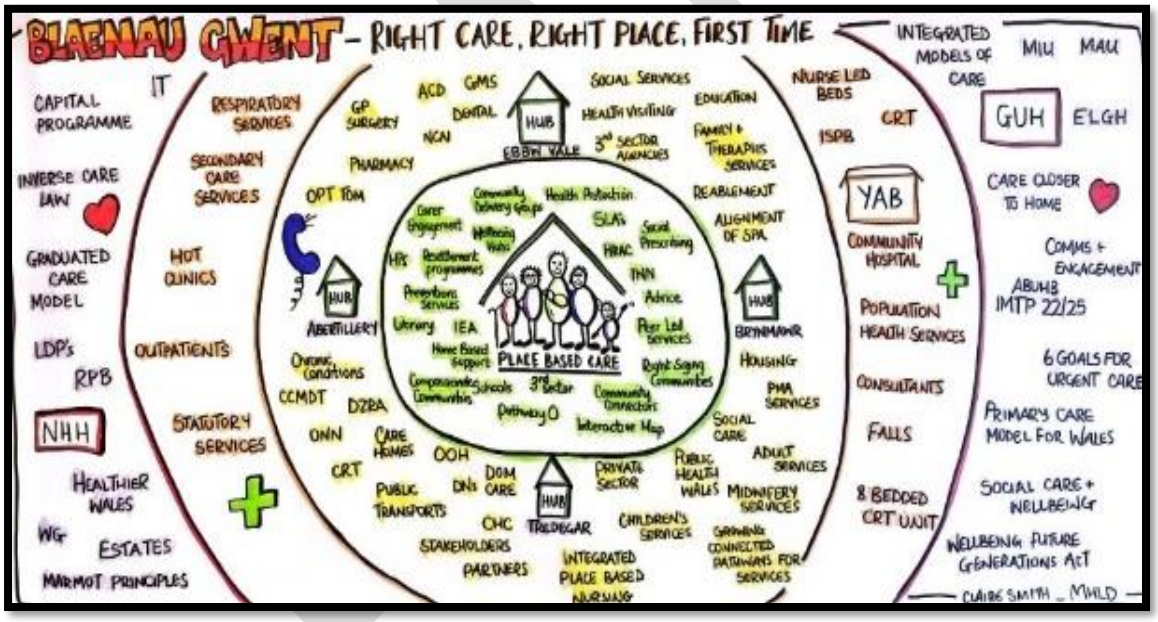
INTEGRATED SERVICE PARTNERSHIP BOARD(ISPB) PLAN
Blaenau Gwent
2023-2026



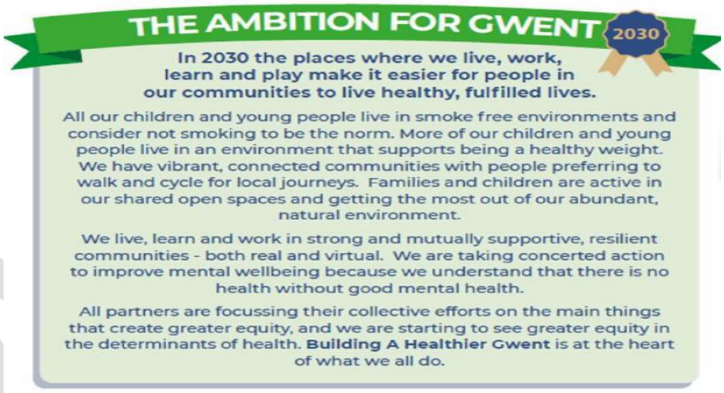



This plan has been split into chapters: -

Chapter 1: Setting the Scene

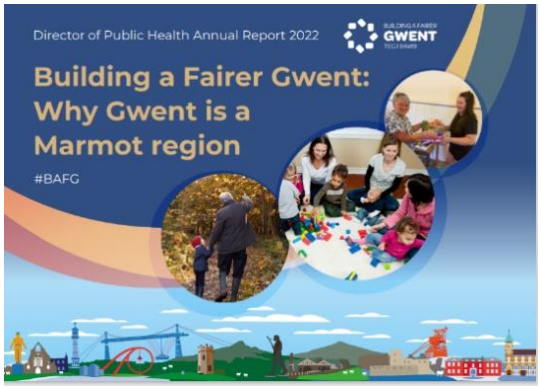
A Healthier Wales sets a target of a fully integrated health and social care system, with a key focus on 'self-care' and the movement of care into the community. The role of the Blaenau Gwent Integrated Services Partnership Board (ISPB) is to act as an enabler for embedding a whole system approach that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

Within the ISPB there is an underpinning intent to improve services and the care that residents receive through working in a more efficient and effective way, this is endorsed through the Marmot Framework for Action, the Social Services and Wellbeing Act requirements and the Transforming Primary Care model through the development of place based working across organisations and structures to enable our greatest asset, our workforce, to focus on empowering communities to be resilient and take ownership of their health wellbeing, removing pressures from our systems through redesigning of services – within the next 12 – 18 months, specifically for older people, supporting early intervention/prevention, prudent healthcare to help strengthen the community response for integrated service delivery.



Across Gwent, there is commitment between health boards and local authorities to work towards becoming a region that aims to tackle and reduce inequalities. Working across all public services to ensure that our policies, approaches, and resources are geared towards creating a fairer, more equal society both for our current population and future generations. By valuing and promoting good health, education and learning we can help people to reach their full potential. This in turn will contribute to creating better informed and connected communities throughout Blaenau Gwent that are fair, open and welcoming to all, where everyone gets to play an active part.

Blaenau Gwent ISPB will focus on the RPB emerging priorities whilst aligning to numerous strategic plans for a whole system approach. Gwent (through Aneurin Bevan University Health Board *ABUHB* and the 5 Local Authorities) has committed to become the first Marmot Region in Wales. This moves beyond access to services that support lifestyle change and tackling the determinants of health, initially focusing on early years and young people, a sector of our population who have been impacted significantly by the pandemic.



This framework sets out action under two policy goals: to create an enabling society that maximizes individual and community potential; and to ensure social justice, health and sustainability are at the heart of all policies. Central to the Review is the recognition that disadvantage starts before birth and accumulates throughout life. This is reflected in the 8 policy objectives below:

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

7. Tackle racism, discrimination, and their outcomes
8. Pursue environmental sustainability and health equity together

Blaenau Gwent faces challenges in terms of health and wealth inequality, the rise of online shopping and the impact on our town centres and social issues affects our families and young people. The range and configuration of services varies depending on local population, geography, nature of local services, and local legacy in terms of how services have developed and evolved. Workforce deficits and increasing case complexities combined with an increase in the volume of residents accessing services has and continues to impact on our ability to provide excellent care and develop meaningful relationships with our communities.

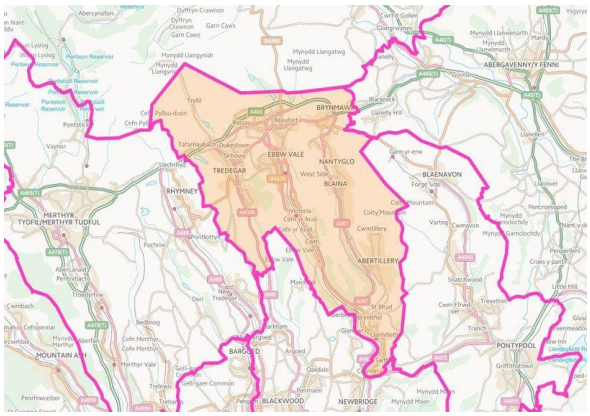
Blaenau Gwent historically has high levels of dependency across social and health care along with increased levels of complexity in our over 65 patient cohort, this has been compounded by the impact of Covid-19 which has impacted on our ability to deliver effective and sustainable services for older people. As an ISPB we are committed to the redesign of Community Services that support frail and/or elderly community members to stay in their own environment, developing our workforce to deliver services focused on chronic disease prevention and management, strengthening opportunities to support people to remain at home.

Collectively we are tackling these issues head on alongside businesses and the local community. The historical decline of heavy industry continues to impact on employment prospects and intergenerational opportunities. We are looking at how we utilise the funding streams that are available to achieve the best outcomes for the population, we are looking at our assets to achieve funding enablers and are removing barriers to enable the population to access what they need, in the right place at the right time. These deficits also act as barriers to delivering the full range of seamless care which is impacting on our ability to develop place-based services by skilled and knowledgeable staff who understand both the population and the locality, bringing together primary, secondary care staff, Local Authority teams and the third sector into one front door to create a locality-based response for those requiring health and social care support to access services. Develop a fully integrated service using local knowledge and data from the population needs assessment to influence services and take forward models of care, planning and coordinating care locally through place based integrated teams who utilise community, voluntary, local authority and primary care services only when self-care and prevention is not an option.

Background information

Blaenau Gwent Borough covers a geographical area of 109 km2 (42.08 square miles), serving an approximate population of 71.852 covering the 4 main towns of-

1. Ebbw Vale
2. Tredegar
3. Brynmawr
4. Abertillery



There is a strong commitment to social justice and a solid work ethic in Blaenau Gwent which is demonstrated by campaigns for improvements in standards of living. Examples of this includes the first ever board of health which marks Blaenau Gwent as the birthplace of the NHS, campaigns for electoral reform, abolition of company run shops, reductions in working hours, many of which still influence the way people live their lives today. The community spirit which is a lasting legacy of these achievements is alive and well today.

In the last 20 years the people of Blaenau have faced challenges including the closure of coal mines and the closure of Ebbw Vale Steelworks, leading to huge job losses. This is highlighted by a 5% reduction in the population which is in contrast to Wales overall which has had a 4% increase. Currently 49% of Blaenau Gwent working residents commute outside the borough to work and commuting distances have increased.

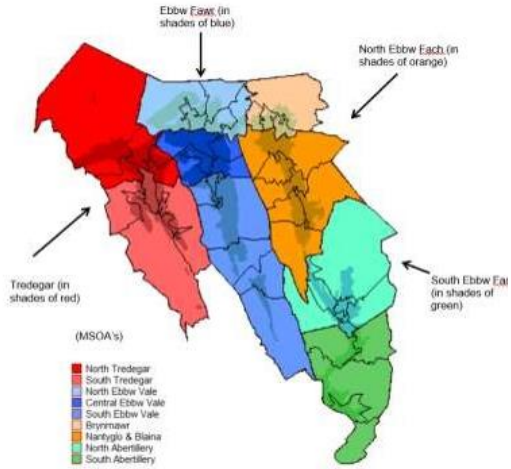
We cannot underestimate the effect of these issues. In the last 20 years there has been significant structural and environmental improvement, following major levels of capital investment and the greening of the valleys as nature recovers from long term scaring caused through the historical industries. To support the effect of the pit and steelwork closures refocus has been geared towards manufacturing and services industry which now makes up part of the local economy.

Within the 4 main towns of Blaenau Gwent:

Ebbw Vale / Ebbw Fawr

The Ebbw Fawr valley contains the area's largest town Ebbw Vale, its neighbourhoods and surrounding villages such as Waunlwyd and Cwm. There are currently six local electoral wards these are: Rassau, Beaufort, Badminton, Ebbw Vale North, Ebbw Vale South and Cwm.

Area	**Km²**– approximately **27%** of the total area of Blaenau Gwent at **109 km²**
Population	The estimated population is **23,408** – approximately **33%** of the total population for Blaenau Gwent at **70,020.**
Population density	The population density is **785** persons per square kilometre, with **30%** of people living in North Ebbw Vale, **33%** living in Central Ebbw Vale and **36%** in South Ebbw Vale. There are **644** people per square kilometre in Blaenau Gwent.
Dwellings	The dwelling count is **6,731** – approximately **30%** of the total number of dwellings in Blaenau Gwent at **30,416**.
General	Ebbw Fawr consists of 3 Middle Super Output Area (MSOA), containing 16 Lower Super Output Areas (LSOAs). By looking at smaller geographical areas, we can see any differences that can impact on well-being.



MSOA Name	LSOA Name
North Ebbw Vale	Beaufort 1
	Beaufort 2
	Beaufort 3
	Rassau 1
	Rassau 2
Central Ebbw Vale	Badminton 1
	Badminton 2
	Ebbw Vale North 1
	Ebbw Vale North 2
	Ebbw Vale North 3
South Ebbw Vale	Cwm 1
	Cwm 2
	Cwm 3
	Ebbw Vale South 1
	Ebbw Vale South 2
	Ebbw Vale South 3

Access to services within Ebbw Fawr

- 3 x GP Practices
- 3 x Dental Practices
- 9 x Community Pharmacies
- 3 x Optometry Practices
- Ysbyty Aneurin Bevan (YAB) (located on the outskirts of the Ebbw Vale town centre and has a total of 96 inpatient beds also incorporating an adult mental health unit)
- Ysbyty'r Tri Chwm

These services all fall under ABUHB Blaenau Gwent West Neighbourhood Care Network.

- 2 x Libraries (Ebbw Vale and Cwm)
- 3 x Post Offices
- 6 x Primary Schools and 1 x Secondary School
- Electric vehicle charging points
- 3 x Local Nature Reserves (Garden City, Silent Valley and Beaufort Hill)

There are 13.3% of poor-quality housing in North Ebbw Vale, 18.2% in Central Ebbw Vale and 25.8% in South Ebbw Vale (1 in 4 households). There is reasonable supply of 2 bed properties in Ebbw Fawr, almost 25% of housing, but there is still likely to be an issue of affordable housing for 8 of 20 single person applicants in receipt of benefits, who cannot access them due to welfare benefit reforms.

The Welsh Index of Multiple Deprivation (WIMD) is the Welsh Government's official measure of relative poverty. It identifies those communities, at LSOA geography, with the highest concentrations of several different types of deprivation. WIMD ranks all LSOAs in Wales from most to least deprived.

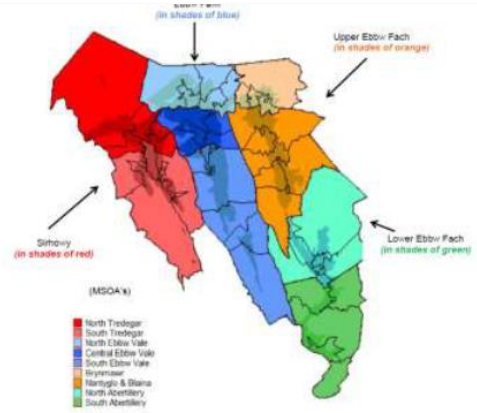
Ebbw Fawr LSOA's in top 10% most deprived in Wales	
Overall deprivation	2 LSOA's – Ebbw Vale North 2 and Ebbw Vale South 1
Income deprivation	2 LSOA's - Ebbw Vale North 2 and Ebbw Vale South 1 with 20% of people living in Ebbw Fawr are in income deprivation.
Employment deprivation	2 LSOA's - Ebbw Vale North 2 and Ebbw Vale South 1 with 20% of people living in Ebbw Fawr are in income deprivation.
Health deprivation	3 LSOA's – Beaufort 2 and Ebbw Vale North 2
Education	3 LSOA's – Rassau 2, Ebbw Vale North 2 and Ebbw Vale South 1
Community safety	4 LSOA's - Ebbw Vale North 1, Ebbw Vale North 2, Ebbw Vale South 2 and Ebbw Vale South 3
Housing	1 LSOA - Ebbw Vale South 1

Tredegar / Sirhowy

The town of Tredegar is based in the Sirhowy Valley area which is named after **the** river that flows through the valley. It contains three local authority electoral wards which are Sirhowy, Georgetown, and Tredegar Central and West.

Area	**32 Km²**– approximately **29%** of the total area of Blaenau Gwent at **109 km²**
Population	The estimated population is **15,506** – approximately **22%** of the total population for Blaenau Gwent at **70,020.**
Population density	The population density is **490** persons per square kilometre, with **54%** of people living in South Tredegar and **46%** living in North Tredegar. There are **644** people per square kilometre in Blaenau Gwent.
Dwellings	The dwelling count is **6,731** – approximately **30%** of the total number of dwellings in Blaenau Gwent at **30,416**.
General	Tredegar consists of 2 Middle Super Output Area (MSOA), each containing 5 Lower Super Output Areas (LSOAs). By looking at smaller geographical areas, we can see any differences that can impact on well-being.

LSOA	MSOA
Sirhowy 1-4 Tredegar Central & West 1-4 Georgetown 1-2	Blaenau Gwent 003 Blaenau Gwent 006



MSOA Name	LSOA Name
North Tredegar	Sirhowy 1
	Sirhowy 2
	Sirhowy 3
	Sirhowy 4
	Tredegar Central & West 3
South Tredegar	Tredegar Central & West 1
	Tredegar Central & West 2
	Tredegar Central & West 4
	Georgetown 1
	Georgetown 2

Access to services within Tredegar/Sirhowy	
 • 2 x GP Practices • 3 x Dental Practices • 9 x Community Pharmacies • 3 x Optometry Practices ***These services all fall under the Blaenau Gwent West Neighbourhood Care Network.***	• 1 x Library • 1 x Bank • 3 x Post Offices (1 provides some banking services) • 4 x Primary Schools and 1 x Secondary School • Electric vehicle charging points under construction in the town centre car park • 1 x Local Nature Reserves (Sirhowy Woodland).

There are 13.7% of poor-quality housing in North Tredegar and 20.3% in South Tredegar (1 in 5 households). There is reasonable supply of 2 bed properties in Tredegar, almost 30% of housing, but there is still likely to be an issue of affordability for single person applicants in receipt of benefits, who cannot access them due to welfare benefit reforms.

The Welsh Index of Multiple Deprivation (WIMD) is the Welsh Government's official measure of relative poverty. It identifies those communities, at LSOA geography, with the highest concentrations of several different types of deprivation. WIMD ranks all LSOAs in Wales from most to least deprived.

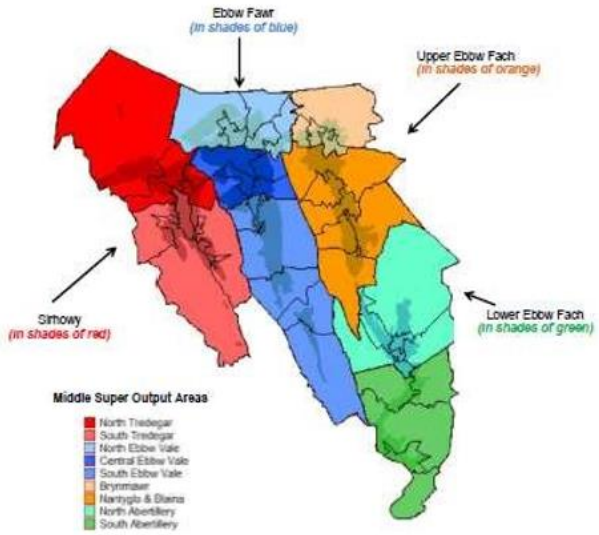
Tredegar LSOA's in top 10% most deprived in Wales	
Overall deprivation	2 LSOA's - Sirhowy 2 and Tredegar Central and West 2
Income deprivation	2 LSOA's - Sirhowy 2 and Tredegar Central and West 2 with 22% of people living in Tredegar are in income deprivation.
Employment deprivation	. 4 LSOA's - Sirhowy 2, Tredegar Central and West 2, 3 and 4
Health deprivation	3 LSOA's - Sirhowy 2, Tredegar Central and West 2, and 3
Education	2 LSOA's - (Sirhowy 2 and Tredegar Central and West 2
Community safety	5 LSOA's - Sirhowy 2 and 4, Tredegar Central and West 1,2 and 4

Brynmawr / Upper Ebbw Fach

Brynmawr, Nantyglo and Blaina are based in the Upper Ebbw Fach part of Blaenau Gwent, which is named after the river that starts at its northern boundary.

Area	**21.1 km²** – approximately **19%** of the total area of Blaenau Gwent at 109km²
Population	The estimated population is **15,069** – approximately **22%** of the total population for Blaenau Gwent at 70,020.
Population density	The population density is **7.14** persons per hectare, with most people living in Brynmawr 1 and Blaina 2. There are 6.42 people per hectare in Blaenau Gwent.
Dwellings	The dwelling count is **6,416** – approximately **21%** of the total number of dwellings in Blaenau Gwent at 30,416.
General	Upper Ebbw Fach consists of 2 Medium Super Output Area (MSOA), containing 10 Lower Super Output Areas (LSOAs). By looking at smaller geographical areas, we can see any differences that can impact on well-being.

LSOA	MSOA
Brynmawr 1-4 Nantyglo 1-3 Blaina 1-3	Blaenau Gwent 002 Blaenau Gwent 005



Access to services within Brynmawr/Upper Ebbw Fach

- 2 x GP Practices
- 2 x Dental Practices
- 3 x Community Pharmacies
- 1 x Optometry practice

These services all fall under the Blaenau Gwent East Neighbourhood Care Network.

- 2 x Libraries (Ebbw Vale and Cwm)
- 3 x Post Offices
- 6 x Primary Schools and 1 x Secondary School
- 2 x Electric vehicle charging points
- 3 x Local Nature Reserves (Cwmcelyn, Terry Rowson and Parc Nant Y Waun).

Over half of the housing **52.8%,** is within the lowest valued housing category with the Blaenau Gwent, average 58.4%, but Wales average 14.5%. The Welsh Index of Multiple Deprivation (WIMD) is the Welsh Government's official measure of relative poverty. It identifies those communities, at LSOA geography, with the highest concentrations of several different types of deprivation. WIMD ranks all LSOAs in Wales from most to least deprived.

Brynmawr/Upper Ebbw Fach LSOA's in top 10% most deprived in Wales

Overall deprivation	Nantyglo 3 is in the top 10% most deprived LSOAs in Wales and Nantyglo 1 & 2, Brynmawr 2 and Blaina 1 are in the top 20% most deprived.

Income deprivation	21.5% of people living in Upper Ebbw Fach are in income deprivation.
Education	Nantyglo 3 is in the top 10% of most deprived areas in Wales.
Community safety	Nantyglo 1, Brynmawr 3 and Blaina 1 are in the 10% most deprived areas in Wales.

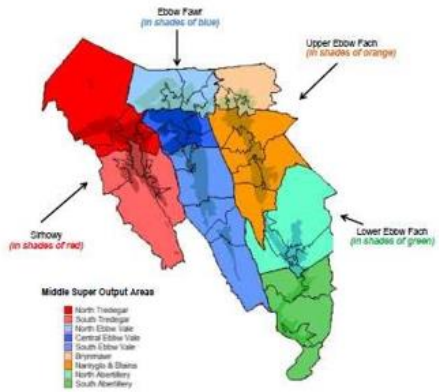
- Overall deprivation = Nantyglo 3 is in the top 10% most deprived LSOAs in Wales and Nantyglo 1 & 2, Brynmawr 2 and Blaina 1 are in the top 20% most deprived.
- Income deprivation = 21.5% of people living in Upper Ebbw Fach are in income deprivation.
- Education = Nantyglo 3 is in the top 10% of most deprived areas in Wales.
- Community safety = Nantyglo 1, Brynmawr 3 and Blaina 1 are in the 10% most deprived areas in Wales.

Abertillery / Lower Ebbw Fach

Cwmtillery, Abertillery, Brynhithel, Six Bells, Aberbeeg, Llanhilleth and Swffryd all form part of the Lower Ebbw Fach Valley, which is named after the river that continues its journey through the area. The main town of this valley is Abertillery but it's surrounded neighbourhoods include; Bournville, Rosheyworth, Cwmtillery, Six Bells, Brynithel etc.

Area	**26km²** – approximately **24%** of the total area of Blaenau Gwent at 109km²
Population	The estimated population is **16,037** – approximately **23%** of the total population for Blaenau Gwent at 70,020.
Population density	The population density is **617** persons per square kilometre, with most people living in Cwmtillery 2 and Llanhilleth 3. There are 642 persons per square kilometre in Blaenau Gwent.
Dwellings	The dwelling count is **7,279** – approximately **24%** of the total number of dwellings in Blaenau Gwent at 30,416.
General	Lower Ebbw Fach consists of two Medium Super Output Areas (MSOA), one called North Abertillery covering Cwmtillery & Abertillery and the other called South Abertillery covering Six Bells, Aberbeeg, Brynhithel, Llanhilleth & Swfrydd. The area contains 11 Lower Super Output Areas (LSOAs). By looking at smaller geographical areas, we can see any differences that can impact on well-being.

LSOAs	MSOAs
Abertillery 1, 2 & 3	North Abertillery
Cwmtillery 1, 2 & 3	
Llanhilleth 1, 2 & 3	South Abertillery
Six Bells 1 & 2	



Access to services within Abertillery/Lower Ebbw Fach

• 3 x GP Practices • 2 x Dental Practices • 3 x Community Pharmacies • 1 x Optometry Practice ***These services all fall under the Blaenau Gwent East Neighbourhood Care Network.***	• 1 x Library • 5 x Post Offices • 6 x Primary Schools • 2 x Electric vehicle charging points • 1 x National Cycle Route, 3 x Local Nature Reserves • 17 x Children's Play Areas There are also- • 1 x Sports Centre, 14 x Outdoor Sports Facilities.

There are **7,279** households in the Lower Ebbw Fach: 3,985 in North Abertillery and 3,294 in the South Abertillery MSOA.

Ebbw Fawr LSOA's in top 10% most deprived in Wales

Overall deprivation	LSOAs in Wales. Cwmtillery 1 is in the top 10% most deprived LSOAs in Wales.
Income deprivation	22% of people in South Ebbw Fach are living in income deprivation
Employment deprivation	16% of working age people are in employment deprivation. This is higher than the Blaenau Gwent (15%) and Wales (10%) averages.
Education	30.5% of adults aged 25-64 have no qualifications. This is higher than the Blaenau Gwent (29%) and Wales (19.5%) averages.

In Summary;

Residents receive out of hospital/general health and social care from independent contractors, local authority and third sector. It has 2 Neighbourhood Care Networks (NCN) areas, East and West, whose purpose is to work across sectors including both public and third sectors to develop and support sustainable services on a local footprint. Across Blaenau Gwent their independent contractors comprise of 10 GP practices, 16 community pharmacies, 10 dental practices 9 optometry practices. Local authority services comprise of; Children Services – Information Advice and Assistance Team, 3 locality-based teams, a 14 plus team, the Placement team, a Supporting Change Team, a My Support Team, a Family Time Team and a Disability Team. Adult Services – Information Advice and Assistance Team.

The Local Authority provides Information Advice and Assistance to all residents, plus care and support to those assessed as having a need. Both Children and Adult Services have an Information Advice and Assistance Team which is the first point of contact for the residents.

Children's Services locality-based teams provide services to children in need, children in need of protection and children who are looked after by the local authority. In addition, Children's Services 14 plus team primarily work with our children looked after, our care leavers and children who present as homeless. The Placement Team assesses and supports our foster carers, kinship cares and those who have special guardianship of children in Blaenau Gwent. The Supporting Change Team and the My Support Team work intensively with children and families with complex needs who are at risk of coming into care and work with children to step them down from residential care. The Family Time Team supports children to have supervised time with their parents whilst they are in care. The Disability Team provides support from 0 -25 before those still require services transition to adult services.

Blaenau Gwent currently has 202 children who are looked after. The majority of these are looked after by Blaenau Gwent foster carers, kinship carers and some children are placed at home with parents. There is a high dependence on private foster care agencies to meet the needs of children with complex needs. Currently the Local Authority does not provide any residential care and are totally dependent on private providers.

The Adult Services division within Blaenau Gwent Social Services supports an average of 1900 adults aged 18 and over at any one time, who require care and support as defined in the Social Services and Wellbeing Act 2014. This includes adults with a range of physical and / or mental health conditions, sensory needs, learning disabilities and substance misuse. We provide an initial preventative Information, Advice and Assistance (IAA) team at the front door to Adult Social Care and this team works closely with the Gwent Frailty Community Resource Team (CRT) including our therapy and reablement support and CARIAD step up / step down temporary accommodation. IAA also provides advice and support in relation to Assistive Technology, housing advice, low level Mental Health and Substance Misuse support. The staff team also in-reach into both our acute and community hospitals alongside colleagues from both the CRT and long-term social work teams.

We have two long term community locality social work teams which have been for many years aligned to the NCN East and West geographical areas and are co-located alongside our community nursing teams. These teams support all adults over the age of 18 including older adults who are living with health conditions including dementia. Our Mental Health and Substance Misuse service is based at Cwm Coch in Ebbw Vale and provides care and support to adults aged 18 to 65 who are being supported by our secondary mental health services. We have a dedicated Supporting People Team that commissions supported housing services including both accommodation based and floating support provision, we provide an alternative to traditional domiciliary care through our Direct Payment Scheme and have strong links to third sector organisations for the provision of preventative support.

Adult Services are responsible for commissioning the external care home (both residential and nursing home), supported living services, domiciliary care and third sector support for vulnerable adults. We also commissioning advocacy support and provide a Deprivation of Liberty (DoLS) authorisation function and, financial appointee support for adults who lack capacity. We host the adult safeguarding team and manage all referrals for adults who are at risk of harm, neglect, or abuse.

Adult Services are also a provider of services. We are the providers of a 36-bed dementia residential care home (Cwrt Mytton) in Abertillery along with a 5 bedded respite care home for adults and children with a Learning Disability (Augusta House) in Ebbw Vale. We have an in-house domiciliary care team that provides over 500 hours of care at 2 extra care schemes in Blaenau Gwent in addition to our emergency care response service and have 4 supported living bungalows and a Community Options (day services) scheme that both provide support to adults with a learning disability.

Population Needs/Health

We recognise the wider implications the global pandemic has had on the residents who have been impacted on the changing landscape in relation to accessing social care and health services and, our key cluster actions continue to focus on developing social care and health services that mitigate the impact of this changing landscape which is set against a backdrop of changing population needs, an anticipated revised population needs assessment which anticipates a further impact on poor wellbeing, rising obesity rates, increase in alcohol consumption, diabetes, access to mental health services and a further decline in economic deprivation associated with the pandemic. The ISPB Plan identifies and agrees priority areas for improvement through strengthened joint working to achieve better outcomes by optimising collective resources.

Our local wellbeing plan and population needs assessment when analysed alongside national and regional statistics, provides both a local and national perspective of our area in terms of the needs of the population.

The latest Population Survey shows that we continue to have above average levels of disability with a total of 31.6% of working age people being defined as disabled (economically active core or work-limiting disabled) compared to 22.8% for Wales. These comparatively high levels of disability lead to a high proportion of people claiming disability-related benefits, with 12.0% of working aged people in Blaenau Gwent claimed EAS or Incapacity Benefit, compared to 8.4% across Wales (May 2016). The underlying cause of these stark inequalities is undoubtedly linked to having the highest percentage of areas, 85.1%, in the most deprived 50% in Wales. Blaenau Gwent is classed as an area of Deep-Rooted Deprivation; that is, they have remained within the top 50 most deprived, roughly equal to the top 2.6% of small areas in Wales for the last five publications of WIMD rankings.

There has been little change in the last decade in relation to inequalities of life expectancy with estimates suggesting healthy life expectancy is increasing only slightly. Females born in Blaenau Gwent today can expect approximately 56 healthy years of life and males approximately 55. For both males and females, Blaenau Gwent has statistically significantly lower healthy life expectancy than Wales as a whole (males, 6 years; females, 6 years) [*across Wales the healthy life expectancy is 62 years for females and 61 years for males in 2018-2020*].

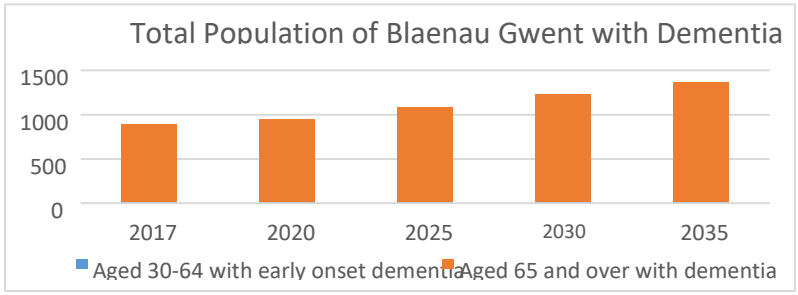
Cardiovascular disease and cancer are the biggest cause of premature mortality. Reducing overall mortality from circulatory disease to levels seen in the least deprived areas of Wales would increase life expectancy in areas like Ebbw Vale by 1.5 years [Males] and 1.3 years [females] with greater potential gains in Tredegar. Similar gains could be made if cancer mortality rates were reduced to the same level (1.3 years in males, 1.2 in females).

Primary Care services are unsustainable in their current format, and we have had historical difficulties in the recruitment and retention of GPs and medical staff within the Community Resource Team (CRT). Blaenau Gwent currently has 3 Health Board Managed GP practices and is therefore the Borough with the most managed practices in the Health Board.

Referrals to Welsh Ambulance Service NHS Trust (WAST) and attendance at Emergency Departments and GP referrals for assessment have increased year-on-year for patients aged over 65 years of age across Gwent. Forecasts suggest that the number of people over 65 will continue to rise at the same rate until the mid-2030s. Across Blaenau Gwent this growing, elderly population is more dependent on both health and social care services, this means that not only are Blaenau Gwent residents most likely to live shorter lives they are likely to enjoy fewer years in good health and for a smaller proportion of their lives. This negatively impacts quality of life, ability to work and the need for health and social services. In Blaenau Gwent the 18-year gap in healthy life expectancy between our wealthiest and poorest communities is significantly exacerbated by 21% of our population living in income deprivation, the consequences of the inverse care law mean a greater number of citizens require our services reinforcing the importance of prevention as a key component of Health Board planning.

Blaenau Gwent saw a 5% reduction in population between 1991 and 2011 which contrasts with the 4% increase across Wales, attributed to the closure of the steel works in 2002. 49% of working residents now commute outside the Borough to work. The population is projected to decrease by a further -1.1% between 2020-2043.

The majority of housing stock is older 19th and 20th century stock with poor energy efficiency and is lacking range and variation, 58.4% of housing is rated as council tax A, the lowest valued housing category with the Wales average at 14.5%.



The Blaenau Gwent population has a poorer level of mental wellbeing than the average for Wales. The number of people with dementia is predicted to increase over the coming years in line with the ageing population. There is a strong link between deprivation and poor well-being/being treated for a mental illness, with 8% of the people in the least deprived quintile reporting a mental health condition, compared with 20% in the most deprived quintile (Public Health Wales, 2016). This report also found that 24% of those who are long term unemployed or have never worked, report a mental health condition compared to 9% of adults in managerial and professional groups in Wales.

Relative child poverty is projected to significantly rise from 29% to 36% in 2021/22 across Wales, Blaenau Gwent is already at 35%, ensuring everyone has the best start in life will have a positive impact on the quality of overall family life. – need to convert this into a plan around early years/first 1,000 days programme. – child poverty strategy and 5 key objectives for tackling child poverty and improving outcomes of low-income families in Wales.

3,945 food parcels were distributed to BG residents between April 2020 and March 2021 – consumer prices, as measured by the Consumer Prices Index (CPI), were 9.1% higher in May 2022 than a year before. Increases in the costs of consumer goods, underpinned by strong demand from consumers and supply chain bottlenecks, have been one factor behind rising inflation. Another important driver of inflation is energy prices, with household energy tariffs increasing and petrol costs going up. From May 2021 to May 2022, domestic gas prices increased by 95% and domestic electricity prices by 54%.

High prevalence of chronic disease - according to a recent population needs assessment, across both NCNs Blaenau Gwent has the highest rates of diseased registered patients (per 10,000 GP registered population) with:

	Indicator	Blaenau Gwent		Caerphilly			Monmouthshire		Newport		Torfaen	
		East	West	East	North	South	North	South	East	West	North	South
Disease Registers (per 10,000 GP registered Population)	Atrial fibrillation (per 10,000 GP registered Population)	222	229	201	242	227	322	257	184	182	262	221
	Chronic obstructive pulmonary disease (per 10,000 GP registered Population)	351	292	218	288	228	196	167	177	202	276	241
	Cancer (per 10,000 GP registered Population)	252	308	268	291	335	436	396	261	263	299	275
	Coronary heart disease (per 10,000 GP registered Population)	440	409	346	412	369	392	341	301	304	395	355
	Dementia (per 10,000 GP registered Population)	54	62	59	63	73	97	82	51	70	71	72
	Depression/Mental Health (per 10,000 GP registered Population)	105	80	85	106	93	107	63	86	114	97	75
	Diabetes patients aged 17+ (per 10,000 GP registered Population)	784	726	637	761	640	626	590	592	622	711	638
	Epilepsy ages 18+ (per 10,000 GP registered Population)	93	91	74	95	78	72	62	71	72	80	79
	Heart failure (per 10,000 GP registered Population)	141	157	83	106	78	188	110	78	82	119	95
	Hypertension (per 10,000 GP registered Population)	1,938	1,819	1,567	1,787	1,644	1,736	1,596	1,349	1,430	1,730	1,487
	Learning disability (per 10,000 GP registered Population)	48	54	40	63	40	36	31	40	46	45	44
	Obesity (per 10,000 GP registered Population)	1,159	1,215	804	1,272	908	1,045	900	742	848	1,010	851

https://statswales.gov.wales/

In Summary.

Blaenau Gwent East

- COPD also, identified as the highest across Gwent registered patients
- Coronary Heart Disease
- Diabetes patients aged 17+ also, identified as the highest across Gwent registered patients
- Epilepsy ages 18+
- Learning disabilities also, identified as the highest across Gwent registered patients
- Depression and Mental Health

According to a recent population needs assessment, Blaenau Gwent West has the highest rates of diseased registered patients (per 10,000 GP registered population) with:

	Indicator	Blaenau Gwent		Caerphilly			Monmouthshire		Newport		Torfaen	
		East	West	East	North	South	North	South	East	West	North	South
Disease Registers (per 10,000 GP registered Population)	Atrial fibrillation (per 10,000 GP registered Population)	222	229	201	242	227	322	257	184	182	262	221
	Chronic obstructive pulmonary disease (per 10,000 GP registered Population)	351	292	218	288	228	196	167	177	202	276	241
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	Hypertension (per 10,000 GP registered Population)	1,938	1,819	1,567	1,787	1,644	1,736	1,596	1,349	1,430	1,730	1,487
	Learning disability (per 10,000 GP registered Population)	48	54	40	63	40	36	31	40	46	45	44
	Obesity (per 10,000 GP registered Population)	1,159	1,215	804	1,272	908	1,045	900	742	848	1,010	851

https://statswales.gov.wales/

In Summary.

Blaenau Gwent West

- Heart failure
- Obesity

Blaenau Gwent East has the highest rate of referrals to Child & Adolescent Phycology (per 10,000 GP registered Population <17 years) across both Blaenau Gwent areas and is the highest across the whole of Gwent.

Poorer mental wellbeing than Wales as a whole - Blaenau Gwent population has a poorer level of mental wellbeing than the average for Wales. The number of people with dementia is predicted to increase over the coming years in line with the ageing population.

Mental health in adults - there is a strong link between deprivation and poor well-being/being treated for a mental illness, with 8% of the people in the least deprived quintile reporting a mental health condition, compared with 20% in the most deprived quintile (Public Health Wales, 2016). This report also found that 24% of those who are long term unemployed or have never worked, report a mental health condition compared to 9% of adults in managerial and professional groups in Wales. [1]

The latest Population Survey shows that we continue to have above average levels of disability with a total of 31.6% of working age people being defined as disabled (economically active core or work-limiting disabled) compared to 22.8% for Wales. These comparatively high levels of disability lead to a high proportion of people claiming disability-related benefits, with 12.0% of working aged people in Blaenau Gwent claimed EAS or Incapacity Benefit, compared to 8.4% across Wales (May 2016).

Childhood Immunisation is a highly effective population measure, in reducing the burden of infectious disease. It helps a child to become protected from diseases caused by bacteria or viruses whilst also protecting others around them. ABUHB Public Health Protection Services are instrumental in driving uptake of immunisation and vaccination programmes, providing the skills and capability to reach into our communities.

The NCN population needs assessment identified in both Blaenau Gwent East and West areas childhood immunisation uptake were benchmarked at 90%+. However, Covid immunisation rate for 5–11-year-olds (Dose 1) 25.6% and Influenza immunisation rates for 2-3 years olds 40.5% uptake and identified as the lowest rate of uptake across Gwent.

Blaenau Gwent has the highest rate of childhood tooth decay in Wales, there remains a strong relationship between mean decay and quintile of deprivation, as demonstrates by the Picture of Oral Health 2018- *Dental Epidemiological Survey of 12-year-olds 2016-17.* The sum of Decayed, Missing and Filled teeth

(D3MFT1) Is the measure of the decay experience of the average child. It is therefore the burden of disease which theoretically could have been prevented and thus key data for evaluation of efforts to prevent decay.

All local authority areas across the Gwent region are predicted to see an increase in the number unpaid care. The predicted increases range from 35.6% in Blaenau Gwent to 58.9% in Monmouthshire over the period of people aged 65 and over that will provide 50+ hours of unpaid care.
Gwent Regional Population Needs Assessment

It is evident from the population health in Blaenau Gwent that there is need to review the ways in which we address and support the population of Blaenau Gwent. By collaboratively working across the partners of the ISPB the wider determinants of health can be addressed, alongside educating the public and enhancing awareness in order to gain support if needed. The potentials of cross organisation service delivery and upskilling professionals to work together will enhance the services available. We believe by addressing the root cause of these issues that the overall health and wellbeing of Blaenau Gwent can be improved.

Integrated Wellbeing Networks

Blaenau Gwent's Integrated Wellbeing Network vision of a Happy, Healthy Blaenau Gwent through our place-based care strategy illustrated below which seeks to deliver

- Empowered people who look after themselves and each other
- Building a stronger community together
- Delivery of services for now and for the future

The Integrated Wellbeing Network (IWN) programme was introduced in 2019 and aims to develop a whole system approach to community well-being and prevention that brings together a wide range of well-being assets on a place-basis. Much resource for well-being already exists across organisations and sectors but is often not connected or aligned and has poor connectivity to community needs and aspirations.

Strategic Context / Drivers

The Blaenau Gwent Integrated Partnership Board's strategic direction is influenced by several drivers for change, with an emphasis on the Social Services and Wellbeing (Wales) Act 2014 which sets out the ambition for greater collaboration between Health, Social Care and the third sector in the delivery of a 'whole system of seamless care and support'. This is endorsed through the Parliamentary Review of Health and Social Care (2018) and the Welsh Government's response via their long-term plan, A Healthier Wales (2018). These documents describe the Quadruple Aim, the creation of a shared commitment to developing and prioritising change within social care and health. We are committed to the provision of excellent, person centred care for individuals and recognise that to deliver excellence requires service re-design and transformation to reduce inequalities in healthcare provision; ensuring timely access to sustainable services; moving care closer to home; and maintaining high quality, safe services which do no harm. We also recognise the breadth of policy which exists and how these will be adopted as an enabler for transformation.

Strategic Context	Enabler for Change
Wellbeing of Future Generations Act (Wales) 2015	Development of our priorities within the context of the 'well-being goals' and 'sustainable development principles' described within the Wellbeing of Future Generations Act (Wales) 2015. The principles are made up of five ways of working – long term – Integrated – involvement – collaboration – prevention - that public bodies are required to take into account when applying sustainable development.
The Social Services and Well-being (Wales) Act (2014)	Requirement for local authorities and health board to jointly undertake an assessment of the needs for care and support and the support needs of carers in the local authority areas.
Strategic Programme for Primary Care	new models of care anticipated to be delivered, at scale, across Wales in the coming years The Transformation Model for Primary Care features heavily within this strategy and depicts a different approach to delivering services, featuring a renewed emphasis on early intervention; a focus on signposting, direct-access and social prescribing services; implementation of a new multidisciplinary workforce model; and greater utilisation of technological developments. At the heart of the strategic programme for primary care is working closely with partners, shifting the focus to a social model of care, ensuring timely access to primary care services when required and working seamlessly across the whole system.
The Primary Care Model for Wales (2019)	provides the national strategic direction for primary care, putting what matters to people are at the heart of this model to ensure the right care is available at the right time from the right source, at home or nearby. This model has provided the context and framework for the development of primary and community care over the last few years to enable a whole system approach to redesign, driven by national quality standards but with flexibility to respond to local community needs. Clusters are seen as pivotal to the delivery of this model.
Last 1,000 days	focuses on the most valuable currency in healthcare – time. The strategy recognises that a significant proportion of people who get stuck in the healthcare system are in the last 1000 days of their life. Using the TODAY model to help draw attention to where time is wasted for those who have the least time to spare, prioritising patient time and giving staff autonomy and responsibility to understand what good looks like for an individual, being able to assess care and activity against that and identify potential problems as part of an integrated team delivering individualised person-centred support.

Clinical Futures Strategy [2018]	the need for clinical modernisation has been recognised in the context of the delivery of the new model of primary and community care. The Clinical Futures Strategy sets out the strategic direction for modernising clinical services and forms part of the Health Boards response to delivering 'A Healthier Wales'.
A Healthier Wales (2019)	the Welsh Government's long-term plan for health and social services in Wales. Its sets out the vision of a 'whole system approach to health and social care' which is focused on health and wellbeing and on preventing physical and mental illness. The plan focuses on 'providing more joined-up services, in community settings', and the aim is to see 'a shift from healthcare which focuses on treating people when they become unwell, to one that provides services which support people to stay well, lead healthier lifestyles and live independently for as long as possible'
Right Care, Right Place at First Times (6 Goals for Emergency Care) (2022)	Sets out the priorities for urgent and emergency care to ensure that patients get the right care, in the right place, first time for physical and mental health. Welsh Government recognises the need for organisations to work in partnership to deliver a co-ordinated, integrated, responsive health and care service to help people to stay well longer
2020 national '*Discharge to Recover and Assess' (D2RA)* model and '*Care Closer to Home*' principles	Assessment and support in a patient's own home and speedier discharge for those admitted are vital aspects of improving flow through the healthcare system. This is complimented by delivering care in a neighbourhood or area, as opposed to a hospital setting.
National review of right-sizing,	'Right-size' community resource to recognise the shift of activity from hospital to communities. Training and development of knowledge and skills is imperative for all staff. The review identified that the current community resource within Gwent is too small to manage an increase in admission avoidance and discharge support, and engagement with the public is important to reassure patients, and importantly, family members of the opportunities that exist closer to home.

Define the key challenges and opportunities

Challenges

Since the pandemic we have seen an overwhelming demand on access to our services and the differing needs of the population that we serve further adds to the challenges being seen in our community hospital settings. In addition, Blaenau Gwent has seen an increase to the total population of over 65 which suggests that there is evidence to support that there is a growing elderly population this will inevitably result in high proportion of the population becoming more independent on both the health and social care systems.

There are significant elements of care provision currently provided within an inpatient setting that could be undertaken in the community to support our residents to remain as close to home as practical during these episodes of care. With data suggesting that Gwent wide ~250 people are referred to acute hospitals each month for conditions that could potentially be managed using a 'frailty approach' and are subsequently assessed out. In addition to this, GPs make 1200-1500 referrals per month into hospital assessment units for those over the age of 65.

Focusing on the principles of right care, right place, first time we will coordinate support for our communities in greater need of care through development of a services designed to maximize benefits for patients and delivered at a locality level to meet the demands of our population. The approach of this scheme supports delivery of improved access to services through the development of our community teams and having piloted the High-Risk Adults (HRA) initiative across Blaenau Gwent we understand that this patient cohort is driving 2/3^{rds} of the Health Boards bed base. We are progressing opportunities to embed an assessment process within our Compassionate Communities model that incorporates our HRA community, where our model can identify and build our compassionate communities' model of support to provide safe alternatives to admission using IAA, CRT, HAAP to strengthen signposting and rapid emergency care as a safe alternative to admission.

There are and will continue to be, challenges to achieve the aims of our ISPB plan and will require the ISPB and local teams to find solutions and respond to address these.

- Cost of living crisis in Wales, has a potential to affect everyone. Anxiety and depression, homelessness, obesity.
- Lack of workforce sustainability across the locality impacting on core service delivery. An inability to recruit and retain both clinical and non-clinical staff across the locality.
- Continuing system pressures across services to be able to develop screening programmes and increase uptake rates
- Succession planning, aging workforce, increase staffing requirement against an aging workforce across Health and Social Care
- Lack of staffing resource to deliver CRT 8 – 8 service.
- Loss of Locum consultant to drive forward Tyleri 8 bedded CRT Unit
- Lack of continuity of service for some funded services such as MSK, Practice based Pharmacists and PWP's.
- Short term funding impacting on opportunities to innovate and test new concepts.
- Highest levels of multiple deprivation across Gwent
- Older population, increasing dementia
- Significant gap in Health inequalities, high number of residents who do not participate in healthy behaviours and a persistent lack of desire to access Health Protection Services, evidenced through 68% who are either overweight or obese, 22% who smoke, 39% who are active for less than 30 minutes a week with 82% not accessing a healthy diet.
- High prevalence of chronic disease, inequality in life expectancy, mortality rates, high prevalence of chronic disease, poorer mental wellbeing,
- Highest rates of childhood tooth decay in Wales and lack of affordable dental care in the locality
- Poor mental wellbeing for both children and adults
- Cardiovascular disease and cancer are the biggest cause of premature mortality in Blaenau Gwent with the lowest take up of screening services.
- Hypertension, obesity, asthma and depression accounts for around 60% of the disease prevalence across the clusters. Above average levels of disability with 31.6% of working age people being defined as disabled. Resulting in a proportion of people claiming disability related benefits - 12% of working aged residents claim EAS or incapacity benefit.
- High levels of antibiotic and opioid prescribing and usage
- Lack of community development opportunities and a population culture that does not identify volunteering as well to improve wellbeing within the locality and this impacts on our ability to deliver place based and graduated care.
- Volunteering and befriending schemes fragile due to uncertainties around long term funding opportunities and this impacts on our ability to deliver place based and graduated care.
- Uncertainty over service for long covid patients from March 2023 until funding has been confirmed

- EPP BG resident specific courses are only available currently in the day because of capacity within the service which does not support those that are working, however there are courses available outside of core hours (evenings and weekends) on a Gwent wide basis
- Sexual Health Services- lack of services available in the BG East Cluster, services have not resumed fully following covid.
- Demand for consultations in general practice continues to grow and the demand for greater choice in the way patients can access primary care, to include digital (i.e., remote & virtual access)
- Demand for flexible extended hours, seven-day service, and same day urgent care
- Reduction in funding for interdependent services (i.e., Social Services)

Opportunities

- Provide ***System Leadership*** which enables collaboration between partner organisations across health and social care to identify and meet the needs of the local population.
- Undertake ***Integrated Planning*** based on detailed assessment of needs and operational plans which set common ambitions between partners for integrated service delivery, service developments and opportunities in the delivery of integrated community-based care to the population of Blaenau Gwent and which responds to the identified needs assessment. In doing this the BG ISPB will:
- Understand the population needs including key priorities
- Understand professional assessment of service pathway gaps, barriers and opportunities articulated by clusters/ professional collaboratives and Local Authorities
- Develop an aligned Integrated Blaenau Gwent Plan which builds upon the plans of the Blaenau Gwent ABUHB & East and West Cluster, BGCBC's Corporate/Business plans and priorities, supporting alignment across organisations.
- Support and influence the development an Integrated Workforce Plan which reflects both the local sustainability of services and the ambitions of the Blaenau Gwent
- To align and jointly ***commission*** a suite of services from organisations that can deliver innovative, outcomes-based services, based upon need as identified within the Integrated Blaenau Gwent Plan.
- To ***enable delivery*** of services to realise the objectives and actions outlined in the Integrated Blaenau Gwent Plan. This will include the selection of information based on existing data to create the framework for the ISPB.
- To ***create a culture which motivates*** all partners within Blaenau Gwent use an innovative approach and intelligence to drive continuous improvements in the provision of integrated services.
- To ensure ***continuous engagement*** with the population of Blaenau Gwent on the work of the BG ISPB and how it is meeting local needs
- To work together to support ***sustainable resources*** for health and social care service providers in Blaenau Gwent to effectively meet the needs of the population and implement the Integrated Plan.
- To identify, monitor and seek assurance that actions are in place to ***mitigate risks*** to partnership working and the delivery of the priorities outlined in Blaenau Gwent Integrated Plan
- Develop a joined up place based approach to management of estates aligned to local service models
- To develop a model which supports that percentage of inpatients who do not need to be in hospital and could be supported in their own home or a care home through the graduated care model taking the form of reablement at home rather than rehabilitation in hospital, where appropriate through expansion of core rapid response services
- To take the learning from the Tyleri nurse led ward and codesign with staff and users a nurse led model of care which provides an environment to develop prudency of skill allocation by supporting the nursing family to reorganise the way they work across the community to reduce handovers and increase satisfaction and experience.
- Realigning Community teams to remove barriers across the locality to meet the needs of people and deliver person centred care
- Development of a federated model which reflects both the needs of our population and to provide sustainable staffing model to deliver a sustainable, whole system approach in delivering place based care

- To review and monitor population health to benefit the population of the borough. Collaboratively work across partners to support individuals and services with the management of long-term conditions (LTC). To look at new ways to enhance the detection of risk factors both through public awareness and professional measures and ensuring that pathways are in place for support to be available / accessible as and when required.
- Enhance the cross organisation / partnership working arrangements to review the high prevalence within Blaenau Gwent, i.e.:
    - Smoking prevalence – Level 2/Level 3 smoking cessation access, Shakedown programme to target children, playground restrictions for smoke free zones
    - Immunisations – immunisations across all population, collaborative working for care homes, children via schools / education support

- To work together collaboratively with stakeholders to achieve our shared vision of creating a more prosperous Blaenau Gwent, identifying areas of good practice and innovation locally that will work towards improving the lives and outcomes of the people living in poverty.
- Identify the key issues for all stakeholders and work together to create opportunities across health, social care, and other public and community services to deliver a range of support and possible solutions that will respond to current and future demands.
- Work together with all stakeholders to redesign services that will tackle key priorities such as housing, mental health, domestic violence and drug and alcohol support.
- Continue to work closely with partners across Wales and a local, regional and National level to support vulnerable groups such as asylum seekers and refugees to ensure the appropriate level of support is provided within the community.

Chapter 2- The Placed-Based Care Model for Blaenau Gwent

Place based systems of care provide opportunities to address the challenges facing the Blaenau Gwent workforce and population as they provide a platform for implementing new models of care with the aim of improving population health and wellbeing. We believe by addressing the root cause of issues- known as the wider determinants of health- that the overall health and wellbeing of Blaenau Gwent can be improved. Our Plan reinforces Blaenau Gwent's Vision of a Happy, Healthy Blaenau Gwent and this is endorsed through our place-based care strategy. This vision is validated by the strategic direction set out in The National Primary Care Programme, A Healthier Wales and Prosperity for All setting out strategic ambitions for increasing workforce sustainability and utilising the third sector to meet the increasing demands upon our core services.

Blaenau Gwent has the highest percentage of areas, 85.1%, in the most deprived 50% in Wales. Tredegar Central and West 2 are classed a small area of Deep-Rooted Deprivation; that is, they have remained within the top 50 most deprived, roughly equal to the top 2.6% of small areas in Wales for the last five publications of WIMD rankings, this stark inequality is undoubtedly linked to the level of deprivation and poverty in the area. The ISPB is committed to improving services provided to residents to reduce inequalities in health and social care provision; ensuring timely access to sustainable services; moving care closer to home; and maintaining high quality, safe services which do no harm.

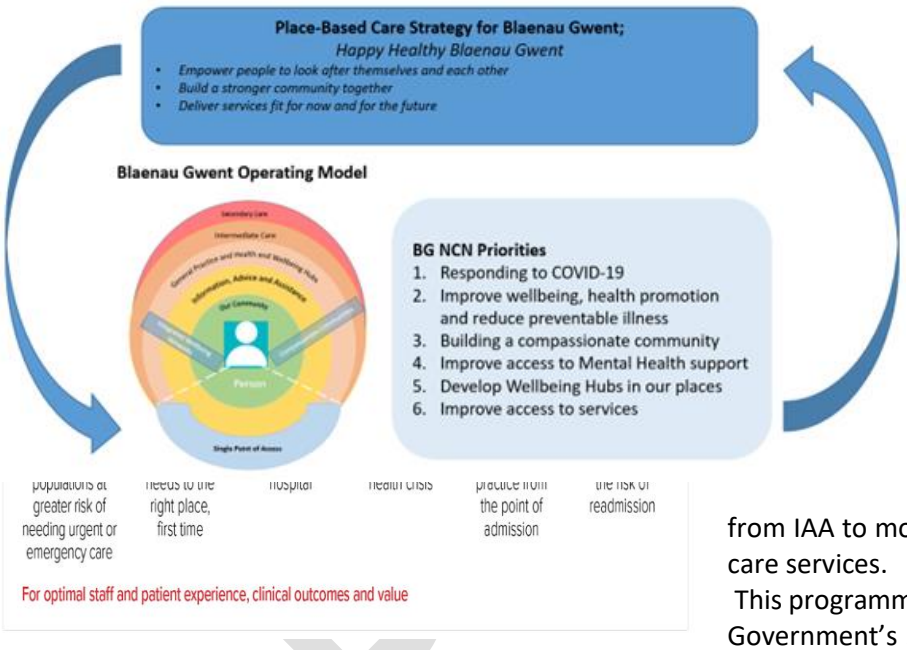
Our Plan reinforces Blaenau Gwent's Vision of a Happy, Healthy Blaenau Gwent through our place-based care strategy which seeks to deliver

- Empowered people who look after themselves and each other
- Building a stronger community together
- Delivery of services for now and for the future

The proposed programme of work seeks to further develop place-based teams across organisations and structures to enable staff to focus on empowering our communities to be resilient and take ownership of their health and wellbeing through early intervention, prudent healthcare, removing system pressures, through supporting early intervention/prevention to help strengthen the community response for integrated service delivery and to support the six goals for Urgent and Emergency Care

Utilising the principles of the Primary Care Model for Wales to deliver on our place-based visions by: -

- Developing a fully integrated service using local knowledge and data from the population needs assessment to influence services and take forward models of care, planning and coordinating care locally through place based integrated teams who utilise community, voluntary, local authority and primary care services only when self-care and prevention is not an option.
- Taking a whole system approach that integrates health, local authority and voluntary sector services, and is facilitated by collaboration and consultation
- Delivering care for people that incorporates physical, mental and emotional well-being, which is linked to healthy lifestyle choices creating stronger communities by empowering people and giving them access to community conversations to access a range of support mechanisms using the no wrong door principle of supporting people to access the services they need wherever they first enter our network: ranging from access to debt and housing advice, to social prescriptions for wellbeing advice and support to help people remain healthy, with easy access to local services for care when it is needed, recognising the graduated response required which can range from IAA to more complex health and social care services.



This programme of work aligns to the Welsh Government's strategic aims for health and social care through the provision of enhanced place-based care, enriching delivery for existing services to provide person centred care which enables early intervention and supportive work to be delivered conterminously with clinical care through the provision of local places.

Blaenau Gwent is a compact borough and there are some elements of the place-based model which are better served at a borough rather than at a town level, but the principles of 'place-based' care apply to both. Many of the population needs in Blaenau Gwent are no different to those found across the country, such as an increasingly elderly populations with the associated increase in co-morbidities and long-term care needs.

However, there are several significant areas in which Blaenau Gwent is an outlier. These include inequalities of life expectancy, mortality rates, high prevalence of chronic disease, poorer mental wellbeing than Wales as a whole and a high percentage of residents who don't participate in healthy behaviours.

As the pictogram to the left indicates by highlighting in red, the % of overweight people, people who do not eat 5 portions of fruit and vegetables a day and who are not active for less than 30 minutes a week is significantly higher than Wales.

This poses a significant opportunity to Blaenau Gwent West NCN given that a significant proportion of the burden of ill health in Blaenau Gwent could be prevented, if:

- More people ate a healthier diet and maintained a healthy weight
- More people were physically active
- Fewer people used tobacco
- Fewer people took alcohol above the recommended amounts.

Equally, it poses a significant challenge in that ingrained behaviours are extremely difficult to change.

The profile outlined above clearly demonstrates the challenges faced in improving the health and wellbeing of the people of Blaenau Gwent, highlighting the need to tackle the wider determinants of health and to focus on the lifestyle and behaviours issues which would alleviate the illness and disease. This needs to be done in partnership and the Borough has a strong, developed relationship between health, social care and third sector services. This has resulted in the development of a joint place-based care strategy which is the means by which the communities in the Borough can be engaged and encouraged to support each other and develop healthier lifestyles, enmeshed with the clinical interventions needed. The impact on the estate is significant, as there must be every opportunity given to aid collaboration between services and to focus as many services as possible on the "place." This has resulted in the development of Health and Wellbeing Hubs, providing this wider support within a "place," to be owned by the population as part of the NCN Development (Accelerated Cluster) Programme where we will deliver a pathway redesign programme building on and drawing together existing initiatives to support high-risk cohorts of people in the community who are at risk of deterioration in their long-term health conditions. This will create a robust resource built on existing foundations that is able to provide additional care at home 24 hours a day, seven days a week, to support our population and reduce days away from home.

Management and mitigation of deterioration will be a key facet of supporting people to stay at or close to home and this will be enabled by collegiate joint endeavour with the individual and their care giver as central partners. This process will be undertaken in parallel with the development of better preventive services also being developed in the Health Board. The redesign will build on work already undertaken as part of the Compassionate Communities/Integrated Well Being Network approach to support community development and management of local networks.

Connected Communities

Blaenau are strengthening both public and third sector integrated ways of working to improve the health and well-being outcomes of our population through high quality care and support. We have a long history of collaboration and have benefited previously from external funding to test new models of care such as Compassionate Communities and delivering support to high-risk adults [HRAC]. We understand the challenges of ensuring citizens receive the right care, in the right place at the right time, first time and we also recognise that this is not always happening in Blaenau Gwent:

We believe by addressing the root cause the wider determinants of health- that the overall health and wellbeing of Blaenau Gwent can be improved. We will build on our initial pilots to articulate an operating model based on collaboration through partnerships.

Health and social care approaches tend to be reactive, responding when a patient or service user experiences a crisis, in order to return them back to health and provide limited support during the periods between crises and this has fostered a culture of dependency and passivity along with an over reliance on our services. Working with IWN, IAA, public and third sector services and a re-focused CC model of service we will implement an MDT virtual ward approach that supports self-care and behaviour change to manage long term conditions and reduce reliance on social care and health systems.

The uniqueness of the Compassionate Communities model is the ability to work across all health, social care and third sector boundaries to coordinate support for individuals at risk or who could benefit from early intervention and prevention support. There are currently inequalities in provision of care where some people are known to multiple (and sometimes too many agencies with duplication of services) whereas others receive little or no support. The development of an MDT approach will provide the mechanism for our community teams to support individuals to receive more preventative, pro-active and coordinated support which includes a range of community based and voluntary services, a whole system approach that integrates health, local authority and voluntary sector services and is facilitated by collaboration and consultation. Led by our Place based Coordinators through our Integrated Wellbeing Networks we will provide choices for our communities that incorporate physical, mental and emotional well-being and is linked to healthy lifestyle choices. We will create stronger communities by empowering people and giving them access to community conversations to access a range of support mechanisms, ranging from access to debt and housing advice, to social prescriptions for wellbeing. advice and support to helping people remain healthy, live well, at home, through prevention, choice, wellbeing and independence with easy access to local services for care when it is needed.

Transformation funding has provided the opportunity to progress this vision through embedding a Compassionate Communities model of care to support our place-based strategy, embedding an MDT approach which delivers appropriate care to people with long terms conditions and supports the management of demand for our services collectively across social care and health, whilst this concept has been partially embraced across our cluster, the pandemic and system pressures have impacted on system wide implementation. The RIF provides opportunities to streamline and further collaborate with our stakeholders to improve health and wellbeing outcomes for our communities, change behaviours and share accountability across all sectors. We will utilise the opportunities that the development of our pan cluster planning group will bring to use the collective resources across Blaenau Gwent – both fixed assets and people across all stakeholders to improve outcomes for our residents.

The ISPB will co-produce with partners and staff across the whole health, social care and third sector to develop seamless services where social, primary and secondary care are not seen in isolation but work together to provide services to improve the experience for people by providing less complex, better coordinated care through the development of a whole system population health social care and third sector model which supports, through co-production the needs of the individual through a person centred model of care.

The benefits of delivering a CC Virtual ward will provide access to multi -professional teams who work alongside GPs. Access to existing telephone (and increasingly digital) systems and workforce roles to signpost and connect people to local services. These services include sources of non-clinical wellbeing support from the third and community sectors as well as clinical care from community pharmacists, dentists and optometrists at a NCN cluster level. We now benefit from a CRT pharmacist and will utilise this service to wrap around an enhanced community model to meet patient needs where delivery of the CC virtual ward evidences a need. We will embed the assessment process for the high-risk adults [HRA] across our Compassionate Communities model to ensure that each individual has coordinated support across community, health and social care services, providing an escalation plan to access care and support whenever required to, as much as we are able to, avoid unnecessary admission into an acute setting.

Our model will focus on self-care and prevention, utilising a range of transformational primary care schemes to support the Compassionate Communities virtual ward model such as the Common Ailments Service, providing a range of treatments without the need for a prescription and GP appointment. Nationally, evidence shows that over 80% of people accessing the service say they would have visited their GP, out-of-hours or A&E if it had not been available. The Choose Pharmacy IT system will be utilised to enable residents to access this expanding range of enhanced services to help alleviate the growing demand on both acute and primary care services.

Chapter 3- ISPB Priorities

Blaenau Gwent locality, as part of the Health Board-wide commitment to develop whole system service models will work collaboratively to improve the interface between services to support people to receive the right care, right place, first time to optimise individual outcomes and experiences.

Our Partnership Board has reviewed our priority actions to ensure that they remain relevant to the changing landscape:

- Delivering the principles of the Social Services & Well-being Act 2014 (the Act), The Wellbeing of Future Generations Act (2015), A Healthier Wales and the Primary Care Model for Wales Ensuring that there is increasing alignment and engagement between the Gwent Regional Partnership Board and Cluster arrangements bringing services together at a local level
- Developing and strengthening the relationship with the Gwent Regional Partnership Board to enable and promote an integrated response to the needs of the local population
- Lead the development of an integrated plan which addresses the health, care and wellbeing needs of the whole population of Blaenau Gwent. This will enable shared accountability and governance across partners including aligning and joint commissioning of resource and service delivery.
- Support the implementation at local level of the partnership agenda, including (but not limited to): -
  - NCN- cluster plans
  - Integrated Borough Business plan
  - Priorities determined by the RPB and the Blaenau Gwent Integrated Services Partnership Board (ISPB)
  - Community Hospitals

The attached table describes a set of objectives (page 23) which have been agreed by the ISPB as key principles and priorities to inform the framework for future planning, implementation, and evaluation ***noting; ISPB priorities will continue to be influenced and refined alongside RPB development and plan-published in April 2023***.

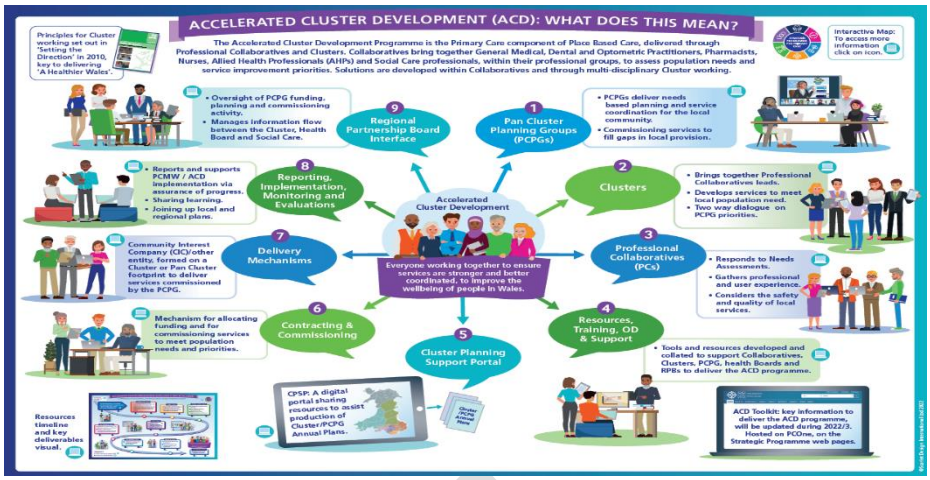
Chapter 4-Enabling Delivery

An integrated approach to planning and provision of services is key to the success of this plan and working in partnership across all sectors on a borough, NCN and placed based level is of paramount importance and having the appropriate forum and governance frameworks to support this approach is essential.

Our goal is to deliver sustainable changes to our system, this means that 'not only have the process and outcome changed, but the thinking and attitudes behind them are fundamentally altered and the systems surrounding them are transformed as well'.

Accelerated Cluster/NCN Development:

A key Enabler to address the health inequalities during 2023-24 is the transition to accelerated cluster working which is seen as the driver for change in developing and providing and accessing health and social care services through collaborative approaches across a local footprint.



The 7 main outcomes of ACD/NCN Development which will be worked towards are:

- Enhancing integrated planning between clusters, health boards and local authorities
- Delivering a wider range of services across the cluster closer to home, meeting population need and priorities.
- Establishing more effective leaders across the system through collaboratives and clusters.
- Improving equity of service provision based on local need.
- Improving the delivery of multi professional / agency services.
- Supporting sustainable services and workforce, ensuring both efficiency and effectivity.
- Empowering clusters with increasing autonomy, flexibility, and vision.

Workforce:

Blaenau Gwent has an established partnership landscape acting as an enabler for patient centred support which stretches across services and organisations. The Integrated Partnership Board has been strengthened with a focus around reshaping our workforce to deliver the right care in the right place, first time through the right staff, with the right skills, through designing integrated pathways regardless of organisations boundaries which focus on people staying well in their own homes and communities. To achieve this ambition an *assessment of demand and capacity* is required to ensure that existing resources are utilised most effectively.

Understanding the whole system and the importance of taking forward a sustainable integrated health and social care approach across primary/ community teams is a priority for the ISPB. In terms of maintaining a robust and responsive 'whole-team' approach, we need to understand the challenges locally and understand the growing needs of our population over the next 5 – 10 years so that we can develop a workforce capable of sustaining these needs.

Digital, Data Intelligence:

We will embrace technology to improve sharing of information and monitoring of specific conditions to improve care for patients and reduce duplication between professionals and the development of Place Based Care will continue to be at the heart of our plans to enable communities to receive as much of their care as possible within an integrated social care and wellbeing hub as close to home as practicable through a range of transformation and re-design opportunities to meet our changing population needs across our 4 hub areas.

Estates:

Our workforce strategy considers what is required in terms of population needs and resources. As an ISPB we will collaborate to identify gaps, continue building partnerships working and integration within social care, health and the third sector in order to develop a joined-up place-based approach to the management of our estates which is aligned to our population need and managed to ensure supports the delivery of our placed based care, prevention, early intervention, self-care.

Our assets are a key component for delivering our place-based strategy. Undertaking an asset mapping of all estates provision alongside a mapping of services – both clinical and non-clinical to ensure that people with the right skills and experience work in an environment that is fit for purpose. Our estate is a key enabler and must take account of other necessary infrastructure, such as information and community technology (ICT); the need for health and care staff to work together in partnership through co-location/design and integration to enable delivery of services in the right place to support the best outcomes and experience for patients. Locally relationships are being built and regular interventions are in place to forward plan and ensure that locally we can influence at a planning level any developments which impact on social care and health services. Relationships are being developed locally to input into the Local Development Plan which guides development within the borough, sets out the long-term future for the borough, to ensure that growth is delivered in the right places and considers the needs of our local communities.

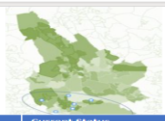
Our Hub vision supports the effective use of clinical and non-clinical resources to improve efficiencies and economies of scales across the health and social system, improving integration through pooled resources to reduce reliance on professional services which providing care as close to home as practical.

Our Hub model will provide holistic social care, health and wellbeing services which have been chosen to meet the needs of the specific community where each hub is located. Where specialist services have been identified as required, these are allocated to our hub model based on geographical demand. We recognise that to deliver place-based care across our locality we need to ensure our estates are fit for purpose. To support this focus, we have developed a set of locality-based Estates Objectives to support this development and ensure that our priorities and commitment are focused. This group will provide the oversight on the development of an Estates Action plan to provide a long-term estate solution across Blaenau Gwent by

- Identifying all assets 'at risk 'and/or requiring investment, setting out clear priorities for investment/dis-investment
- Undertake a baseline of all estates across Blaenau Gwent to determine demand and capacity for all services
- Development of an action plan to progress the development of the 4 key hubs across the locality
- Explore the use of Section 106 or Community Infrastructure Levy funds, RPB development of hub and spoke funding, ICRF - to support the development of our 4 key hubs
- Review the Council's regeneration plans and any opportunities to link these with the development of place-based care across our locality.

Blaenau Gwent West NCN

Summary:
PBC – x2 Places Tredegar and Ebbw Vale
6 GP Practices
GP List Size Population: 38,884



NCN Lead: Simon Donovan

"Place"	Development	Current Status	Timescale	Funding	Priority Order
Blaenau Gwent West –Tredegar	Working towards building being watertight – January 2023. Planned handover of the building is now rescheduled for 25th July 2022 due to weather conditions. Noted additional cost pressure of 750k if entitlement is proven. Schedule of accommodation completed. GP room allocations completed	3 operational sub groups have been established to ensure tasks required will be completed in readiness for opening date • Health & Wellbeing • Operational Sub Group • Communication and Engagement –established Finalisation of the Operational Policy and individual service schedules to be completed and signed off by Project Team. GP computer requirements to be finalised Telephone system in the process of being finalised with both GP surgeries Tredegar and Glan-yr-Afon Finalisation of commissioning plan Continuing to review service risk register Pursue Bevan specific Service groups- Communication and Engagement, Operational Subgroup, Project Team as we work towards handover Development of a Day-to-Day plan prior to the opening of the building and 3 weeks after Development of SOPs for each service Updated revenue costs for building use being revised – meeting being progressed with BPA	25 July 23	In place	High
Blaenau Gwent West – Ebbw Vale	Capital Expression of Interest approved for Ebbw Vale Wellbeing Centre 11/22 Discussions required to determine most appropriate location, Glyn Ebwy utilised until Hub confirmed Development of service model ongoing. CRT and DN team relocated, clinical services in operation - Podiatry, Health Visitors, Midwifery, AWDPP, Diabetes Nurse,	GE - Internal H & S/condition survey completed and highlighting significant issues on site. Awaiting full report to progress. Building IT installation awaiting service capacity resulting in delays for hub development to release capacity for Glan Rhyd, PYC and Cwm. Awaiting completion of lease and SLA	TBC	RIF confirmed for BC	High

Blaenau Gwent East

Summary:
PBC = x 2 Places ie Brynmawr and Abertillery
5 GP Practices
GP List Size Population: 32, 775

NCN Lead: Isolde Shore Nye

"Place"	Development	Current Status	Timescale	Funding	Priority Order
Blaenau Gwent East – Brynmawr	Hub completed 2018, currently houses managed practice	Practice isn't part of NCN collaborative due to staffing deficits, pressures Requirement to work collaboratively to develop place based response with services operating on population basis	ongoing	n/a	Med
Blaenau Gwent East – Abertillery	No clinical services running out of GMS led to baseline across Blaenau Gwent to understand capacity across the locality, scoping undertaken across 9 Health Board owned sites [progress delayed due to re-deployment of staff member]	• Early indications showing that of the rooms available, 14.5% of clinical space is unused. • By end of February set up wider service group meeting to take forward baseline results and work collaboratively across services to develop a place-based response with services operating on a local population basis where appropriate, utilising all the clinical spaces available to us. • Where buildings are not suitable for clinical use, we need to identify the non-clinical needs of each of our services and work together, through the principles of agile working to deliver a response that meets the needs of all the services in the Borough.	Ongoing	n/a	Med

The emphasis of the Welsh Government is on building sustainable Welsh communities by tackling the challenges presented by population and economic change. Blaenau Gwent is recognised as an area that will be facing high levels of economic and social challenges, there is a need for Blaenau Gwent to grow in a way that will build a sustainable community to increase general prosperity levels.

The Local Development Plan for Blaenau Gwent highlights the need to retain its population, diversify its economy, regenerate its town centres, and improve opportunities for its residents. Key priorities will be to focus on sustainable development sustainable development, which makes the most efficient use of land, reduces the need to travel and gives priority to the use of previously developed land. It will provide the central framework around developing sustainable transport links, affordable housing, clean and vibrant town centres, modern facilities and employment opportunities.

Finance:

Across ISPB organisations / stakeholders' financial budgets align to be able to support services / workstreams to meet the need of the population.

There is a clear strategic direction set by Welsh Government in the National Model for Primary Care. This model aligns with local innovation, with the focus on a multi-professional workforce so people can be seen in the right place by the right person at the right time to best meet their needs. It is recognised that there are challenges across health and social care for the recruitment and retention of staff. This brings its own challenges with the ability to meet public expectation as well as the increasing demand on services across Blaenau Gwent.

In order to support the sustainability and availability of service access the ISPB will need to look at collaborative working for a whole system approach. Once gaps in delivery have been identified the ISPB will directly commission services utilising budget within the next 12-18 months, there will be agreed needs based commissioning planning and monitoring of services.

The ISPB also has opportunities to look at current budgets (including budget management), individually and jointly with a view in collectively making more robust access to meet the local need. The following are funding enablers and will be reviewed by the ISPB:

- Pooled budgets - Pooled budgets combine funds from different organisations to purchase integrated support to achieve shared outcomes.

- Regional Integration Fund (RIF) – is Health and Social Care, 5-year fund to deliver a programme of change from April 2022 to March 2027. The RIF will build on the learning and progress from the previous Integrated Care Fund (ICF) and Transformation Fund (TF) and attempts to create a sustainable system change through the integration of health and social care services. Key features and values include:
    - A strong focus on prevention and early intervention
    - Developing and embedding national models of integrated care
        - Community based care – prevention and community coordination
        - Community based care – complex care closer to home
        - Promoting good emotional health and well-being
        - Supporting families to stay together safely, and therapeutic support for care experienced children
        - Home from hospital services
        - Accommodation based solutions
    - Actively sharing learning across Wales through Communities of Practice
    - Sustainable long-term resourcing to embed and mainstream new models of care
    - Creation of long-term pooled fund arrangement
    - Consistent investment in regional planning and partnership infrastructure

- Participatory Budgeting – this enables people/residents of the borough to make decisions about how all or part of a public budget is spent. There can be many challenges to overcome when budgeting for, designing and implementing effective services. But participatory decision making can be a vital step towards delivering a better quality of life by meeting the communities most important needs.

- NCN (Neighbourhood Care Network) Budgets - 2 NCN budgets 1 Blaenau Gwent East and 1 Blaenau Gwent West, the value fluctuates year on year as they're standardly driven by the patient list size as well as the uncertainty of any potential uplifts for the year. Reviewing of current budget allocation, evaluation and monitoring of services/projects and exit strategies to be enforced to ensure that we are optimising the budgets to meet the needs of the population.

- Additional Borough budgets across Health, Social Care and Third Sector (ABUHB, BGCBC, GAVO, IWN) – review of current budgets and additional opportunities to be sought based on local need.

Experience, Quality & Safety:

The Health and Social Care (Quality & Engagement) (Wales) Act 2020 puts legal duty on us to provide services of good quality and to make improvements as required to ensure our population receive the best possible outcomes. Working on a place-based basis and delivering care to patients as close to where they live will require us to have robust governance arrangements for the quality, and safety of our services. In addition, ensuring that skills and experience are paramount to all aspects of health, social care and third sector resource to support the success of any transformation work to shift care out of the traditional hospital setting.

The health board has patient quality and safety forums for each of its divisions where the focus is on review and monitoring of key aspects but also very much on learning following local and other areas and sharing of best practice. The divisional forums sit within an organisational structure to support quality and patient safety

The ISPB endorse a firm commitment to continue to mature approach to workforce and financial planning over the planning cycle.

Priority	**Strategic alignment**: SPPC key programme priorities	ISPB Priority Objective 1	ISPB Priority Objective 2	ISPB Priority Objective 3	**Strategic alignment**:	Activity/ project budget	Funding source(s)	Current status	Comments
	RPB	Identify the gaps within priority between health, social care and third sector. Establish organisational delivery to meet local need 2023-2024	Review RPB Action plan to inform short, medium to long term plan 2023-2025	Execute a local workforce analysis across organisations to optimise the current and future workforce models 2024-2026	Marmot principle			What is the current status – short description only	comments you feel may be relevant here – for example barriers to success, workforce issues etc.
Children and Young People	1. To improve outcomes for children and young people with complex needs through earlier intervention, community-based support and placements closer to home. 2. To ensure good mental health and emotional well-being for children and young people through effective partnership working especially mitigating long term impact of Covid.	Workshops will take place during 2023 to identify gaps	Workshops will take place during 2023 to identify gaps to inform/build action plan in the short/medium/long term for the ISPB	Priority during 2024-26			Once gaps in delivery have been identified the ISPB will directly commission services utilising budget within the next 12-18 months		
Older People	1. Improve emotional wellbeing for older people by reducing loneliness and social isolation with earlier intervention and community resilience 2. Improve outcomes for people living with	Workshops will take place during 2023 to identify gaps	Workshops will take place during 2023 to identify gaps to inform/build action plan in the short/medium/long term for the ISPB	Priority during 2024-26			Once gaps in delivery have been identified the ISPB will directly commission services utilising budget within		

Priority	**Strategic alignment**: SPPC key programme priorities	ISPB Priority Objective 1	ISPB Priority Objective 2	ISPB Priority Objective 3	**Strategic alignment**:	Activity/ project budget	Funding source(s)	Current status	Comments
	RPB	Identify the gaps within priority between health, social care and third sector. Establish organisational delivery to meet local need 2023-2024	Review RPB Action plan to inform short, medium to long term plan 2023-2025	Execute a local workforce analysis across organisations to optimise the current and future workforce models 2024-2026	Marmot principle			What is the current status – short description only	comments you feel may be relevant here – for example barriers to success, workforce issues etc.
	dementia and their carers 3. support older people or return following a period of hospitalisation, to their own homes and communities through early intervention, integrated care models and a whole system approach 4. To mitigate the long-term impact of Covid-19 pandemic through, especially reducing waiting lists and times to access support, appointments and medical procedures						the next 12-18 months		
People with disabilities	1. Support disabled people, including sensory impairment, through an all-age approach to live independently in appropriate accommodation and access community-based services, including transport	Workshops will take place during 2023 to identify gaps	Workshops will take place during 2023 to identify gaps to inform/build action plan in the short/medium/long term for the ISPB	Priority during 2024-26			Once gaps in delivery have been identified the ISPB will directly commission services utilising budget within the next 12-18 months		

Priority	**Strategic alignment**: SPPC key programme priorities	ISPB Priority Objective 1	ISPB Priority Objective 2	ISPB Priority Objective 3	**Strategic alignment**:	Activity/ project budget	Funding source(s)	Current status	Comments
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	2. Ensure people are supported through access to accurate information, assistance and 'rehabilitation' where required. 3. Improve transition across all age groups and support services								
People with learning disabilities	1. support people with learning disabilities to live independently with access to early intervention services in the community; and greater public awareness and understanding of people with learning disabilities needs	Workshops will take place during 2023 to identify gaps	Workshops will take place during 2023 to identify gaps to inform/build action plan in the short/medium/long term for the ISPB	Priority during 2024-26			Once gaps in delivery have been identified the ISPB will directly commission services utilising budget within the next 12-18 months		
Autistic Spectrum disorder	1. Provide more timely diagnosis of Autistic Spectrum Disorder and access to support services and information and advice 2. Improve awareness, understanding and	Workshops will take place during 2023 to identify gaps	Workshops will take place during 2023 to identify gaps to inform/build action plan in the short/medium/long term for the ISPB	Priority during 2024-26			Once gaps in delivery have been identified the ISPB will directly commission services utilising budget within		

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	acceptance of autistic people						the next 12-18 months		
Awareness of mental health	1. Increased understanding and awareness of mental health amongst the public to reduce stigma and help people to seek support earlier 2. Improve emotional well-being and mental health for adults and children through early intervention and community support	Workshops will take place during 2023 to identify gaps	Workshops will take place during 2023 to identify gaps to inform/build action plan in the short/medium/long term for the ISPB	Priority during 2024-26			Once gaps in delivery have been identified the ISPB will directly commission services utilising budget within the next 12-18 months		
Unpaid carers & Young carers / young adult carers	1. Support unpaid carers to care through flexible respite, access to accurate information, peer to peer support, effective care planning and through increased public understanding 2. Improve well-being of young carers and young adult carers, and mitigate against	Workshops will take place during 2023 to identify gaps	Workshops will take place during 2023 to identify gaps to inform/build action plan in the short/medium/long term for the ISPB	Priority during 2024-26			Once gaps in delivery have been identified the ISPB will directly commission services utilising budget within the next 12-18 months		

Priority	**Strategic alignment**: SPPC key programme priorities	ISPB Priority Objective 1	ISPB Priority Objective 2	ISPB Priority Objective 3	**Strategic alignment**:	Activity/ project budget	Funding source(s)	Current status	Comments
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	the long-term impact of Covid-19 pandemic								
Housing	1. A multi-agency partnership approach to ensure appropriate housing and accommodation for older people and vulnerable citizens 2. ensure effective use of Disabled Facilities Grants and appropriate partnership support and available resources 3. Homelessness requiring a collaborative response from public services and partners, especially the non-use of B&B accommodation for young people, and through prevention and early intervention.	Workshops will take place during 2023 to identify gaps	Workshops will take place during 2023 to identify gaps to inform/build action plan in the short/medium/long term for the ISPB	Priority during 2024-26			Once gaps in delivery have been identified the ISPB will directly commission services utilising budget within the next 12-18 months		