

"Leading a Fulfilled and Healthy Life"

**A Health, Social Care and Wellbeing Strategy for
Newport
2008 – 2011**

DRAFT FOR CONSULTATION



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Local Health Board**
Casnewydd
Newport



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CITY COUNCIL
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Chapter 1. The Purpose of the Health, Social Care and Wellbeing Strategy

The purpose of having a Health, Social Care and Wellbeing Strategy is to set out the joint vision for improving the health, wellbeing and independence of the people of Newport. The Health and Social Care services provided will have an important part to play in improving our health and wellbeing but we also know that other factors play a very big part in whether we achieve the health and happiness that we all desire for ourselves and our families. These factors include:

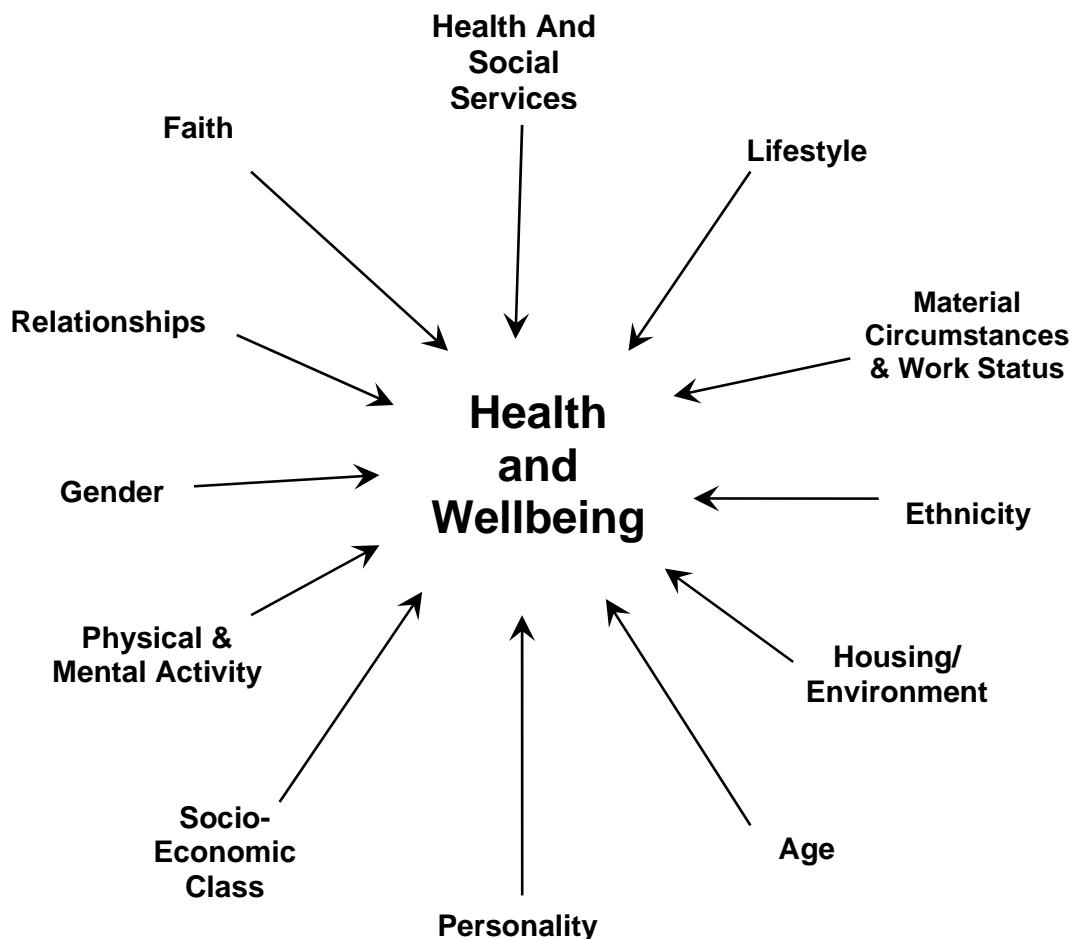


Figure 1: What influences our health and wellbeing?

The Development of the Health, Social Care and Wellbeing Strategy 2008-11

The Welsh Assembly Government requires that Local Health Boards and Councils jointly lead the development of the local Health, Social Care and Wellbeing Strategy. In Newport the development of the strategy is being jointly led by Newport Local Health Board and Newport City Council with partner organisations in the statutory, voluntary and private sectors. The main requirement for the new HSCW Strategy will be that the agreed Strategy:

- Presents a consolidated vision of what the statutory partners with others expect success to look like in March 2011; and
- Acts as the commissioning context for the statutory agents in using their resources jointly to achieve this vision. In order to achieve this, the statutory partners i.e. the Local Health Board and the Local Authority will work together to design, purchase and provide services to meet the objectives of this strategy.

The relationship with the Children and Young People's Plan (CYPP)

The Health, Social Care and Wellbeing Strategy is for everyone living in Newport and so naturally includes all members of families however the Children and Young People's Plan is the detailed plan for the improvement of the health and wellbeing of the children and young people of Newport. This plan is currently being developed and must be formally adopted during July 2008 for publication in September 2008. References to this forthcoming plan will be made throughout this Health, Social Care and Wellbeing Strategy.

Chapter 2. What is our Vision for this Health, Social Care and Wellbeing Strategy?

It is now widely recognised that our wellbeing and health is greatly determined by the circumstances in which we live.

Both health and wellbeing are affected significantly by choices we make. For example, smoking, excessive drinking and drug abuse all seriously undermine our health, and good nutrition, proper rest and sufficient physical activity will enhance our health and sense of wellbeing. Making the right choice may be made easier or harder depending on where and how we live. It will be influenced by our sense of belonging to a community, the quality of our housing, our employment status, relative wealth, working environment, air and water quality and whether we care for others.

The NHS in Wales is being modernised led by the “Designed for Life” principles which aim to produce a world class health service in Wales. Whilst there have and will be many improvements to diagnosis and treatment the living environment can also be improved to promote good health.

In Newport the policy that guides all environmental development is the Unitary Development Plan (UDP) 1996 – 2011. Work is now underway on a new Local Development Plan (LDP) which will replace the UDP in 2011. Connected working and policy integration is one of the five major themes of the LDP process set down by the Welsh Assembly Government.

Example of policy integration with the LDP

The Going for Gold scheme, funded by Newport City Council and Newport Local Health Board, is designed to get people more active, more often. This will need to be endorsed and supported by the local development plan in terms of its overall strategy and aims and in providing adequate open space, green space, leisure and health facilities in order that the citizens of Newport can easily take part in

healthy activities. Equally important to this will be the potential location and designation of cycle ways within the LDP.

In summary the three key factors influencing our health and wellbeing are:

- Our surroundings and environment.
- The way in which we choose to live our life.
- How and when we access health and social care services.

Because of these factors that influence our health and wellbeing this strategy must attempt to address both changes needed to health and social care services and also in the ways in which we lead our lives as individuals. In addition, as statutory agencies we need to consider how best to ensure that other services which impact on health and wellbeing, for example, housing, educational and employment support are designed to maximise their positive impact on health and wellbeing.

The primary purpose of the Health, Social Care and Wellbeing Strategy is to focus on health and wellbeing of the people of Newport. The vision for Newport with regard to the other wider determinants of health such as education, employment and housing can be found in other key strategies / plans which are detailed below:

- Community Strategy 2005-2015
- Children and Young People Plan 2008 – 2011
- Community Safety Strategy
- Local Development Plan
- Local Housing Strategy 2004-2009
- Single Education Plan

The Health, Social Care and Wellbeing Partnership will seek to influence the planning of the other key strategies so as to improve the wider determinants of health and wellbeing in Newport.

2.1 The Route to Health Improvement

In order to ensure that we are all focused on improving the health and wellbeing of the citizens of Newport it is recommended that “The Route to Health Improvement” organisational development package (published by Welsh Local Government Association February 2006) be used as a tool in achieving this. This approach requires the creation of a Corporate Health Improvement Group (CHIG) made up of senior officers in charge of the range of local government services together with the local Director of Public Health. The CHIG is meant to meet quarterly to initially exchange information of activities that contribute to the health of the population and then to go on to coordinate developments effectively.

2.2 Key Challenges

This Health, Social Care and Wellbeing Strategy will therefore concentrate on a number of key challenges:

- How we should encourage, advise and support individuals to take better care of themselves.
- How we should highlight the need for other service areas, for example housing and educational services to be targeted in a way to support the development of better health and wellbeing.
- How we should improve health and social care services to support individuals in preventing ill health or distress, in returning them to good health or wellbeing and in maintaining them in that state.
- How we should address the current pattern of inequality across the City in terms of health and wellbeing and of access to services.

First, however let us consider the current health and wellbeing status of the people of Newport. We have described some of the links between the way we live our lives and our current state of health and wellbeing. The following chapter describes in more detail what our current status is and where we need to improve it.

Chapter 3. Population Health Status – why should we be concerned?

3.1 The population of Newport

Newport is the 8th largest local authority area in Wales and has a resident population of 139,600. After Cardiff, Newport has the second highest proportion in Wales of minority ethnic communities rising from 3.5% in 1991 to over 5% in 2006. The actual population living in the city at any one time will be larger than this as Newport has at least 500 asylum seekers living in the city and a suspected “failed asylum seeker” population of around 200. Newport also has a large economic migrant population and is a popular visiting destination for many hundreds of gypsies and travellers every year.

In Newport 48% of the residents are male and 52% female – reflecting the fact that a greater proportion of females survive beyond 60 years of age. Of the population 6% are under 5 and 16% are aged 65 or over. Both age groups tend to make the greatest use of health and social services.

As an expanding and modernising city, Newport is likely to have a growing population for the foreseeable future, especially as we currently have the highest fertility rate in Wales. Also it is estimated that by 2010 the numbers aged over 65 will rise by 6.5% from the 2001 total, and those over 85 by 46%. It was estimated at the last census, 11.2% of the total population of Newport were providers of unpaid care.

In Newport the general population is ageing (rising from 18.7% aged over 60 in 2001, to 22% in 2014/15). As life expectancy grows, patient care becomes more complex, with individuals coping with a number of long term conditions such as diabetes, rheumatism and asthma. In Newport over half of people over 65 report that they have this type of limiting long term illness. The interplay of different conditions, and the medications required to treat these, makes the care of older people extremely complex. Of all the older people living

in Newport 15% live alone, potentially creating an additional level of demand on services.

Older people as a group tend to have a lower income than the general population and the incidence of limiting long term illness tends to increase with age.

3.2 The overall health status

The overall health status of the people in Newport is similar to that previously reported in recent years. Generally, the population's health is comparable to that in the rest of Wales. Currently in Newport, the prevalence of obesity, coronary heart disease, strokes and respiratory disease, are marginally lower than the Welsh average but are still high compared to the rest of the UK. The number of deaths from cancer is following the national trend and reducing slightly. However these two facts give no grounds for complacency as not only is the health of the population in South Wales worse than most of the rest of the UK, Newport has many specific significant health problems which are worse than the Welsh average and which need addressing as a matter of urgency. In addition there are considerable differences in health status between the richer and poorer areas. It is our intention to narrow these differences substantially over the next few years and we therefore need to understand better both the root cause of the inequality, and in particular, the nature of the measures that we need to put in place to address this. For example we will be undertaking a detailed health needs assessment of our ethnic minority population during 2008. This review will be undertaken by a Public Health specialist and will help guide us in drawing up a detailed action plan for improving the health of our ethnic minority communities.

Specific areas of concern in Newport include:

- **Low birth weight babies**

The rate of low birth weight babies is slightly higher Newport than in the rest of Wales. Low birth weight is associated with poor maternal health, a low level of education, poor nutrition, alcohol consumption and smoking both pre-conceptually and during

pregnancy. There is evidence pointing to the link between low birth weight and chronic diseases such as diabetes and coronary heart disease in adulthood for low birth weight babies.

- **Excess Winter Deaths for people aged over 65 years of age**

Between 2001 and 2004, Newport was the fourth worst unitary authority for excess winter deaths in older people. Also people over the age of 65 years of age in Newport have significantly higher number of hospital admissions compared to the same age group in the rest of Wales.

- **Diabetes**

The rate of diabetes is high in Newport with 6.3% of adults report being treated for diabetes which is against a Welsh Average of 5.3%.

- **Alcohol Misuse**

Newport has a significantly higher number of adults being admitted to hospital for alcohol related illnesses compared to the rest of Wales.

- **Mental Health**

The Office for National Statistics has found that 1 person in 4 will have a mental health problem in any given year and that 1 person in 6 has a mental health problem at any one time. The Welsh Health Survey 2003/4 shows that 10% of people in Newport aged over 16 years are receiving treatment for a mental health problem, compared with an overall proportion of 9% for Wales. These statistics relate to Newport as follows:

Population (2004 estimate)

139,458

Population aged 18-64 (from 2004 estimate)

81,836

For people aged 18-64 years:

Mental health problem

a) at any one time 13,639

b) in any given year 20,459

People receiving treatment for a mental health problem
8,184

- Women 5,532
- Men 2,357

- **Oral (mouth and dental) Health**

The children in Newport have some of the worst teeth in Wales despite having had relatively high levels of NHS dentistry in Newport. The city has the fourth highest number of fourteen year olds with dental caries (tooth decay). This can mainly be attributed to an inappropriate diet and poor personal dental hygiene.

- **Air Quality and Health**

Poor air quality, caused by the presence of air pollution, can impact on human health, typically by irritating the lungs and airways or by passing into our blood via the lungs. Those most at risk are children, older people and people with existing health problems especially those concerning the lungs or heart. Assessment of the information collected from monitoring has identified several areas of Newport that require measures to improve air quality to meet national objectives

3.3 Social and Economic Status

It is an established fact that the economic and social circumstances that individuals and families live in have a profound effect on their health. E.g. low educational achievement, unemployment and living in a lone parent family often mean that people will have a limited income causing relative poverty which is linked to poor health.

Education

Newport has a higher than Welsh average proportion of people aged 16-24 with no educational, vocational or professional qualifications at 23.8%. Such individuals are much less likely to be in well paid employment.

Unemployment

At 6.2% Newport has a higher than Welsh average rate for people aged 16-74 years economically active unemployed.

Lone parent families

At 29.7% Newport has a higher than average proportion of children living in lone parent families.

Housing and homelessness

Newport's annual house price increase since 1998 has been broadly in line with the Welsh average, but with Newport's average house price being consistently 4% higher than the Welsh average. Between July-Sept 2002 and July-Sept 2003, the average house price in Newport increased by 20% which is higher than the Welsh average increase and significantly higher than the England and Wales average increase.

Homeless households in priority need increased by 70% in 2003/04 and homelessness applications increased by 50% in the last 3 years. In 2005-06 a total of 1035 people presented themselves as homeless, of which 357 were from young people aged 16-24.

3.4 Lifestyle choices affecting health

The following lifestyle habits have a major impact on a person's present and future health:

Smoking

Smoking is known as the single biggest avoidable cause of disease and early death in Wales. It kills around 114,000 people in the UK every year (Peto *et al*, 2003). In 2007 25.8% of adults in Newport reported that they were smokers, the Welsh average being 27.1%, (Welsh Health Survey 2003/05). As well as contributing to coronary heart disease and strokes, a third of cancer deaths are associated with smoking.

Weight control

In Newport (2004) 54% of the population are overweight or obese. Poor dietary habits, lack of physical activity and excessive alcohol

consumption can lead to an individual becoming overweight. Obesity makes people more prone to cardiac problems, diabetes, cancer and orthopaedic problems.

Eating a healthy diet

In Newport (2004) only 38% of people reported eating the recommended “5 portions of fruit and vegetables a day”. Also Newport has a very low breastfeeding rate and poor infant feeding practices. A poor diet is associated with a third of coronary heart disease and a quarter of cancers in the UK and for poor dental health.

Physical Activity

In Newport (2004) 69% of adults reported not doing the recommended amount of physical activity daily i.e. half an hour of moderately vigorous activity five times a week and a Sports Council for Wales study in 2004/5 reported on Newport’s Adult activity participation rates show a large proportion of the population (57%) as being completely inactive, against a Welsh average of 45%. Keeping physically active protects against stroke and coronary heart disease. It also has beneficial effects on weight control, blood pressure and diabetes. It also protects against brittle bones and maintains muscle power and increases people’s general sense of wellbeing.

Alcohol and Drug Misuse (Substance Misuse)

In Newport (2004) 39% of people reported drinking above the recommended sensible guidelines for alcohol consumption i.e. 14 units per week for a woman and 21 units per week for a man. Excessive alcohol intake is linked to many health problems, including raised blood pressure, certain types of cancer, strokes, fertility problems, stomach problems, pancreatitis, liver disease, mental health problems, violence, accidents and suicide.

The on-going impact of illegal drug use is a recognised issue within the Community Safety Partnership of Newport. Situated on the main M4 corridor with easy links to Bristol, Birmingham and London, the City of Newport has become a focal point within South East Wales which has resulted in higher than average levels of drug use.

Safe Sex

In Newport there is evidence to show that not all of the sexually active population choose to practice “safe sex” i.e. using a condom when having sex, to protect against unplanned pregnancies and the transmission of sexual diseases, some of which can be life threatening e.g. HIV and Hepatitis C. Reported cases of syphilis and gonorrhoea have increased in Newport and there has been a significant increase in cases of Chlamydia and Human Papillomavirus, which may have no obvious symptoms in many people, but can cause infertility and cervical cancer in later life.

3.5 The Carers of ill and disabled people in the community

In 2001, 11.2% of the total population of Newport were providers of unpaid care. Without this voluntary caring the statutory services would be overwhelmed. Many carers of older people are themselves in older age groups. In 2002 18% were 65-74; 16% were 75-84 and 3% were 85 or over. However being a carer often places great strain on that carer's health, and insufficient effort has traditionally been paid to ensuring that carers' health and social wellbeing needs are themselves properly met to enable them to continue providing the support to their relatives,

A substantial number of young people also find themselves in the role of carer, and they are not able to enjoy the same opportunities as their peers because of their caring responsibilities. Newport Young Carers Project is currently working with around 60-70 young people. The project has already had to prioritise those who have responsibility caring for a parent (rather than those sharing care for a sibling), but there is still likely to be a much larger number of young people whose caring role is hidden.

Given this situation what should our objectives for this strategy be?

Chapter 4. Objectives of the Strategy – the principles at the heart of Newport’s Health, Social Care and Wellbeing Strategy

Newport’s Health, Social Care and Wellbeing Strategy represents a firm intention to work together to improve the health of the population. At the heart of this effort there are set of key principles and methods:

- 1) The people of Newport will have more information, support and advice on living a healthy life and avoiding illness and dependency and will be encouraged to take the responsible course of providing for themselves that healthy and fulfilled life.
- 2) Work will be undertaken with children and young people and their families to encourage healthy lifestyles for future generations.
- 3) People will be treated with consideration and respect and services will be planned and provided with a focus on the outcome for the service user. These “outcome focused services” will aim to achieve the goals, aspirations or priorities of services users.
- 4) The role and needs of carers as “unofficial” providers of care will be recognised and taken into account in all service planning and development. Carers’ own health and wellbeing needs will also be properly considered.
- 5) More services will be jointly provided by Health and Social care agencies, be they public, voluntary or private, and there will be more integration of service delivery.
- 6) Citizens will be able to receive more support and services in their own home and / or in facilities in their locality
- 7) More of the people at most risk of ill-health and / or in need of support will receive targeted advice and assistance

Chapter 5. How do we stay well and enjoy a healthy lifestyle? – Information and services to help when making choices

The diagram in the introduction to this strategy shows how many things can influence and contribute to someone's health and sense of wellbeing.

In summary people who have a good job, house and good relationships with their family and friends are more likely to enjoy good health and possess a strong sense of wellbeing. People with these advantages have a better chance of staying healthy especially when they eat healthy food and taking regular exercise.

5.1 The need for a Healthy Living Strategy

With the new emphasis on healthy living, public services must reorganise and learn to provide the sorts of information, advice and assistance required by the people of Newport. During the consultation period it is hoped to learn what actual assistance would be most useful as answers to the following question are sought:

- How do we best help people, including people with health problems, to have active lives and enjoy healthy eating?

5.2 The basis for a Healthy Living Strategy

In the meantime agreement has been reached and activity continues on a number of healthy living schemes:

- Newport's Housing Strategy
- An Oral Health (mouth and dental health) Promotion Strategy is being updated
- Newport's Mental Health Strategy will be progressed
- Newport's Substance Misuse Strategy will be revised for 2008/2011

- A revised Nutrition Action Plan is being developed with a particular emphasis on addressing the issue of obesity
- The strategy for Sexual Health will be further developed
- The Healthy Schools scheme, with all Newport schools as members will be further developed
- The “Going for Gold” exercise and activity strategy will be further developed

Meeting Housing Need

The following measures are in the existing Housing Strategy:

- Development of a clear process in Social, Wellbeing and Housing for deciding funding and development priorities in keeping with housing need, new projects to be project managed by the Housing Enabling team who are tasked with Housing Association liaison
- Develop particular housing schemes aimed at the Black and Minority Ethnic community through the Black and Minority Ethnic Housing Strategy, for example sheltered schemes for older Black and Minority Ethnic residents
- Progress the pilot study on Choice Based Lettings and development of a Common Housing Register
- Establish an effective Section 180 bid procedure with partner organisations through the Homelessness Forum
- Review of City Council Sheltered Schemes with high void levels as rental loss is being incurred.
- To deal with the backlog in the adaptation programme and streamline the service as part of the Council’s strategy to deal with delayed discharges
- Undertake a feasibility study on the potential for establishing a renewal area
- Improve up-take of the Empty Property grant by reviewing the criteria and targeting Registered Social Landlords
- To create a Landlord’s Forum within the City
- Improving Housing Benefit delivery by exploring the potential to develop a Service Level

- Agreement with Housing Benefit Service
- Reducing the level of unfitness in owner/occupied homes
- Reducing the decline of properties into unfitness

Nutrition

A good diet is essential for health and wellbeing, in order to continue the promotion of good nutrition in Newport work is about to start on the new Newport Nutrition Action Plan for Newport for 2008-2011. This will follow on from the 2005-2007 Action Plan, which has been a very successful bringing about many positive health promoting initiatives throughout the city, such as the breastfeeding premises scheme, fruit and vegetable co-ops and the “healthy lunch box” initiative.

It is hoped that the new Action Plan will also produce effective sustainable initiatives that will help improve nutrition, resulting in an improvement in the wellbeing of the people of Newport. It has been proposed that the work for the new Nutrition Action Plan should be driven forward by the following sub-groups; Obesity, Pre-School Children, School Aged Children and Older People.

Many agencies who have contributed ideas and work in the field of nutrition in the past two years will be working on the new Action Plan as well as a representative from the board of the LHB, and representatives from the commercial sector.

Help with Smoking

The Welsh Assembly Government launched the All Wales Smoking Cessation Services in 2004. It is a free NHS service providing intensive support, advice and encouragement for all those who want to quit smoking.

The All Wales Smoking Cessation service offers a 7-week course, facilitated by a Smoking Cessation Specialist. The support programme consists of six weekly one-hour sessions, which provide

support for clients. Week one is preparation for quitting, week two is the quit date when the client is expected to stop smoking completely as best practice states that cutting down is ineffective. Week three to five allow the group to discuss withdrawal symptoms and the benefits of quitting and week six covers relapse prevention. Clients are followed up at four weeks post-quit date.

Most groups in the locality are held at the leisure centre in Newport. Also in Newport groups are held in the three electoral wards of Lliswerry, Bettws and Pillgwenlly. Stop Smoking Clinics are also being held in GP surgeries, currently Rugby Surgery, Bellevue and Bettws Health Centre, Lliswerry medical centre and Alway surgery have clinics. In autumn 2007 Malpas Brook Medical Centre, Ringland Health Centre and St Brides Medical Centre will have clinics. Workplace groups are also offered where there is demand.

The National Service Framework for Children and Maternity Services requires the Children and Young People's Plan (CYPP) to identify how it will tackle smoking by children. The Smoke Bugs scheme will continue to operate through the Primary School system to alert children to the dangers of smoking at an early age.

The Sure Start programme will continue to include work with young mothers to help them keep away from smoking.

Substance Misuse

The Local Substance Misuse Action Team operates under the guidance of the Welsh Assembly Government and has adopted four key themes to continue the joint partnership working to create a professional, inclusive and effective response to substance misuse across the City.

The four themes in the LSMAT Action Plan are:

- Children, Young People and Adults – to help children, young people and adults resist substance misuse in order to achieve their full potential in society, and to promote sensible drinking in the context of a healthy lifestyle
- Families and Communities – to protect families and communities from anti-social and criminal behaviour and health risks related to substance misuse
- Treatment – to enable people with substance misuse problems to overcome them and live healthy and fulfilling lives and in the case of offenders, crime free lives.
- Availability – to stifle the availability of illegal drugs on our streets and inappropriate availability of other substances.

The Newport Local Substance Misuse Action Plan is founded on the belief that all those living in the city should have the means to live their lives free of the scourge of substance misuse and therefore that all users should have easy and ready access to a range of counselling and treatment services when they are needed.

Education on the use of alcohol and drugs will continue and be developed and the role of the Substance Misuse Coordinator will be extended.

GP screening for alcohol misuse of people of all ages and the use of specific counselling will be improved and developed.

Mental Health

There is a need to raise awareness and provide education about mental health issues for non mental health service providers. Part of this strategy will involve working in partnership with Mind Cymru to deliver Mental Health First Aid Training and Applied Suicide Intervention Skills Training (ASIST) to improve understanding and responses to mental distress.

Existing mental health services need to focus on vocational and social outcomes. Service users, commissioners and service

providers need to be involved in developing outcome focused commissioning and monitoring processes.

As a means of responding to the Mental Health National Service Framework a multi-agency Mental Health Promotion Strategy is being developed by the Strategic Planning Group.

Oral Health (mouth and dental health)

Working in close connection with some of the Nutrition sub-groups, an Oral Health Promotion Group is also going to be established in Newport in early 2008 to investigate and introduce effective ways of improving oral health in Newport.

The Sure Start Dental Health programme will continue to work with early years providers to promote good dental care by children and their parents including the issue of dental health packs.

Newport Healthy Schools Scheme

The Newport Healthy Schools Scheme is a Welsh Assembly Government funded project which is part of the Welsh Network of Healthy School Schemes. The aim of the scheme is to improve the physical, social, mental and emotional health of pupils, teachers and the wider school community through positive health promoting action.

The scheme started in September 2001 and worked with ten local schools to improve various aspects of health. All Newport schools are now part of the scheme. Schools are asked to work towards achieving seven Healthy School awards:

Phases 1- 3: Schools must complete three health promoting actions per phase. At least two of the actions in each phase must be ongoing.

Phases 4-7: Schools must complete one health promoting action every two years (as well as keeping the previous actions sustainable).

By means of the CYPP Sure Start programme the Healthy Schools approach will continue to be extended to playgroups and all registered early years education providers will be required to achieve Healthy Playgroup status.

Sexual Health

Safe sexual health and easy access to services is important to both adults and young people alike. Newport is experiencing the benefits of the Welsh Assembly's Sexual Health Modernisation Programme, which aims to provide a quality and equitable service to all.

There have been many developments in local sexual health services to date which have provided new opportunities for access to treatment and advice:

- Newport's young people's condom distribution scheme (Willy Nilly) encompasses sexual health information and signposting to professional services via the Willy Nilly website www.willynilly.org.uk. This was launched in 2005 to improve young people's access to health related information and local services.
- The 'Clued Up' information booklet, distributed through schools and the youth service to inform about young people's services.
- The Sexual Health Outreach Worker, funded by the Cymorth programme, to provide sexual health advice and drop in sessions for young people in a variety of settings including youth clubs and the Youth Information Shop.
- The school nurse Sex and Relationships Education Programme, in place within 63 % of Newport's Secondary Schools (5/8 schools), offering access to confidential advice and further support.
- Newport Local Health Board funded free Emergency Hormonal Contraception Distribution Scheme, available to all women through participating local pharmacies (see Willy Nilly website for more information)

- The young people's community Chlamydia testing service (C4C) offering free urine testing for boys in community settings by trained nurses
- Re-organisation of Genito-Urinary Medicine clinic schedules, offering clients the opportunity of speedier access to services via a 'walk-in' clinic.

These initiatives have improved the opportunities for young people (up to 25) to access information around sexual health issues, and of all women to access free emergency hormonal contraception. All adults and young people can contact their GP, local sexual health clinic, GU Med clinic (details on www.willynilly.org.uk) or local pharmacy for further details.

During the next 3 years, the Health Social Care & Wellbeing partners will be working with the stakeholders to continue raising awareness to the risks of unsafe sex due to the overall incline in various sexually transmitted infections in the UK. We will also be working through commissioning arrangements with Gwent Healthcare Trust to modernise sexual health services and improve access in both clinical and non-clinical settings.

Case example – sexual health and services

Kate was worried that she could become pregnant. She'd had unprotected sex with her new partner Matt the previous night at a party. It was their first time to have sex. They both realised they needed to seek help and advice as they were at risk from sexually transmitted infection. Neither of them was aware of each other's previous sexual history, but they were both aware of the high risk of chlamydia and pregnancy from not using condoms.

Kate was aware of how emergency hormonal contraception (EHC) works from when she had school sex and relationship education. She logged onto the Willy Nilly website (www.willynilly.org.uk) to look for information on Newport LHB's free EHC scheme and find out which pharmacies she could use. She then looked up the nearest family planning clinic to arrange a chlamydia screen test, and discuss

contraception, although Kate's GP practice also offers contraceptive services.

Matt was reluctant to visit the Genitourinary Medicine (GUM) Clinic due to horror stories he had heard! He'd found their number in Newport's 'Clued Up' booklet which gave information on opening times. He spoke to his GP who informed him of the community Chlamydia screening service (C4C) operating in his area. He went along for a test, which was a simple urine sample.

Both Matt and Kate were asked about previous sexual partners should the test come back positive in order for them to be contacted for possible treatment, they were both very happy with the confidential service that they received and wondered where those horror stories came from.

*For more information on any of these services please contact:
Gwent Healthcare Trust Sexual & Reproductive Health: 01633
623714*

Older People and winter deaths

Britain has one of the highest rates of winter deaths in Europe. Almost 2.4 million older people in Britain live in homes that are cold enough to cause illness. In an attempt to prevent excess winter deaths of the older population Newport is continuing to support and take part in the "Keep Well This Winter" campaign.

Keep Well This Winter is a campaign which provides information and support to people aged 65 and over to enable them to keep well during the winter months. The campaign runs from September to February, and in Newport brings together a range of initiatives from the Welsh Assembly Government, National Public Health Service, Gwent, Health Care Trust, Newport City Council, Newport Local Health Board, Voluntary Sector and many others into one programme.

The main messages promoted by the campaign are:

- *Keep well – get a free flu jab if you are over 65, or younger with certain conditions (contact your GP)*
- *Keep warm – keep your rooms heated to a temperature of 18°C - 21°C*
- *Keep safe – avoid slips & trips: consider installing grab rails, level shower access, and suitable lighting. Fit locks & chains to doors for security.*

*Please ring NHS Direct Wales **0845 46 47** for more information about **Keep Well This Winter**. The **KWTW** leaflet contains contact details for repairs, grants and home adaptations. Visit the website www.kwtw.org.uk*

Going for Gold

Going for Gold is an innovative project designed to:

- get more people, more active, more often
- enhance physical and mental health and activity levels of participants
- reduce unnecessary demand on health services
- encourage people to take more responsibility for their own health
- appeal to hard to reach communities and sedentary population
- co-ordinate the efforts of Newport's existing physical activity providers
- link to and compliment other existing and proposed physical activity interventions
- raise the profile of physical activity opportunities in Newport
- motivate and reward Newport residents for being active and improving their health knowledge and understanding

Walking, swimming, cycling and two health literacy modules are the activities that will form the basis of Going for Gold in the first instance. Any person who lives or works in Newport will be eligible to join the scheme. Cycling, Walking and swimming are all excellent sources of aerobic exercise, which can be accessed by a wide range of ages,

and both genders. Regular physical activity raises fitness levels, postponing or avoiding the onset of chronic disease and reducing obesity.

The “health literacy” modules will focus on giving people more skills and confidence to deal with first aid problems themselves; being more aware of accident prevention at home, in work and outside; and knowledge about better nutrition, avoiding substance misuse, healthier eating and so on. Many of the situations that end up at GP surgeries or in hospital Accident and Emergency departments could be avoided, or where they are relatively minor complaints could be dealt with by families themselves or by advice from a Community Pharmacist for example. Reliable and accessible skills courses will be provided using, wherever possible, the skills of volunteers and educators already engaged in this type of activity.

The 5x60 Activity Scheme

Based on the official advice that children and young people benefit from an hour’s physical activity at least 5 times per week this scheme will continue to be promoted by Newport City Council Sports Development Officers.

Flying Start and Sure Start

The Flying Start programme targets the most vulnerable and needy families in defined areas of Newport and provides increased Health Visitor support, parenting programmes and free childcare for children up to 2 years.

Sure Start Health Access programmes will continue to work with vulnerable families to increase health awareness and promote healthy living and ensure that families access mainstream services appropriately. There will be continued advice on breastfeeding, general infant health, parenting issues and support for postnatal depressed women.

Newport’s Air Quality Action Plan – monitoring our environment

Assessment of the information collected from monitoring has allowed the identification of several areas of Newport that require measures to improve air quality to meet national objectives. These areas were therefore designated Air Quality Management Areas.

Newport City Council currently has seven declared Air Quality Management Areas (AQMAs). The AQMA's were declared because assessments of air quality found that the annual mean objective for nitrogen dioxide was not being achieved. The primary source of pollution in all seven areas is considered to be road transport.

The action plan is in the final draft stages but once adopted by the council it will set out a range of transport-focussed measures intended to improve air quality. Many of these have already begun to be implemented or are at the planning stage.

The Air Quality Action Plan is likely to be officially adopted by the Newport City Council during December 2007.

Despite our best efforts to stay well, sometimes we may get ill or be in need of supporting services. The following chapter describes what we can expect for the future of health and social care services

Chapter 6. What happens if we do get ill or are in need of supporting services? – The future of service delivery

The major challenge is to translate what people want into a new strategic direction for service modernisation and development. This strategic shift will help people to live more independently in their own homes and will focus more on their overall wellbeing. This will require earlier intervention and better coordinated services. In delivering this strategic shift there is a commitment to a health and care system that provides fairness, inclusion and promotes respect and dignity for people from all sections of the community.

The longer term aim is to bring about a substantial realignment of the whole health and social care system. Far more services will be delivered, safely and effectively, in settings close to home. Services will become integrated and built around the needs of individuals rather than those of the services themselves.

6.1 The Aims

We want the people of Newport to:

- Be given the opportunity and encouraged to take much greater responsibility for health and wellbeing. More information and support will be available to help maintain a healthy lifestyle.
- Stay as independent and healthy as possible
- Be looked after by their GPs and their teams for longer and only be referred to hospital if absolutely necessary
- Be seen for treatment within an acceptable timescale
- Be accommodated in comfortable and appropriate facilities that meet their specific needs
- Benefit from closer working across all health and social care services. People will receive better continuity of care.

- Benefit from “one-stop” service – only having to give details and information once and experiencing care delivered in a seamless way irrespective of the organisation providing the service.
- Have services provided more locally through improved community and neighbourhood care services by the most appropriate organisations.
- Benefit from being discharged from hospital at the right time and managed appropriately thus helping to avoid re-admission. All vulnerable people will be assessed and support made available to help maintain independence.

6.2 What will change?

Over the coming years the people of Newport can expect to see three major changes in the way that we arrange services:

- Better Primary and Community Health Care and Support
- Better access to and more outcome-focused Social Care Services for service users
- Closer Integration of Health and Social Care Services

Better Primary and Community Health Care and Support

Our current services must change to support the pressure arising from improved opportunities to detect illness, an ageing population and increased lifestyle-related illness.

This means:

- GPs and other community clinicians such as nurses, Physiotherapists and Occupational Therapists looking after patients for longer before handing over to hospital settings. This

will allow hospitals to concentrate on providing more specialist services.

- Better access by GPs and community clinicians to diagnostic facilities e.g. X-rays and blood tests.
- Better use of technological advances to minimise the costs of service provision and improve quality of care.
- Maximum use of the skills of GPs and other community clinicians to free up consultants to concentrate on providing specialist care.
- Prevention of any duplication of services in the interests of efficiency.
- The way in which certain services are provided, such as sexual health services to young people, will be reviewed so that they are at times and in places that young people feel able to access them.
- Development of Local Care and Treatment Centres that have the potential for devolution of many hospital services.

Better access to and more outcome-focused Social Care Services for service users

Support for the normal activities of daily life is something that people generally provide for themselves and for each other. It is a strength of our society that we often provide this type of support for our family, friends and neighbours.

There are times when the needs of individuals go beyond what friends and family can cope with. In these circumstances Social Services may be provided.

In line with our strategic aims it is intended that Social Services will focus more on helping people manage their own independence and wellbeing.

Over the coming years we will:

- Improve services to help people avoid dependency by introducing a Neighbourhood Warden or “Floating Support” service.
- Increase the provision of Luncheon Clubs for older people
- Improve access to services and introduce outcome-focused assessment for care services.
- Change the way that domiciliary care (care at home) is provided so that more reablement for disabled people is available.
- Introduce a specialist domiciliary care service for people with dementia
- Make better use of technology (Telecare) to assist people living at home to remain independent.
- Establish single point of contact for all adult Social Services.
- Make better and more consistent use of the Unified Assessment process.
- Improve access to services including more information/advice and signposting to other services.
- Provide a consistent point of contact for all Protection of Vulnerable Adult (PoVA) referrals and initial PoVA assessment and investigation.
- Develop a Social Care Long Term Conditions service to collaborate with the development of Health Care Services in Newport.

- The CYPP will continue to develop joint working between health, education, social services, the Police and other community partners to expand the Preventative Services Programme.
- The CYPP will promote the use of a common assessment framework to facilitate better joint working to ensure early identification and early resolution of problems.

Closer Integration of Health and Social Care

To address current and future needs we have taken a fresh look at how needs are being met and how services are being delivered. We aim to improve local access to services by providing more integrated health and social care services.

We believe that these changes need to be delivered by:

- Integrating commissioning services for older people by pooling of commissioning budgets and a single plan for meeting need
- Integrating provision of services by bringing together health and social care services to reduce duplication
- Development of joint commissioning and quality assurance arrangements as part of the development of the CYPP

To gain confidence and experience of integrated services we propose, in the first instance, to:

- Integrate the Health and Social Care Long Term Conditions Team
- Jointly Commission Residential and Nursing Home places
- Integrate the Health and Social Care Rapid Response service
- Further integrate the community Mental Health Service

- Further integrate the community Learning Disability Service
- Further integrate the community Reablement Service
- Utilise Section 33 ¹agreements to formalise funding governance and management arrangements
- Develop the Flying Start model and the provision of integrated services teams as part of the CYPP
- Explore the possibility of Local Health Board direct management of community health services

¹ Section 33 of the Health Act Wales 2006 allows for the pooling of budgets between NHS bodies and Local Government for specified purposes

Chapter 7. What success will look like in 2011

Changing lifestyle makes individuals feel healthier and happier very quickly, but it may take longer than the three years of this strategy to see the full benefit of such changes, particularly in such areas as the prevention of diseases caused by long term poor lifestyle choices.

Whilst some changes will begin early in the period of this strategy the full range of plans for modernisation of health and social care services is anticipated to take up to 20 years to be felt.

Major milestones will be reached with the building of the new Local Care and Treatment Centres and the opening of the Newport's new local general hospital but these are all likely to be beyond 2011. In the meantime many developments will be taking place in the organisation and delivery of services.

7.1 Planned service improvements for the people of Newport

Strategic

In order to deliver the vision outlined major strategic changes are needed in the way that services are delivered in Newport with more services being provided as close to people's homes as possible. This should help Newport residents to remain at home for longer and maintain their independence.

- The strategy of shifting health services from secondary to primary and community care will be continued as appropriate by developing care pathways and implementing a demand management strategy. It is planned to appoint several clinical champions to assist with this work, particularly in the areas of diabetes and respiratory disease.
- A multidisciplinary community health team will be developed which will provide a range of generalist and specialist

services that are preventative, interventional and educational. This service will build on the existing skill sets available in both community and hospital settings.

- The plans in relation to the location and type of facilities required to provide efficient, effective and timely services in the community will be finalised.
- Planning will continue for the reprovision of services provided by the Royal Gwent Hospital as part of the Clinical Futures programme.

Scheduled Hospital Care

The aim is for people to maintain a healthy lifestyle and reduce the dependence on health and social care services, however, when people need them, services must be available in a timely manner, therefore:

- There will be a reduction in referral to treatment times to 32 weeks for 95% of admitted patients and 98% of non admitted patients.
- There will be a reduction in the maximum waiting time for inpatient and day case treatment to 14 weeks.
- There will be a reduction in the maximum waiting time for a first outpatient appointment to 14 weeks
- There will be a reduction in the maximum waiting time for access to most diagnostic services to 8 weeks.
- There will be a reduction in the maximum waiting time for access to most therapy services to 14 weeks.
- Patients diagnosed with cancer following an urgent referral will start their treatment within 62 days of receipt of referral

- Patients diagnosed with cancer not following an urgent referral will start definitive treatment within 31 days of diagnosis.
- All patients referred by a GP or other medical practitioner for cardiology treatment to adult secondary or tertiary cardiology will receive definitive treatment within 32 weeks of receipt of the original referral.

Women's and Children Services

It is widely recognised that the children of today will become the adults of the future and it is therefore crucial that their behaviour is influenced, along with their mothers, to ensure that they engage with preventative services from an early age, therefore:

- There will be improved access to most sexual health services (HIV and sexually transmitted infection testing and routine contraception advice)
- Uptake rates for all childhood vaccinations will be maintained and where possible improved
- The outcome of recent reviews of school health nursing services, health visiting and community paediatric services will be implemented
- The Flying Start programme will be extended and affiliated with core health visiting provision and Surestart programmes will be extended to support parents to access mainstream health services.
- Services for disabled children are a priority area for the CYPF. Responses to a 2007 review will include the development of the South Gwent Children's Centre which will deliver therapy services and other support to families.
- Improvements to our child and adolescent mental health services will continue, ensuring that the right training and

support is in place for healthcare professionals so that they are able to deliver timely and appropriate care and services to patients

The priorities of the forthcoming Children and Young People's Plan (CYPP) will be identified by the work of a series of Executive Development Groups in the near future. Child and Adolescent Mental Health Services, children with disabilities and the provision of early support to families have already been identified as priorities.

Mental Health

People with mental health problems benefit from receiving their treatment in the community. Admission to hospital should be avoided as far as possible, therefore:

- An assertive outreach mental health service will be established and developed to provide intensive support to clients who are in danger of disengaging with the service and people with newly diagnosed mental health problems
- The success of the Crisis Resolution/Hospital at Home team will be built upon to ensure that patients with mental health problems are able to avoid admission to hospital unless absolutely necessary.
- The management of NHS and Local Authority mental health teams will be integrated

Intermediate Care

One of the major driving forces behind the vision of a healthier population with greater independence is the need to provide services and keep people out of hospital unless absolutely necessary. If people need to go to hospital, then their stays should be kept as short as possible before returning home, therefore:-

- A dedicated multi disciplinary stroke team, including specialist nursing staff, will be established
- There will be further reductions in the number of delayed discharges from hospital.
- There will be continued commissioning of voluntary organisations to provide advice and services to the people of Newport.
- There will be continued development of the long term conditions team, rapid response team and reablement team and a review of the rehabilitation and discharge pathway to achieve a reduction in emergency admissions and average length of stay for people suffering with chronic conditions.
- There will be continued implementation of the intermediate care action plan, ensuring effective inter-agency working, ensuring appropriate staffing levels and skill mix and ensuring that care is provided in appropriate alternative settings to allow the acute hospital and care homes to provide care for those who require acute intervention.
- There will be continued development of services e.g. respiratory diseases, diabetes, stroke, developing clinical pathways and using clinical champions to facilitate a shift to community based care.

Primary and Community Care

The essence of the strategy is for as much care as possible to be provided in a primary and community care setting away from hospital, therefore:

- There will be development of the services that are provided to vulnerable groups (e.g. homeless, asylum seekers and refugees) ensuring that they have access to general medical

services, nurse/health visitor led targeted outreach services, and accessible information on developing healthy lifestyles.

- There will be a continued roll out of the programme of medicines management reviews to ensure that individuals are being prescribed the most effective medicines.
- There will be continued development of a new model of primary and community care nursing services leading to the full integration of the roles of district nurses, health visitors and the long term conditions nursing team.
- There will be continued commissioning of enhanced services from our primary care providers in order to further develop services in the community.
- There will be continued planning of three local care and treatment centres including the replacement of Ringland Health Centre.

It is planned that people admitted to the Royal Gwent Hospital will have access to a Social Worker by exactly the same method as people in their own home. This will mean a much more consistent approach to gathering important personal information that makes best use of information technology and contributes to the Unified Assessment process. All requests for assistance will follow the new route in which a specialist Duty and Assessment Team rather than being sent to a longer term Social Work team which often causes delays. Assessments of need will be outcome-focused in that there will be early and constant reference to what the person needs and what they would like to see as the outcome of the support given.

Case examples of changes to services

1. Orthopaedic Operation – before and after service improvements

Mrs Jones visits her GP with a painful knee and receives an appointment within 8 months. Her consultant refers her for diagnostic tests and to physiotherapy. On receipt of the diagnostic tests, at her second consultant appointment, Mrs Jones is told that she will need an operation. She is placed on the waiting list. After about 7 months, she is given an appointment for pre-operative screening and later the operation. Mrs Jones remains in hospital for 10 days to recuperate from her operation and receives medical rehabilitation. Mrs Jones may or may not be seen by a social worker and may or may not receive social care services to maintain her independence as she recovers

In the future, Mrs Jones will still visit her GP, who would arrange diagnostic tests and refer her immediately to the MPT3 service for relief while the team determine whether she is likely to need surgery. If surgery is needed, Mrs Jones would visit the hospital to see her consultant, who would have access to all of the test results undertaken in the community. Her hospital stay would be significantly shorter because Mrs Jones would receive rehabilitation and reablement at home from the community team, including any social care services, rather than in a hospital setting.

2. Frail Elderly Patient with multiple long term conditions – before and after service improvements

Mr Morgan is 86 years old, lives alone and finds it difficult to control his long-standing illnesses. He is regularly referred to the hospital Medical Assessment Unit by the out of hours service. On average, he stays in hospital for 4 weeks whilst his condition is stabilised. During this time, his home care package is stopped, making it more difficult to safely discharge him quickly and further extending his hospital stay. On discharge, he accesses support from the Reablement Team during weekdays. A few weeks later, on a Saturday evening, he contacts the out of hours service in some distress...

In the future, Mr Morgan will receive education to help manage his conditions, and support from the Expert Patient scheme. In addition, he will have regular comprehensive reviews in his GP surgery, and there are close communication links between the surgery, community team and domiciliary care staff who will provide both reablement and maintenance services to promote his independence. As a result, Mr Morgan will not become ill as often as he used to and recognises the signs when he deteriorates. Should he contact out of hours, feeling ill, they check his individually designed care plan with him, to make sure he has followed the advice. If Mr Morgan is ill, and the care plan has not helped, the out of hours service will refer him to the community team where Mr Morgan will receive a rapid assessment and diagnosis, and a treatment plan is started in his own home.

3. The Carer of a Patient with Dementia Falls Ill – before and after service improvements

Mrs Williams is 79 and cares for her husband who is 83 and suffers from mild dementia. Mrs Williams has been feeling tired of late, when she gets up too quickly from her armchair, she becomes very dizzy and falls over, fracturing her wrist and bruising her legs and side. Mrs Williams is admitted to hospital, by ambulance, where the wrist is plastered, and investigations are started to discover why she fell. Because there is no-one to care for Mr Williams, there is no alternative but to admit him to hospital as well, for the duration of Mrs Williams' stay. As a result of his admission, Mr Williams becomes more disorientated, and is assessed as unfit to return home safely. Recommendations are made for Mr Williams' admission to specialist residential accommodation. Because of her fracture, Mrs Williams needs home care support to help her look after herself after she is discharged. Following her fall, Mrs Williams becomes fearful that she might fall again, and restricts the number of times she goes out because of this. As a result, Mrs Williams becomes depressed and feels generally less able to cope without support, increasing the home care support package that she needs and restricting the number of times she visits her husband, because she cannot drive. Mr and Mrs Williams mental health problems worsen as a result of their separation.

In the future, Mr Williams will be able to access an emergency respite home sitting service whilst his wife goes into A&E. After an initial assessment and wrist plastering, Mrs Williams would return home with an appointment date within a week for further investigations to determine the cause of her fall. Additionally, the community alarm and response service would install a falls detection Telecare package as a safety precaution in case Mrs Williams falls again before her health problems are resolved. The couple require some home care support whilst Mrs Williams recuperates. This care package is provided by generic workers who are able to assist Mrs Williams, and also deliver a planned reablement package as directed by an OT and physiotherapy assessment. As a result of the assessment, the social worker within the reablement team arranges for Mr Williams to attend local day activities once each week, providing Mrs Williams with some respite.

7.2 Patients and Service Users with Long Term Needs

It is particularly important that services required to support people with long term needs are well coordinated. The nature of the services required will vary from one person to another but also from one condition or need to another. Specialist Strategy Groups have been working on service developments in the following areas:

People with a Physical Disability or Sensory Impairment

During the period of this HSCW Strategy progress will be made on the following features of the Service Model

- To provide joint services, in partnership with all relevant organisations, for service users and their carers to enable them to live full and independent lives.
- To ensure equitable access following a unified assessment to non institutionalised services across Newport that demonstrate an understanding of the key principles of the social model of disability.

- To actively encourage service users and carers to participate in the planning and commissioning, monitoring and delivery of services.
- To work toward the development of a non impairment-specific Disability People's Group in Newport to encourage the participation and involvement of disabled people in prioritising and planning service developments.
- To empower disabled people to improve their fitness, wellbeing and adopt healthy lifestyles and improve access, based upon best practice to all services.
- To ensure disability equality and to challenge prejudice, stereotypes and assumptions about disabled people.
- To promote and extend disabled people's capacity to be able to work and learn.
- To promote independent living through the extended use of Direct Payments.
- To ensure that all children and young people with disabilities receive the support and opportunities they need to reach their full potential.
- To improve the transition from children's to adult services.

Older People

The HSCW Strategy aims to meet the expectations of older people and their families and to recognise the important contribution that older people make within our community. Service developments will be founded on the principles that all older people have a right to:

- Independence
- Participation
- Care

- Self-fulfilment
- Dignity

During the period of this HSCW Strategy progress will be made on:

- Engagement_- to comply with NSF Objective 3. To ensure that older people are actively engaged and involved in health and social service planning and review
- Person Centred Care to comply with NSF Objective 4._To ensure that Advocacy services for older people are available, valued and accessed when appropriate
- Promoting Health & Wellbeing in Older Age / Person Centred Care to comply with NSF Objective 5._To ensure Specific health promotion programmes are developed to meet the needs of local older people
- Living Longer & Healthier lives to address the Health & Wellbeing agenda in line with Older People's Strategy. To prevent / delay and reduce the impact of onset of illness through programmes that address the risk factors and promote healthy living.
- Promoting Independent Living by Early Detection of Illness and Promotion of Good Health
- Valuing Older people: Older Persons Strategy: To promote positive images of older people and ensure understanding & respect and to enhance engagement & participation of older people in planning

People of working Age with Mental Health Needs

During the period of this HSCW Strategy progress will be made on the following features of the Service Model

- The implementation of the Mental Health Act
- Improving workforce numbers and skills to meet service need
- Developing a Mental Health Promotion Strategy
- Further developing effective crisis intervention and intensive home treatment services
- Developing crisis accommodation and emergency respite that provides an adequate and prompt response to preventing hospital admission
- GP Practices to have access to a named mental health link worker. Improving the support, liaison and co-ordination between specialist services and primary care
- Effective liaison and communication between primary and secondary care
- Addressing gaps in training for practice staff and increasing the usage of standardised mental health assessment tools in primary care
- Improving access to psychological therapies in primary care
- Further develop Assertive Outreach Service
- Expanding the access to and availability of 'talking therapies' services
- Develop a broader range of day services that focuses on recovery and wellbeing, better integrating service provision, and

improving services considering options for providing more services out-of-hours and more employment initiatives.

- Supporting the development of more voluntary sector provision.
- Develop a range of floating support accommodation that meets the needs of service users and allows people to move through services as part of their rehabilitation and recovery.
- Develop early intervention services for young people with a diagnosis of psychosis.
- Increase the range of dedicated initiatives for people with a mental health problem from a black or ethnic minority background.

Older People with Mental Health Needs or Dementia

The strategy aims to meet the needs and expectations of older people who experience problems with dementia or mental ill-health. It is important to note that there are two distinct types of service user in this group, those with functional illnesses, such as depression, Bi-polar disorders and psychosis, and those with organic mental disorder such as dementia.

During the period of this Health, Social Care and Wellbeing Strategy progress will be made on the following features of the Service Model:

- Integrated multi-disciplinary Community Teams with close links to Primary Care (including liaison over In-Reach service to care homes)
- Community Teams provide multi-disciplinary assessment and planning of care
- Community Teams as pathway to full range of Secondary Care

- Developing links to Intermediate Care service especially over transfers of care
- Liaison Service with acute hospital service
- Commissioning to work with Community Teams to support and extend the range of procured services including domiciliary care and appropriate care home provision
- Development of Memory Clinic service
- Development of Carers Assessment procedures and Carers Support Groups
- Development of services for Younger People with Dementia
- Integration of some in-house services such as day hospital and day care settings
- Development of Intensive Home Treatment service
- Developing use of Telecare

People with a Learning Disability

Services will be developed on four key principles:

- Rights
- Independence
- Choice
- Inclusion

Significant progress should be achieved over the next 3 years with respect to the Wales Programme for Improvement Action Plan. This includes:

- The provision of improved day service, education, training and work opportunities.

- Provision and implementation of an accommodation strategy.
- Implementation of a challenging behaviour strategy.
- Provision and implementation of an effective transitional planning strategy (e.g. inter-agency steering group, single inter-agency policy).
- Integration of health and social services.

In addition the next 3 years should involve:

- The modernisation of Council services (e.g. day services, family aide service, supported living schemes).
- The provision and implementation of an employment strategy and a social enterprise strategy, with both contributing to improved job opportunities for disabled people.
- The provision and implementation of a strategy for people with Autistic Spectrum Disorders.

7.3 Support to Carers

Carers are the people who provide the majority of care in our community. The valuable role that carers play is fully recognised including the fact that they provide help and support in ways which might otherwise not be available. Public Services will work in partnership with carers to maintain their caring role and respect their contribution to care in our communities.

The work of carers is supported to some extent by a range of services provided by the statutory, voluntary and independent sectors but there is more to be done.

The Carers Strategy

A revised Carers Strategy will cover the three year period from April 2008 to March 2011. The focus of service improvements within the new Strategy will be:

- To help all agencies involved in community care, community health and community development to promote the health and wellbeing of Carers.
- To ensure that the role that young carers play is recognised and that they receive the specialist support that they need.
- To better inform the allocation of resources to meet the identified needs of Carers
- To continually improve the identification of unpaid carers in Newport, therefore leading to a better understanding of the caring role and the improvement of support services.
- To develop a performance management approach to carers issues, which informs the above aims and objectives
- To ensure that carers are not disadvantaged as a consequence of fulfilling their caring role
- To ensure the awareness of carers rights in areas such as access to employment, education and leisure opportunities
- To contribute to the existing national and local strategic objectives;

Carers Contact Centre - Newport provisions Market, High Street, Newport

The centre is run in partnership between the Council and Gwent Association of Voluntary Organisations. It provides a good source of

information and advice to carers in the heart of the community of Newport.

They advise carers on their rights in general and their rights to have an assessment of their needs as a carer. They provide a wide range of free information leaflets, advice on benefits, support groups, health, travel and holiday services for disabled people, home safety and much more. Staff also provide outreach information sessions at GP practices in Newport.

7.4 Performance management of the Health, Social Care and Wellbeing Strategy

Governance of the Partnership

The partnership between Newport Local Health Board and Newport City Council is underpinned by a Memorandum of Understanding that was formally approved by both organisations in June 2007. The goal of the memorandum is:

“To facilitate the citizens of Newport in leading self-determining and fulfilled lives in conditions of good health and wellbeing. In order to enable our citizens to live such lives, where support is needed from the City Council or the Local Health Board and their partner agencies, it should be provided seamlessly and effectively in whichever way best serves the needs of the citizen.”

The partnership will be governed by a pattern of regular meetings between senior officers and between senior members of the Council, the Local Health Board and partner organisations.

The Health, Social Care and Wellbeing Strategy Joint Officer Group

The HSCW Strategy JOG is jointly chaired by the Chief Executive of Newport Local Health Board and by Newport City Council’s Corporate Director with responsibility for social wellbeing.

Other members are the senior officers of the LHB and of the Council who chair the range of joint planning groups together with local representation from Gwent Healthcare NHS Trust and Gwent Association of Voluntary Organisations.

The JOG meets bi-monthly and oversees the detailed work of implementing the Strategy and it will report to the partnership meetings.

The Health, Social Care and Wellbeing Strategy exists to improve the wellbeing and health of the people of Newport. It is therefore very important that we develop ways to measure how well we are doing together. A series of performance measures based on the strategic objectives will be in place designed to measure how well services are becoming more modern and helpful to service users.

Requests for further information on Newport's Health, Social Care and Wellbeing Strategy is available from:

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