INTEGRATED SERVICE PARTNERSHIP BOARD (ISPB) PLAN

CAERPHILLY

2023-2026

v2 30 June 2023

CONTENTS

This plan has been split into chapters: -

Chapter 1 - Setting the Scene

The aim of the ISPB is to deliver 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. It will work to ensure that there is increasing alignment and engagement between the Regional Partnership Board (RPB) and NCN (Cluster) arrangements bringing services together at a local level to address the needs of the local population.

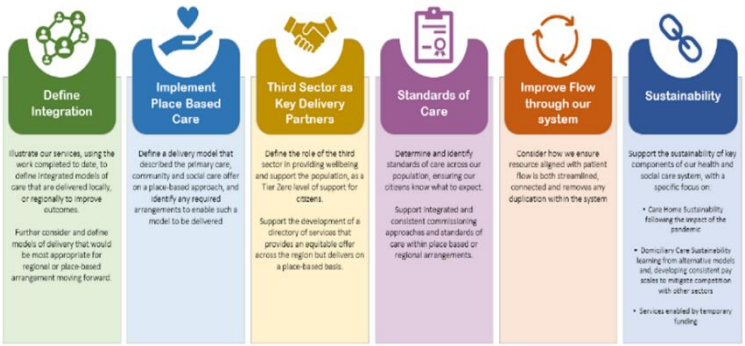
As a result, this plan has been provided with the ambition to improve the population health and wellbeing at a local level, supporting people to stay well, lead healthy independent lifestyles and reduce inequalities. It will be the cornerstone of our Integrated Service Partnership Board (ISPB) business, enabling us to be clear and purposeful in our actions and to hold ourselves accountable for delivering our priorities, for the benefit of the communities we serve.

Current services need to evolve to sustain and improve operational delivery. There is necessity to change historical ways and patterns of working that no longer meet the needs of today's society and future generations. Evolution is required to address a number of key factors including:

- Demand for health and social care is growing and will continue to grow; we have an aging population, with patients living longer and with more complex needs, which intensifies the challenges faced by all sectors.
- All of our health, social care and community services need to be sustainable in the short, medium, and longer term.
- Our population is characterised by pockets of health inequalities, linked to socio-economic deprivation the current financial climate will further impact these areas.
- Our estate is not robust to provide services for now and the future.

Aneurin Bevan University Health Board (ABUHB) and Caerphilly County Borough Council (CCBC) are duty bound by The Social Services and Well-being (Wales) Act 2014 to plan, develop and improve services jointly, working with other stakeholders including the general public to engage, plan and promote services in relation to well-being. All aspects of our strategic and operational planning will need to consider the Well-being of Future Generations (Wales) Act 2015 to ensure that anything we do supports its ambitions for a prosperous, resilient, sustainable, healthier, more equal Wales with cohesive communities, a vibrant culture and thriving Welsh language.

This is the first ISPB plan for Caerphilly and comes at a time when there is significant need for us to work better together to address the challenges and take opportunity to provide a more co-ordinated approach to planning and operational service delivery. Caerphilly has a local delivery group which is multistakeholder but led by CCBC and focussing on the deliverables of the Gwent Public Services Board (GPSB) and the ISPB actions and IDG actions will need to be aligned locally to ensure we work together and avoid duplication.



There are a number of Gwent wide strategic plans to which any local planning needs to align, the most notable being the Gwent Regional Partnership Board (RPB) and GPSB. These will be considered within this plan to ensure we are working to deliver on the aims outlined in these.

The area of Gwent has been declared a Marmot region and the ABUHB Director of Public Health Annual Report 2022 outlines why and how going forward we can work to address inequalities in our region.

Caerphilly ISPB support the Marmot Review outcomes which sets out a framework for action under two policy goals:

- To create an enabling society that maximizes individual and community potential;
- 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.

The adoption of Gwent to be a Marmot area will enable a framework from which all aspects of service provision can be planned and delivered. Its eight principles will help ensure that inequality across the board is a key consideration and will support services in addressing inequality from birth though childhood, adulthood, and old age.

Marmot's 8 policy principles below are used within this document under which our work area priorities are identified:

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.

Crucially, we must take our citizens on the journey with us, so that they are continuously co-designing the model and truly own and feel responsible for not only their community, place-based care, but for their own health and well-being.

Background Information:

Caerphilly Borough lies at the heart of both the South Wales Valleys and the Cardiff Capital Region and covers a large geographical area of 278 km2 (107 square miles). It is approximately just over 18.6 miles long and nearly 11 miles wide and runs from the Brecon Beacons National Park in the north, to Cardiff and Newport in the south. It is bordered to the north by Merthyr Tydfil, the west by Rhondda Cynon Taf, and to the east by Blaenau Gwent and Torfaen local authorities. Its health board boundaries are Cwm Taf Health Board and Cardiff & Vale University Health Board. It has a resident population of approximately 181,731 (Mid-Year 2020 Stats Wales). The General Practitioner (GP) registered population is higher than the residency at 187,000 people registered who receive out of hospital/general health and social care from Aneurin Bevan University Health Board (ABUHB), independent contractors, local authority and third sector.

Other areas in Wales refer to Neighbourhood Care Networks (NCNs) as Clusters. Within Caerphilly ABUHB operates across 3 NCN areas, namely, North, South, and East whose purpose is to work across sectors including both public and third sectors to develop and support sustainable services on a local footprint. Across Caerphilly there are key independent contractors that are integral to our health and social care system comprising of 21 GP practices, 43 community pharmacies, 25 dental practices and 19 optometry practices. There are 25 residential/nursing homes, 93 schools (primary & secondary), 39 community centres, 18 libraries within the borough. A snapshot at the end of January 2023 showed that Caerphilly currently had 14 providers who gave domiciliary care for 751 people with a total allocation of 5351 hours (average 7 hours per person).

Population Needs:

There are a number of needs that are evident from both a national, regional, and local perspective that are well documented and reported via various policy documents and media methods. The increased numbers in our older population with multiple morbities requires us to change the way in which we provide our services and to ensure where appropriate they are cared for at home with relevant services, thus reducing demand on our hospital services. The redesign of older persons services and the embedding of integrated teams to support people in the community who are at risk of deterioration in their long-term health conditions is a priority for us and the aim is to be able to provide care 24 hours a day, every day in or as close to home as possible. The need to work across generational boundaries to respond to current need whilst also undertaking preventative measures is essential to ensure we have resilient communities and sustainable services.

Our NCNs will be key in the deliverables outlined in this plan and have their own Integrated Medium-Term Plan (IMTP) for their areas which are refreshed annually. The NCN IMTPs include some locally produced population needs information whilst awaiting further analysis of need on a regional level via the Regional Partnership Needs Analysis which when available will be referenced within the Caerphilly plan. Key population need across the health, social and wellbeing agendas include:

- Recognising the impact that the pandemic has had on our local communities and the potential deconditioning of members of our populations.
- Progressing service recovery from the impact of the pandemic and improve areas where there has been delays in the provision of care.
- Addressing the significant growth in demand for health and social care services including:
  - Access to health services across primary and secondary care.
  - Nursing home care for older people.
  - Domiciliary care to support people in their own homes.
  - Residential and nursing care for people with learning disabilities.
  - Independent sector residential care for children.
- Responding to the increased demand for health and social care for our aging population, who have complex needs.
- Potential impacts that current cost of living pressures will have on local populations and how this will affect the daily health and wellbeing of people and communities.
- Identifying and addressing the mental health needs of the local populations and work with communities to improve their mental wellbeing to develop more resilient communities.
- A particular focus to preventative agendas which in the short, medium, and longer term will bring benefits. From a health perspective this will include vaccination and screening programmes and services to promote healthier lifestyles.

There are multiple strategic drivers within Wales with the key plan being Welsh Government's plan for health and social care in Wales: 'A Healthier Wales', which includes a number of models which will support better outcomes for all in Wales. One key model is the broader Primary Care Model for Wales and putting what matters to people at the heart of this model will make sure the right care is available at the right time from the right source, at home or nearby. The model focuses on:

- Service developments based on demand; planning and transformation which is led through coordinated local care teams.
- The promotion of healthy living by making well-being less of a medicalised term.
- Service planning and delivery across local communities.
- A more preventative, pro-active, and coordinated care system which includes general practice and a range of services for communities.
- A whole system approach that integrates health, local authority, and voluntary sector services, and is facilitated by collaboration and consultation.
- Care that includes physical, mental & emotional well-being, linked to healthy lifestyle choices.
- Integrated and effective 24/7 care with priority for the sickest people during out-of-hours.
- Creating stronger communities by empowering people and giving them access to a range of assets, ranging from access to debt and housing advice, to social prescriptions for gardening clubs and the leisure centres.
- Advice/support to help people remain healthy, with easy access to local services when needed.
- Strong and professional leadership across sectors and agencies to drive quality improvement.
- Technological solutions to improve access to information, advice, care, and to support self-care.

It is key that we keep an informed public and explain services and their benefits in order to gain success as well as educate and empower people to take ownership of their own health. When people understand the importance of self-responsibility, they are more likely to adopt habits that maximise their health and well-being. The following will enable and assist to take this forward:

- Communication strategies that will focus on care to promote new models and service developments to both the public and professionals.
- Empowered Communities encouraging people to make informed choices with help of their local care team, including them in the design of services and using feedback on user experiences. Local champions can share positive experiences of health/community care and interviewing, and coaching techniques are usually effective in motivating people to change their habits.
- Support for well-being, prevention, and self-care as it is identified that when people and carers are able to make decisions about their treatment, they are more likely to practise self-care and take responsibility for their health. There are also local resources available to promote self-care and self-referral, and technology can help with monitoring, self-care, and communication.
- Healthcare professionals can now refer to a greater range of services, which provide up-to-date information and advice on health and well-being. These must be easily accessible, easy to maintain and meet the needs of the community. People will be able to talk to their health teams in a range of ways – by phone, email or video call – to help decide on the best treatment for them.
- Seamless working for staff across departments, this increases efficiency and ensures the community can access clinical, social and managerial expertise. Coordinated teams include professionals like pharmacists, physiotherapists, social workers, paramedics, physicians' associates, occupational therapists, mental health counsellors, dieticians, third sector workers and other local authority staff, who manage the everyday needs of the local population. Coordinated teams / multi-disciplinary teams break down barriers within health and social care systems to promote seamless working and cultural change, which will ultimately benefit the community.
- Effective telephone systems are designed to direct people to the most appropriate professional or service. Telephone advice is appropriate for many people's needs and, if given by a suitably

experienced professional, can safely and effectively reduce the number of face-to-face consultations. This model assesses the urgency of the need, can direct people to the best service for them I.e. Care Navigation directing people to other professionals including optometrists, dentists who can manage eye, tooth and oral health problems; community pharmacists who can treat common ailments and deal with medication-related problems; and physiotherapists who can manage musculoskeletal problems; non-clinical services with referrals assisted by link workers or teams that provide non-medical support.

- Out-of-Hours Care, the 111 service manages people with urgent needs in the out-of-hours period. The systems enable professional teams to have access to up-to-date clinical records, which is essential so people receive appropriate care, especially those with complex conditions and/or at the end of life. The 111 service is supported by a national virtual directory of services and also signposts people to local services and sources of help at any time of the day.
- Directly accessed services will provide access to a range of local health services including community pharmacists for advice and treatment (Common Ailment Scheme); optometrists for advice and treatment of routine and urgent eye problems (WECs); dentists for toothache and oral health; physiotherapists for musculoskeletal problems; and audiologists for hearing problems.
- Integrated care for people with multiple care needs means GPs and advanced practitioners have more time to care for complex cases, who are often elderly with more than one illness, at home or in the community. This usually incurs longer consultation times to assess, plan and coordinate anticipatory care. People with both health and social care needs can be supported by uninterrupted care from community resource teams and other integrated teams.
- Welfare, housing, and employment problems can be better managed through a whole system, multi-professional approach. Coordinated teams are well placed to care for acutely ill people who can be treated at home and at community centres. These community teams can also facilitate a faster discharge from hospital. This offers a more proactive/preventative approach to care, and when people are treated earlier, they respond better to advice and support for selfcare resulting in better outcomes and experiences for them. This also potentially offers a wider range of planned care for the community, including outpatient appointments, treatments, and diagnostic tests.
- Caerphilly Cares provides opportunities to engage with residents, providing support at the earliest point and ensuring support is joined up. This is a central gateway for Caerphilly residents which ensures people are able to receive the right support, in the right place at the right time. Caerphilly Cares understands the variety of need an individual may face (focussing on early intervention), provides advice, support and signposts to internal and external community support. This service/programme empowers and builds on community resource as well as enables people to become more resilient and live as independently as possible.

In order to support transformation, The Primary Care Model for Wales must be supported by effectively designed infrastructure designed for enhanced multi-professional working. Local facilities and data systems must be flexible and responsive to future changes and support multi-professional working. People should be encouraged to use digital options to seek and receive care, while providing departments with direct access to services in the community that can deliver quality care closer to home. This will enable the outcome of the model to improve health and well-being, build stronger communities as well as improving the morale, motivation, and well-being for our staff with the aim to increase recruitment and retention of staff and ultimately provide longer lasting models of care.

Caerphilly County Borough Council is currently drafting its corporate plan for the period 2023-2028. Caerphilly NCN Management Team are working closely with the policy officers within the council to ensure that the ISPB plan compliments their corporate plan and that there is minimal duplication with joint actions and outcomes aligned and agreed.

Challenges & Opportunities:

There are, and will continue to be, challenges to achieve the aims of this plan and will need the ISPB and local teams to find solutions and respond to address these: -

- Any wave of a new vaccine resistant variant of Covid that necessitated further lockdown type restrictions would hinder operational delivery and ongoing recovery of health and social care provision. The rules/ guidance around staff self-isolation will also result in reduction of workforce resulting in additional pressure on our clinical and social care teams.
- The ongoing sustainability of all health and social care services on an operational level is paramount and although prioritised we have high levels of recruitment and retention difficulties which impacts on delivery. Key areas most notably being domiciliary care providers but also to a high degree in relation to GPs, paramedics, pharmacists, nurses, social workers etc.
- Recruitment particularly to short, fixed term/secondment roles can result in roles not being filled or not receiving applications from most suitable candidates. Funding cycle arrangements must exist to be able to overcome this and to ensure we have sufficient and skilled staff to deliver care.
- The high level of waiting times across the NHS in Wales will impact on an individual's health, wellbeing, and outcomes.
- The number of monthly reported Pathway of Care Delays are significant within Caerphilly and evidence the urgent need to address the pressures across the system, most notably in the ability to provide domiciliary care.
- The well reported / documented cost of living pressures will impact on the wellbeing of people and is likely to increase demand across health and social care.
- Medicines shortages and supply challenges remain a key challenge for our community pharmacy and GP practice contractors, increasing workload and delays to accessing medication. Implementing the actions detailed in the Review of Dispensing Volumes in Community Pharmacies through collaborative working, including increasing prescribing intervals, will help mitigate these challenges at a local level. National processes need to be assured for the supply of medication into the UK and onward to our populations.
- The delivery of the Digital Medicines Transformation Portfolio, specifically the Primary care Electronic Prescription Service, will have the potential to reduce workload within our primary care contractor teams and improve patient safety and access to medication. The roll-out of the programme will result in significant business change across the contractor network and the NCN will need to support the change locally with national direction and associated resources.
- Delivery of the Accelerated Cluster Development (ACD) programme will be dependent on the success of the transition year and more robust governance and delivery frameworks for the borough. The collaborative engagement and contractual delays will impact on this.

Opportunities:

There are always opportunities we can take that will improve the way in which we plan and provide our services. In particular in the next year the ACD/NCN development programme and the ISPB opportunities include:

- Provide greater leadership across our services with better collaboration between partner organisations to identify and meet the needs of the local population.
- Support and influence the development an Integrated Workforce Plan which reflects both the local sustainability of services and the ambitions of the borough.
- Identify service pathway gaps, barriers and opportunities articulated by clusters/ professional collaboratives and Local Authorities
- Undertake Integrated Planning based on detailed assessment of needs and operational plans which set common ambitions between partners for integrated service delivery.

- To work together to support sustainable resources for health and social care service providers to effectively meet the needs of the population.
- To implement the Redesign of Older Persons programme to better meet the needs of our residents and to provide care in, or as close to, home as possible.
- To align and jointly commission a suite of services from organisations that can deliver innovative, outcomes-based services, based upon need.
- To enable delivery of services to realise the objectives and actions outlined in this plan
- To create a culture which motivates all partners within the borough to use an innovative approach and intelligence to drive continuous improvements in the provision of integrated services.
- To ensure continuous engagement with local communities on the work of the ISPB and how it is meeting local needs.

Chapter 2- Place Based Care / Care Closer to Home Caerphilly

Place Based Care and Care Closer to Home have a number of distinct differences yet are very similar in what they are aiming to achieve and as such go hand in hand whilst planning and implementing services locally. The table of some of the key defining elements is given below: -

* Place Based Care	**Care Closer to Home
• The initiative commenced directly within the community.	• The intention is to create even better care locally, with support and treatment available across a range of community-based services.
• It is enabled, rather than run, by the health board in partnership with other organisations.	• 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.
• A group is formed that directs the initiative and has an active reporting structure to the wider community.	
• Authority has been provided entirely to the organising group.	• The initiative may be provided in consultation with the public but was not started in the community.
• A transfer of resource and funding (or agreed budget) has been provided to the organising committee.	• Other partners may be involved however it may be just a HB initiative

**References include Kings Fund, PHE, PHW* ***References – WG, A Healthier Wales*

The geographical borough of Caerphilly is large and of variable deprivation and services will need to be multifaceted to be centred on the people and their community but on an identifiable geographical area. This will ensure that the agreed "places" are best equipped to design, develop, and implement services that will improve communities within the defined place resulting in better outcomes for individuals.

On review of pre-existing arrangements, it is evident that the "places" within stakeholders differs and is a complex area and it is impossible to realign to be the same as a whole. Going forward the ISPB will review on a workstream-by-workstream basis to be able to collaborate and align wherever possible.

From a health perspective the vast majority of contact with our patients is in primary care so having robust and sustainable local primary and community services will be crucial and over recent years

work has been ongoing to align our services on to provide care as close to where people live and also to support communities to become resilient through development of place-based initiatives. This is where participatory budgeting will be of benefit to enable local groups/communities to develop and sustain initiatives locally.

The diagram below shows the borough split into the three agreed neighbourhood care network (cluster) areas, namely North, East, and South. These are then further divided in to eight "places". The small white dots represent a main GP practice site. The map below shading indicates levels of deprivation (the darker the shade the greater the deprivation).

Caerphilly North NCN (x3)

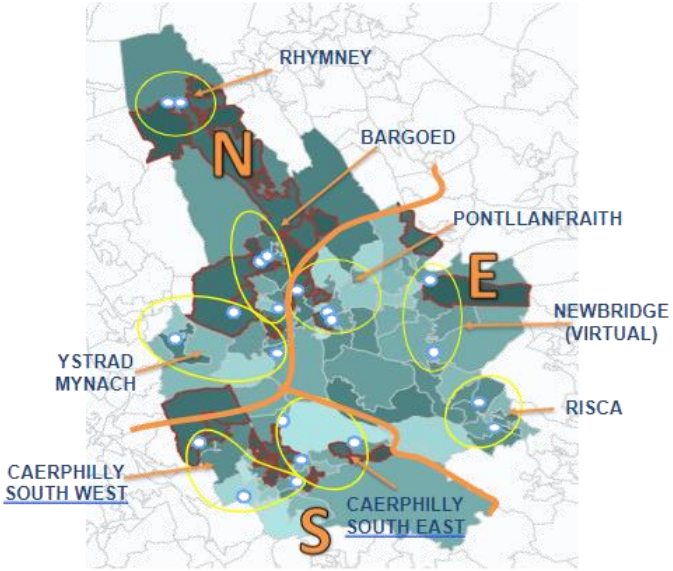
- Rhymney
- Bargoed
- Ystrad Mynach

Caerphilly East NCN (x3)

- Pontllanfraith
- Newbridge
- Risca

Caerphilly South NCN (x2)

- Caerphilly Southeast
- Caerphilly Southwest

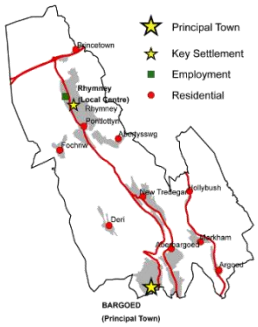


The maturity of some of the places is variable across the borough but all will require investment in ensuring the aims of delivery of services at a local level.

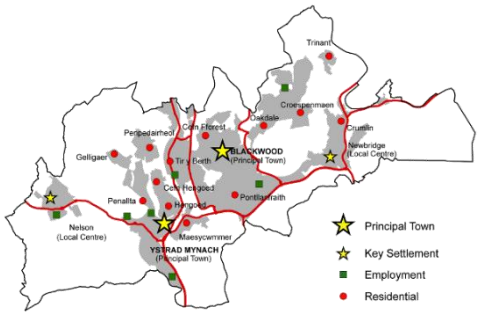
From a local authority perspective there are several defined geographical splits which align to the varying elements of the organisation. For the purpose of the Local Development Plan the borough is split into 3 defined strategic areas which each have their own master plans, namely Strategy Area 1: Heads of the Valleys Regeneration Area (HOVRA), Strategy Area 2: Northern Connections Corridor (NCC) and Strategy Area 3: Southern Connections Corridor (SCC).

Please see diagrams below of these areas.

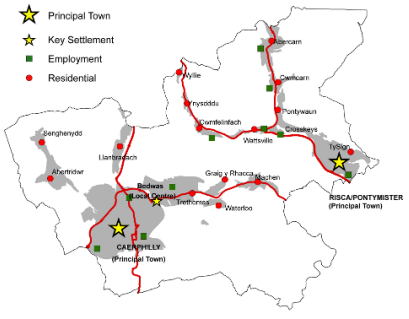
Strategy Area 1: HOVRA



Strategy Area 2: NCC



Strategy Area 3: SCC



For the purposes of this plan, it is written from an NCN footprint perspective as this is the ideal model for the local implementation of work areas in relation to health and social care.

CAERPHILLY NORTH

Caerphilly North has a GP practice population of 63,965 and covers the electoral wards of Twyn Carno, Moriah, Darren Valley, New Tredegar, Pontlottyn, Bargoed, Aberbargoed, Gilfach, St Catwg, Nelson, Ystrad Mynach, Hengoed and Maesycwmmer. The three "Place Based" are Rhymney, Bargoed and Ystrad Mynach.

The area has good road and rail transport links with some areas having easy access to the A470 and Heads of the Valleys and some areas are only a short distance from Merthyr Tydfil which brings opportunity for work and social links.

There are high areas of deprivation within Caerphilly North with particular note of the areas within Twyn Carno, Moriah, Darren Valley, New Tredegar, Bargoed, Aberbargoed and Hengoed.

The proportion of the population aged 65 years and over was 16.6% for the area as a whole, slightly higher than the borough average of 16.5% and lower than the Wales average of 18.3%. The proportion ranged from 12.2% in Hengoed ward to 21.5% in Gilfach ward. The proportion of males aged 16-74 years who were long-term sick or disabled was higher in 12 out of 13 wards than the Wales average of 6.5% and higher than the county borough average of 8.6% in eight out of thirteen wards in the community area –The proportion ranged from (5.2%) in Ystrad Mynach ward to (16.2%) in Twyn Carno ward, with an average for the community area as a whole of 10.5%. The proportion of females aged 16-74 years who were long-term sick or disabled was higher than the county borough average of 7.8% in nine of the thirteen wards in the community area. Only 3 wards, Nelson, Ystrad Mynach and Maesycwmmer were level with the Wales average of 6.0%. The proportion ranged from 6.0% in Nelson, Ystrad Mynach and Maesycwmmer wards to 11.9% in Twyn Carno ward, with an average for the community area as a whole of 9.5%.

Place: Rhymney

To the very north of Caerphilly borough which borders with Rhondda Cynon Taf Local Authority / Cwm Taf Health Board and is an area of high deprivation. People living in this area often cross the border to receive services, most notably from Prince Charles Hospital which is easier for them to access via road and public transport.

Rhymney is the local centre for HOVRA and it has the potential to provide a tourism gateway into the County Borough from the Heads of the Valleys area and further afield. Centrally located in terms of the HOVRA it is uniquely placed to help change the perception of the subregion through enhancing the visitor and tourism role the area has to offer, by for example the development of the Valleys Regional Park. There are countryside recreation facilities in the area, which, together with the strategic cycle routes and footpaths that run throughout the area, contribute to the considerable potential for enjoyment of the rural environment that Rhymney has to offer.

Rhymney Integrated Health & Social Care Centre (RIHSCC) located on Lawn Industrial Estate that opened in December 2013 hosts a number of health and social care services who work in a more collaborative way to provide services. The site consists of two GP practices, a dentist, an optician, and a pharmacy. On the lower ground floor there is a 12 bedded in patient unit (Redwood Suite) that can take direct admissions from Caerphilly GPs and also provide rehabilitation and reablement services to ensure individuals meet their potentials to remain independent. There is an onsite social services day centre which as well as residents within the community attending can be accessed by inpatients from Redwood Suite. On the ground floor there are a number of consulting/meeting rooms from which community and outpatient clinics are held.

Place: Bargoed

Set within the Caerphilly North NCN area and is an area of high deprivation. Bargoed is the principal town in the HOVRA. As the main town, Bargoed provides a range of functions and services that are not available elsewhere in the Caerphilly part of the Heads of the Valleys area. The importance of the town is recognised by the Heads of the Valleys programme and Welsh Government who invested in the 'Angel Way' Relief Road which improved the accessibility and attractiveness of the town and supports public and private investment into Bargoed Town Centre.

It is recognised that the majority of 3rd sector and local authority wrap around services operate out of facilities within the Bargoed Town centre and the surrounding area with good public transport access. Therefore this "place" would need to operate on a hub and spoke model. There is some expansion space within Bryntirion Surgery but the location does not lend itself to being a fully integrated site with LA partners.

There are a number of sustainability concerns for clinical services with recruitment and retention to the area proving difficult. The health board were necessitated to take on the management of a previously independent GP practice and this arrangement continues to operate with the eventual aim to make it independently viable again.

Place: Ystrad Mynach

Set within the North of the borough but from a local authority perspective is identified within their LDP as the Northern Connections Corridor (NCC) area and has an associated town centre regeneration strategy. It is important developments in this area are considered through the ISPB to ensure that any opportunity to work collaboratively is sought.

Ystrad Mynach is a key area with the potential to connect the most deprived parts of the County Borough in the north with economic, leisure and cultural opportunities offered in the Mid Valleys area and in the south of the County Borough.

There are varying elements of demography with some experiencing greater poverty than others. The Nelson area borders with Cwm Taf / RCT areas and cross border issues can complicate provision of services in this area.

Ystrad Mynach is well served in terms of the transportation network being located along the main Rhymney to Cardiff railway line, complemented by a park and ride facility. It is strategically located at the intersection of the A469 and A472 road corridors. Given its strategic location, the town has become the location for a number of vital public services including a college of further education and an area police station. It's the main centre for local government with their headquarters building being located at Tredomen. Ystrad Mynach hosts the local general hospital (Ysbyty Ystrad Fawr) which serves the whole of the County Borough. The presence of all these major services means that Ystrad Mynach is also a significant employment centre for our population.

Within this identified area there is considerable housing development outlined within the local development plan that will have implications across a number of health, social and educational sectors. There is increasing need to respond to ensure that sustainable services can operate from fit for purpose estate.

There are 3 identified GP practices within this "place", the largest of which is constrained by the building in which they operate and there are also sustainability concerns in relation to the staffing infrastructure across the practices within the Ystrad Mynach area.

CAERPHILLY EAST

Caerphilly East from a health perspective combines elements of the NCC and SCC from the LA perspective. For the purposes of this plan, it is written from an NCN footprint of Caerphilly East. As already highlighted above the non-alignment of strategic areas is identified as a gap that requires attention.

Caerphilly East NCN has a practice population of 67,411 and consists of the electoral wards of Abercarn, Argoed, Blackwood, Cefn Fforest, Crosskeys, Crumlin, Newbridge, Pengam, Penmaen, Pontllanfraith, Risca East, Risca West and Ynysddu. The three "Place Based" areas as outlined in this plan are Pontllanfraith, Risca and Newbridge.

The NCN has good road and rail transport links with some areas having easy access to the M4 and some areas are only a short distance from Newport which brings opportunity for good work and social links. There are varying areas of deprivation within Caerphilly East NCN. The areas within Caerphilly East indicated as having higher levels of deprivation include areas of Newbridge and Risca.

The proportion of the population aged 65 years and over was 17.3% for the community area as a whole, higher than the county borough average of 16.5% and lower than the Wales average of 18.3%. The proportion ranged from 11% in Argoed ward to 20.5% in Crosskeys ward.

The proportion of males aged 16-74 years who were long-term sick or disabled was higher than the county borough average of 8.6% in five wards in the community area – Cefn Fforest ward (12.8%), Argoed ward (10.7%), Pengam ward (9.2%), Crosskeys ward (9.1%) and Ynysddu ward (8.9%). Every ward apart from Blackwood ward (5.9%) and Penmaen ward (6.5%) had a higher proportion than the Wales average of 6.5%. The proportion ranged from 5.9% in Blackwood ward to 12.8% in Cefn Fforest ward, with an average for the community area as a whole of 7.7%.

The proportion of females aged 16-74 years who were long-term sick or disabled was higher than the county borough average of 7.8% in three wards in the community area – Cefn Fforest ward (10%), Pengam ward (8.8%) and Argoed ward (8.6%). All wards in the community had higher proportions than the Wales average of 6.0%. The proportion ranged from 6.1% in Penmaen ward to 10% in Cefn Forest ward, with an average for the community area as a whole of 7.6%.

Unhealthy behaviours are predictors of mortality and morbidity. Caerphilly East does not have particularly high rates for smoking and low physical activity in comparison to other NCNs. Obesity rates are reasonably high. Following a large engagement event and discussion at NCN meetings, members of the NCN continue to be keen to address smoking rates and also to address rates of obesity and low physical activity together with other partners including community pharmacies.

Caerphilly East NCN has always tried to maximize uptake of preventative services. There is scope for further improving uptake of childhood immunizations, influenza immunizations and screening services.

Place: Pontllanfraith

Pontllanfraith is very close to the LA principal town of Blackwood. Blackwood has experienced significant levels of public and private investment in recent years with the development of substantial new retail units in both the north and south of the town. It is critical to the success of the NCC in servicing the needs of the population in the immediate and wider area including the Heads of the Valleys Regeneration Area.

Pontllanfraith Health Centre is a site that accommodates one GP practice as well other health board services and shares its car parking with Avicenna Medical Centre. Plans have been drafted to update the site which would result in the ability to further develop and introduce additional place-based services including health, social care and third sector provision. There is a bid currently submitted for capital funding with Welsh Government for this development.

Place: Newbridge

From a health perspective this place is "virtual" with no physical hub. It was developed to enable clinically aligned services to be allocated on a smaller population basis across the Newbridge and Risca areas.

Place: Risca

This place is aligned from a health perspective to two GP practices, namely Risca Surgery and Wellspring Medical Centre. The health board has a site at Risca Health Centre that offers community-based interventions.

Local authority are currently progressing plans in relation to the former Ty Darran site which will see the development of a new facility including sheltered housing accommodation, flexible communal and outdoor spaces offering increased opportunities to improve tenants' health and wellbeing.

CAERPHILLY SOUTH NCN

Caerphilly South NCN has a practice population of 56,259 and consists of the electoral wards of Aber Valley, Bedwas Trethomas and Machen, Llanbradach, Morgan Jones, Penyrheol, St James and St Martins. The two "Place Based" areas as outlined in this plan are Caerphilly Southeast and Caerphilly Southwest. The associated Local Authority area is the SCC and there is a regeneration strategy the covers "Caerphilly Basin".

The NCN has good road and rail transport links with some areas having easy access to the M4 and some areas are only a short distance from Cardiff which brings opportunity for good work and social links.

There are varying areas of deprivation within Caerphilly South NCN. The areas within Caerphilly South indicated as having higher levels of deprivation include Lansbury Park, Graig Y Rhacca, elements of Penyrheol and Aber Valley.

The cluster has 6 GP practices with some of these having branch surgeries also. These are Aber Medical Centre, Courthouse Medical Centre, Nantgarw Rd Medical Centre, Tonyfelin Medical Centre, Ty Bryn Surgery and The Village Surgery.

The proportion of the population aged 65 years plus was 15.5% for the community area as a whole, lower than the county average of 16.5% and lower than the Wales average of 18.3%. The proportion ranged from 12.8% in Aber Valley ward to 17.6% in St Martins ward.

The proportion of males aged 16-74 years who were long-term sick or disabled was higher than the county borough average of 8.6% in two out of seven wards in the community area – Penyrheol ward (11.6%) and Aber Valley ward (9.4%). Every ward apart from St Martin's ward (4.4%) had a higher proportion than the Wales average of 6.5%. The proportion ranged from 4.4% in St Martins ward to 11.6% in Penyrheol ward, with an average for the community area as a whole of 7.6%.

The proportion of females aged 16-74 years who were long-term sick or disabled was higher than the county borough average of 7.8% in three of the seven wards in the community area – St James ward (9.9%), Aber Valley ward (9.1%) and Llanbradach ward (8.2%). Only St Martin's ward (3.4%) and a percentage lower than the Wales average of 6.0%. The proportion ranged from 3.4% in St Martins ward to 9.9% in St James ward, with an average for the community area as a whole of 7.2%.

Place: Caerphilly Southeast

This area covers the east side of the Caerphilly "basin" and borders with Newport to the east and Cardiff to the South. It has three aligned GP practices, namely Courthouse, Ty Bryn and Village surgeries. The local areas and populations these practices serve vary in terms of deprivation. The general practice estate infrastructure for this area is very good and there are no obvious sustainability concerns for these.

There is a health board building in Trethomas which was constructed in the 1970s which has over the last few years be reviewed and developed as a clinical hub offering a broader range of services. Plans have been drafted to update the site which would result in the ability to further develop and introduce additional place-based services including health, social care and third sector provision. There is a bid currently submitted for capital funding with Welsh Government for this development.

Place: Caerphilly Southwest

This area covers the west side of the Caerphilly "basin" which borders with Cardiff to the south and Rhondda Cynon Taf to the west. It has three aligned GP practices, namely Nantgarw Road Medical Centre, Aber Medical and Tonyfelin Surgery. The local population demographic and level of deprivation is variable. The Aber Valley is a key priority area for development to ensure that health, social and third sector services are provided from fit for purpose estate and are sufficiently resourced to ensure residents receive intervention as close to home as possible. The surgery/clinics within both the Abertridwr and Senghenydd areas are very poor and require urgent attention. A bid for capital funding was approved by Gwent Regional Partnership Group in Autumn 2022 and submitted to Welsh Government for consideration.

Chapter 3 - ISPB Priorities

Caerphilly ISPB have agreed the Marmot Principles under which key RPB, PSB and local priorities can be aligned and a table to reflect this is shown as Appendix 1. Using these as a framework will give assurance that as an ISPB we are working in the right direction to meet the needs of our populations as well as addressing the inequalities across the borough. The ISPB will use this approach across the partnership working for future planning, implementation, and evaluation of services.

The ISPB plan will continue to be influenced and refined specifically alongside the RPB and PSB work and plans which are due to be published in Spring 2023.

In addition, a summary table for agreed workstreams and actions is shown as Appendix 2 and this will form the basis for ongoing monitoring and review. The Marmot Principles outlined below give details of the requirement and key priorities: -

Marmot Principle 1:
Giving every child the best start in life

The First 1000 Days research has demonstrated how important these are on the longer-term outcomes for children within our communities and the need to reduce the gap between those most disadvantaged and those not. A key objective outlined in the CCBC corporate plan is to create a model from antenatal to 7 years to meet families' needs at the right time, in the right place, by the right person.

The online platform **Healthier Together** *(https://abbhealthiertogether.cymru.nhs.uk)* was released in Spring 2021 and supports aspects of family life through the stages of maternity, early child health development, health and wellbeing for children and young adults. The health board's IMTP outlines key action areas and how they will measure how well we are doing against these.

There is a need to continue the work to reshape services and processes to achieve a co-ordinated provision for children from birth to seven years of age which since April 2021 has commenced with any requests for support being accessible via the Family Information Service Hub. The funding via the Midwifery and Early Years system brings together a number of key services to undertake this co-ordinated approach to the very youngest in our communities. Going forward service modernisation and improvement to reduce inequality and achieve the best outcomes can only be undertaken with an equitable collaborative approach across sectors.

The key priorities for the ISPB as outlined in Appendix 2 are:

- **Reducing the impact of poverty within early years** - create an antenatal to 7 years model to meet families' needs at the right time, in the right place, by the right person.
- **Good Health in Pregnancy** - Support to stop smoking in pregnancy; Weight management during pregnancy; Ante-natal Education Programme
- **Healthy Child Wales Programme** - Increased support and encouragement of breast feeding for new mothers
- **Childhood Immunisation** - Children's Flu Vaccination Programme

Marmot Principle 2:
Enabling all children, young people, and adults to maximize their capabilities and have control over their lives.

The need to 'improve education opportunities for all' remains a priority outcome with short and longer-term plans required for those currently in education settings as well as future generations. There are a significant number of key areas of attainment outlined in the CCBC corporate plan in relation to education and ensuring the needs of all children are met across a number of settings. It focusses on the skills that children will need to take them on to employment opportunities, traineeship schemes and work experience.

The NEST Framework is a planning tool for Regional Partnership Boards that aims to ensure a 'whole system' approach for developing mental health, well-being and support services for babies, children, young people, parents, carers and their wider families across Wales. The ISPB will need to ensure its aims for cross agency working to focus on helping children of all ages to support their mental health and wellbeing needs at every opportunity.

The key priorities for the ISPB as outlined in Appendix 2 are:

- **Mental Health Resilience in Children and Young adults** - Embed key principles, values and practices that align with the NYTH|NEST Framework.
- **Mental Health & Wellbeing - IRIS (Domestic Violence) -** Increase uptake of training across all GP practices in the borough

- **Support being a Healthy Weight** – Support for the Level 1 Sustainable Food Communities Programme; Obesity Pathway Development; Eating Disorder Services
- **Education Programme for Patients (EPP)** - Provision EPP to improve self-management for patients living with long-term conditions - creating less demand on health and social care services".

Marmot Principle 3:
Creating fair employment and good work for all

An objective within the CCBC corporate plan is enabling people to be ready for work and to help prevent longer term problems that are associated with low skills and lack of employability. CCBC contribute towards resolving issues that affect employment within the local economy.

Employment is still seen as one of the main routes out of poverty (although there is a growing rise of in work poverty) so it is important that we look at ways we can equip people for 'sustainable' and 'well paid' employment.

Education is a key factor in this, outcomes to improve attainment are outlined within the education objectives. CCBC plans are ongoing to improve the education opportunities for all whether in mainstream or alternative educational pathways and supporting learning that enables young and adult employment opportunities including a focus on future skills.

Before employment begins there can be many related support programmes that help to get people in a position in order to be work ready, low level mental health needs, low motivation, lack of confidence and several other factors play a part in getting a person to a position where they are ready to train or write a CV or attend an interview.

Several projects already exist to help grow people's confidence and to give them a voice that puts them in a better state of mind to start looking at employment needs and opportunities.

A key priority for the ISPB is:

- to ensure that individuals are prepared and have good health to be able to commence and sustain themselves with employment.

Marmot Principle 4:
Ensuring a healthy standard of living for all

Caerphilly borough is a prime example of a local authority area which has varying levels of deprivation and inequities. It is documented that people residing in areas of higher deprivation are more likely to suffer ill health and the life expectancy can vary as a result of this. The ongoing legacy of the COVID-19 pandemic continues to impact on local populations and there will be cases where there have been delays in people receiving care that will require additional investment over coming years.

To address inequalities and the impact of the pandemic it will require the collaborative working of stakeholders through effective planning and operational delivery of services. It is imperative that we also work at a very local level and with individuals to encourage them to take ownership of their lifestyle choices which is key to reducing their risk of poor health and potentially a premature death.

In addition, people with complex needs need to be able to access and receive services to support their daily living within their community. This includes: -

- Older People *(inc Dementia)* to: -
  - improve emotional wellbeing for older people by reducing loneliness and social isolation with earlier intervention and community resilience.
  - improve outcomes for people living with dementia and their carers.
  - support older people to live, or return following a period of hospitalisation, to their own homes and communities through early intervention, integrated care models and a whole system approach.
  - mitigate the long-term impact of Covid-19 pandemic through, especially reducing waiting lists and times to access support, appointments, and medical procedures.
- People with Health and Physical Disabilities: -
  - To support disabled people, including sensory impairment, through an all-age approach to live independently in appropriate accommodation and access community-based services, including transport.
  - Ensure people are supported through access to accurate information, assistance and 'rehabilitation' where required.
  - Improve transition across all age groups and support services.
- People with a Learning Disability: -
  - To support people with learning disabilities to live independently with access to early intervention services in the community; and greater public awareness and understanding of people with learning disabilities needs.
- Autism: -
  - Provide more timely diagnosis of Autistic Spectrum Disorder and access to support services and information and advice.
- Sensory Impairment: -
  - Ensure people are supported through access to accurate accessible information, assistance and 'rehabilitation' where required.
  - Many people felt lonely and isolated during the pandemic and highlighted a need for increased opportunities for more accessible social interaction.

The work of the IWN and developing and providing services on a local level will enable communities to have greater engagement and will ensure they meet the needs of that community. Local hubs will be a key development and will mean that people will be able to access a broader range of services closer to where they live.

The work of Caerphilly Cares, as a single point of contact to provide end to end support for Caerphilly residents provides an aim of improving wellbeing and resilience. Caerphilly Cares in partnership with GAVO collaborates and supports a wide range of community and voluntary organisations, recognising the importance they play in building community resilience via:

- Volunteering
- Referrals in and out
- Financial support
- Supporting foodbank/fareshare/community pantries/food networks
- Community organisation/group support

Caerphilly Cares supports:

- Community wellbeing priorities and projects
- Cost of living crisis priorities, projects and future plans
- Community development priorities
- Volunteering priorities and future plans

To be able to achieve this principle it is essential that our workforce is fit for purpose through sufficient resource and skills to provide sustainable services. The ISPB will work with colleagues across sectors to identify gaps and to understand the barriers in recruitment and retention.

The key priorities for the ISPB as outlined in Appendix 2 are:

- **Improving Community Health and Wellbeing**
  - Establishing Locality (hub) based model.
  - Addressing the mental health needs of the local populations and work with communities to improve their mental wellbeing and develop more resilient communities.
- **Full implementation of the IRIS domestic violence Training and support programme**.
- **Urgent Primary Care Centres** - Analysis of demand/capacity to determine the need for further urgent PC care centres.
- **Development of revised service pathways**
- **Workforce wellbeing**
- **Workforce sustainability**
- **Access to services**

Marmot Principle 5:
Creating and developing sustainable places and communities

To achieve sustainable places and communities it is essential that service providers in the areas are also sustainable. The workforce that supports these services need to effective and there is an urgent requirement to address the recruitment and retention difficulties that are being experienced across a number of disciplines in health and social care. Our workforce will need to be able to adapt to work in an agile way using existing and emerging technologies to support their working day and to be able to take service out of more traditional settings into community hubs and venues.

The work of the integrated wellbeing network (IWN) is essential to this principle, they work in a small number of areas within the borough and has laid a good foundation for moving forward. The IWN local team are engaged with all sectors and in particular 3rd sector to offer and sustain services on a local level across all aspects of physical and mental health and social care. They contribute to creating healthy communities by strengthening well-being and resilience, improving population mental well-being and promoting the well-being of the workforce.

The ISPB will continue to work with the IWN to progress the programme objectives: -

- Establish place-based coordination and development of wellbeing resources.
- Identify ways that hubs can be centres for wellbeing resources in the community.
- Develop the wellbeing workforce (people delivering services and support).
- Ensure easy access to wellbeing information and support.

CCBC established the 'Caerphilly Cares' team, which offer a new centralised coordination and response triage service for residents in need of support for issues such as food poverty, debt or rent arrears, isolation, or loneliness. It is accessible via a single point of contact who assist individuals in getting to the root cause of their issue, meaning they will only need to explain their situation once.

The implementation of the accelerated NCN Development Programme is one way that will drive the health and social care agenda on a local footprint. Caerphilly is in the process of establishing its collaborative groups and associated frameworks and this will be led via the ISPB with some programme direction from the central development team.

The key priorities for the ISPB as outlined in Appendix 2 are:

- **Implementation of the NCN (ACD) Development Programme**
- **IWN Work programme**
- **Workforce Sustainability**
- **Staff Wellbeing**
- **Digital technologies**
- **Agile and mobile workforce**

Marmot Principle 6:
Strengthening the role and impact of ill-health prevention

The long-term aim is to ensure preventative programmes are in situ and operate successfully thus reducing demand on core services later in life or during seasonal periods where illness prevalence can increase.

The local NCN meetings held have been themed to focus on preventative work streams and in the last year have been on mental health, exercise referral, diabetes, and smoking cessation. An ongoing rolling programme of topical themes will be used to support and give focus to particular topics at appropriate times of the year.

The last few years have been evident of the importance and success of vaccination programmes with the implementation of the COVID vaccination resulting in most of the population being able to return almost completely normal daily living. This and other vaccination programmes are essential to us being able to keep people well and to avoid the need for them to seek interventions across our health and social care services. The ISPB will continue to promote the importance of vaccination and aims to seek improvement in uptake rates. A particular focus will be 2–3-year-old flu vaccination cohort working with colleagues to understand best practice and models to achieve this.

The NCNs in the past have always strived to promote and increase the uptake in all cancer screening programmes including Breast, Bowel & Cervical as this is a key way in which early detection of cancers can and will result in better outcomes. The COVID pandemic has resulted in people being more comfortable with digital platforms and technologies we will explore avenues locally as to how we can use these to promote the importance of taking up the offer of screening.

Work across sectors to address the mental health needs of the local populations and work with communities to improve their mental wellbeing and develop more resilient communities is one way in which we can reduce and prevent ill health.

The health benefits for giving up smoking are well documented but there are other associated benefits that could be used as a motivator too and focus on this is to be considered in 2023-24.

The Diabetes Preventative Programmes is ongoing in the north of the borough whereby health care support staff engage with patients who have a HBA1c in the pre diabetic range. They will provide brief intervention advice and support to patients/carers/families in relation to healthy lifestyle,

nutrition, and weight management. A subsequent follow up appointment is made 12 months later with a further HBA1c. It will extend to all practices within the borough as a rolling programme.

Obesity increases the risks of people becoming unwell and diet and lifestyle choices is an area where the preventative agenda could benefit long term health and reduce the demand on services. The ISPB through the collaborative working within the NCNs will continue to work across all sectors to improve and sustain Tier 0 services to address the obesity issues.

In the next year we will aim to complete the full implementation of the IRISi Training programme. This training equips GPs and practice staff to identify patients affected by domestic violence and abuse and refer them to specialist services, benefiting the patient and saving NHS resources.

To enable people to lead healthier lives we need to ensure that their home is of a good standard and the council are working to deliver adaptations to ensure that where necessary homes are accessible and adapted to meet individual needs. They will also increase the supply of housing by supporting opportunities to bring long-term, empty homes in the private sector back into use and tackle the determinants of poor health and wellbeing by improving housing conditions across sectors.

The key priorities for the ISPB as outlined in Appendix 2 are: –

- Improve & sustain services to tackle obesity.
- Improving Uptake of All Screening Programmes.
- Smoking Cessation.
- Diabetes Prevention Programme.
- Flu/COVID Vaccination Programme Support.
- Address availability, condition & sustainability of homes and provide advice, assistance, or support to help improve people's well-being.

Marmot Principle 7:
Tackle racism, discrimination, and their outcomes

It is essential that people within the borough are treated equally and fairly in every aspect of their daily living and no individual or group of people should be discriminated against or placed at a disadvantage because of their identity or background.

There are a number of regulatory requirements that we will need to acknowledge and meet that will ensure that moving forward as an ISPB we are advancing the equality agenda and putting inclusion at the forefront of what we do. The Equality Act 2010 (Statutory Duties) (Wales) Regulations 2011 outlines links to legislation and regulations covering the Welsh Language Standards and Human Rights issues and how it supports 4 of the 7 aims of Welsh Government's Well-being of Future Generations (Wales) Act 2015; A healthier Wales, A more equal Wales, A Wales of cohesive communities and A Wales of vibrant culture and thriving Welsh language.

ABUHB as an organisation are working very hard to ensure all aspects of its environments and services are offered to be inclusive for its staff, patients, and visitors and that it understands, respects, and supports their needs on an individual basis.

CCBC held a number of engagement events and consulted on their Strategic Equality Plan 2020-2024 which highlighted a number of overarching themes as well as specific issues and barriers in relation to the draft objectives outlined. Despite best efforts there were elements of the community that did not respond including individuals representing local religious groups or the black and minority ethnic community which is something that will need to be improved. Of those responses received a number

of key actions which could be applied across all health and social care service provision were identified and have been included as key areas of focus within the ISPB work plan.

The key priorities for the ISPB as outlined in Appendix 2 are:

- Language Provision - Across all service elements, information should be provided in formats and language choice (including British Sign Language) to ensure that it is accessible to all.
- Ensuring the development of Welsh language remains a priority
- Staff Training - Employees should have equality and diversity training
- Equality Impact Assessments - The need to review and strengthen internal processes for undertaking Equality Impact Assessments

Marmot Principle 8:
Pursue environmental sustainability and health equity together.

CCBC outline in their regeneration strategy that quality of life is the general perception of well-being for our communities and how varying elements can improve this perception. It states –

> *"having access to; good housing; a thriving town with a wide range of community and cultural facilities and services; access to quality green and open space; access to excellent care services, all set in the context of a well-respected and looked after natural and built environment. All have a part to play in creating the right conditions for better health, well-being and greater physical activity. The contribution made by the environment to quality of life and good health cannot be overstated."*

The strategy outlines the need to promote and maximise the benefits of outdoor spaces and country parks and the ISPB will work collaboratively to support the implementation of proposals and schemes to improve the wellbeing of our population.

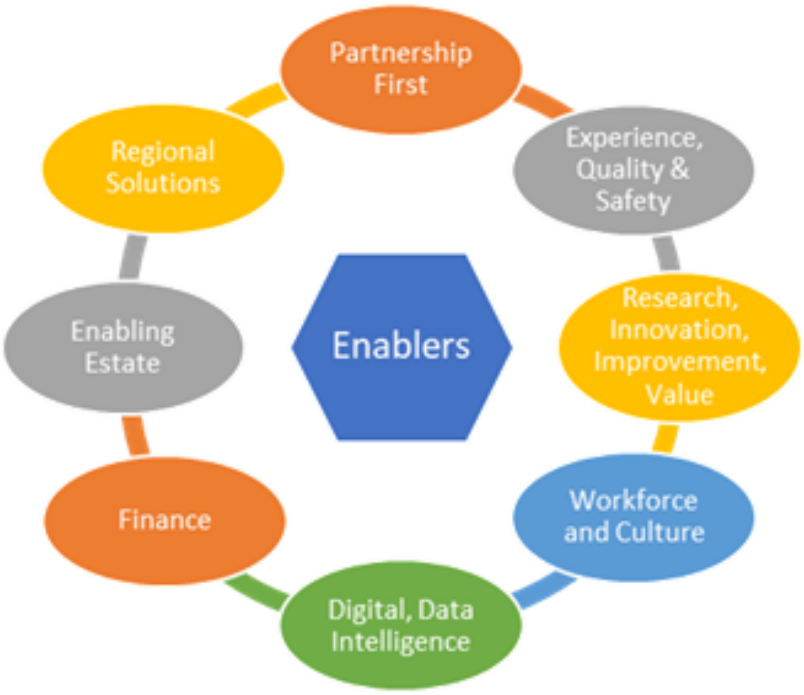
The IWN undertook a Nature Prescribing pilot which enhanced opportunities to support health and wellbeing on a local level which was positively evaluated in Summer 2022. The aim is to continue with the scheme and to implement the recommendations of the evaluation.

The key priorities for the ISPB as outlined in Appendix 2 are:

- Actively support and promote the ongoing as well as the development of new country park events and raising awareness that outdoor recreational activity and its benefits for physical and mental health and wellbeing.
- Increase the level of outdoor recreation and leisure facilities to meet future demands and improving access to play/sports pitches.
- Examine feasibility of increasing access to school-based sports facilities outside of school hours.
- Increase provision and quality of useable allotment space throughout the county borough through new provision and minimising unusable space on existing sites.
- Nature prescribing - Mainstream the previously evaluated pilot for provision of low-level wellbeing support in nature/outdoor environments i.e. nature prescribing in association with IWN and third sector.

Chapter 4-Enabling Delivery

There are a number of models and plans that can be used to demonstrate how any plan can be implemented and demonstrate the key enablers for this.



ABUHB in its IMTP (2022-25) gave the diagram opposite that shows the enablers key to the success of its plan. Caerphilly ISPB have adopted this format to demonstrate how it will enable as a borough of multiple stakeholders how each element which is essential to success will support the plan deliverables.
To ensure you achieve the aims of the plan it is important to have a framework aimed to capture information and provide assurance on delivery and demonstrate clear outcomes.

The Caerphilly ISPB plan has developed the framework opposite to reflect the Marmot Principles and associated elements and outcomes and will use this for reporting and monitoring purposes.

A reporting template will be developed with key measures for reporting and discussion as a key part of the ISPB agenda.

Partnership First:

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.

Accelerated Cluster/NCN Development - The WG directive to implement the Accelerated Cluster Development programme is seen as key to achieving greater partnership working. Its aim is to meet the cluster population health and social care needs through effective and robust planning and service delivery with 2022/3 is being seen as key transitional year to its implementation.

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.

Locally within Caerphilly the programme will:

- Have an Integrated Service Partnership Board (ISPB) which will deliver the function of the Pan Cluster Planning Groups (PCPG) aligned with national guidance.
- Seek to create sustainable system change through the integration of health and social care services, raising awareness of the benefits and opportunities for improving population outcomes through collaboration and strengthening partnership arrangements.
- Work with the Service improvement Manager (SIM) to support improvements as well as monitoring and evaluation of projects / proven concepts of change.
- Develop business cases and associated adoption/exit strategies and in particular to work towards proven concepts movement to core funding.
- Implement and innovate projects which are relevant to our population in order to improve outcomes for all our residents, reducing the impact of on the day demand.
- SIM will support the local collaborative leads and assist with empowering the collaboratives.
- Further progress the development of place-based care and services offered from strategically located “hubs.”
- Ensure full NCN/Cluster collaboration to meet population needs and maintain local voice.

- IWN local team engaged to deliver care and support ACD to our citizens. We will contribute to creating healthy communities by:
  - Promote the well-being of the workforce across Gwent.
  - Strengthening community well-being and resilience
  - Improving population mental well-being
- Work with our Integrated Wellbeing Network manager and colleagues in 3rd sector to offer and sustain services on a local level across all aspects of physical and mental health and social care.

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 sharing best practice. The divisional forums sit within an organisational structure to support quality and patient safety.

The ISPB through improved collaborative/integrated planning and provision of services will need to ensure that the experience of interventions our citizens receive are effective and are sustainable both now and into the future.

Research, Innovation, Improvement, Value

The ISPB will engage and support with all aspects of research, innovation, improvement and value across our respective employing organisations. As a university health board ABUHB continuously work to maintain and develop new links to support these key aspects and have introduced AB Connect which brings together teams to facilitate this and to support the transformation of clinical service delivery.

A key aspect of the ACD programme is service development and improvement and each area has aligned service improvement managers to focus on this and who will work with the collaboratives and ISPB to develop proposals and undertake evaluation.

Workforce and Culture

Supporting the Health and Social Care Workforce

As previously outlined within this plan, standing still is not an option and transformation of services to enable effective and sustainable provision in the short, medium, and longer term is essential. This will require all aspects of our workforce resource to be engaged and dynamic to meet the needs of new models of service delivery.

A key action of the ISPB will be to work with colleagues across sectors to understand the barriers in recruitment to essential roles including promotion of working in the local area.

From a health perspective, to achieve a shift of care to out of hospital settings will necessitate sufficient resource who are equipped with the confidence and skills to deliver care in community settings or a patient's own home. The acuity of patients being maintained out of hospital has

increased as well as the demand and this will necessitate us to adapt to a broader professional model to meet their needs.

The vast majority of an individual's contact with health is via their local GP practice. Recruitment to GP roles and health professions has proved difficult and NCNs will work towards achieving the varying models of the broader context of primary care where employment of other professional roles offers an alternative to the first line of contact being the GP. The table below shows the potential general practice workforce modelling options that are currently being considered in order to support workforce sustainability and future service planning.

GP and NER Professional Required per Skill Mix		Low Intensity GP requirement per Population	Medium Intensity GP requirement per Population	High Intensity GP requirement per Population
Orthodox Model	1 GP FTE	2,000	1,800	1,600
Partial Skill Mix	1 GP FTE & 1 NERs FTE (1:1)	3,000	2,700	2,400
Full Skill Mix	1 GP FTE & 2 NERs FTE (1:2)	3,600	3,300	3,000

In addition, recruitment to roles such as Psychological Health Practitioners, Health Coaches and Community Connectors will be able to bolster services at a lower level. We will also need to consider the estate requirements / capital project prioritisation as a more diverse skill mix requires greater physical space to run services.

There are significant workforce factors that require attention and a key focus during 2023/24 will be to review the workforce modelling and potential future opportunities across all collaboratives and service areas.

The NCNs also acknowledge the importance of the provision of a local clinical training academy that has over recent years enhanced the pool of available resource. Funding arrangements for the future provision of the academy are under discussion.

NWSSP Certificate of Sponsorship Team have supported GP Practices and individuals to establish Licencing and Sponsorship with the Home Office. Welsh Government have a funded model for GP Practices who wish to establish the right sponsorship as part of their employment of a newly qualified GP which the NCNs will promote and support.

The impact of the pandemic on some aspects of our workforce has been significant and the need to ensure the wellbeing needs of staff are supported where possible. Previously a 6-week pilot of Mindfulness Sessions run by Caerphilly MIND was undertaken but due to the high level of clinical demand on services the ability for staff to attend was difficult. Where funding allows this will be considered as an offer to staff during 2023-24. In addition, a rolling programme of wellbeing events commenced in Caerphilly in December 2022 with plans to hold these 2-3 times per year.

Digital, Data Intelligence

It is evident that digital technologies and tools will improve and enhance a broad number of operational services and the experience of the populations we serve. Improving the skills of both our residents and workforce to use digital solutions will result in greater accessibility to information and better engagement across a broad range of services and information.

The use of digital data and technologies to support and improve Welsh populations is outlined in The Digital Strategy for Wales with 6 key objectives with the expectation for public sector services to work together to improve public services; develop the economy and; reduce inequalities.

Caerphilly Council have a Customer and Digital Strategy document in place which outlines the aim to be a whole system digitally led organisation to ensure improvements in the customer experience and outcome of public services.

"Our Digital Strategy – Transformation through Digital" outlines how ABUHB will make the best use of digital technology to enhance health and care in Gwent alongside enabling staff to deliver holistic care and high-quality services. It will follow four key themes –

- Digital community – Enable people to manage their health and care needs independently wherever possible
- Digital organisation – Enable staff to be equipped to deliver truly holistic care and high-quality services
- Digital data, information and intelligence – Getting the maximum we can from our data and information
- Digital foundations – Provide fast, highly reliable and secure devices, storage and network

All ISPB stakeholder organisations need to be signed up to digital transformation across their respective services and be able to adapt to respond to a dynamically changing environment. With continuous review and updates Caerphilly can be assured they are at the forefront of this and will be able to achieve the transformational agenda outlined in the national digital strategy.

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 within Caerphilly borough.

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. The ISPB has opportunities to look at current budgets (including budget management), individually and jointly with a view in collectively making more robust applications 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 Caerphilly County Borough to make real 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 - 3 NCN budgets Caerphilly North, Caerphilly East and Caerphilly South, the value fluctuates year on year as they're standardly driven by the patient list size as well as the 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 including the CCBC Caerphilly Cares Budget and additional Health, Social Care and Third Sector (ABUHB, CCBC, GAVO, IWN) – review of current budgets and additional opportunities to be sought based on local need.

Enabling Estate

Welsh Government's vision is stated as 'to achieve the best possible health and well-being for all people in Wales, whatever their circumstances, or wherever they live'.

The ISPB vision for primary and community care services is to provide services locally in fit for purpose primary and community care sites offering a broad range of health and social care services. This could be achieved and would change and enhance the individual person/patient experience.

It is essential that services are developed to reflect the unique needs of local communities and that care, when safe and appropriate, will be managed at home or as close to home as possible through integrated health and social care teams working across all sectors.

The large geographical area and high population of Caerphilly are key considerations when planning the integrated "Place Based Care" hub approach. It is recognised that in some areas physical site developments offer an opportunity to progress place-based care, however where estate infrastructure is more difficult a "hub & spoke" model will need to be considered.

The ISPB will consider estate alongside any service development and team/model requirements. There is already a number of key areas identified as high priority across health and local authority with ABUHB identifying the Aber Valley of highest priority, followed by Ystrad Mynach.

Aber Valley:

Currently the Valley is served by two GP practices – the Aber Medical Practice which has its main surgery in Abertridwr with branch surgeries in Llanbradach and Bedwas and Nantgarw Road Medical

Centre which operates its main site in the Castle View area with a branch in the Aber Valley in Senghenydd. In early 2020 both these practices saw an increase in their registered patient cohorts as a result of the Lansbury Surgery closure.

This increase in practice population is adding further pressure to a surgery already constrained by space limitations and the poor condition of the estate. This would be further exacerbated should the Senghenydd branch surgery ever close. There is also a planned additional 200-250 homes in Abertridwr.

There is opportunity to stream-line the primary care services in the Aber Valley, rationalising the primary care estate in a new build that could also accommodate additional health and social care wrap around services as well as linking with the excellent community provision and support that exists in the area.

A number of potential sites have been identified and a capital application to WG was agreed at the regional ICF/RIF meeting in Autumn 2022 and will now move to be prepared as a formal submission for consideration.

Ystrad Mynach:
Within this area there is considerable housing development outlined within the local development plan that will have implications across a number of health, social and educational sectors. There is increasing need to respond to ensure that sustainable services can operate from fit for purpose estate.

Oakfield Street Surgery is at capacity and would within the current infrastructure would not be able to support any further increase in registered list size within its current location. There are a number of practices within the vicinity that pose sustainability concerns and therefore there is a requirement to review the area in a wider context.

Caerphilly Town:
The council has been successful in its bid for a new leisure and wellbeing centre near to the town centre close to Caerphilly Business Park which will replace the existing facilities at Virginia Park. The £20million awarded to fund the scheme has come from central government "Levelling Up" fund. The ISPB will need to work across partners to ensure the scheme is developed to meet the wellbeing needs across health, social and third sector care.

Via the ISPB the relevant partners will be able to review and discuss the estate across the borough and seek to identify opportunities to work better together to both rationalise and develop the infrastructure to deliver care and other services in joint settings as close to where people live.

Regional Solutions

Caerphilly ISPB will continue to work with the Gwent wide RPB and PSB to ensure services, care and support is in place to best meet the needs of their respective population. Caerphilly will work with them to identify and agree schemes and funding mechanisms for delivery particularly in relation to schemes outlined in this plan which will bring benefits to all generations including those with complex needs.

Conclusion

This is the first ISPB plan and has brought together the challenges, opportunities, and strategic aims of a number of other plans across both the health and local authority organisations.

Going forward working as an ISPB through with a more integrated system leadership approach across health and social care we will be able to undertake improved joint needs assessments, planning and service developments focussing on the needs of local populations.

There are a vast number of ongoing workstreams and priorities across services and as an ISPB we will need to initially focus on those where there is greater need to ensure sustainability of our services as well as service developments.

In the year 2023-24 the agreed focus areas are highlighted in the work plan (Appendix 2). For these workstreams the NCN development office has drafted an evaluation template (Appendix 3) and this will be used for each of these areas which will be routinely reported and reviewed through the ISPB agenda. A reporting/forum governance framework has been drafted to give clarity on how all aspects of the plan will move between given groups and forums – see Appendix 4.

A summary "Plan on A Page" is also included on the next page and it provides a very brief overview of our aims, key workstreams, enablers and how we will work together to deliver sustainable services to the people of Caerphilly Borough.

The ISPB aims are to: -

- Provide integrated system leadership
- Provide partnership based detailed assessment of need & plans
- Understand professional assessment of service gaps, barriers and opportunities
- Develop an Integrated Workforce Plan.
- Assess integration maturity across organisations.
- Align/agree commissioning arrangements
- Manage/monitor all Caerphilly Section 33/Part 9 partnership agreements
- Enable delivery of priorities outlined in the ISPB Plan.
- Create a culture which motivates all partners
- Enhance the Integrated Wellbeing Network (IWN)
- To approve and monitor utilisation of specific budgets and explore collaborative opportunities e.g., pooled budgets
- To identify, monitor and seek assurance across partner organisations to ensure the delivery of the priorities outlined in the ISPB Plan.

Delivering Sustainable Care Closer to Home

Caerphilly Integrated Service Partnership Board Plan – 2023-24

What are we doing / going to do?

- Providing easily accessible "place based" health & social care
- Working to ensure services are sustainable.
- Ensuring appropriate utilisation of estate infrastructure.
- Developing service models, pathways, and teams to meet the needs of a diverse population.
- Working across organisations to support staff wellbeing
- Working to ensure we have an agile and mobile workforce equipped with the skills to meet population needs.
- Analysing demand/capacity to determine need for a local Urgent Primary Care Centre
- Implementing the NCN (ACD) Development Programme
- Continuing the Integrated Wellbeing Network work programme
- Supporting the provision of low-level wellbeing support in nature/outdoor environments i.e., nature prescribing in association with IWN and third sector.
- Using data/evidence to inform decision making.
- Using IT/ technology to enhance/improve service delivery.
- Utilising appropriate preventative services to keep people well including flu & COVID immunisation / childhood immunisation / smoking cessation / weight management / exercise schemes.
- Creating antenatal to 7 years model to meet families' needs at the right time, in the right place, by the right person.
- Improving mental health resilience in children / young adults
- Implementing IRIS (Domestic Abuse) training programme.
- Providing Education Programme for Patients (EPP) - to improve self-management with long-term conditions.
- Reducing impact of poverty by supporting people into better employment prospects.
- Investing in new/existing Caerphilly Homes to deliver social value outcomes.

How are we delivering change?

- Work with partners to establish wrap around health and wellbeing services
- Partnership Working in relation to estate prioritisation & rationalisation
- Use of preventative, early opportunity, and self-management approaches
- Caerphilly Integrated Services Partnership Approach
- Use prudent pathways to improve planned care
- Use Multidisciplinary Team to undertake active signposting
- Recruit, train & educate our workforce to ensure needs of population met

"Enablers"

- Partnership First
- Experience, Quality & Safety
- Research, Innovation, Improvement, Value
- Workforce and Culture
- Digital, Data Intelligence
- Finance
- Enabling Estate
- Regional Solutions

How will we know if we have made a difference?

ISPB/NCN Accelerated Development Evaluation Reporting Process

APPENDIX 1: Principle and Priority Alignments

Marmot Principle	ABUHB Priority	CCBC Priority / Objectives	Gwent PSB Objective	Gwent RPB Priorities
Give every child the best start in life	• Every Child has the best start in life. • Getting it right for children and young adult	**Objective 1** Improve education opportunities for all. **Objective 3** Address the availability, condition, and sustainability of homes throughout the county borough and provide advice, assistance, or support to help improve people's well-being. **Objective 5** Creating a county borough that supports a healthy lifestyle in accordance with the Sustainable Development Principle within the Well-being of Future Generations (Wales) Act 2015 **Objective 6** Support citizens to remain independent and improve their well-being	Obj 1: We want to create a fairer, more equitable and inclusive Gwent for all	**Children & Young People:** • To improve outcomes for children and young people with complex needs through earlier intervention, community-based support and placements closer to home. • To ensure good mental health and emotional well-being for children and young people through effective partnership working especially mitigating long term impact of Covid. **Autism:** • Provide more timely diagnosis of Autistic Spectrum Disorder and access to support services and information and advice
Enable all children, young people and adults to maximise their capabilities and have control over their lives	• Every Child has the best start in life. • Getting it right for children and young adult • Adults in Gwent live healthy and age well. • Older Adults are supported to live well and independently. • Dying well as part of life	**Objective 1** Improve education opportunities for all. **Objective 2** Enabling employment. **Objective 3** Address availability, condition & sustainability of homes and provide advice, assistance, or support to help improve people's well-being. **Objective 4** Promote a modern, integrated, & sustainable transport system that increases opportunity, promotes prosperity, and minimises adverse impacts on environment. **Objective 5** Creating a county borough that supports a healthy lifestyle in accordance with the Sustainable Development Principle within the Well-being of Future Generations (Wales) Act 2015 **Objective 6** Support citizens to remain independent and improve their well-being	Obj 1: We want to create a fairer, more equitable and inclusive Gwent for all	

Marmot Principle	ABUHB Priority	CCBC Priority / Objectives	Gwent PSB Objective	Gwent RPB Priorities
Create fair employment and good work for all	• Getting it right for children and young adult • Adults in Gwent live healthy and age well. • Older Adults are supported to live well and independently	**Objective 1** Improve education opportunities for all. **Objective 2** Enabling employment. **Objective 4** Promote a modern, integrated, and sustainable transport system that increases opportunity, promotes prosperity, and minimises the adverse impacts on the environment. **Objective 6** Support citizens to remain independent and improve their well-being	Obj 1: We want to create a fairer, more equitable and inclusive Gwent for all	
Ensure a healthy standard of living for all	• Every Child has the best start in life. • Getting it right for children and young adult • Adults in Gwent live healthy and age well. • Older Adults are supported to live well and independently	**Objective 3** Address availability, condition & sustainability of homes and provide advice, assistance, or support to help improve people's well-being. **Objective 4** Promote a modern, integrated, and sustainable transport system that increases opportunity, promotes prosperity, and minimises the adverse impacts on the environment. **Objective 5** Creating a county borough that supports a healthy lifestyle in accordance with the Sustainable Development Principle within the Well-being of Future Generations (Wales) Act 2015 **Objective 6** Support citizens to remain independent and improve their well-being	Obj 1: We want to create a fairer, more equitable and inclusive Gwent for all Obj 2: We want to create a more climate-aware Gwent, where our environment is valued and protected, ensuring our wellbeing now and for future generations	**Health & Physical Disabilities:** • To support disabled people, including sensory impairment, through an all-age approach to live independently in appropriate accommodation and access community-based services, including transport. • Ensure people are supported through access to accurate information, assistance and 'rehabilitation' where required. • Improve transition across all age groups and support services.

Marmot Principle	ABUHB Priority	CCBC Priority / Objectives	Gwent PSB Objective	Gwent RPB Priorities
Create and develop healthy and sustainable places and communities	• Every Child has the best start in life. • Getting it right for children and young adult • Adults in Gwent live healthy and age well. • Older Adults are supported to live well and independently		Obj 1: We want to create a fairer, more equitable and inclusive Gwent for all	**Mental Health:** • We need to improve emotional well-being and mental health for adults and children through timely early intervention and community support. **Sensory Impairment:** • Ensure people are supported through access to accurate accessible information, assistance and 'rehabilitation' where required. • Many people felt lonely and isolated during the pandemic and highlighted a need for increased opportunities for more accessible social interaction.
Strengthen the role and impact of ill-health prevention	• Every Child has the best start in life. • Getting it right for children and young adult • Adults in Gwent live healthy and age well.	**Objective 1** Improve education opportunities for all. **Objective 3** Address availability, condition & sustainability of homes & provide advice/assistance/ support to help improve people's well-being. **Objective 4** Promote a modern, integrated, and sustainable transport system that increases opportunity, promotes prosperity, and minimises the adverse impacts on the environment.	Obj 1: We want to create a fairer, more equitable and inclusive Gwent for all Obj 2: We want to create a more climate-aware Gwent, where our	

	• Older Adults are supported to live well and independently • Dying well as part of life	**Objective 5** Creating a county borough that supports a healthy lifestyle in accordance with the Sustainable Development Principle within the Well-being of Future Generations (Wales) Act 2015 **Objective 6** Support citizens to remain independent and improve their well-being	environment is valued and protected, ensuring our wellbeing now and for future generations	
Marmot Principle	**ABUHB Priority**	**CCBC Priority / Objectives**	**Gwent PSB Objective**	**Gwent RPB Emerging Priorities**
Create and develop healthy and sustainable places and communities	• Every Child has the best start in life. • Getting it right for children and young adult • Adults in Gwent live healthy and age well. • Older Adults are supported to live well and independently	**Objective 1** Improve education opportunities for all. **Objective 2** Enabling employment. **Objective 3** Address availability, condition & sustainability of homes & provide advice, assistance, or support to help improve people's well-being. **Objective 4** Promote a modern, integrated, and sustainable transport system that increases opportunity, promotes prosperity, and minimises the adverse impacts on the environment. **Objective 5** Creating a county borough that supports a healthy lifestyle in accordance with the Sustainable Development Principle within the Well-being of Future Generations (Wales) Act 2015 **Objective 6** Support citizens to remain independent and improve their well-being	Obj 1: We want to create a fairer, more equitable and inclusive Gwent for all	**Older People inc Dementia** • To improve emotional wellbeing for older people by reducing loneliness and social isolation with earlier intervention and community resilience • To improve outcomes for people living with dementia and their carers • To support older people to live, or return following a period of hospitalisation, to their own homes and communities through early intervention, integrated care models and a whole system approach • To mitigate the long-term impact of Covid-19 pandemic through, especially reducing waiting lists and times to access support,

				appointments and medical procedures **Carers:** • Support unpaid carers to care through flexible respite, access to accurate information, peer to peer support, effective care planning and through increased public understanding. • Improve well-being of young carers and young adult carers and mitigate against the long-term impacts.
Tackle racism, discrimination, and their outcomes	• Every Child has the best start in life. • Getting it right for children & young adults • Adults in Gwent live healthy and age well. • Older Adults are supported to live well and independently. • Dying well as part of life	**Objective 1** Improve education opportunities for all. **Objective 2** Enabling employment. **Objective 5** Creating a county borough that supports a healthy lifestyle in accordance with the Sustainable Development Principle within the Well-being of Future Generations (Wales) Act 2015 **Objective 6** Support citizens to remain independent and improve their well-being	Obj 2: We want to create a more climate-aware Gwent, where our environment is valued and protected, ensuring our wellbeing now and for future generations	**People with a Learning Disability:** • To support people with learning disabilities to live independently with access to early intervention services in the community; and greater public awareness and understanding of people with learning disabilities needs. **Mental Health Outcome:** • Increase understanding and awareness of mental health amongst the public, to

				reduce stigma and help people to seek support earlier.
Marmot Principle	**ABUHB Priority**	**CCBC Priority / Objectives**	**Gwent PSB Objective**	**Gwent RPB Priorities**
Pursue environmental sustainability and health equity together	• Getting it right for children and young adult • Adults in Gwent live healthy and age well. • Older Adults are supported to live well and independently. • Dying well as part of life	**Objective 1** Improve education opportunities for all. **Objective 3** Address the availability, condition, and sustainability of homes throughout the county borough and provide advice, assistance, or support to help improve people's well-being. **Objective 4** Promote a modern, integrated, and sustainable transport system that increases opportunity, promotes prosperity, and minimises the adverse impacts on the environment. **Objective 5** Creating a county borough that supports a healthy lifestyle in accordance with the Sustainable Development Principle within the Well-being of Future Generations (Wales) Act 2015 **Objective 6** Support citizens to remain independent and improve their well-being	Obj 1: We want to create a fairer, more equitable and inclusive Gwent for all Obj 2: We want to create a more climate-aware Gwent, where our environment is valued and protected, ensuring our wellbeing now and for future generations	

APPENDIX 2: Work Plan Action Table

	Workstream	Information/ Detail	Marmot/ RPB/PSB Alignment	Key Priority		
				23-24	24-25	25-26 TBC
Early Years & The Best Start in Life	Reducing the impact of poverty within early years	• Create an antenatal to 7 years model to meet families' needs at the right time, in the right place, by the right person.	MP1	H	H	
	Good Health in Pregnancy	• Support to stop smoking in pregnancy. • Weight management during pregnancy	MP1	M	H	
	Childhood Immunisation	• Children's Immunisation Programme • Flu Vaccination Programme	MP1	H	H	
	Access to Services	• Improve the access to services for key workstreams identified in the RPB priorities, ie Autism, LD and MH Support Services.	MP1	H	H	
	Mental Health Resilience in Children and Young adults	• Embed key principles, values and practices that align with the NYTH|NEST Framework. Link: NEST framework (mental health and wellbeing): introduction | GOV.WALES	MP2	H	H	
Mental Health & Wellbeing	Mental Health & Wellbeing - IRISi (Domestic Violence)	• Full implementation of the IRISi Training and support programme, which enables GPs and practice staff to identify patients affected by domestic violence and abuse and refer them to specialist services. The NCN will work with practices who have to date not been able to implement this and offer support to achieve this.	MP2	H	-	-
	Improving population mental well-being	• Continuation of investment in the Dementia Roadmap	MP4	H	H	
		• Work with colleagues across the NCN footprint to address the mental health needs of the local populations and work with communities to improve their mental wellbeing and develop more resilient communities	MP4	H	H	

		• Improve awareness of and access to self-help support for mental well-being and resilience by integrating and making visible services which build	MP4	H	H	
		• Review the model and funding arrangements for low level mental health support including Psychological Health Practitioners, Community Connectors, and nature/outdoor environment prescribing.	MP4	H	H	
	Nature/Social prescribing	• Mainstream the previously evaluated pilot for provision of low-level wellbeing support in nature/outdoor environments i.e., nature prescribing in association with IWN and third sector. Outdoor Green Spaces Coordinator to be employed to support the programme	MP5 MP8	H	H	
	Maximise the economic benefits of Country Parks	• Actively promote country parks for outdoor activity and their benefits for physical/mental health wellbeing.	MP5 MP8	H	H	
Community Resilience *(incl preventative workstreams)*	Improving Community Health and Wellbeing	• Establishing Locality (hub) based model.	MP4 MP5	H	H	
		• Via the IWN Work programme – Establish place-based coordination and development of wellbeing resources. – Identify ways that hubs can be centres for wellbeing resources in the community. • Ensure easy access to wellbeing information and support.	MP4 MP5	H	H	
	Support being a Healthy Weight	• Continue to work with colleagues across all sectors to improve and sustain services to address obesity issues.	MP2 MP5	H	H	
	Musculoskeletal (MSK) Pathway	• Review and evaluate the first contact physiotherapy service within Caerphilly in line with the community MSK hub approach.	MP4	H		

	Education Programme for Patients (EPP)	• Provision of education programme for patients (EPP) to improve self-management for patients living with long-term conditions.	MP2	H		
	Community Health Coaches *Potential activity (funding dependant)*	Health Coach will provide support/advise on healthy weight; alcohol; exercise; smoking cessation; chronic condition educational programmes. Will reduce demand on GP time which will enable clinicians to focus on more medical needs.	MP2	M		
	Urgent Primary Care Centres / Minor Illness Hub *Potential activity (funding dependant)*	The development of a hub at an identified location within the borough to be run by clinicians such as Advanced Nurse Practitioners, MSK specialists, Paramedics, Prescribing Pharmacists to address same day needs of individuals who are unable to be seen at their own practice due to capacity constraints. Will improve access for GPs by freeing up their time to enable them to see more complex patients.	MP4	M		
	Virtual MDTs *Potential activity (funding dependant)*	Establishment of virtual MDTs which will provide opportunity to discuss individual patients by linking GPs with other practitioners (CRT, DN teams, Social Services, Mental Health etc). Will require a new role of a Coordinator to facilitate the meetings on behalf of the multiple services.	MP4	H	H	
	Care Homes – Clinical In Reach to Support Care Homes *Potential activity (funding dependant)*	Establishment of service to undertake clinical assessment of care home patients. Would work collaboratively with wider community services, ensuring patients receive equitable health care whilst aiming to prevent avoidable hospital admissions of the frail/elderly. Staff will be trained to complete comprehensive geriatric assessments, falls assessments, clinical frailty scoring and undertake clinical interventions, and diagnostics with interpretation of results. Through the appointment of a suitably qualified practitioner medication reviews will be undertaken. In addition would ensure that the team are trained in Advanced Care Planning (ACP) which will enable them to advocate for care home residents, giving them a voice in their future care wishes.	MP5	H	H	

	Improving Uptake of All Screening Programmes	Continue to promote and increase the uptake in all screening programmes (AAA, Breast, Bowel & Cervical)	MP5	H	H	
	Smoking Cessation	To give a particular focus to smoking cessation to bring a number of benefits to the resident/patient.	MP5	H	H	
	Diabetes Prevention Programme	Caerphilly North continued participation in Diabetes Prevention pilot to extend to other practices within cluster.	MP5	H	H	
	Flu/COVID Vaccination Programme Support	Support Flu/COVID vaccination programmes via: - the provision of temporary staff support, to provide increased programme support specifically for vulnerable groups i.e. housebound. - awareness advertising, continue public awareness campaigns via publications. Work with the communication and engagement team to promote the importance and benefits of programmes.	MP5	H	H	
Workforce	Workforce Sustainability	There are significant workforce factors that require attention and a key focus during 2023/24 will be to review the workforce modelling and potential future opportunities across all collaboratives and service areas. Community Connectors/Link Workers – • Agree model and employ additional connectors/link workers to be aligned to GP practices. Will meet with individuals who are struggling with social issues and low-level care and to seek "what matters to them". The connector will assist in identifying any local support or useful opportunities to signpost/introduce the individual to. Aspects could include isolation, loneliness, domestic violence, poverty/finance and how this affects wellbeing. First Contact Physiotherapist (FCP) – • Re-establish F2F appointments within GP practices	MP3 MP4 MP5	H	H	

		• Review the provision in line with Gwent wide MSK community hub model.				
	Workforce Wellbeing	• Improving confidence, knowledge, and skills to enable our workforce to respond to mental distress and support good mental well-being. • Ensure our staff - – have access to NHS stop smoking services – Be supported for active travel. – Be aware of how to access health & wellbeing programmes	MP3 MP4 MP5	H	H	
	Language Provision	• Across all service elements, information should be provided in formats and language choice (including British Sign Language) to ensure that it is accessible to all. • Ensuring the development of Welsh language education provision remains a priority	MP8	M	M	
	Staff Training	• Staff to be equipped with the skills and experience to undertake their roles. • Employees should undertake all necessary mandatory and statutory training. • Staff to have an annual review with view to supporting their wellbeing and career development and aspirations. • Provision of staff training to raise awareness of equalities and Welsh language issues to empower staff to identify and tackle discrimination and stereotyping	MP8	H	H	
Other Priorities	Implementation of the NCN (ACD) Development Programme	• Implement the Accelerated Cluster Development programme to achieve greater partnership working and to meet population needs through effective and robust planning and service delivery. • Create sustainable system change via integration of health and social care services.	MP5	H	H	H

		• Work with the Service improvement Manager (SIM) to support improvements as well as monitoring and evaluation of projects / proven concepts of change. • Develop joint business cases and associated adoption/exit strategies and in particular to work towards proven concepts movement to core funding. • Support the local professional collaboratives development.				
	Digital technologies	Achieve the implementation of the Welsh Community Care Information System (WCCIS) to enable greater health and social care integration Support GP practices to offer digital platforms for patients. • Improve access to GPs for more complex patients. Including - econsult - Patients able to use forms-based service to request GP advice without the need to book an appointment or contact the GP practice face to face or by telephone. • mysurgery app - utilise the App to manage their health and connect with their GP surgery remotely whenever they need to. Provides patients with a central resource at the touch of a button to access their surgery's services and health information using a smartphone or tablet device.	MP5			

APPENDIX 3: Evaluation Template

(pg 1)

<PROJECT NAME>

CAERPHILLY

INTERIM EVALUATION

VERSION <0.0>

<DD/MM/YYYY>

1. PROJECT OVERVIEW

1.1 Project background

Brief description of the challenge/ identified need, intended project delivery model, scope and timescale – lifted from project business case

1.2 Objectives

Identify the key objective(s) and how they link to the key drivers (NCN/ISPB/IMTP/RPB Area Plan)

1.3 Investment

£ and resource and timeline (identify any 'match' funding)

Table 1. *<project>* Annual Allocation of Funding

2017-2018	2018-2019	2019-2020	2020-2021	2021-2022	2022-2023	2023-2024
£xx	£xx	£xx	£xx	£xx	£xx	£xx
					Total Allocation	£xxx

1.4 Measurement strategy

Identify the demonstratable measures of the project – RBA format

Table 2. *<project> RBA* Measurement Framework

How Much?	How Well?	Impact?

2. PROJECT EVALUATION

2.1 Delivery model

Was the model delivered as intended or has the project evolved?

Scalable population for impact/reach

(pg 2)

Table 3. *<project>* Funding Utilisation

Year	Funding Allocation	Actual Spend	Variance	Comment
2017/2018	£xx	£xx	£xx	
2018/2019	£xx	£xx	£xx	
2019/2020	£xx	£xx	£xx	
2020/2021	£xx	£xx	£xx	
2021/2022	£xx	£xx	£xx	
2022/2023	£xx	£xx	£xx	
2023/2024	£xx	£xx	£xx	
Total	£xx	£xx	£xx	

2.3 Project Outcomes

Data analysed and summary presented against the projects measurement strategy, qualitative data (case studies etc)

Given project data, analyse for effectiveness (Individual / System impact, Social Return on Investment, Value For Money etc)

Where possible any comparative projects (alternative projects with same objective but different model)

3. PROJECT SUMMARY

3.1 Summary

Brief summarisation of the project backgrounds, evolution, outcomes

3.2 Risk

Based on the evaluation, identify risk associated with project of ceasing funding eg financial risk, workforce risk, reputational risk etc

Considerations for expanding /upscaling project

3.3 Recommendations

Taking a view of the information collated (objective view – no personal recommendations), provide recommendations/options to be considered for business case development eg revise model take forward / bolster / sustainability planning / Exit strategy

Appendix 4 – Reporting/Meeting Structure Framework