based on GP clusters (Neighbourhood Care Networks) with the aim of aligning resources more effectively.

What we will deliver through the joint Area Plan:

- 1. Integration of care and support provision to key client groups as set out in Part 9 of the Act and emphasised through RPBs statements of strategic intent for older people, children with complex needs and carers.**
- 2. Adopt a place based approach through 'Care Closer to Home' strategy as foundation stone that underpins health and social care service integration.**

Joint Commissioning & Pooled Budgets

In taking forward the implementation of the Act, it is recognised that commissioning has a vital part to play in planning, shaping and putting into place the services needed for citizens to improve well-being. A Regional Joint Commissioning Group (RJCG) was established in late 2015 and co-ordinated by the regional Transformation team to identify regional commissioning priorities.

The RJCG identified the following priorities:

- A common regional domiciliary care strategy - a domiciliary care regional plan is being developed and this will result in a position paper and options for the future design and delivery of care and support at home. This will include some immediate activity and identify longer term goals. This work is closely linked to the National Commissioning Board's (NCB) domiciliary care work stream detailed below.
- A regional review of commissioning resources as part of the PNA and market sufficiency analysis with a view to adopting an integrated approach.
- Take forward options for integrated commissioning and pooled budgets for older peoples' care homes. This work is also closely linked to the NCB as the Gwent region is the designated pilot region for developing a Model Partnership Agreement for joint commissioning and pooled budgets for care home placements.
- Prevention and Well-being, role of the 3rd Sector and place based approaches linked to the development of the Care Closer to Home strategy.
- Commissioning priorities for Children with Complex needs will be taken forward by the Children and Families Partnership Board.
- Commissioning priorities for Carers including young carers will be taken forward by the Carers Partnership Board.

The RJCG links closely with the National Commissioning Board (NCB) that has been established for health and social care in Wales.

The national group has a high level project plan and a number of work streams covering:

- A national market analysis of care homes (for over 65's)
- A model agreement for pooled budgets for care homes in Wales
- Domiciliary care
- Learning disability services
- Services for children with complex needs
- A commissioning capacity and capability review
- Options for securing services (flexible and innovative approaches to the procurement of health and social care services).

Pooled Funds

The Regional Partnership Board (RPB) is currently considering a governance structure and partnership arrangements with existing groups that are well placed to lead on specific core themes across the PNA e.g. South East Wales Violence against Women, Domestic Abuse and Sexual Violence Board, Dementia Board, Carers Partnership Board, Mental Health and Learning Disability Local Partnership Board. The RPB will also explore partnership arrangements with wider regional groups such as local authority Public Service Boards - especially in relation to links to the Well-being of Future Generations Act - Gwent Area Planning Board for Substance Misuse, Gwent Welfare Reform Partnership and In One Place Programme.

The 2015 partnership regulations require partnership bodies within each Regional Partnership Board to establish and maintain pooled funds in relation to:

- the exercise of their care home accommodation functions (as noted, the Gwent region is a pilot to start this work, which requires joint commissioning of placements and pooled budgets by April 2018);
- the exercise of their family support functions; (Integrated Family Support Services is a Welsh Government funded programme and managed by Newport City Council; and is included within the governance arrangements of the RPB);
- the specified functions they will exercise jointly as a result of the combined population assessment report and area plan.

The Gwent region already has well established formal pooled budgets in place for:

- **GWICES - Gwent Wide Integrated Community Equipment Service.** This is a Section 33 agreement under the National Health Service (Wales) Act 2006, with an identified lead commissioner and single contract monitoring process. There is a PIN hierarchy in place so that those operational staff needing to prescribe and order equipment are registered and able to access those equipment types that they need, with this being tracked to the relevant partner declared budget contribution and out turn. It has brought a consistent process of equipment specification, procurement, delivery, collection and cleaning/disposals across the region.
- **Gwent Frailty Programme.** This is also a Section 33 Agreement under the NHS (Wales) Act 2006 to deliver intermediate care services with consistent overarching aims and objectives to ensure best value and evidenced based service models for the residents of all five Gwent localities. It also includes appropriate funding contributions to support a repayment timeline for Welsh Government 'Invest to Save' funding.

Close engagement with Welsh Government has confirmed that Section 33 process is still applicable under the Act for Part 9 partnership arrangements, but governance arrangements need to make clear that it is the RPBs who take oversight.

What we will deliver through joint Area Plan

- 1. Deliver RJCG action plan to deliver joint commissioning arrangements for identified priorities above.**
- 2. Continue to link with NCB to progress national proposals across the region.**

Preventative Services

Prevention is at the heart of the Welsh Government's programme of change for health and social care. There is a need to focus on prevention and early intervention in order to make health and social care services sustainable for the future. It is vital that care and support services do not wait to respond until people reach crisis point. This preventative approach applies to both adults, children and young people; however, the regional response may differ in focus for each group. For example GP clusters makes sense for adult services, but school based clusters may make better sense for children and young people. Therefore, the geographical organisation of prevention and support services for children and adults may look different; but the strategic intent based on prevention and well-being will be consistent.

The Act is seeking to maximise the well-being of people and to rebalance the focus of care and support to prevention and earlier intervention. This will lead to increased preventative services in the community to minimise the escalation of individual needs to critical levels. This means that existing services will need to be reviewed and some may need to be decommissioned if no longer considered effective.

Local authorities have a duty to ensure an appropriate range and level of preventative services that:

- Help prevent, delay and reduce the need for care and support
- Promote the upbringing of children by their family
- Minimise the effect of people's disabilities
- Help prevent abuse or neglect
- Enable people to live as independently as possible
- Reduce the need for care or supervision orders, criminal proceedings against children, or taking children into local authority care or secure accommodation

There is a need to strengthen the preventative approach that is already available across programmes and services, building and extending the activity base in order to make sure that services are available when people need them. We must ensure that people and communities have the information and support they need in a timely way to identify 'what matters to them'. The Region will give further detailed consideration to how it can best put in place arrangements to deliver an approach that meets the local need and individual need. The implementation of the 'Care Closer to Home' strategy will play a major role in this.

The nature and level of preventative services provided or arranged must be designed to meet the needs for care and support of carers identified in this population need assessment report. Included in each core theme section are proposals for early intervention and prevention programmes. Also included is a high level indication of services that can support the preventative agenda. The RPB will expand on the mapping of services through development of the joint Area Plan and 'Care Closer to Home' strategy, to ensure that there is a clear understanding of the resources available within communities.

In terms of resource management, there is a need for a focus on earlier intervention rather than concentrating resources and effort further down the care pathway or on crisis management. There are a number of examples of good practice, but these are often only available in one area, yet they often need to be available across Gwent, as equity and consistency of provision is an important focus for the RPB.

As part of 'Care Closer to Home' strategy ABUHB will set out how a preventative approach can be delivered in partnership with local authorities across the region. There are a number of preventative programmes funded through Welsh Government such as Communities First, Families First, Flying Start and Supporting People. Approximately £55 million is funded through the 4 'anti-poverty' programmes across the region each year. In addition Intermediate Care Funding (ICF) makes a significant contribution to prevention and a reduction in hospital admissions. There are also a number of initiatives across the region that aim to reduce social isolation. There is a need to align resources to ensure synergy between the various funding streams and to avoid duplication. The RJCG have already linked with the third sector in the region to start the process of identifying where support is most needed; and Housing Associations are also key partners in preventative service delivery.

Case Studies: Torfaen Pathfinder Pilot

The Torfaen Pathfinder is a Welsh Government pilot focussing on understanding the early years' system and enabling system change to improve outcomes in early years (Torfaen is one of two pilots chosen across Wales).

The pilot aligns with the First 1000 days Collaborative Programme outcomes:

- The best possible outcome for every pregnancy
- Children in Wales achieve their developmental milestones at two years of age
- Children are not exposed to or harmed by multiple adverse childhood experiences (ACEs) in the first 1000 days

A First 1000 days strategic group has been established which includes Torfaen leads for Early Years, Family First, Flying Start, anti-poverty programmes and the Aneurin Bevan Gwent Public Health Team. An in-depth mapping of the early years' system has been completed including mapping of all relevant anti-poverty programmes and financial allocations to programmes. Detailed mapping was completed for Flying Start and non-Flying Start areas.

The Pathfinder pilot is primarily an early intervention model and will focus on:

- exploring the possibility of screening for ACEs during the antenatal and/or during birth visit to enable earlier intervention to occur where required.
- exploring the feasibility of developing and implementing a common assessment tool across the early years' provision.
- evaluating the role of the healthy babies advisor, and gain an understanding of the future potential.
- alignment and integration of the Torfaen First 1000 days programme outcomes with the planning and commissioning of local services, including the anti-poverty programmes, to inform future commissioning arrangements.

A statutory requirement of the Act is for local authorities and health boards to discharge their responsibilities to provide or secure services that help prevent need. Also, as a requirement of the Well-being of Future Generations Act, a preventative sustainable principle is clearly set out. There is an opportunity to align both of these important and connected pieces of legislation to focus on preventative services in the future and there is an opportunity for the RPB and local Public Service Boards (PSBs) to adopt one overarching strategic preventative approach across the region.

What we will deliver through the joint Area Plan:

- 1. Explore a single prevention agenda across the region with PSBs and linked to Well-being of Future Generations and SSWB Acts which also includes Housing Associations.**
- 2. Align anti-poverty programmes across the region to set out a single preventative model based on consistent assessment principles, joint workforce and joint commissioning.**
- 3. Through the implementation of the 'Care Closer to Home' strategy ensure that prevention and early intervention is supported and enabled in a consistent manners across the region.**
- 4. Delivery of RJCG work plan with third sector to maximise and align activity to prevent escalation of need and build on existing models of good practice such as befriending, social prescribing etc. and to promulgate the development of social enterprises and co-operatives where possible.**
- 5. Support Early Years Pathfinder pilot and use key messages to shape early intervention models.**

Information Advice & Assistance (IAA)

Promoting well-being involves not only the provision of services to prevent the need for care and support but also the provision of information, advice and assistance that people may need to take control of their day to day lives. There is a duty on local authorities, with support from their local health boards, to ensure the provision of an Information Advice and Assistance (IAA) service for all people in their area, not just people who have an immediate need for care or support.

Local authorities are required to provide an IAA service and must include, as a minimum, the publication of information and advice on:

- how the care and support system operates in the local authority area
- the types of care and support available
- how to access the care and support that is available; and
- how to raise concerns about the well-being of a person who appears to have needs for care and support.

The information, advice and assistance service is an opportunity to change the perception of social care and support services in Wales. It must promote early intervention and prevention to ensure that people of all ages can be better supported to achieve their personal outcomes and should be considered to be a preventative service in its own right through the provision of high quality and timely information, advice and assistance. Local Health Boards must provide local authorities with information about the care and support it provides. Other partner organisations, including third and independent sector organisations should also be included.

The regional team facilitate an adult services and children services practice development group to support front line practitioners deliver and implement the Act.

The groups have also developed a regional IAA framework and policy to help ensure consistency across the local authorities and ABUHB. Each local authority must take its lead from the RPB on how to design, plan and develop the model for the information, advice and assistance service that will ensure people find information easy to access. Local authorities should produce a communications strategy to promote their information, advice and assistance service and the regional team facilitate a regional communications group, where the 5 communication managers meet to develop regional newsletters and consistent messages in relation to the Act. The regional communications group has also developed and published a regional communication and engagement strategy.

Case Studies: FISH Monmouthshire

Monmouthshire redesigned their information service to a community based model called 'Finding Individual Solutions Here' (FISH), following feedback from citizens highlighting that they want easy access to information and a prompt response when they contact services. FISH is set out over community hubs so that people have access to the right person without being passed between call handlers, and so that services are able to respond with the right information and support as required. When people contact FISH they will be speaking directly to staff that will be 'listening to understand' and looking to facilitate solutions - this may take place over the phone or face to face.

Local authorities must use information gathered through the population needs assessment to design, develop and continually improve the IAA service. The IAA performance data for 2016/17 is limited as it is a transition year and an opportunity for local authorities to develop the IAA service.

As well as helping to prepare access points to IAA services and/or assessment to implement consistent IAA processes across the region, the regional team have also facilitated the development of the DEWIS website which will be a key resource to ensure accurate and timely IAA. NHS 111 service is the NHS non-emergency contact number to speak to a highly trained adviser, supported by healthcare professionals who will ask a series of questions to assess symptoms and immediately direct people to the best medical care. Working links between DEWIS and the 111 service are being considered.

What we will deliver through the joint Area Plan

- 1. Further support and develop DEWIS website so it becomes the 'go to' place for information on support, advice and assistance.**
- 2. Continue to support consistent information dissemination and stakeholder engagement through regional communications group.**
- 3. Use IAA performance management data to inform design of services.**

Social enterprises, Cooperatives, User Led Services & the Third Sector

The Act Part 2, section 16 introduces a duty on local authorities to promote the development, in their area, of not for private profit organisations to provide care and support and support for carers, and preventative services. These models include social enterprises, co-operative organisations, co-operative arrangements, user led services and the third sector. The local authority must promote the involvement of people for whom these care and support or preventative services are to be provided, in the design and operation of that provision. The duty to promote means that local authorities must take a proactive approach to planning and delivering models that will meet the well-being needs of all people - children, young people and adults - in promoting models which are based on social values.

Care to Co-operate is a three year project funded by the Welsh Government under the Sustainable Social Services Third Sector Grant Scheme. It has been developed in partnership with the Social Co-operation Forum and will be delivered by the Wales Co-operative Centre. Care to Co-operate will support the development of social co-operatives, social enterprises and consortia. There are examples of user led services developing across the region - recently a Dementia Friendly Community group in Blaenau Gwent was established - and the Transformation Team will work closely with the Wales Co-operative Centre and the third sector to ensure the joint Area Plan will set in place clear actions and targets to support community assets at an individual, community and population level.

What we will deliver through the joint Area Plan:

- 1. Work with Wales Cooperative Centre to increase and support number of voluntary led services in local communities through 'Care to Co-operate'.**

Workforce Development

The region has a Workforce Development Board and delivery plan which is monitored by the Board. Focus has been on supporting staff to ensure they are trained and skilled to implement and deliver the Act. Workforce Development managers and the regional Transformation Team meet regularly, prior to the board to ensure consistent developments across the workforce, joint training and continuous development of the regional training plan.

The regional has developed an Organisational Development management programme this year which focused on the delivery of the Act and the requirement to change the culture within organisations and measure performance. A programme was developed which included middle managers from both social care and health. This has resulted in us focusing on the wider integration agenda and we are developing a further management programme to deliver on the 'Care Closer to Home' strategy. This is in the early stages and we are working with Workforce Development leads in ABUHB to present an outline proposal to the regional Leadership Group. At an operational level we ensure that those local authorities that were not part of the 'Outcome/Collaborative Conversations' pilot training are supported in the interim, and will continue to support the training in the future.

Local Workforce Development Managers and the regional Transformation team form part of a National Social Services and Well-being Act Workforce Development Group. The group ensures coordinated development across Welsh Government, Care Council for Wales and regional and Workforce Development teams. It is not clear as yet if this group will continue to meet as the Delivering Transformation Grant will form part of the RSG. Regardless, there will need to be a focus on raising the profile of the care sector as a career path and raising standards through commissioning.

Case Studies: The Raglan Project

The Raglan Project was a pilot project looking at how to deliver a high standard of relationship-based home care to people with dementia; and replaced task-based care with flexible care that is focused on the social and emotional needs as well as the physical needs of the person being supported. Before the care begins, staff members establish a relationship with the person receiving care. Staff are then given the freedom to decide for themselves how the relationship and care should be managed – and their decisions are supported rather than controlled by management. It has been possible for people with complex care needs to stay at home rather than moving to permanent residential care or hospital and people have been supported back to independence and re-engaged with their local community. There is also clear evidence that staff have better morale, health, well-being and job satisfaction.

What we will deliver through the joint Area Plan

- 1. Continue to support delivery of regional WFD Board work programme and facilitate national links through national group**

Links to National Groups

The regional Transformation Team has supported a number of Welsh Government national task and finish groups to help prepare for the implementation of the Act. Health and social care principles still require further development as the regions implement the Act and specific work streams have been formalised through the Association of Directors Social Services (ADSS).

- **Business Intelligence** - The objective is to influence and support national consistency in the implementation of the performance measurement framework and associated business intelligence processes and also influence the introduction of underpinning systems such as WCCIS and DEWIS (a regional Business Intelligence group with membership from the 5 local authority social services business managers feeds into this group)
- **New Approaches to Practice** - the objective is to support the development of new approaches to processes and practice in areas such as advocacy, assessment, eligibility, care planning and the information, advice and assistance service (Regional Practice Development groups for Adult and Children Services feeds into this group)
- **New Ways of Working** - The objective is to support the development of new models of service including preventative services, commissioning and social enterprises responding to population assessments.

The Transformation Team represent regional views on each of the ADSS groups. The Welsh Local Government Association (WLGA) and Social Services Improvement Agency (SSIA) coordinate a Population Needs Assessment development group and the Transformation Team are also represented.

Advocacy

Under Section 145 of the Social Services and Well-being Act, Welsh Government issued and consulted upon a draft code of practice in relation to advocacy. It is a principle of the Act that a local authority respond in a person-centred, co-productive way to each individual's particular circumstances. Individuals and their families must be able to participate fully in the process of determining and meeting their well-being outcomes through a process that is accessible to them.

The code also sets out the requirements for local authorities to:

- Ensure that access to advocacy services and support is available to enable individuals to engage and participate when local authorities are exercising statutory duties in relation to them and;
- To arrange an independent professional advocate to facilitate the involvement of individuals in certain circumstances.

Local authorities must arrange for the provision of an independent professional advocate when a person can only overcome the barrier(s) to participate fully in the assessment, care and support planning, review and safeguarding processes with assistance from an appropriate individual, but there is no appropriate individual available.

Advocacy can be a preventative service in itself and will be considered as part of the range and level of services required to meet identified need. The Transformation Team have already started to map advocacy provision across the region and consider potential options going forward.

The regional provider forum includes members from the third sector including Age Cymru who have developed the **'Golden Thread Advocacy Programme'** which has been funded by Welsh Government for 3 years to run alongside and support the implementation of Part 10 of the Social Services and Well-being (Wales) Act 2014.

The programme's key aims are:

- To support the commissioning of independent professional advocacy through a sustainable, strategic approach.
- To improve the availability of advocacy services to adults across Wales.
- To improve the well-being of individuals through advocacy and to give them a stronger voice.

Through the joint Area Plan we will bring third sector partners and commissioning teams together to fully map advocacy services and identify good practice and gaps in provision. We will also promote independent advocacy provision and work closely with the third sector umbrella organisations to identify solutions. Heads of Children's Services are currently considering a single advocacy service across the region with the Local Health Board - previously a commissioned service was in place across Blaenau-Gwent, Caerphilly and Torfaen.

Care Council for Wales have developed a specific Advocacy training module, and this is set to be taken forward in 2017.

What we will deliver through the joint Area Plan

- 1. Alignment of advocacy provision to identified priorities across partner agencies.**
- 2. Work with the Golden Thread Advocacy Programme across the region through regional provider forum.**
- 3. Support Children's Services joint commissioning of a single advocacy service.**
- 4. Joint approach to advocacy provision with third sector partners especially in promotion of independent advocacy.**

Transitions

The transition process between a service/support can be an anxious and sometimes vulnerable time for any person but especially for young people and their families. During this period young people may stop receiving health services that they may have had since a very young age and move on to equivalent adult services which can be structured and funded differently. The Social Services and Well-being (Wales) Act is an all-age Act so addresses issues relating to transition. The Regional Partnership Board has responsibility for ensuring there are services, care and support to meet the needs of all people in the region and hence will ensure there is an effective partnership working between ABUHB and local authorities.

There is a statutory requirement on schools to organise transition planning for their pupils with special educational needs. Adults may move from one organisational support service in health to other support services in social care. Also, adults, children and families are transient and will move across local authority boundaries.

The key groups for effective transition across the 8 PNA core themes are:

- **Autism Spectrum Disorder** - Welsh Government have developed an ASD Strategic Action Plan and priorities will be implemented locally
- **Disabled Children** - effective planning between health and social care
- **Looked After Children** - especially in relation to 'When I am ready'
- **Preventions** - national preventative programmes such as Families First and Supporting People operate in each area and effective transition between programmes and local authorities when people move is required to ensure seamless portability.

National Outcomes Framework (NOF)

In identifying the range and level of services necessary to meet need, local authorities and Local Health Boards must be informed by the National Outcomes Framework (NOF). The NOF is made up of the well-being statement, which articulates what the Welsh Government expects for people who need care and support, and outcome indicators to measure whether well-being is being achieved. When the data is available and published the PNA and corresponding joint Area Plan will seek to ensure that we will use the NOF in identifying the level of services necessary to meet need.

The PNA has also taken into account and utilised the resources of information in the following Outcomes Frameworks:

- **Public Health Outcomes Framework** - covering all ages of the population and with particular reference to physical and mental health and well-being.
- **NHS Outcomes Framework** - covering all ages and physical and mental health and well-being.
- **Early years Outcomes Framework** - with particular reference to the section on children and young people including mental and physical health and well-being.

Equality Impact Assessment (EIA)

Local authorities and Local Health Boards must undertake an Equality Impact Assessment as part of the process of undertaking a population assessment, which must include impact assessments on; Age, Disability, Gender Reassignment, Marriage and Civil Partnership, Pregnancy and Maternity, Race, Religion and Beliefs, Sex and Sexual Orientation. The joint Area Plan will set out detailed actions required to implement key findings from the PNA and an EIA will be more effective at the plan level.

Links to Well-being of Future Generations Act

The Social Services and Well-being Act shares similar principles with a number of key national/regional strategies, and in particular the Well-being of Future Generations (WFG) Act.

There are a number of key areas where the Acts complement and reinforce the need for a collaborative approach:

- **Principles** - under the WFG Act specific sustainable principles are set out which are similar to the principles under the Social Services and Well-being Act (early intervention, prevention, partnership working, co-production) and there is an opportunity to align work streams.
- **Population Assessments** - a statutory requirement of the WFG Act is to undertake a Well-being Assessment of the whole population in a local authority area. This PNA has been produced alongside Well-being Assessment in each local authority to avoid duplication. A regional Gwent Strategic Well-being Assessment Group (GSWAG) has overseen the coordination of the alignment of both assessments and the Transformation Team are members of the group.
- **Partnership Governance** - there are statutory duties under each Act to establish a partnership to oversee the implementation of each Act. Under the SSWB Act Regional Partnership Boards (PPB) are established across regions and under the WFG Act Public Service Boards (PSB) are included on a statutory footing in each local authority area. The work of both boards to promote Well-being is clear and alignment of work streams will be beneficial to avoid duplication and create synergy between partners.
- **Service Mapping** - there will be a need to understand the levels of service available across the region and in local communities to maximise resources. The close working between the RPB and local PSBs will facilitate a joint mapping of services and identify where there are gaps in provision.
- **Action Planning** - both Acts set out arrangements for action plans following population assessments - joint Area Plan under the SSWB Act and Well-being Plans under the WFG Act. An alignment of the corresponding action plans will avoid duplication of priorities and focussed activity for specific priorities. A 'common language' and template will also ensure good 'read across' the plans.

Secure Estate

Population assessments must take account of the care and support needs of populations from the secure estate in order to fulfil the requirements of section 11 of the Act. The code of practice in relation to part 11 contains full details in relation to local authority's responsibility for the care and support for those in the secure estate. Monmouthshire is the only local authority in the region where secure estates are located. The Transformation Team have supported training to staff and management to ensure elements of the Act are being planned and implemented. The joint Area Plan will include details on actions required to implement the statutory duties in the Act.

Safeguarding and links to Strategic Partnerships

There are a number of statutory partnerships with individual strategies, action plans and governance arrangements. This PNA aims to acknowledge that some partnerships are better placed and delivering strategic agendas and the actions identified will complement and support the work of these partnerships and not duplicate efforts.

Adult Safeguarding Board

The Gwent-wide Adult Safeguarding Board (referred to as GWASB) is the forum responsible for the strategic leadership, monitoring and reviewing of adult safeguarding practice in Gwent; and is as an opportunity for partners to work together across the region, to embed interagency partnership for the strategic leadership, monitoring and reviewing of adult safeguarding practice.

As of the 6th April 2016, The Gwent-wide Adult Safeguarding Board is a statutory Board as set out in Part 7 of the Social Services and Well Being (Wales) Act 2014.

The Board's purpose is twofold:

- to protect adults in Gwent becoming 'adults at risk' and;
- to protect adults who have been abused or neglected or are at risk of abuse.

The Board has a role in co-ordinating and ensuring the effectiveness of regional organisations to safeguard adults at risk, but it is not accountable for their operational work. Each member agency of the Board remains responsible and accountable for the safeguarding service delivered in their organisations. The Board's vision is to ensure that all adults in Gwent are safeguarded effectively through partnership working and community engagement. The Board provides strong leadership, governance and accountability and promotes the rights of adults at risk to live in safety and actively works to prevent, identify and investigate alleged abuse. The Boards objectives and functions can be viewed in its partnership.

South East Wales Safeguarding Children Board

Safeguarding and promoting the welfare of children requires effective coordination in every local area and the Act puts in place regional Safeguarding Children Boards, which are the key statutory mechanism for agreeing how the relevant organisations in each local area will cooperate to safeguard and promote the welfare of children, and for ensuring the effectiveness of what they do. The South East Wales Safeguarding Children Board (SEWSCB) has replaced the five former Local Safeguarding Children Boards in Blaenau Gwent, Caerphilly, Monmouthshire, Newport and Torfaen,

The SEWSCB has the lead strategic role in ensuring that children and young people in the South East Wales region are protected from abuse, neglect and exploitation and discrimination, and live in an environment that promotes their well-being and life chances. The SEWSCB is also a multi-agency partnership comprising of representatives from Gwent Police, Social Services and Education Directorates from the five Local Authority areas, the Voluntary Sector, Youth Offending Services, the All Wales Probation Trust, CAF/CASS Cymru, Housing, Public Health Wales and Aneurin Bevan Health Board. The purpose of this partnership working is to hold each other to account and to ensure safeguarding children remains high on the agenda across the region.

This PNA will not replicate the work programmes of both Adult and Children's Boards but complement and link to the underpinning board action plans. Safeguarding is a core feature of the implementation of identified actions in this needs assessment and during the development of the joint Area Plan, we will set out clearly the safeguarding actions under each core theme. However, during the engagement with citizens and partners in developing the PNA concerns such as Child Sexual Exploitation, elder abuse (especially with an aging population) as well as general safeguarding is still a concern. The RPB will work closely with the Safeguarding Boards to ensure a strategic partnership approach and delivery of safeguarding processes is achieved.

Gwent Substance Misuse Area Planning Board (APB)

The Gwent Substance Misuse Area Planning Board (APB) covers Blaenau Gwent, Caerphilly, Monmouthshire, Newport and Torfaen and contains representatives of these five local authorities; membership is also drawn from Aneurin Bevan University Health Board (ABUHB), Gwent Police, National Offender Management Service (NOMS), Aneurin Bevan Gwent Public Health Team and a representative for service users and carers. The Gwent APB provides advice and support to responsible authorities in order to plan, commission and monitor delivery of high quality treatment and prevention services that are based on the needs of substance misusers, families and communities. The APB currently discharges an annual regional SMAF budget of £4.4m on behalf of the 5 local authorities to provide adult and young person's drug, alcohol and family support services within the region.

In 2014/15 the Gwent Substance Misuse APB commissioned **Gwent Drug and Alcohol Service (GDAS)** to provide an integrated drug, alcohol and family support service. GDAS is a consortium comprised of Kaleidoscope (lead agency), Drugaid and G4S and employs over 100 staff. It operates from a wide variety of local bases throughout Gwent, within community venues and an outreach service. The APB has recently undertaken a re-commissioning process for **substance misuse services for children and young people**. The specification for the new service includes a focus on prevention and early intervention as well as training for professionals and community workers involved in direct work with children, young people and families.

It is anticipated that these services will work closely with other teams such as mental health, sexual health, school nursing and youth services. In view of the disproportionate impact of alcohol in deprived communities the services will link with multi-agency panels and programmes that can provide more intensive support such as Flying Start, Families First and Communities First. ABUHB has recently established an **Alcohol Care Team** at the Royal Gwent Hospital and Neville Hall Hospital which provides an alcohol specialist nurse service linked to mental health liaison teams and the in-reach and community-based services provided by GDAS.

Similar to safeguarding board arrangements, the RPB will complement the work of the APB through the development of the joint Area Plan.

Next steps & joint Area Plan

The 2015 partnership arrangement regulations require local authorities and Local Health Boards (LHB) to form partnerships in order to carry out the population assessments required by section 14(1) of the 2014 Act. The Area Plans required to be prepared by local authorities and Local Health Boards under section 14A should also be prepared on a joint basis. Developing an Area Plan jointly will create consistency with the combined population assessment process and contribute significantly to the objective of integrated and sustainable care and support services. It will also enable partners to discharge the section 14A(2)(f) duty in the 2014 Act to set out the details of anything they propose to do jointly in response to the population assessment.

The Area Plan should set out the specific care and support services proposed to be provided or arranged in relation to each core theme and in how actions will be delivered:

- Jointly by partners;
- by each individual local authority; and
- by the Local Health Board.

This PNA has highlighted high level priorities under each core theme and necessary process developments required to implement the priorities. The basis of the Area Plan will be the priorities under each core theme and process developments. There are two types of suggestions actions.

1. Actions required to improve outcomes for people & promote well-being.
2. Actions to improve regional processes.

The high level actions to progress through the joint Area Plan are set out and we will develop a more robust analysis of actions required to deliver outcomes through the development of the Area Plan. We will also set out in detail the process actions required to develop a regional approach.

High level Actions to be progressed through the joint Area Plan

Core Theme	Actions to be progressed through joint Area Plan
Children & Young People	<ul style="list-style-type: none"> Support Children and Family Partnership Board's review of local arrangements for children with complex needs and delivery of work programme with a focus on Looked After Children. Consistent models of practice and alignment of Welsh Government's early intervention and preventative programmes. Develop and deliver a regional ACE action plan with a focus on earlier intervention and mental health support for children and young people through community based assets.
Older People	<ul style="list-style-type: none"> Develop place based approach 'Care Closer to Home' including consistent delivery of community connectors across the region to reduce social isolation. Further develop 'Dementia Friendly Communities.' Develop domiciliary care joint commissioning process with National Commissioning Board and linked to Care Standards Social Improvement Wales 'Above and Beyond' Report and the 'Care and Support at Home' Strategic Plan currently being developed by Care Council for Wales.
Health/ Physical Disabilities	<ul style="list-style-type: none"> Implement 'Care Closer to Home' Strategy. Align with 5 local Well-being Assessments required under Well-being of Future Generations Act and explore joint action planning for wider detriments to health.
Learning Disabilities / Autism	<ul style="list-style-type: none"> Support Mental Health and Learning Disability Partnership Board review Gwent Strategy for Adults with a Learning Disability 2012/17 and set out key regional commissioning, integration actions. Local implementation of Welsh Strategic Action Plan including development of new Integrated Autism Service.
Mental Health	<ul style="list-style-type: none"> Review and align regional strategies to Together for Mental Health Delivery plan. Coordination of consistent community based services such as community connectors/social prescribers. Multi-agency place based models which include wider partners such as Housing Associations, employment support and community programmes. Accurate Information, Advice and Assistance through DEWIS and Five Ways to Well-being.

Core Theme	Actions to be progressed through joint Area Plan
Sensory Impairment	<ul style="list-style-type: none"> Use good practice and effective pathways to develop regional commissioning principles. Ensure accurate, accessible and timely Information, Advice and Assistance through DEWIS and other means. Work in partnership with third sector to identify new models to support rehabilitation process and supply of low vision tools.
Carers	<ul style="list-style-type: none"> Coordination of consistent community based services such as community connectors/social prescribers to identify and support carers. Review of medical prompting to better support carers. Accurate Information, Advice and Assistance through DEWIS and Five Ways to Well-being. Review of and align third sector commissioning principles to support befriending for carers requiring support. Ensure that the implementation of the care closer to home strategy increases the community level support for carers. Consistent commissioning across health and social care to ensure equitable, region wide and effective models of carer support including flexible respite.
Violence against women domestic abuse and sexual violence	<ul style="list-style-type: none"> Implementation of 'Ask and Act' as part of Welsh Government pilot. Strategic alignment with VAWDASV Board, needs assessment and strategic plan.

High Level Process Development Actions to be delivered through the joint Area Plan

Core Theme	Actions to be progressed through joint Area Plan
Service Mapping	<ul style="list-style-type: none"> Continue to build on existing service mapping through the 'Care Closer to Home' strategy, Regional Joint Commissioning work stream and Supporting People programme and link specifically to priorities identified therein.
	<ul style="list-style-type: none"> Further develop and enhance the DEWIS website so it becomes the primary directory of resources for the region.
	<ul style="list-style-type: none"> Work with PSBs to ensure wider service mapping is integrated with that of Health and social care as an important step towards the creation of a public service response at community level.
Health & Social Care Integration Mental Health	<ul style="list-style-type: none"> Integration of care and support provision to key client groups as set out in Part 9 of the Act and emphasised through RPBs Statements of Strategic Intent for older people, children with complex needs and carers, as well as strategy statements for Mental Health and Learning Disability (including Autism).
	<ul style="list-style-type: none"> Adopt a place based approach through 'Care Closer to Home' strategy as foundation stone that underpins health and social care service integration.
Joint Commissioning and Pooled Budgets	<ul style="list-style-type: none"> Implement RJCG action plan to deliver joint commissioning arrangements for identified priorities for Act Part 9 requirements.
	<ul style="list-style-type: none"> Continue to link with National Commissioning Board to progress national work priorities and proposals across the region.
Preventative Services	<ul style="list-style-type: none"> Explore a single prevention agenda across the region with PSBs and linked to Well-being of Future Generations and SSWB Acts which also includes Housing Associations.
	<ul style="list-style-type: none"> Align anti-poverty programmes across the region to set out a single preventative model based on consistent assessment principles, joint workforce and joint commissioning.
	<ul style="list-style-type: none"> Through the implementation of the 'Care Closer to Home' strategy ensure that prevention and early intervention is supported and enabled in a consistent manner across the region.
	<ul style="list-style-type: none"> Delivery of RJCG work plan with third sector to maximise and align activity to prevent escalation of need and build on existing models of good practice such as befriending, social prescribing etc. and to promulgate the development of social enterprises and co-operatives where possible.

Core Theme	Actions to be progressed through joint Area Plan
Preventative Services	<ul style="list-style-type: none"> Support Early Years Pathfinder pilot and use key messages to shape early intervention models.
Information, Advice and Assistance	<ul style="list-style-type: none"> Further support and develop DEWIS website so it becomes the 'go to' place for information on support, advice and assistance.
	<ul style="list-style-type: none"> Continue to support consistent information dissemination and stakeholder engagement through regional communications group.
	<ul style="list-style-type: none"> Use IAA performance management data to inform design of services.
	<ul style="list-style-type: none"> To support further initiatives across the region that supports consistency of approach to IAA e.g. self-assessment exercises, peer reviews.
Social Enterprises	<ul style="list-style-type: none"> To work with regional workforce managers and Social Care Wales to ensure that cultural change programmes are embedded and on-going.
	<ul style="list-style-type: none"> Work with Wales Cooperative Centre to increase and support number of voluntary led services in local communities through 'Care to Co-operate'.
Advocacy	<ul style="list-style-type: none"> Alignment of advocacy provision to identified priorities across partner agencies.
	<ul style="list-style-type: none"> Work with the Golden Thread Advocacy Programme across the region through regional provider forum.
	<ul style="list-style-type: none"> Support Children's Services joint commissioning of a single advocacy service.
	<ul style="list-style-type: none"> Joint approach to advocacy provision with third sector partners especially in promotion of independent advocacy.

Appendix

- A number of the appendices referred to throughout this PNA are still being developed and some plans such as local authority Well-being Plans required under the Well-being of Future Generation Act are currently going through a consultation phase.
- This PNA would be too large a document if the appendices were 'embedded'

Appendices source list

1. Social Services and Well-being Act Data Catalogue report
2. Regional Well-being of Future Generations Act data report
 - a. Blaenau Gwent Well-being Assessment
 - b. Caerphilly Well-being Assessment
 - c. Monmouthshire Well-being Assessment
 - d. Newport Well-being Assessment
 - e. Torfaen Well-being Assessment
3. Care Closer to Home report
4. Supporting People Regional Plan
5. Regional Partnership Board Statements of Intent
 - a. Children with complex needs
 - b. Older People
 - c. Carers
6. Terms of Reference Citizen Panel
7. Terms of Reference Provider Forum
8. Regional IAA policy
9. Transformation Team Advocacy Report
10. Transformation IAA Report
11. Gwent Substance Misuse Area Planning Board Needs Assessment

Working in Partnership



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd
Aneurin Bevan
Health Board



Cyngor Bwrdeistref Sirol
Blaenau Gwent
County Borough Council



CAERPHILLY
COUNTY BOROUGH COUNCIL
CYNGOR BWRDEISTREF SIROL
CAERFFILI



CYNGOR
monmouthshire
COUNTY COUNCIL
sir fymwy

TORFAEN
COUNTY
BOROUGH



BWRDEISTREF
SIROL
TORFAEN



Newport
CITY COUNCIL
CYNGOR DINAS
Casnewydd