Partneriaeth Ranbarthol Gorllewin Morgannwg | West Glamorgan Regional Partnership

WEST GLAMORGAN REGIONAL PARTNERSHIP

ACTION PLAN

2023-27

This document is available in alternative formats.

Please contact the West Glamorgan Transformation Office via email at west.glamorgan@swansea.gov.uk with details of your requirements.

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West Glamorgan Regional Partnership

West Glamorgan Regional Partnership is established on a non-statutory footing in 2014 as part of the Social Services and Wellbeing (Wales) Act 2014 to progress and oversee the work of the Region's Health and Social Care Programme. The Act came into effect on 6th April 2016 and introduced a statutory role for a Regional Partnership Board and specific responsibilities.

The objectives of the West Glamorgan Regional Partnership Board are to ensure the partnership works effectively together with the following responsibilities:

- To respond to the Population Needs Assessment carried out in accordance with section 14 of the Act
- To ensure the partnership bodies provide sufficient resources for the partnership arrangements
- To promote the establishment of pooled funds, where appropriate
- To ensure that services and resources are used in the most effective and efficient way to improve outcomes for people across the region
- To prepare an annual report for Welsh Ministers on the extent to which the Board's objectives have been achieved
- To provide strategic leadership to ensure that information is shared and used effectively to improve the delivery of services and care and support, using technology and common systems to underpin this.

Vision and Aims of the Partnership

West Glamorgan developed a co-produced set of vision and aims at its inception that the region continues to follow:

- We will drive transformational improvements in wellbeing, health and care for the populations we serve through better practice, better services, better technologies and better use of resources.
- We will change the way that we work with citizens away from paternalistic care to shared responsibility and co-production.
- We will secure the delivery of seamless care which will meet the outcomes that matter to the people we serve and support through integration, earlier intervention and prevention
- We will manage our common resources collaboratively and pool resources wherever we can.
- We will have a single and simple governance structure covering Public Service Boards, the Regional Partnership Board and sub-structures for the region.

The Regional Programme exists to:

- Drive continuous improvement in wellbeing, health and care in partnership.
- Work in co-production with partners from the third sector, voluntary sector, private sector, statutory sector and our citizens to secure more seamless care in communities.
- Cross service boundaries to develop better, more seamless care.
- Promote a healthier region through asset-based communities.
- Make sure our agencies put people at the heart of wellbeing, health and care transformation, integration and prevention.
- Help to make sure that people live healthier and happier lives
- Deliver the Regional Transformational Strategy and Plan

Strategic Priorities for Regional Transformation as outlined in the Area Plan

Strengthening Communities

Transforming Health and Care Services at Home

Regional Integration

Transforming Complex Care

Transforming Emotional Wellbeing and Mental Health Services

Community and Older People – Vision and Aims

This priority focusses on the development of new models of financially sustainable and integrated community health and care to support people to remain living safe and well within own homes and communities.

Enable individuals to remain as independent as at all possible and in the own home for as long as possible.

Increase Respite Services in line with increasing demand.

Develop and Enhance Prevention approaches to reduce the need for acute and long-term care.

Reduce social isolation and loneliness.

Develop and enhance falls prevention care.

Ensure safe and timely discharge from hospital.

Strengthen the Discharge to Recover and Assess Pathways and ensure we support the individual in what matters to them.

Continue to make West Glamorgan a Dementia Friendly Region

To Ensure Sustainable Care Provision and High-Quality Care Homes

Community and Older People – Action Plan

Strategic Aim	What we will do	What will this deliver?	What will this mean?
RPB Strategic Priority Transforming Health and Care Services at Home **Models of Care Community Based Care – Prevention and Community Coordination (MC1)** **Community Based Care – Complex Care Closer to Home (MC2)**	Strengthened, revised and consistent coordination of integrated admission avoidance support (MC1)	Reduced unscheduled care admissions for Over 65's	Older people receive appropriate support at the right time, avoiding admission to hospital.
	Implement the National Discharge to Recover and Assess model via the regions integrated services model. (MC5)	Discharge from hospital via the most appropriate pathway Streamlined assessment and discharge processes	• Reduced length of stay in an acute hospital. • Reduced unscheduled care admission. • Health and mobility of patient does not deteriorate. • Providing care and support in their communities. • People can return to their place of residence with least restrictive care.
	Refined information management to strategically support demand and capacity modelling and develop comprehensive integrated dashboard in Power BI to inform on key metrics and identify deficiencies across services. (Enabling Digital Programme)	• A "live" system that will enable staff to understand the demands on the system and make appropriate decision making to support people across services. • Provides partners with a system that enables reporting on Results based accountability measures. • Provides partners with a system that ensures service user qualitative information. • Identify gaps in provision. • Greater understanding of demand / issues across services	• A system that supports the modelling of workforce and commissioned services for the future • Partners are more informed on trends in demand and able to better plan resources, enabling more effective future planning. • Improved efficiency / allocation of funds across services • Partners have a greater understanding of the quality and impact of support to service users.
	Revise the Schedules of the existing section 33 agreements for Intermediate Care Services (MC5)	• Updated information of staffing and resource management for the Home First Service.	• Ensure that we have a pooled budget that supports the delivery of services for the region and enables West Glamorgan to continue to deliver integrated services.

Promoting Good Health and Wellbeing (MC3) **Home from Hospital (MC5)**		• More robust governance arrangements to ensure oversight of performance and finance monitoring	• Partners will have better oversight of the resources for integrated service delivery across the region
	Delivery of supported discharge third sector support (MC5)	• Earlier support and discharge will be facilitated through third sector. • Reduced length of stay in hospital following an unscheduled care admission (again for over 65's)	• Clinically optimised patients are supported to leave hospital as quickly as possible with the appropriate level of support
	Maximise resources to deliver community reablement packages of care to maximise independence (for up to 6 weeks) or existing package of care where reablement potential has already been reached. (MC5)	• Earlier support and discharge. • Reablement services that enable people to live within their communities and reduces the need for a long-term care package. • Reduced length of stay in hospital following an unscheduled care admission (again for over 65's)	• Reduced length of stay in an acute hospital. • Reduced unscheduled care admission. • Older people are supported to remain at home following a period of community reablement and a general reduction in the level of support required following discharge including domiciliary care and care home placements. • Older people recuperate quicker in a community setting, shortening length of stay in hospital
	Maximise resources to allow recovery and assessment in a bedded reablement facility where home is not currently possible. (MC5)	• Earlier support and discharge. • Bedded reablement services that enable people to return home to their communities and reduces the need for a long-term care home placement. • Reduced length of stay in hospital following an unscheduled care admission (again for over 65's)	• Reduced length of stay in an acute hospital. • An increase in the number of people supported to return to their own homes. • General reduction in the level of support required following a period of reablement, including domiciliary care and care home placements
	Care packages will be coproduced with individuals, carers, and families, recognising the importance of people	• A reduction in over prescription of social care. • Increase the use of community-based solutions	• Improved outcomes for patients, their families and staff working within the Home First Service. Individuals are

	supporting their own health and wellbeing. (MC5)		enabled to enact their own strengths and supported only where needed. • High levels of patient, family, and staff satisfaction of the Home First Service • Person receives care that is tailored to their needs
	Develop and Enhance Prevention approaches to reduce the need for acute and long-term care (MC1)	• An increase of 'Community capacity' of services and other responses that enable people to live more independently, in or near to their own homes. • A developed community care model with a full range of preventative and early intervention services are available locally. • Strengthened, revised and consistent co-ordination of integrated admission avoidance support, including Step up facilities / care	• Older people receive appropriate support at the right time, avoiding admission to hospital. • People can remain in their own home and live more independently in or near to their own home. • Reduced length of stay in an acute hospital. • Reduced unscheduled care admission.
	Increase Respite options in line with increasing demand (MC3)	More respite services available to the carers and individuals (delivered by the carers programme)	• Support for individuals or carers of individuals to remain living as independently as possible for as long as possible in or near to their own home. • Improved emotional health and wellbeing for carers. • Carers and those they care for are more empowered to choose respite / short break suitable to their needs
	Increase community provision to reduce social isolation and loneliness (MC1)	Suitable services for citizens to access (community groups, Social & Micro Enterprises), e.g., informal social groups. A range of befriending services provided by volunteers	• Individual resilience enhanced and improved. • Improved emotional health and wellbeing which prevents escalation of needs or interventions

<table>
<tr><td rowspan="4"></td><td>Develop and enhance falls prevention care (MC1)</td><td>To provide a Falls Response Service (FRS) to the people residing in Swansea and Neath Port Talbot within a cluster footprint</td><td>Advice and guidance for older people which prevents the risk of falling.
More timely care for frail and older people who require treatment, avoiding the need for hospital admission or Welsh Ambulance Service
Reduced unscheduled care admission.</td></tr>
<tr><td>To Ensure Sustainable Care Provision and High-Quality Care Homes (MC6)</td><td>A quality standard which is utilised across the region when commissioning placement in Care Homes.
A quality standard which is utilised across the region when commissioning Domiciliary Care</td><td>People of West Glamorgan can be assured that their care delivery at every level is of the highest standard.</td></tr>
<tr><td>Continue to enable carers to support their individuals particularly in support of expediting or avoiding discharge.</td><td colspan="2">Being delivered by the Carers Partnership Programme</td></tr>
<tr><td>Continue to make West Glamorgan a Dementia Friendly Region</td><td colspan="2">Being delivered by the Emotional Wellbeing and Mental Health Programme</td></tr>
</table>

Wellbeing and Learning Disability – Vision and Aims

The Learning Disability board has been established to ensure that Children, Young People and Adults with a Learning Disability in West Glamorgan have a sense of belonging and can participate fully within inclusive communities; they have access to additional support to imagine and reach their full potential and current barriers and inequalities experienced by people with a learning disability in West Glamorgan are replaced by an active assertion of their Human Rights

Develop a capital plan to develop accommodation for people with complex needs.

Reduce social isolation and loneliness

Improve the child to adult transition services

Increase the uptake of Annual Health Checks of people with Learning Disabilities

Increase and develop opportunities for employment for people with Learning Disabilities

Develop a Pooled Fund for Individuals with Learning Disabilities

Wellbeing and Learning Disability – Action Plan

Strategic Aims	What we will do	What will this deliver?	What will this mean?
RPB Strategic Priority: Transforming Complex Care	Coproduce a regional strategy and action plan for people with a Learning Disability living in the West Glamorgan region. This includes the Implementation of the findings of the Welsh Government Improving Lives: Improving Care Review (2021) (MC1)	• A Regional strategy with clear objectives and deliverables that are co-produced by people with lived experience. • A timeline and prioritisation of deliverables that has been coproduced with individuals with Learning Disabilities.	• Increased independence through improved access to services • Improved outcomes for people with a learning disability • People with a learning disability engaging in positive lifestyle behaviours and accessing health services before becoming very unwell
Models of Care Community based care –prevention and community coordination (MC1) Community based care – Complex Care closer to home (MC2)	Pilot a pooled fund between health and social care to support integrated working across all Learning Disability services within the region (via a section 33 agreement)	• Agreement for a pooled fund for shared service delivery across Learning Disability Services • Clearly defined KPI's will be developed to support the implementation	• Partners will have clearly defined joint priorities and targets. • Defined financial contributions and agreement on any uplifts • Eliminate delays in decisions around funding which ensures individual's needs are met in timely manner • Refocus of resources around ensuring progression for individuals
Promoting good emotional health and wellbeing (MC3)	Set up a Learning Disability Liaison Forum to ensure the work of the region is co-produced (enabler)	• Ensuring voices of those affected and with lived experience can feed into the work of the board	• Increased independence and improved outcomes for people with a learning disability • Increase of representation, voice and influence in governance structure and their local communities • People feel more empowered as their voices and opinions are heard
Home from Hospital (Home First) (MC5)	Coproduce, develop a plan and implement a programme that Increases opportunities for people with a learning disability to be involved in their local community (MC3)	• Increase in the number and range of activities for people with a Learning Disability. • Increase and develop opportunities for training, volunteering and employment	• Increased independence and improved outcomes for people with a learning disability • More choice of meaningful activities and opportunities to be involved within their local communities.

Accommodation Based Solutions (MC6)		for people with Learning Disabilities	• Improved emotional health and wellbeing for individuals • Reduced social isolation and loneliness
	Promote Annual Health Checks of people with Learning Disabilities. (MC1)	• Reducing health inequality for people with a learning disability. • Decrease escalating health needs of individuals with a Learning Disability as they now have an Annual Health check	• People with a learning disability engaging in positive lifestyle behaviours and accessing health services before becoming very unwell
	Develop a Regional Transition Policy for Children and Young People (MC1 and MC2) This will be delivered by the Children and Young People Programme		
	Develop a capital plan to develop accommodation for people with complex needs (MC2, MC5 and MC6)	• Timely transition out of hospital • Reduction in number of people in specialist LD hospital care • Reduction in people in residential care • Increase in number of people moving into suitable care that supports progression and develops independence. • Increase in complex care needs being met closer to home	• An increase in people supported to return home or into suitable accommodation in a timely manner. • Providing the appropriate level of care and support at the right time. • Greater understanding of demand across the service enabling better future planning and resource allocation to ensure people's needs are met. • A system that supports the modelling of workforce and commissioned services for the future.

Children and Young People – Vision and Aims

Our vision for this programme is that services across West Glamorgan **support children and young people to be safe, healthy, and prosperous**.

To achieve this, we will need to work closely with Children and Young People, their carers, their families, local communities, and other important stakeholders such as Education in order to hear the 'voice of the child' and understand their rights/needs to co-produce services and support that will meet their needs.

Continue to develop and implement the NEST/NYST Framework

Develop and enhance the services to support the Emotional Wellbeing

Develop Accommodation Solutions to support Children and Young People

Develop and enhance services that wrap around families to promote keeping families together

Develop and enhance the prevention and early intervention services

Support the "Voice of the Child" being promoted when developing services

Children and Young People – Action Plan

Strategic Aims	What we will do:	What will this deliver?	What will this mean?
RPB Strategic Priority **Transforming complex care**	Review and improve models of care that wrap around families to keep families together. (MC4)	• Children and Young People are supported to remain within their family where it is safe and appropriate for them to do so • Reduced need for children to become looked after • Appropriate allocation of resource to families	• Children and Young People to remain within their family • Looked after children number remain stable • Children and families receive the right wrap around support services • Improved emotional well-being and mental health for Children, Young People and Families
Models of Care MC1: Community Based Care – Prevention and Community Coordination MC 2: Community based care – complex care closer to home	Identify and implement transformative prevention and early intervention services (MC1, 3, 4)	• Delivery of services that are more aligned to Children, Young People and Families. • Improved alignment of resources across the region • Improved awareness prevention and early intervention services • Increased awareness in the preventative services and schemes across the region • Increased use of digital platforms (e.g. Tidy Minds) • Improved Information, Advice and Assistance services available	• Improved emotional well-being and mental health for Children, Young People and Families • More children and Young People receive the right support at the right time from the right service • Less Children and Young People experience enhanced services • Reduction in number of children requiring complex residential support
MC 3: Promoting good emotional health and well-being MC 4: Supporting families to stay together safely, and	Develop a regional EWBMH Strategy for CYP (MC3)	• Improved access to Emotional Health and Well-Being support services • Implement a No wrong Door policy for Children and Young People across the region • Improve a whole Systems Approach to change across the region (including NEST/NYTH and Whole School	• Children, Young People and families experience Improved Emotional Health and Well-Being • Children, Young People will always access right service at right time in right place

therapeutic support for care experienced children MC 6: Accommodation Based Solutions		System approach) ensuring that services are accessible and inclusive for all CYP, including disabled children and young people	
	Co-produce, pilot and implement a Regional Transition Policy for Children, Young People with learning disabilities and complex care needs to ensure smooth transition into adult services at the right time. (MC 2)	• Improved support and progression for Children, Young People to transition well. • Improved planning based on accurate data collection and demographics to allocate appropriate child to adult provision. • Joined up partnership working between child and adult services	• Young People will receive person centred support whilst they transition to adult services. • Young People will be involved and empowered to shape their future outcomes. • Young People will be able to access appropriate adult services at the right time to maintain good health and well-being
	Deliver a new regional model for safe, secure accommodation and wrap around support for Children and Young People with complex needs, with a focus on prevention and early intervention. (MC 3, 6)	• Increased sufficiency of suitable placements for children and young people in the region • Improved provision/wrap around support with a focus on prevention and early intervention to reduce the need for Children, Young People to escalate into further complex accommodation provision • Housing solutions that support families, in support of Children and Young People with Mental Health issues or a Learning Disability • Increased understanding of the demand for services versus the capacity and transform services to be able to meet this demand	• Children and Young People will have a range of timely, sufficient and suitable accommodation solutions • Children and Young People will receive person centred accommodation provision • Children and Young People will be able to live as independently as possible and experience positive outcomes
	Develop a robust comms and engagement plan that will ensure the voices of Children and Young People, Parents,	• Improved mechanisms that ensure the voice of the child is heard and acted upon throughout the decision making	• Children and Young People will feel heard • Parents, Carers, Families, Guardians will feel heard

	Carers, Families, guardians and others are considered and heard (MC 3)	and governance of the Regional Partnership Board • Increased participation and engagement, in consultation exercises (MC 3, 4) • Increased co-produced materials, decision making and solutions	• Children, Young People, Parents, Carers, Families, and Guardians feel empowered to help shape and design services
	Develop solutions to ensure earlier access to Neurodevelopmental (ND) and Autism services for CYP and their families in order to address waiting lists: Refer to ND and Autism Action Plan		

Autism and Neuro Developmental Disorders – Vision and Aims

Autism and Neurodevelopmental Disorders (NDD) is a new Programme established to ensure that people with autism and NDD have access to the services and support to participate fully within their communities and live fulfilled lives.

- Ensure groups are formed at a local level to support social interaction, deliver information and advice assistance
- Reduce the number of people waiting for a diagnostic assessment
- Develop and enhance the availability of preventative services that would enable autistic people in their daily lives
- Provide appropriate and timely access to mental health and well-being services
- Improve child to adult transition services
- Further planning in terms of the requirements from the ALNWA Act around a fully inclusive education service needs to continue.
- Ensure a common understanding and consistency across the partners in the way the data is recorded and analysed.
- Engagement with people with autism and their carers to inform future developments for autism services.
- Better sharing of information between partner organisations and people, particularly in terms of the services that are available across the region.

Autism and Neuro Developmental Disorders – Vision and Aims

<table>
<thead>
<tr><th>Strategic Aim</th><th>What we will do</th><th>What will this deliver?</th><th>What will this mean?</th></tr>
</thead>
<tbody>
<tr>
<td rowspan="5">RPB Strategic Priority

Transforming complex care

Models of Care Community Based Care – Prevention and Community Coordination (MC1)

Community Based Care – Complex Care Closer to Home (MC2)</td>
<td>Implementation of Welsh Governments Autism Policy via the mapping and review of services across West Glamorgan against the Code of Practice on the Delivery of Autism Services, including planning the requirements from the ALN Act. (MC2)</td>
<td>• Review of the arrangement for Autism Assessment and Diagnosis
• Review of the Arrangements for Accessing Health and Social Care Services
• Review of the Arrangements for Awareness Raising and Training on Autism
• Review of the Arrangements for Planning and Monitoring Services and Stakeholder Engagement</td>
<td>• This will secure the sufficient provision of services that meets the needs of Autistic people and their families or carers.
• Reduce the number of people waiting for a diagnostic assessment</td>
</tr>
<tr>
<td>Coproduce, develop a plan and implement a programme that Increases opportunities for people with a Autism & NDD to be involved in their local community (MC3)</td>
<td>• Increase in the number and range of activities for people with Autism & NDD
• Increase and develop opportunities for training, volunteering and employment for people with Autism & NDD</td>
<td>• Increased independence and improved outcomes for people with autism & NDD
• More choice of meaningful activities and opportunities to be involved within their local communities.
• Improved emotional health and wellbeing for individuals.
• Reduced social isolation and loneliness</td>
</tr>
<tr>
<td>Review and develop local groups that support social interaction for individuals with Autism and NDD (MC1)</td>
<td>Overview of the current local services available and identified any gaps in communities</td>
<td>Individuals with Autism and NDD are supported to interact and connect with their local communities which will support their emotional health and wellbeing</td>
</tr>
<tr>
<td>Develop and enhance the availability of preventative services that would enable autistic people in their daily lives (MC1)</td>
<td>• Work experience, training, and education opportunities for individuals
• Create opportunities for individuals to develop their independent living skills</td>
<td>Enables individuals to live as independently as possible and to develop their daily living skills</td>
</tr>
<tr>
<td>Set up an Autism and NDD Liaison Forum to ensure the work of the region is co-produced (enabler) (MC3)</td>
<td>Ensuring voices of those affected and with lived experience can feed into the work of the board</td>
<td>• Increased independence and improved outcomes for people with autism or NDD</td>
</tr>
</tbody>
</table>

<table>
<tr><td rowspan="5">Promoting Good Health and Wellbeing (MC3)</td><td></td><td></td><td>Increase of representation, voice and influence in governance structure and their local communities
People feel more empowered as their voices and opinions are heard</td></tr>
<tr><td>Refined information management to strategically support demand and capacity modelling (Enabling Digital Programme)</td><td>A system that will enable staff to understand the demands on services and make appropriate decision making to support people.
Provides partners with a system that enables reporting on Results based accountability measures.
Provides partners with a system that ensures service user qualitative information collected.
Identify gaps in provision.
Greater understanding of demand / issues across services</td><td>A system that supports the modelling of workforce and commissioned services for the future
Partners are more informed on trends in demand and able to better plan resources, enabling more effective future planning
Improved efficiency / allocation of funds across services
Partners have a greater understanding of the quality and impact of support to service users.</td></tr>
<tr><td colspan="3">Develop a Regional Transition Policy for Children and Young People (MC1 and MC2)
This will be delivered by the Children and Young People Programme</td></tr>
<tr><td colspan="3">Provide appropriate and timely access to mental health and well-being services. (MC3)
This will be delivered by the Emotional Wellbeing and Mental Health Programme</td></tr>
<tr><td colspan="3">Provide appropriate and timely access to learning disability services. (MC3)
This will be delivered by the Wellbeing and Learning Disability Programme</td></tr>
</table>

Emotional Wellbeing and Mental Health – Vision and Aims

The Emotional Wellbeing and Mental Health Programme covers mental health as a broad subject across health and social care but focuses on transforming services for adults with or at risk of developing mental health problems. Overarching strategic direction on mental health ensures alignment with other regional programmes of transformation where mental health is a key theme or dependency, such as the Regional Housing Partnership, Carers Partnership, Children and Young People Programme and Learning Disabilities Programme.

The scope of the Emotional Wellbeing and Mental Health Programme covers our regional strategic approach to improving the mental health and wellbeing of our population. Our vision for this programme is **people with mental health conditions and problems can access the services and support where, when and how they need it across health and social care**.

- Develop a strategy in coproduction to support the changes in mental health issues across the region
- Promote the preventative services for Children and Young People and Adults
- Continue to implement the Welsh Dementia Standards and Action Plan
- Work with colleagues to reduce factors that increase mental health issues
- Develop and Enhance prevention and low-level support services for people with Mental Health.
- Ensure that planning is based on accurate data collection and demographics

Emotional Wellbeing and Mental Health – Action Plan

RPB Strategic Priority and Model of Care	What we will do	What will this deliver?	What will this mean?
Emotional Wellbeing & Mental Health Strategy			
RPB Strategic Priority Transforming Mental Health Services **Models of Care** Community Based Care – Prevention & Community Coordination (MC1) Community Based Care – Complex Care Closer to Home (MC2) Promoting Good Emotional Health & Wellbeing (MC3) Accommodation Based Solutions (MC6)	Coproduce and implement a new regional strategy along with implementation plan for Emotional Wellbeing and Mental Health to support the changes in mental health issues and demand across the region. (MC3)	• Implementation plan and new projects to deliver objectives of the strategy to deliver: • Increased access to low level tier 0/ tier 1 services across the region and reduced demand on higher tier services. • Improved multi agency working and delivery of joined up services which improves the quality-of-service delivery. • Increased focus on preventative services, and services which intervene early.	• Improved general emotional health and wellbeing across the region. • Correct, and timelier referral to the right services across the region which will meet the needs of the population at the right time and in the right way, preventing escalation of need and bumped demand. • Increased preventative services and schemes which are easily accessible. • Reduce the need for duplicate self-referrals as people will be able to self-refer to right service the first time. • Improved, easier to access services
	Develop and enhance prevention and low-level support services for people with Mental Health. (MC1)	• Increased knowledge across the region of the various services and schemes available • Improved access to low-level support services • Improved alignment of resources across the region	• People will have access to the right support which meets their needs, at the right time. • People are empowered to make the right choices for their own support/ treatment. • Professionals understand what other services are available in our region, which will allow them better signposting, faster access to support and shorter waiting time.
	Develop and enhance Mental Health links into the Cluster Networks (MC1)	• Increased community support and solutions for lower tier mental health services • Increased peer support, social prescribing, community groups to	• People can receive the right support from within their community. • People will have improved general wellbeing and mental health because there

		improve emotional well-being and mental health. • More people are involved with Cluster Networks	are more activities and schemes available to them. • People will live in stronger communities, which enhance and support one another.
	Promote the preventative mental health services for Adults (MC1)	• Increased awareness in the preventative services and schemes there are across the region. • Increased use of digital platforms. • Improved Information, Advice and Assistance services available	• People make better, more informed choices, improve their wellbeing, and receive faster support for mental health issues
	Coproduce the implementation of the regional Dual Diagnosis Strategy (MC3)	• Deliver a joint working protocol across services. • Increase awareness amongst the workforce in relation to substance misuse and mental health issues. • Increase accessibility of the service to reach more of the population cohorts. • Improve joint planning, working and sharing of information across services. • Increased coproduction of future services with those with lived experience, carers, family, and professionals	• People will receive person centred treatment which meets their whole need. • People with mental health and substance issues will have one access point for diagnosis, treatment, and support. • Less stigma will be associated with substance misuse for those with mental health issues. • People will feel empowered in developing future services designed around real need
	Dementia		
	Implement the Welsh Dementia Standards and Action Plan in line with the national agenda and timelines (MC3)	• Reduces the need for out of county placements. • Improves quality of dementia care across the region • Increased use of innovative and transformational models of care	• People living with dementia receive the support they need as early as possible. • People living with dementia in the region are empowered to live as independently as possible, for as long as possible, taking an active role in their communities.

			• People are more aware of how to live well with dementia, and how to communicate well with a person living with dementia. • Carers of those living with dementia receive better support that meets their needs. • People living with dementia have person centred care packages because there are increased options of support and models of care available
	Review the models of care for provision of Day Services and Residential Care for people living with dementia (MC6	• Improved Day Care services which meet the needs of those living with dementia and their carers • Improved, modern Residential Care services which meet the needs of those living with dementia and their carers. • Innovative, transformative models of care which use assistive technology to promote independent living	• People live more independently, at home or in a residential care setting. • People remain in and part of their communities. • People receive person centred care in an environment which promotes their health and wellbeing.
	Older People's Mental Health		
	Raise awareness with colleagues to reduce factors that increase mental health issues such as poverty, substance use, unemployment, and digital exclusion. (MC3)	• Improved joint planning and working across the region in relation to the provision of mental health and wellbeing services. • Raised awareness with employers across the region of how-to better support staff emotional health and wellbeing. • Implementation plan to meet the needs of the population. • Increased awareness amongst employers across the region of how to prevent mental health issues from	• People will not need to rely on public and voluntary services across the region as support will be more readily available in the workplace. • Reduced referrals to public services as appropriate help and support is available within the workplace and the wider community. • People will experience the right support and the earliest opportunity which isn't always from primary care. • People in the general workforce will be more aware of the relation between mental health issue and substance use and this will

		escalating and support staff experiencing a mental health crisis	allow them knowledge to address those needs appropriately.
	Generic Programme		
	Ensure that planning is based on accurate data collection and demographics (MC3)	• Review and develop the PNA and MSR to ensure solutions are tailored to the needs of our population, addressing the gaps and most prominent issues.	• People continue to receive solutions which are tailored to their needs
		• Increased understanding of current issues and challenges facing the population.	• The population have their needs met in a more effective way. • People live more positive lives, experience faster access to services, shorter waiting times, faster assessment and access to treatment or advice.
	Develop a capital plan to develop accommodation for people with complex mental health needs (MC6)	• Timely transition out of hospital • Reduction in people in residential care • Increase in number of people moving into suitable care that supports progression and develops independence. • Increase in complex care needs being met closer to home. • An increase in people supported to return home or into suitable accommodation in a timely manner. • Greater understanding of demand across the service enabling better future planning and resource allocation to ensure people's needs are continuously met.	• People receive the appropriate level of care and support at the right time, in the most appropriate setting. • People have access to modern, innovative accommodation settings which will enhance their emotional health and wellbeing • People feel empowered as they given more choice in how and where they live. • People are encouraged to remain part of their communities

Carers – Vision and Aims

The Regional Carers Strategy defines our five-year strategy for cares in West Glamorgan. The co-produced strategy was approved in RPB in February 2021. The strategy establishes a clear, concise vision statement and mission statement which will guide our regional plans and actions over the next five years. It also describes the values which we will uphold throughout our efforts to deliver the strategy and the subsequent Action Plans.

The West Glamorgan Carers Partnership has been existence for a number of years and in 2021 established a Carers Liaison Forum to facilitate more regular engagement and coproduction with carers.

Our Mission

We will work together to improve the wellbeing of carers in West Glamorgan by listening, being supportive and delivering changes through the Regional Partnership that meet the rights and needs of carers.

Our Vision

Unpaid Carers are identified, recognised and supported to care. They have a life alongside caring and have a feeling of well-being, throughout their caring journey.

Provide increased short breaks/respite - more innovative approaches are needed.

Ensure that any services development for carers are coproduced which includes the views of young carers

Reduce social isolation and loneliness for carers.

Improve information, advice and advocacy

Improve Carers assessments

Improve information on Direct Payments

Improve Communication with Carers

Develop opportunities for carers to identify themselves

Carers – Action Plan

Strategic Aim	What we will do	What will this deliver?	What will this mean?
RPB Strategic Priority Strengthening Communities **Models of Care** Community Based Care – Prevention and Community Coordination (MC1) Community Based Care – Complex Care Closer to Home (MC2) Promoting Good Health and Wellbeing (MC3)	Review and transform the current respite/ short breaks provision across the region	Improved respite and short break provision which is fit for purpose and meets the needs of service users and carers. (Not all respite needs to be short stay in residential care settings)	• Carers and the people they care for will have more choice to select respite/ short breaks provision which meets their individual needs • Services that support the caring role and lightens the load (not necessarily replacement care) • Carer can receive support to enable carers to stay in work or education • Carers can access services to maintain health and wellbeing • Carers are empowered to develop contingency plans for their loved ones
	Review, promote and improve the access to services for carers (MC3)	• Services are tailored to meet the needs of carers • Increased number of carers assessments • Increased number of applications for Direct Payments • Increased number of applications across funded carers services • Increased provision in services which have responsive and flexible access to mental health and well-being services for carers	• Carers can access services in a quicker, more efficient way • Carers have more autonomy in how support is delivered
	Develop a clear communication and engagement plan (MC1)	• Improved clarity around carers events and communications • Promotion of the services available for carers	• Carers will feel heard • Carers will understand how and where they can take part in activities across the region • Carers will have increased awareness of carers services

Home from Hospital (MC5)		• Increased engagement in consultation exercises to capture the voice of carers	
	Ensure accurate and high-quality information, advice and assistance (IAA) (MC1)	• Coproduced information materials are developed and shared amongst carers across the region • Increased use of accurate IAA material will reduce the failure demand across the sector	• Information is targeted at key areas where carers might identify themselves e.g. mapped across the caring journey and public services • Carers' information is available at key access point to health and social care. e.g. GPs, diagnosis, hospital discharge and social services access points • Routes to carers assessments are clear and easy to navigate
	Pilot a local Carers Hub at a location which is convenient and easily accessible to carers (MC3)	• A physical hub for carers to meet one another, support each other and access key services, information, advice and assistance	• Carers feel part of a strong and vibrant community which supports each other • Carers have opportunity to meet and support each other in a safe, comfortable environment • Carer led groups are commonplace
	Raise awareness of the essential role of carers across the region, including the challenges and issues facing carers today (MC3)	• More people register as carers across the region • Increased consultation with carers in the wider programme • Increase in the number of carers eligible for Direct Payments	• Carers experience improved health and well-being • Carers are consulted in all matters relating to carers and solutions are coproduced • Carers rights are a priority across the region
	Care provision will be coproduced with individuals, carers and families, recognising the importance of people supporting their own health and wellbeing. (MC5)	• Provision of care packages which are tailored to individual needs of the person • Increased use of community support and most effective use of social care.	• Improved outcomes for carers, their families and staff. • High levels of carer, family and staff satisfaction