Greater Gwent Health, Social Care & Well-being Partnership
Partneriaeth Lles, Iechyd a Gofal Cymdeithasol Gwent Fwyaf

Social Services and Wellbeing Act

Population Needs Assessment

Gwent Region Report

DRAFT Nov 2016

Cyngor Bwrdeisdref Sirol Blaenau Gwent County Borough Council
CAERPHILLY CAERFFILI
monmouthshire sir fynwy
Newport City Council Cyngor Dinas Casnewydd
TORFAEN COUNTY BOROUGH BWRDEISTREF SIROL TORFAEN
GIG CYMRU NHS WALES Bwrdd Iechyd Aneurin Bevan Health Board

Index

How to view this Population Needs Assessment (PNA)

'What it is and what it is not!'

1. **This PNA is not an exhaustive list of graphical data but includes appendices where further data is included.**

2. **This PNA will include links to other supporting information such as the local Wellbeing Assessments required under the Wellbeing of Future Generations Act – we do not want to duplicate large sections of information in this PNA which is included in other documents**

3. **This PNA uses the PNA toolkit developed by Welsh Local Government Association (WLGA) and Social Services Improvement Agency (SSIA) to set out the levels need in the situational analysis and services required in the response analysis**

4. **This 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 Wellbeing Act data catalogue developed by Data Unit Wales as a starting point.**

5. **This PNA is based on the views of citizens and providers, and co-production is a core design principle. Citizens and providers helped identify the emerging areas of interest under each core theme.**

6. **This PNA will use the latest research. This PNA is not adopting a 'blank canvass' 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 this PNA will incorporate, but not replicate.**

7. **The core theme chapters will read as executive summaries and highlight regional priorities linked to the emerging areas of interest; 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 regional Area Plan required following the publication of this PNA – again this list is not exhaustive but a starting point.**

9. **This 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 regional 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 Wellbeing Act Population Needs Assessment which will be central to promoting wellbeing, 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 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 Wellbeing 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 Wellbeing 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 by 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 and the RPB **will act as a joint committee to oversee the process.**

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

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 Board (RPB) to manage and develop services to secure strategic planning and partnership working; and to ensure effective services, 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) 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 Wellbeing of Future Generations Act – Gwent Area Planning Board for Substance Misuse, Gwent Welfare Reform Partnership and In One Place Programme.

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 – under the *'Care Closer to Home'* strategy (see section 2) – in each of the GP cluster areas of which there are 12 in the Gwent region.

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, 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 Wellbeing of Future Generations Act

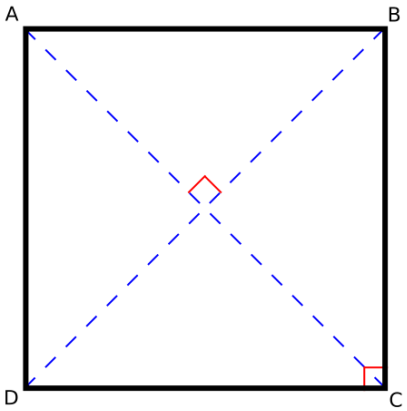
The Social Services and Wellbeing Act (the Act) shares similar principles with a number of national strategies and legislation. However, the Act shares almost identical principles with the Wellbeing of Future Generations Act with the main difference between the acts being the time frame: the PNA under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

Social Services and Wellbeing Act Principles	**Sustainable Principles: Wellbeing 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 wellbeing objectives
	Integration: Consider how the proposals will impact on wellbeing objectives, wellbeing 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 wellbeing 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 regional Area Plan and local Wellbeing Plans required under subsequent acts.

Social Services and Wellbeing Act Prioritisation Matrix 'Centering the Square'

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 above 4 factors and we call this 'centering the square'



1. **Engagement – what have people told us?**
   Needs identified by vulnerable groups, providers and wider population.

2. **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?

3. **National policy and strategies – What are we expected to deliver?**
   Are the emerging priorities representative of national drivers and is funding provided through national funding streams?

4. **Partnership working and resources – What resources do we have to deliver?**
   Are there existing partnerships, funding and resources in place to deliver priorities and do the priorities require multi-agency input or single agency working?

Emerging Priorities: Social Services and Wellbeing Act Population Needs Assessment

A series of workshops were organised to identify emerging 'areas of interest' related to the core themes of the PNA. The workshops took place with the regional citizen panel, provider forum and Leadership Group (Directors of Social Services and Chief Executives from ABUHB, third sector umbrella organisations GAVO and TVA). **The emerging areas of interest are focused on the needs of adults and children who access health and social care support**

CORE THEME	Emerging Areas of Interest
Children & Young People	• Accommodation and local placements for children with complex needs • Transition arrangements between children and adult services and simpler processes for children with complex needs • Earlier intervention and community based support linked to school hubs • Looked After Children including education achievement • Mental health support for children
Older People	• Isolation of older people • Dementia • Simpler coordination of services including Continuing Health Care • Appropriate accommodation for older people • Person centered support where person is listened to, with earlier intervention and community resilience
Carers	• Young Carers and support for siblings • Flexible, bespoke support including Information, Advice and Assistance • Flexible respite for carers • Training and peer to peer support for carers • New models of support for carers
Mental Health	• Increased understanding and awareness of mental health • Emotional support for children in care • Less social isolation more community support • Early intervention and community support which is timely including advocacy.
Learning Disabilities	• Independent living with access to early intervention services in the community and good public awareness (including Carer's education – what is acceptable?) • Young people with autism, accommodation, access to day services • Employment and training opportunities for people with learning disabilities • Dementia amongst people with learning disabilities • Appropriate Accommodation

Physical Health & Sensory Impairement	• Support people with physical and sensory needs with independent living • All age approach to physical disabilities • Accessible transport, accommodation and community based services • Access to medication where required
Violence against women domestic abuse and sexual violence	• Training for all • Healthy relationship awareness especially in schools • Family services • Support for victims • Service analysis and mapping

Demography – What does Gwent look like?

Gwent comprises of 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.

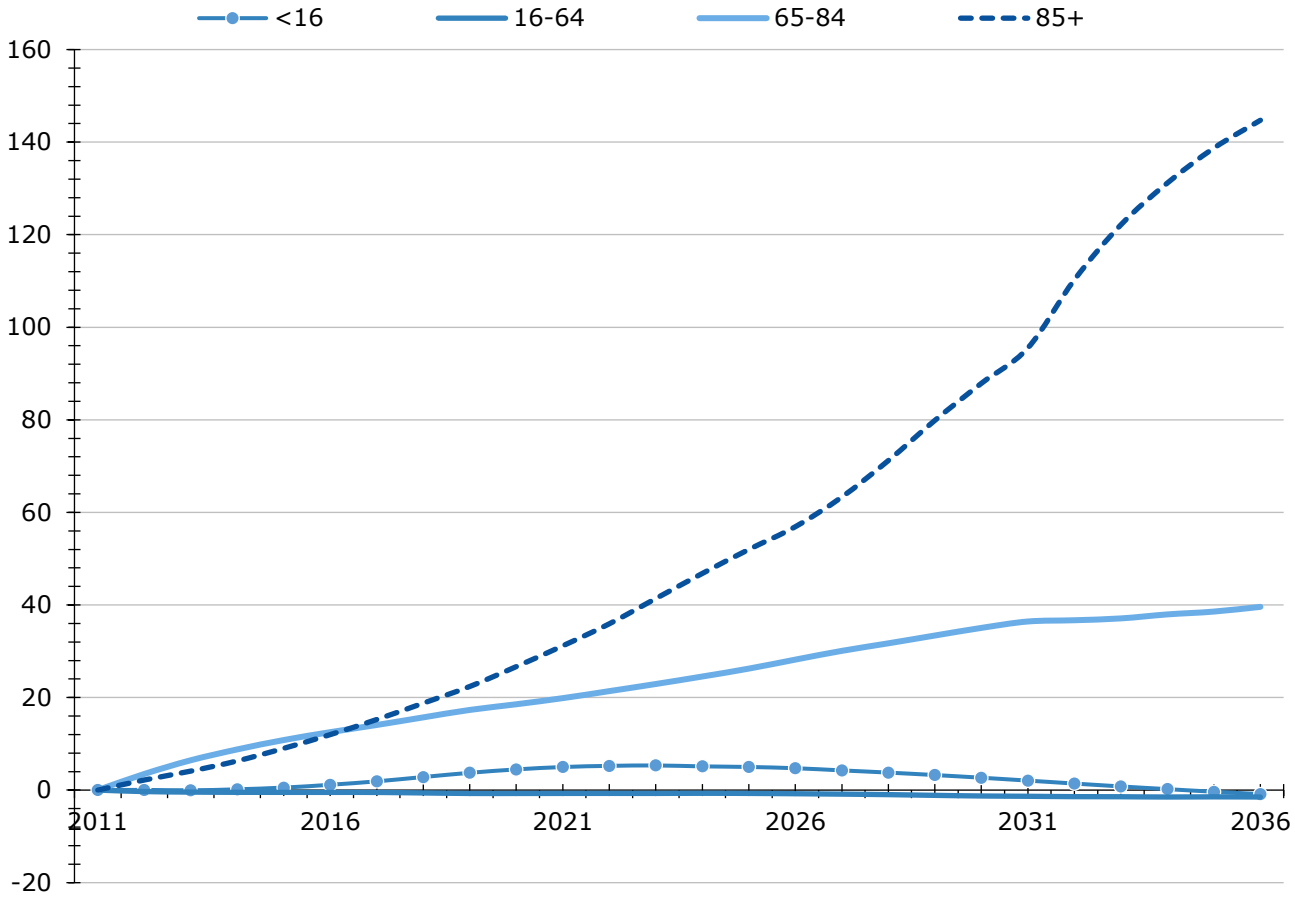
Newport City is the third largest urban centre in Wales with a population of 146,841*. The city has the second largest number of people from minority ethnic communities of all the Welsh counties (after Cardiff) and has continued to increase since 2009 when the figure was estimated at 6.6% of the population.

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 40.66% of the Gwent total.

Each local authority is required to produce a Wellbeing Assessment (WBA) under the Wellbeing 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)

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

- 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 family 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 Wellbeing Assessment in each area, and this draft 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 regional 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.

SECTION 1

Engagement and what people have told us – a culture not a process!

Engagement is central to the development of the 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 wellbeing.

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

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 the 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 the analysis of the questionnaire in the draft PNA but information will be included in the final PNA.

II. Focussed work with vulnerable groups

We have also engaged the views of those who would otherwise be hard to reach and marginalised including those of 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 the PNA we have also engaged

with youth forums, 50 plus forums, parenting forums, citizen panels, carers groups and learning disability groups.

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.

IV. <u>Wider population in partnership with Wellbeing Assessments</u>
We have linked closely with partners developing local wellbeing assessment under the Wellbeing of Future Generations Act and have included questions in relation to care and support needs in wider engagement events.

2. Engage with providers and 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 to 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 have 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 wellbeing?
iii. What services are needed?

4. Summarise

We have undertaken pre engagement 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 Wellbeing Assessments under the Wellbeing of Future Generations Act. A summary of the compiled feedback will be included in the final PNA as Wellbeing Assessments have not been published to date and a robust analysis is required.

5. Set out how information has been reflected in the assessment – W*hat 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 will also set out clearly in the PNA: what people told us and what we will do.

What People Told Us and What We Will Do

People told us that

Mental health support for children and supporting children and families in our community earlier to stop them moving into care is important **and we will:**

Through our preventative and early intervention programmes such as Families First and Flying Start we will ensure a regional approach and that all staff work together to maximise resources so that we can act earlier.

Isolation of older people and Dementia is a worry for many **and we will:**

Continue to develop our community connectors across the region and build on our approach to Dementia Friendly Communities to not just support people with dementia but all people in our community

We want to live in our own homes, live independently and feel listened to including people with physical and sensory needs **and we will:**

Ensure the workforce that support people will determine 'what matters most' and we will review the way in which we commission services to reflect even further the views of citizens

We want flexible, bespoke support including up-to-date information and advice and Assistance especially for people who are carers and **we** will**:**

Continue to develop our DEWIS regional website to provide people with current information

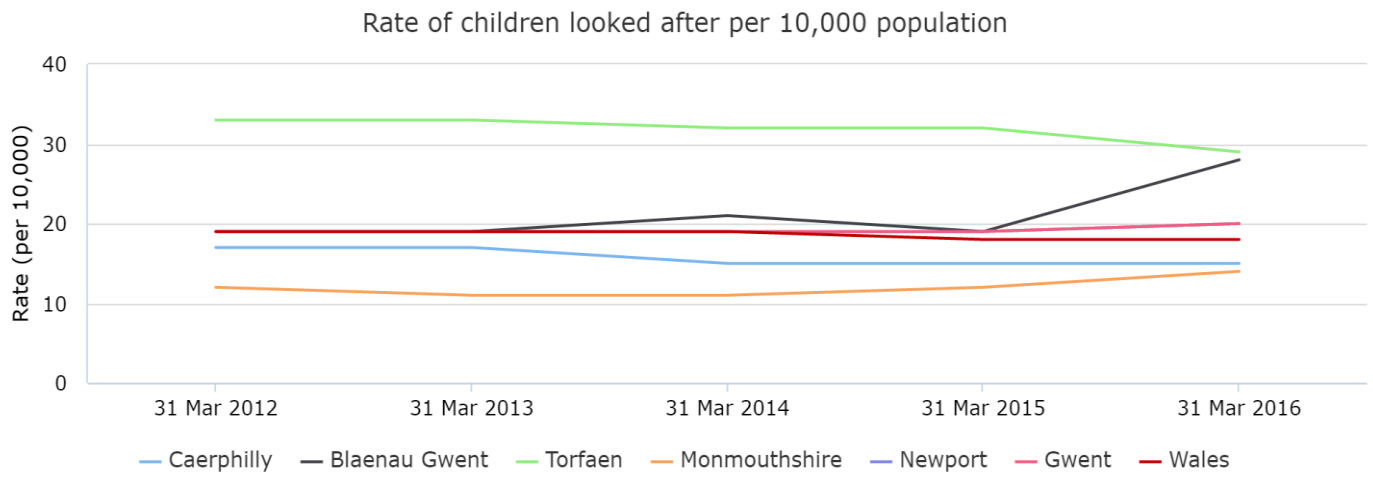
Children and young people

A demography and population profile for individual local authorities is included in the 5 local Wellbeing 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. Pre-engagement workshops with the regional citizen panel, provider forum and leadership group identified the following emerging areas of interest:

- **Accommodation and local placements for children with complex needs**
- **Transition arrangements between children and adult services and simpler processes for children with complex needs**
- **Earlier intervention and community based support linked to school footprints**
- **Needs of Looked After Children including education achievement**
- **Emotional wellbeing/mental health support for children young people**

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.



	Caerphilly	Blaenau Gwent	Torfaen	Monmouthshire	Newport	Gwent	Wales
31 Mar 2012	17	19	33	12	19	19	19
31 Mar 2013	17	19	33	11	19	19	19
31 Mar 2014	15	21	32	11	19	19	19
31 Mar 2015	15	19	32	12	19	19	18
31 Mar 2016	15	28	29	14	20	20	18

Source: Welsh Government (WG)

Figure CYP3 shows the rate of looked after children per 10,000 population across the Gwent region over the period 2011 to 2015. All local authority areas have seen some fluctuation over the period. Caerphilly has seen the largest decrease over the period with Monmouthshire seeing the highest increase.

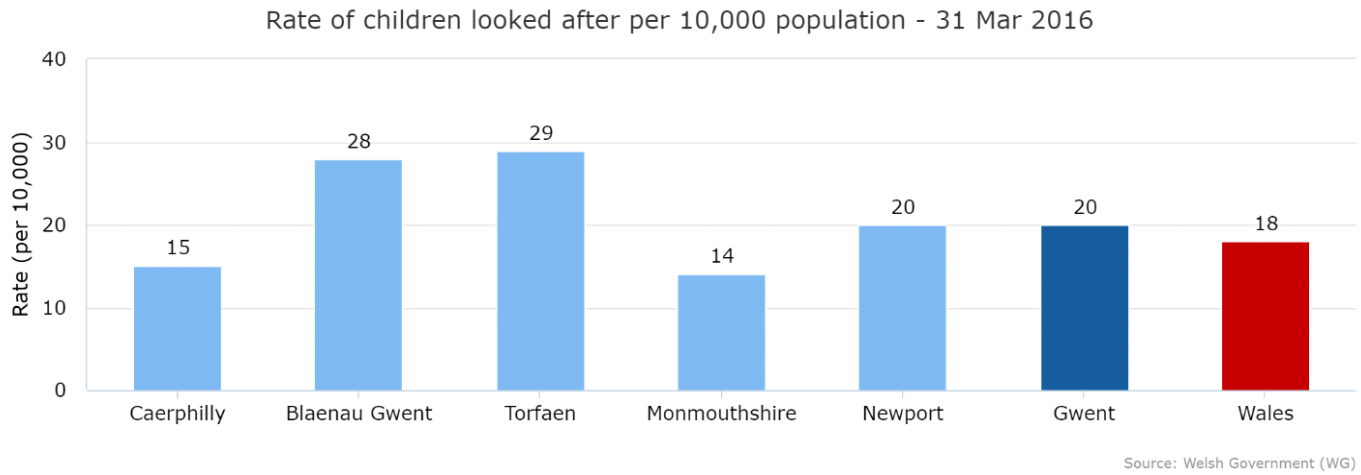


Figure shows the rate of children looked after per 10,000 population on 31 March 2016 across the Gwent region. This ranged from 14 per 10,000 population in Monmouthshire to 29 per 10,000 population in Torfaen. This compares with 20 per 10,000 population for the Gwent region and 18 for Wales on 31 March 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 in some cases 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 form across health, social care and education. There is no set definition for children with complex needs at a regional level, but as a starting point the CFPB considers the following client groups to have complex needs: people with Autistic Spectrum Disorder (ASD) and/or a learning disability; children with complex physical disabilities and; children and young people who

have experienced developmental trauma and people who can present challenging behaviour. The CFPB have identified the following priorities:

- Emotional Well-being and Mental Ill-Health across the age range, including children and young people, maternal and infant mental ill-health with the view to identify any gaps in current support provision and to develop new services and/or transform current services;
- Multi-agency assessment and planning for children and young people with complex needs – with the view to improve joint referrals, joint assessment and joint commissioning of services for this group;
- Out of county placements for children and young people with complex needs - with the view to plan and develop local services where appropriate (including possible residential provision)
- Obesity in children and young people *(this will be linked to local Well-being Plans and the work of Public Service Boards)*

The CFPB have overseen progress against the 4 priorities

- A gap analysis in emotional well-being and mental health services project (completed 2015) and through recent funding, as part of the national programme 'Together of Children and Young People' and more recently 'Integrated Autism Service', new services have been developed such as Enhanced Early Intervention in Psychosis (14-25 Age Group), Enhanced Crisis Outreach Team. extended Eating Disorder Service, extended Emergency Liaison Service and Dialectical Behaviour Therapy Service
- Develop a hub and spoke model of service delivery in ABUHB children's centres to support the children and young people with disabilities and their families/carers; and test an innovative integrated model to implement integrated multi-agency and multi-disciplinary assessment and planning in the Caerphilly LAs (ICF funding).

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.***

Flying Start and **Families First** are preventative programmes who 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.

<u>Actions and next steps</u>

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. Welsh Government are currently exploring a joint outcomes framework across the 4 programmes but there are initial discussions exploring consistent assessment principles, consistent workforce training and joint commissioning opportunities across the region. Information, Advice and Assistance (IAA) will also direct families to appropriate resources and support; and Family Information Services are key partners as the 'front door' in each local authority for general information. 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 and 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 and 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. 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**
- **NHS Adverse Childhood Experiences (ACE)**

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

- **Support Children and Family Partnership Board's review of local arrangements for children with complex needs and delivery of work programme.**
- **Consistent models of practice and alignment of Welsh Government's early intervention and preventative programmes**

Older people

A demography and population profile for individual local authorities is included in the 5 local Wellbeing 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 Older People are categorized as being over the age of 55 years and receiving care and support services. Pre-engagement workshops with the regional citizen panel, provider forum and leadership group identified the following emerging areas of interest

- **Isolation of older people**
- **Dementia**
- **Simpler coordination of services including Continuing Health Care**
- **Appropriate accommodation for older people**
- **Person centered support, people listened to, with earlier intervention and community resilience**

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.

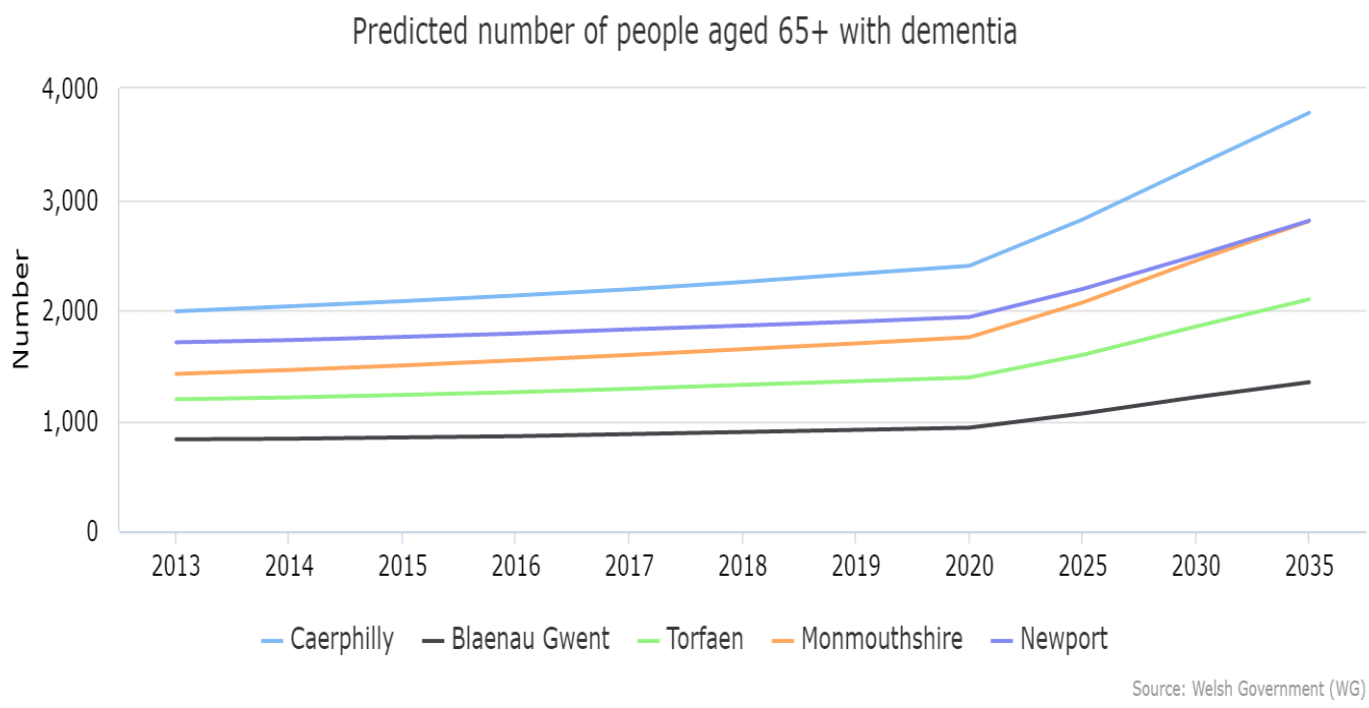


Figure OP2 shows the predicted number of people aged 65 years or older with dementia over the period 2013 to 2035. It shows that across all local authority areas in the Gwent region an increase in the number is predicted. The increases range from 62.1% in Blaenau Gwent to 97.1% in Monmouthshire over the period 2013 to 2035

.

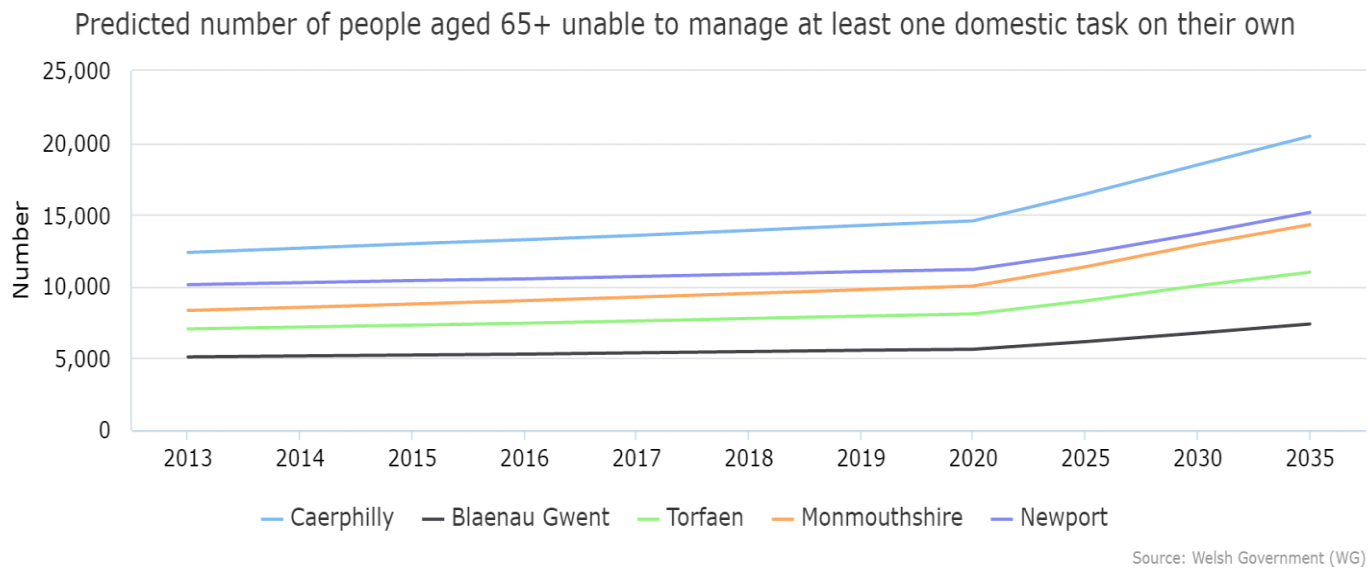


Figure OP1 shows the predicted number of people aged 65 years or older who are unable to manage at least one domestic task on their own over the period 2013 to 2035. It shows that all local authority areas across the Gwent region are predicted to see an increase in the number. The predicted increases range from 44.9% in Blaenau Gwent to 71.6% in Monmouthshire in the percentage 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.

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 **percentage of 85 year old's increase by 90% by 2030** and a growth of 30-44% of people with dementia.

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 multiagency approach and one that we aim to build on to address the wellbeing needs and aspirations of our older citizens.

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 2015/16 and on to 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 development workshops – ***Care Closer to Home*** – 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.

Actions and next Steps

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

- Working together to reduce social isolation and loneliness through community connectors, social prescribing, volunteer activity and schemes such as ABUHB ChaT scheme.
- Develop further *'Dementia Friendly Communities'*
- Wider integration of a 'team around the person' and place based approach on Neighbourhood Care Network (NCN) footprint, linked to the '*Care Closer to Home Strategy' and* to make use of community hubs to focus on keeping people well in the community and to support independence. *[See Section 1]*
- 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.

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 Information Advice and Assistance service and by using the new integrated assessments to ensure that there is a holistic approach to indoviduals that supports independence a reduces hospital admissionsThe 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.

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 7/7, 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

- *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 considered and implemented during 2017/18.
- Taking forward a 'better life' programme to support *care homes* in giving sustainable, high quality and consistent care to support wellbeing.

- Supporting 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.
- We will develop the working relationships with Registered Social Landlords (RSL's) established through the 'In One Place' project to look at generating new socially owned domiciliary care provision on a place based approach.

New models

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**

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

- **Develop place based approach *'Care Closer to Home'* including consistent delivery of community connectors across the region**
- **Further develop *'Dementia Friendly Communities'***
- **Pilot 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

A demography and population profile for individual local authorities is included in the 5 local Wellbeing Assessments. An abbreviated demography is included in section 1 of this PNA which also includes the population projection for the region. Pre-engagement workshops with the regional citizen panel, provider forum and leadership group identified the following emerging areas of interest:

- **Support people with physical and sensory needs with independent living (sensory needs covered separately elsewhere)**
- **All age approach to physical disabilities**
- **Accessible transport, accommodation and community based services**
  - **Access to medication where required**

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.

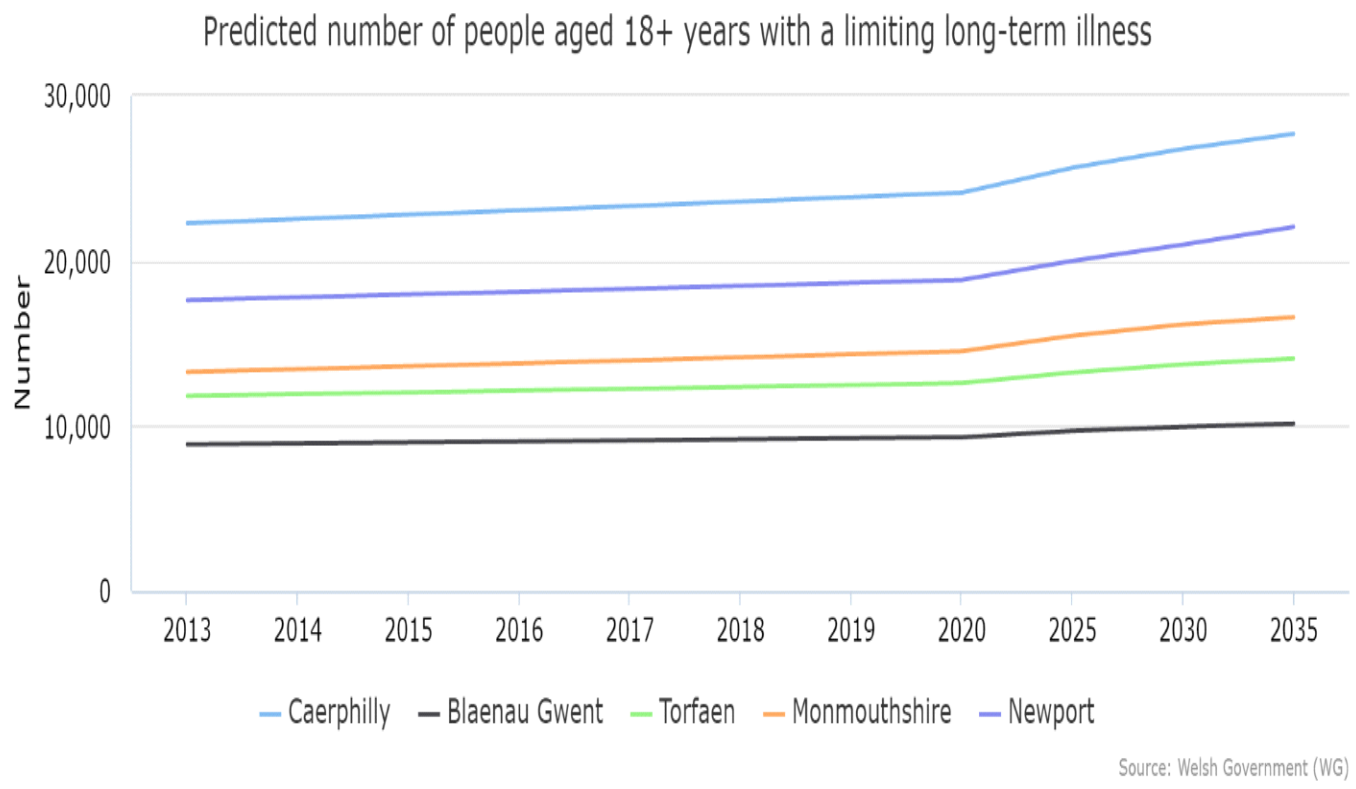


Figure PH1 shows the predicted number of people aged 18 years or older with a limiting long term illness over the period 2013 to 2035. It shows that all local authority areas across the Gwent region are predicted to see an increase in the number. The predicted increases range from 14.1% in Blaenau Gwent to 25.1% in Newport.

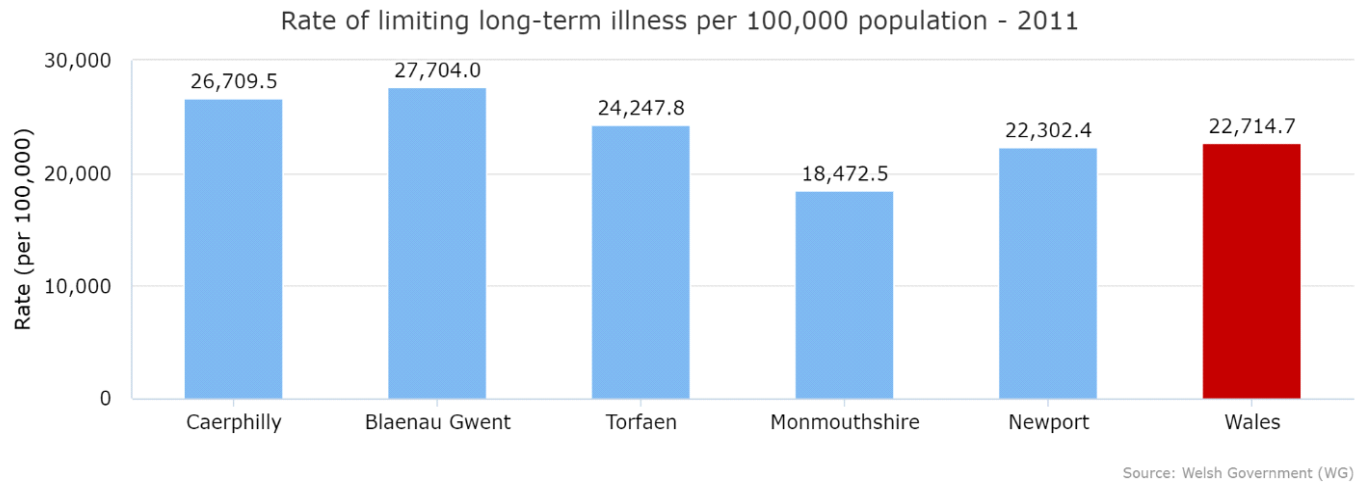


Figure PH2 shows the rate of limiting long-term illness per 10,000 population in 2011. Across the Gwent region the rate ranged from 18,472.5 per 100,000 population in Monmouthshire to 27,704.0 per 100,000 in Blaenau Gwent.

What do we know?

Physical Disability – Facts and 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 areas 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'. 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. These include people registered under Section 29 of the National Assistance Act 1948 who are normally resident in the local authority. 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 higher proportions of people registered could be reflective of the demographics of the local area, for example an older resident population. It could also be influenced by differences in local authority procedures and their capacity for registering people as having a physical/sensory disability. 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.

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 area providing information, advice and assistance to help people connect with their community, access support and promote wellbeing. Support to enable people to maintain employment when living with an illness or disability (mental of 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. **Gwent Five Ways to Wellbeing Network** aims to support professionals to promote and protect the mental health and well-being of the population. The Five Ways to Wellbeing are a wellbeing 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 adult social care and 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 totaling £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 care.

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 wellbeing and support people to lead and maintain a healthy lifestyle.
- Support people to 'self-manage' their illness or disability and have more control over their life.
- Ensure consistent delivery of **community connectors and social prescribers** across the region 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 and 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 – including adaptation of homes, access to services (this includes transport) – to prevent escalation of need and crisis.
- Explore joint commissioning opportunities between **Intermediate Care Fund and Supporting People programme** for people 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 Wellbeing Assessments in each local authority area**
- **Regional Mental Health & Learning Disability Strategy**

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

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

Learning Disability/Autism

A demography and population profile for individual local authorities is included in the 5 local Wellbeing Assessments. An abbreviated demography is included in section 1 of this PNA which also includes the population projection for the region. Pre-engagement workshops with the regional citizen panel, provider forum and leadership group identified the following emerging areas of interest:

- **Independent living with access to early intervention services in the community and good public awareness (including Carer's education – what is acceptable?)**
- **Young people with autism, accommodation, access to day services**
- **Employment and training opportunities for people with learning disabilities**
- **Dementia amongst people with learning disabilities**
- **Appropriate Accommodation**

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.

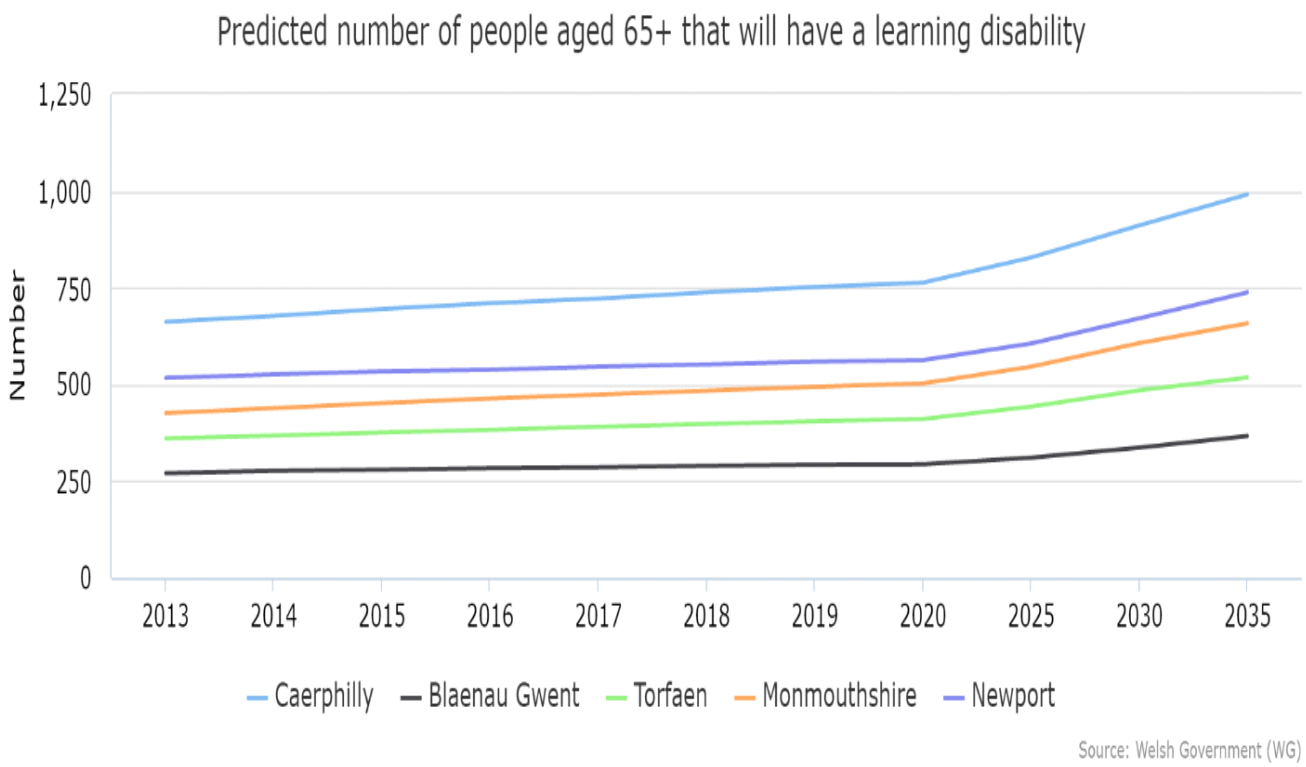


Figure LD1 shows the predicted number of people aged 65 years or older that will have a learning disability over the period 2013 to 2035. All local authority areas across the region are predicted to see an increase in the number. The predicted increases range from 35.4% in Blaenau Gwent to 54.5% in Monmouthshire.

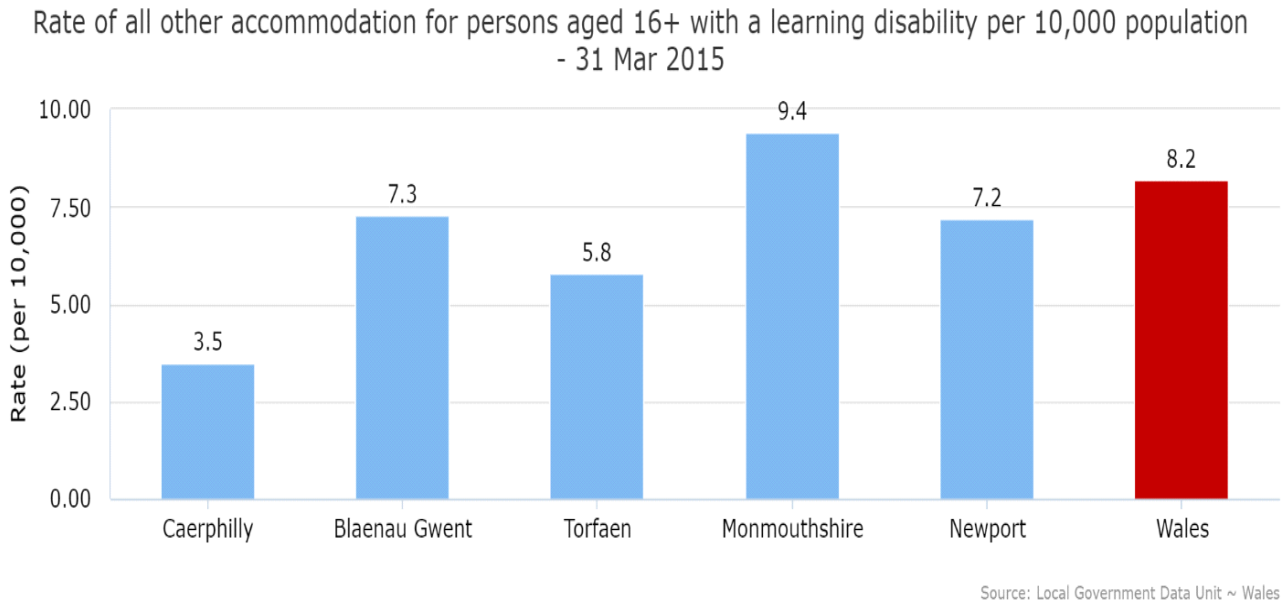


Figure LD3 shows the rate of all other accommodation for persons aged 16 years or older with a learning disability per 10,000 population at 31 March 2015. The rate ranged from 3.5 per 10,000 population in Caerphilly to 9.4 per 10,000 population in Monmouthshire. This compares with 8.2 per 10,000 population for Wales.

What do we know?

Learning Disability – Facts and 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. 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.

Autistic Spectrum Disorder (ASD) – 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.
- ASD affects more males than females.
- All individuals with an ASD have impairments in the same three areas (i) social interaction (ii) social imagination (iii) social communication
- Many people with an ASD have not been diagnosed, and therefore may not realise they have the condition. This is especially true for adults.

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 service 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.

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 for referral to first assessment appointment has been established. There will also be improvements to adults 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, 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.

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 material available through national ASD website www.asdinfowales.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 have been approached by many 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 and 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 regional 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, 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 Wellbeing 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. Pre-engagement workshops with the regional citizen panel, provider forum and leadership group identified the following emerging areas of interest:

- **Increased understanding and awareness of mental health**
- **Emotional support for children in care**
- **Less social isolation more community support**
- **Early intervention and community support which is timely including advocacy.**

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.

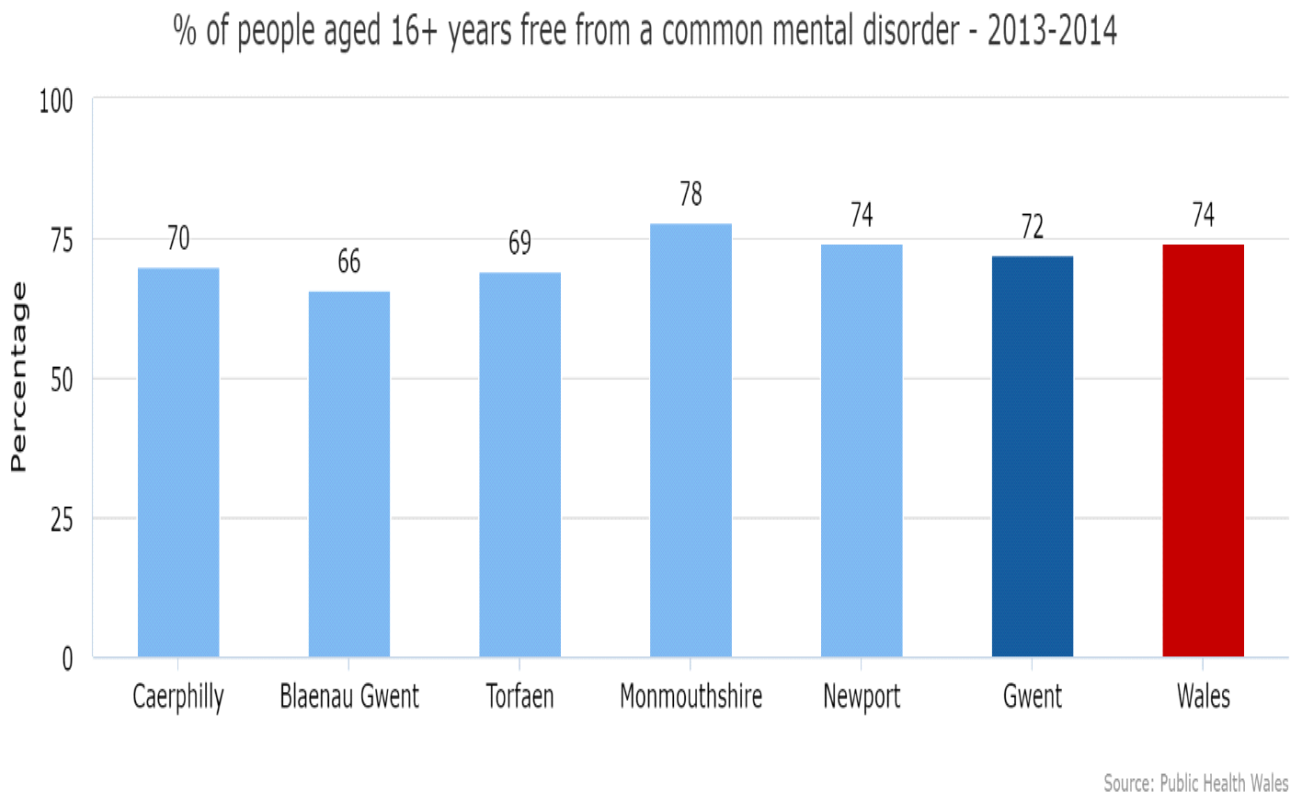


Figure MH1 shows the percentage of people aged 16 years or older free from a common mental disorder in 2013-2014. The percentage ranged from 66% in Blaenau Gwent to 78% in Monmouthshire. This compares with 72% of people aged 16 years or older free from a common mental disorder for Gwent and 74% for Wales.

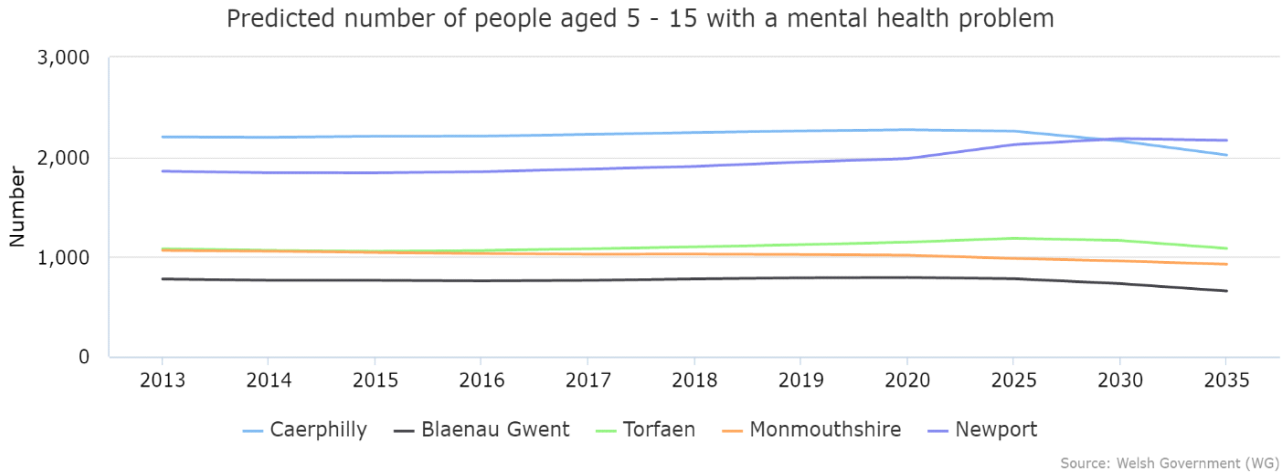


Figure MH3 shows the predicted number of people aged 5 – 15 with a mental health problem over the period 2013 to 2035. Across the local authority areas in the Gwent region both Torfaen and Newport are predicted to see increases of 0.4% and 16.6% in the number of people aged 5 – 15 with a mental health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

- 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.

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.**

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)
- Information and advice

Primary care plays a crucial role in delivering effective mental health care and treatment. A requirement from Welsh Government (The Mental Health (Wales) Measure) aims to strengthen the role and throughout Wales there are local primary care mental health support services organised around GP communities. These services are aimed at individuals of all ages who are experiencing mental health problems and include the development of primary mental health teams. For example a **LEAP team (Listen, Engage Act and Participate) w**as established in the north of the Caerphilly borough 2014-16, bringing together staff from health and social care to take all primary care and secondary care referrals from 5 GP practices. The model explored what a team without boundaries can achieve through working with patients in an integrated way, putting the service user at the centre of support and a team around a person approach.

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 wellbeing. **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. There are pockets of good examples across the region and Caerphilly County Borough's Communities First structure includes Communities' First mental health officers who work with people of all ages presenting with low mental health issues. This 'self help' service encourages people to establish networks in their own communities. 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.

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.

Actions and next steps

Preventative and Early Intervention including Information, Advice and Assistance (IAA) – We will continue to develop the Community Connector and 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 the ABUHB 'Care Closer to Home' model and a place based approach. We will also build on the 'Five Ways to Wellbeing' 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

- **National Together for Mental Health Delivery Action Plan**
- **Together for Mental Health Gwent**
- **ABUHB IMTP**

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

- **Review of 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 Wellbeing**

Sensory Impairment

A demography and population profile for individual local authorities is included in the 5 local Wellbeing 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. Pre-engagement workshops with the regional citizen panel, provider forum and leadership group identified the following emerging areas of interest:

- **Access to accurate information and assistance to understand and use that information**
- **Access to low vision tools**
- **Public transport system that is convenient and easy to use**
- **Access to 'rehabilitation' e.g. re-teaching someone how to do things safely again such as crossing a road**
- **Having sufficient financial resource to cope with the additional cost of living**

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.

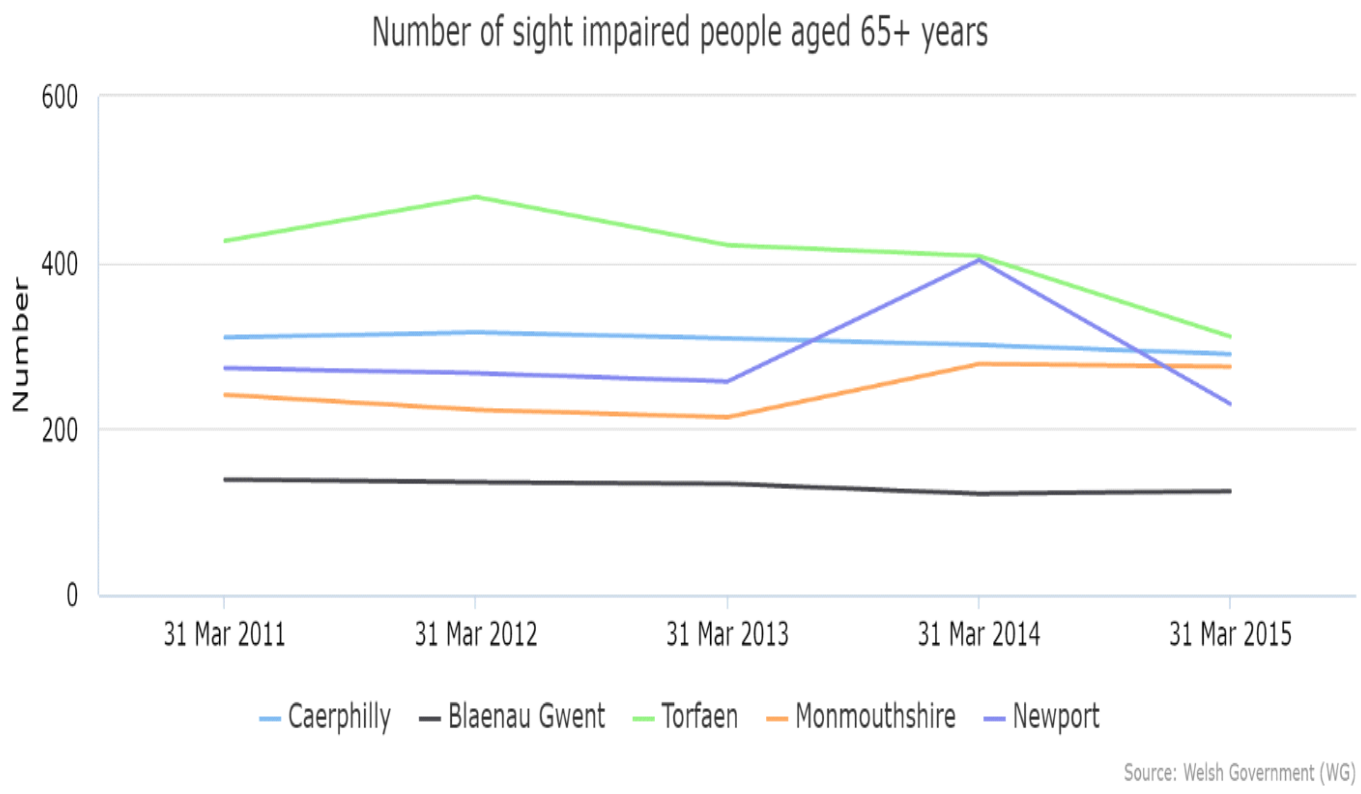


Figure above shows the number of sight impaired people aged 65 years or older over the period 31 March 2011 to 31 March 2015. Across the local authority areas in the Gwent region, Monmouthshire has seen an increase of 14.1% in the number over the period, from 241 at 31 March 2011 to 273 at 31 March 2015. 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 such as people who are hard to reach (evidence shows that people from some ethnicities are 6 times more likely to experience sight loss but are less likely to engage; those 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 body 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.

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.

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 (LVSW) was founded in 2004 with, the aim of providing a more accessible low vision service for the population of Wales, in regards to travel time, waiting time and convenience, whilst delivering a service of a high clinical standard.

- The LVSW 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 LVSW has increased, with 8049 LVSW assessments being performed between April 2015 and April 2016 (WG, 2016).
- By 2015, the LVSW had completely replaced all secondary care based low vision services in Wales. The LVSW 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 LVSW 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 LVSW 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.

Action Plan & 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.
- 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 and 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 Officer 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 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 regional 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 Wellbeing 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'. Pre-engagement workshops with the regional citizen panel, provider forum and leadership group identified the following emerging areas of interest.

- **Young Carers and support for siblings**
- **Flexible, bespoke support including Information, Advice and Assistance**
- **Flexible service models of respite support for carers**
- **Training and peer to peer support for carers**
- **New models of support for carers including support for carers base on 'life after care'**

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.

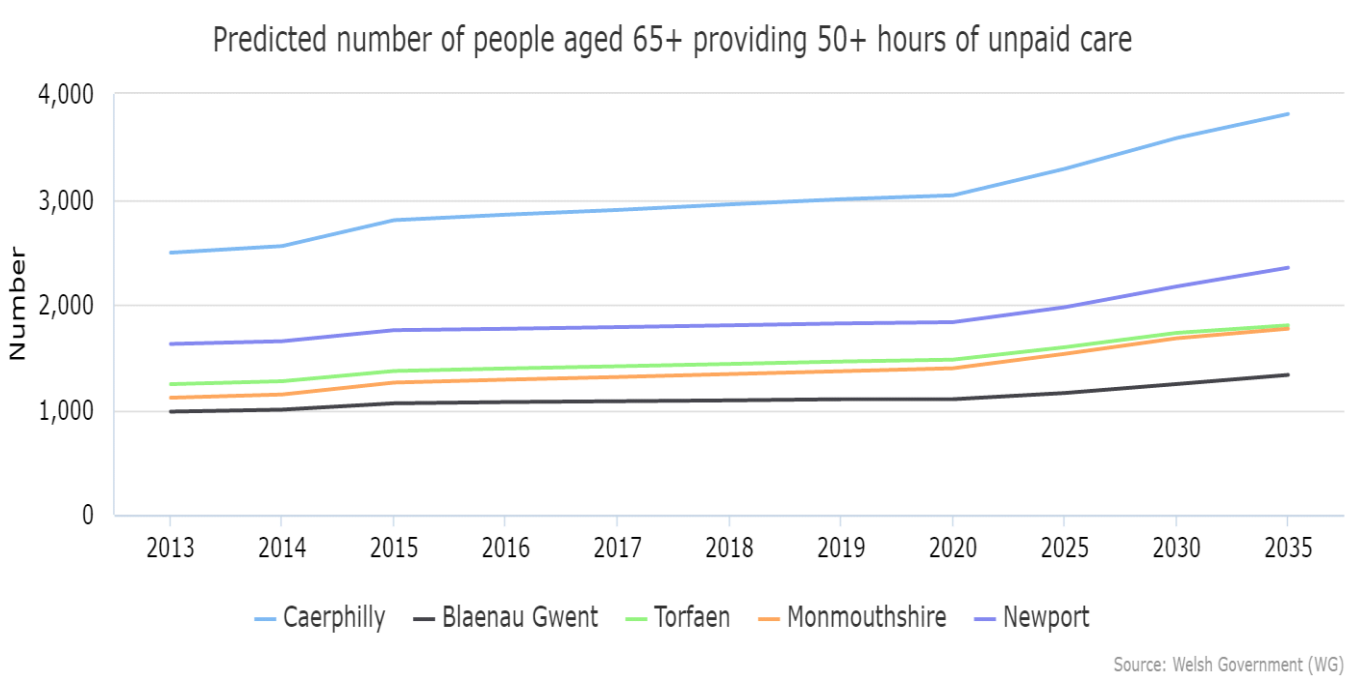


Figure above shows the predicted number of people aged 65 years or older providing 50 hours or more of unpaid care over the period 2013 to 2035. All local authority areas across the Gwent region are predicted to see an increase in the number. The predicted increases range from 35.6% in Blaenau Gwent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

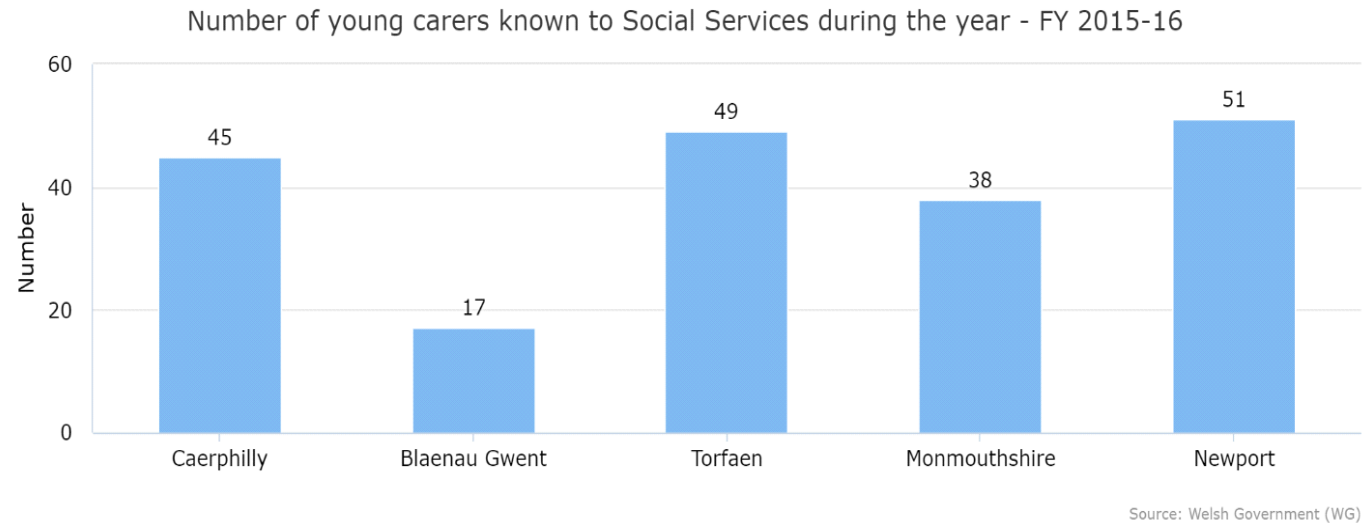


Figure shows the number of young carers known to Social Services during the year 2015-16. It shows that the number ranged from 17 in Blaenau Gwent to 57 in Newport.

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 (Wales) 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.

What are we doing?

Following the implementation of the Carers Strategy (Wales) Measure in 2012 a multiagency 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 multiagency Greater Gwent Carers Programme Board ('Carers Board') has been established. The Carers Board is Chaired by the 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.

In the next period, 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 and 2017/18 is targeting the following areas:

- Advocacy support,
- Support to young adult carers and transition,
- Mental health and well-being support for carers,
- 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. A new community support group has been established in Blaenau Gwent to support people living with dementia and their carers. The group aim to raise and spend local funds to ensure people can attend support groups such as dementia cafes and is one of the first groups to be established under the new service models agenda

Action Plan & Next Steps

Preventative and Early Intervention including Information, Advice and 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*) is under development and will provide a database of service information for citizens (including carers). This will be a useful tool in facilitating easy to access links to local information.
- A targeted approach will continue within health services to: raise awareness through acute medical wards and at hospital discharge stage, information provision and support links with GP surgeries – ensuring 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 staff training needs to be sustainable and work is required by each partner organisation to ensure that carer awareness training is sustainably absorbed into core functions, making use of an all Wales awareness raising e-learning tool accessible to all partner 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
- In relation to dementia we will deliver Social Care Wales 'Good Matters' framework
- We will also explore how medicines prompting can be better delivered through region wide, community based service models that ensure equity of support
- 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.
- Continue to support new models such as the Friends of Dementia group in Blaenau Gwent.

Advocacy – arrangements are being discussed at Carers Programme Board meeting in late 2016.

Links to key strategies

- **Regional Partnership Board Statement of Intent**
- **Regional Dementia Strategy**
- **Social Care Wales 'Good Works'**

Summary and what we will deliver through the regional 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 Wellbeing**
- **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**

Violence against women, domestic abuse and sexual violence

A demography and population profile for individual local authorities is included in the 5 local Wellbeing 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*[i]. Pre-engagement workshops with the regional citizen panel, provider forum and leadership group identified the following emerging areas of interest:

- **Training for all and healthy relationship awareness especially in schools**
- **Family services**
- **Support for victims**
- **Service analysis and mapping**

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.

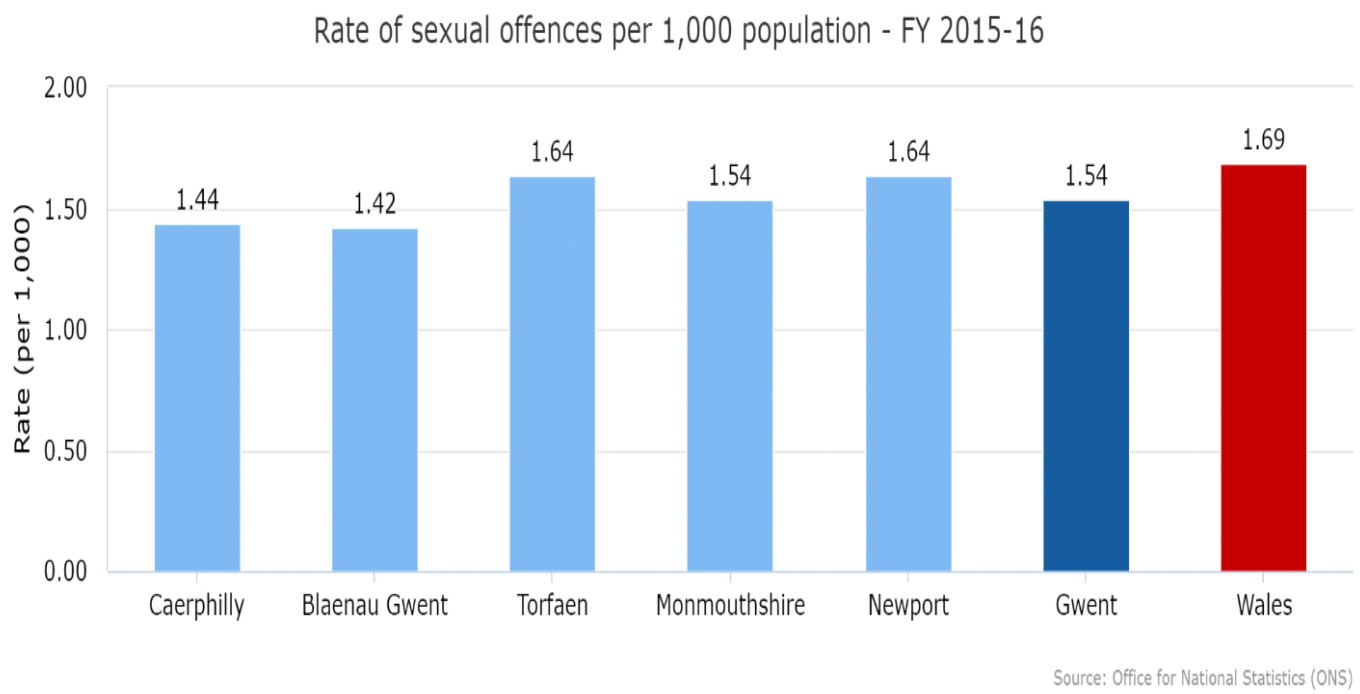
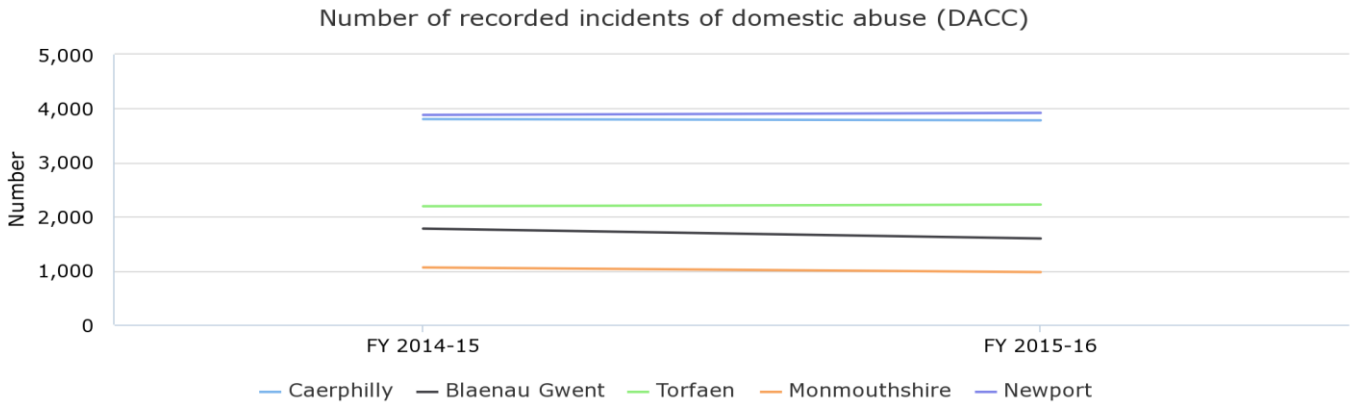


Figure V1 shows the rate of sexual offences per 1,000 population in 2015-16 across the Gwent region. The rate ranged from 1.42 per 1,000 population in Blaenau Gwent to 1.64 per 1,000 population in both Torfaen and Newport. This compares with 1.54 per 1,000 population for Gwent and 1.69 per 1,000 population 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

Source: Gwent police

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 Wellbeing (Wales) Act 2014; and provides a unique opportunity to embed VAWDASV as a priority in determining the well-being of Wales.

We know that the reporting of domestic abuse is considerably lower than actual incidents – reported incidents vary between 23% (Walby and Allen 2004) and 35% (Home Office 2002; Office for National Statistics 2013) of actual – and this will need to considered in planning going forward. 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*** 20115/16 (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.

What are we doing?

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 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 and Early Intervention including Information, Advice and 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 and 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 regional Area Plan.

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

SECTION 2

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 i.e. the '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 Wellbeing Act codes of practice, citizens and social care workforce must be engaged in the process of identifying the range and level of services necessary. In developing the PNA engagement with citizens and providers to identify the range of services took place at the same time as identifying the level of needs for care and support and support needs of carers. 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 emerging areas of interest identified on page 8, we have included specific service mapping work – for example Monmouthshire mapped the IAA entry points across the borough.

In parallel to the development of the PNA the ABUHB are developing an overarching ***'Care Closer to Home'*** strategy for the effective and sustainable model of integration of care, centred on the GP cluster model also known as Neighbourhood Care Networks (NCNs) and integrated community wellbeing hubs. 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. This information will form the basis of the region's community well-being response in addition to close work with service providers and for a.

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 Regional 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 Wellbeing 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 regional 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 and 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, 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 of 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 regional 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 wellbeing. A Regional Joint Commissioning Group (RJCG) was established in late 2015 and co-ordinated by the regional 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 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 Wellbeing, 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 steams 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)

<u>Pooled Funds</u>

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 commission 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 20006, 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 RPB's who take oversight.

What we will deliver through regional 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 wellbeing 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 that 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 regional 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.

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 **Wellbeing 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 regional Area Plan:

1. **Explore a single prevention agenda across the region with PSBs and linked to Wellbeing of Future Generations and SSWB Acts**
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. **Through RJCG work 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 and 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.

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. However, interim data has been collected and will be included in the final PNA.

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 regional 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 enagement through regional communications group**
3. **Use IAA performance management data to inform design of services**

Social enterprises, Cooperatives, User Led Services and 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 that exist to provide opportunities and services, which make a real difference to people's lives. There are examples of user led services developing across the region – recently a Dementia Friendly Community group in Blaenau Gwent – and the Transformation Team will work closely with the Wales Co-operative Centre and the third sector to ensure the regional Area Plan will set in place clear actions and targets to support community assets at an individual, community and population level can help create support in local communities.

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 Wellbeing 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 DTG will form part of the RSG.

What we will deliver through the regional 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 regional Area Plan we will being third sector partners and commissioning teams 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.

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 regional Area Plan

1. **Alignment of advocacy provision to identified priorities across partner agencies**
2. **Support Golden Thread Advocacy Programme across the region through regional provider forum**
3. **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 regional Area Plan will seek to ensure that we will use the NOF in identifying the level of services necessary to meet need.

Equality Impact Assessment

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. We will expand on EIA in the final PNA but it is likely that the regional 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 Wellbeing of Future Generations Act

The Social Services and Wellbeing Act shares similar principles with a number of key national/regional strategies, and in particular the Wellbeing of Future Generations (WFG) Act. There are a number of key areas where the Acts compliment 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 Wellbeing 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 Wellbeing Assessment of the whole population in a local authority area. This PNA has been produced alongside Wellbeing Assessment in each local authority to avoid duplication. A regional Gwent Strategic Wellbeing 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 wellbeing 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 – regional Area Plan under the SSWB Act and Wellbeing 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 regional Area Plan will include details on actions required to implement the statutory duties in the Act.

Next steps and Regional Area Plan

The 2015 partnership arrangement regulations require local authorities and LHBs 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 and promote wellbeing
2. Actions to improve regional **processes**

The high level actions to progress through the Regional Area Plan are below 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 Area Plan

CORE THEME	Actions to be progressed through regional Area Plan
Children & Young People	▪ Support Children and Family Partnership Board's review of local arrangements for children with complex needs and delivery of work programme. ▪ Consistent models of practice and alignment of Welsh Government's early intervention and preventative programmes
Older People	▪ Develop place based approach *'Care Closer to Home'* including consistent delivery of community connectors across the region ▪ Further develop *'Dementia Friendly Communities'* ▪ Pilot 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	▪ Implement 'Care Closer to Home' Strategy ▪ Align with 5 local Wellbeing Assessments required under Wellbeing of Future Generations Act and explore joint action planning for wider detriments to health
Learning Disabilities/ Autism	▪ 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	▪ Review of 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 Wellbeing
Sensory Impairment	▪ 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	▪ 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 Wellbeing ▪ 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
Violence against women domestic abuse and sexual violence	▪ 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 Regional Area Plan

Service Mapping	▪ 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
	▪ Further develop and enhance the DEWIS website so it becomes the primary directory of resources for the region
	▪ 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	▪ 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)
	▪ 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	▪ Implement RJCG action plan to deliver joint commissioning arrangements for identified priorities for Act Part 9 requirements.
	▪ Continue to link with National Commissioning Board to progress national work priorities and proposals across the region
Preventative Services	▪ Explore a single prevention agenda across the region with PSBs and linked to Wellbeing of Future Generations and SSWB Acts
	▪ Align anti-poverty programmes across the region to set out a single preventative model based on consistent assessment principles, joint workforce and joint commissioning
	▪ 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
	▪ Through RJCG work 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.
	▪ Support Early Years Pathfinder pilot and use key messages to shape early intervention models
Information, Advice and Assistance	▪ Further support and develop DEWIS website so it becomes the 'go to' place for information on support, advice and assistance.

	▪ Continue to support consistent information dissemination and stakeholder engagement through regional communications group
	▪ Use IAA performance management data to inform design of services
	▪ To support further initiatives across the region that supports consistency of approach to IAA e.g. self-assessment exercises, peer reviews
	▪ To work with regional workforce managers and Social Care Wales to ensure that cultural change programmes are embedded and on-going
Advocacy	▪ Alignment of advocacy provision to identified priorities across partner agencies
	▪ Support Golden Thread Advocacy Programme across the region through regional provider forum
	▪ 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 Wellbeing Plans required under the Wellbeing of Future Generation Act are currently going through a consultation phase.
- This PNA would be too large a document if the appendices were 'embedded'
- The final PNA will include a comprehensive list of appendices and hyperlinks but for the consultation phase a list has been highlighted below
- The appendices will be used throughout the consultation phase, however if you wish to view the documents separately, please contact phil.diamond@torgaen.gov.uk

Appendices source list

1. Social Services and Wellbeing Act Data Catalogue report
2. Regional Wellbeing of Future Generations Act data report
    a. Blaenau Gwent Wellbeing Assessment
    b. Caerphilly Wellbeing Assessment
    c. Monmouthshire Wellbeing Assessment
    d. Newport Wellbeing Assessment
    e. Torfaen Wellbeing 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 Citizen Panel
8. Regional IAA policy
9. Transformation Team Advocacy Report
10. Transformation IAA Report