Area Plan
2023-2028

Cwm Taf Morgannwg
Bwrdd Partneriaeth Rhanbarthol | Regional Partnership Board

www.ctmregionalpartnershipboard.co.uk


Gwasanaethau

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1. Introduction

The Cwm Taf Morgannwg Regional Partnership Board (RPB) is one of seven RPBs in Wales.

We bring together people who use services, with professionals from the NHS, social care, education, housing, the third and private sectors.

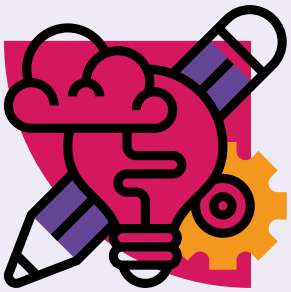
By working together, we aim to improve the wellbeing of the population, and how health and social care services are delivered.

The duty to prepare and publish area plans is set out in section 14A of the Social Services and Well-being (Wales) Act 2014 ('the 2014 Act'). Area plans must be prepared jointly by local health boards and the local authorities within the local health board area, under the direction of the Regional Partnership Board.

They must reflect the fundamental principles of the 2014 Act: voice and control, prevention and early intervention, well-being, and co-production.

This Regional Plan sets out how the Cwm Taf Morgannwg Regional Morgannwg Partnership Board will respond to the findings of the Cwm Taf Morgannwg Population Needs Assessment to guide what heath, social care and wellbeing services are needed in our communities.

As a RPB, we want to ensure decisions are being influenced and shaped by those who live and work in our communities. To gather experiences, insights and ideas, we led a series of engagement activities called hackathons' over a period of 100 days. This involved bringing together professionals and those with lived experiences to look at challenges and create solutions.



What is a hack-a-thon?

The hackathons gave people an opportunity to collaborate with song writers, artists, poets and story tellers to bring to life their experiences, feelings and ideas for the future.

The feedback from these events were captured in our Population Needs Assessment. It was important to widely profile these experiences, so we held a series of events called 'Hear Our Voices'. The events showcased powerful songs and stories written with our communities to inspire positive change.

Watch a film about our Hear Our Voices showcase below.

'Hear our Voices'

In order to provide a better future for the people of Rhondda Cynon Taf (RCT), Merthyr Tydfil and Bridgend, public services must understand the population that live in the area now and the population likely to live here in the future.

This involves an understanding of the wider context of people's lives, what is important to communities, the things impacting on their wellbeing and their individual need for care and support. This knowledge enables services to plan and work more effectively together, including the commissioning of innovative solutions and new models of service delivery, in line with the requirements of the Social Services Wellbeing (Wales) Act (2014).

The completion of the Population Assessment in 2021 has been a significant milestone for the Regional Partnership Board.

The Population Needs Assessment included a range of both quantative and qualitative data which has helped us to understand better what matters to our residents and communities. We believe that the Assessment provides us with a stronger platform from which we will develop our future plans together.

In addition to the Population Needs Assessment the Welsh Government requires local authorities and partners to produce a regional Market Stability Report (MSR) that assesses the sufficiency of care and support services and the stability of regulated services (Regulated by Care Inspectorate Wales). This activity must be carried out as set out in the Partnership Arrangements (Amendment) and Regulated Services (Market Stability Reports) (Wales) Regulations 2021.

You can access the Market Stability Report for CTM here.

* Statutory requirement under the 2014 Act.

This Regional Area Plan is our response to what the Cwm Taf Morgannwg Population Needs Assessment and the Market Stability Report told us.

It is a five year plan, prepared in line with statutory guidance issued by Welsh Government. The plan outlines the range and level of services to be provided in response to the needs for care and support identified in the Population Needs Assessment and Market Stability report.

While this is a five year plan, the priorities and actions identified will be reviewed annually to monitor progress. When appropriate, the plan will be amended to reflect any changes needed. This will empower and enable people in Cwm Taf Morgannwg who need care and support to live the best lives they can and achieve the outcomes that matter to them.

2. Cwm Taf Morgannwg Population Needs Assessment

In 2014, the Welsh Government published the Social Services and Well-being (Wales) Act 2014.

The Act put a 'duty' on Local Authorities, Cwm Taf Morgannwg University Health Board and partners (including the voluntary sector) to think about the overall well-being of people who use care and support services and the carers who help them.

As part of the Act, there was a requirement to jointly carry out an assessment of the care and support needs of our population and the needs of carers. This involved looking at the range and level of services required to meet those needs, as well as the range and level of preventative services.

A summary of the key messages can be found here.

This information has been analysed to identify needs, demand and key messages and will be used to help build a picture of care and support needs for people in Cwm Taf Morgannwg.

We can use what we have learned in this Assessment to think about the ways in which we provide care and support services and, more importantly, how we can work better together to make sure that our services are doing the best for individuals and our communities.

3. Priority Groups

The SSWB Act requires us to look at the care and support needs of the following groups of people in particular:

- Health and physical disabilities
- Learning disabilities and autism
- Mental health
- Sensory loss
- Unpaid carers
- Violence against women, domestic abuse & sexual violence
- + secure estate

4. Development of the Regional Plan: **2022 Hackathon Series**

As part of our annual engagement plan for the Regional Partnership Board activities, a series of hackathon engagement events took place between September-November 2022 to help inform the development of the Regional Area Plan.

As mentioned in our introduction, hackathons were originally piloted as an innovative engagement tool in 2021 as part of the regional 100 Days of Engagement Framework to assist in the creation of the latest Population Needs Assessment.

Our style of hackathons bring together users of services, services providers, and key decision makers in Cwm Taf Morgannwg. The events provide a meaningful space to embark on a process of co-creating and co-designing creative conversation starters upon which further crucial operational and strategic conversations can be undertaken. This helps to inspire and inform positive service improvement and change, and forms the basis of the area plan chapters below.

Watch our film here to find out more

400 people, including users of services and professionals, have directly fed into our Regional Area Plan.

More detail of what each event involved is below:

23.09.2022	**Co-producing Co-production** A hackathon to co-design the regional definition of co production and to develop the basis of a co-production charter, that will later inform a regional co-production strategy for Cwm Taf Morgannwg.
07.10.2022	**Learning Disabilities** A hackathon focusing on a range of case studies that have been highlighted over the past 12 months within learning disability services, to co-design potential solutions for improvement, and the development of wider regional strategies.
14.10.2022	**Mental Health and Wellbeing** A hackathon exploring individual experiences from users of services and the workforce about what mental health and wellbeing means to them, and what is needed to improve population mental health and wellbeing across the region moving forward.
28.10.2022	**Children and Young People** A hackathon exploring the citizen priorities that were identified for children and young people throughout the 100 Days of Engagement Framework in 2021. At this hackathon young people had the opportunity to come together with professionals to share their experiences under each of the priorities and develop creative solutions for future discussion. The work from this hackathon will also feed into the regional work surrounding the NEST Framework and the review of the Regional Statement of Intent for Children and Young People.
04.11.2022	**Older People and Dementia** A hackathon with two primary focuses: loneliness and isolation, and dementia. This hackathon brought together older members of our communities alongside older people, befriending and dementia services to discuss what it means to be an older person in our communities and what challenges they face on a daily basis.

11.11.2022	**Accessibility of Services** A hackathon that brought together those with a range of accessibility needs to look at the barriers and challenges they face in relation to engaging with and having access to the support services they need. This hackathon brought together users of services who experience sensory loss, physical disabilities and mobility issues, and those with communication difficulties to share their experiences and help co-design solutions to help improve the accessibility of our services.
18.11.2022	**Unpaid Carers** A hackathon that brought together unpaid carers from all walks of life, to provide them with a platform to be seen, heard and understood. The hackathon focused on a number of key challenges faced by unpaid carers including access to respite care, mental health and emotional wellbeing support for unpaid carers, and carers' assessments.

These hack-a-thons were supported by four further events in community settings:

07.09.2022	Cartoon drawing with people with learning disabilities to represent their independence and wide range of skills and interests.
12.10.2022	Wellbeing walk and creative activities to explore loneliness and isolation, and the benefits of wellbeing support.
02.11.2022	Tea dance for older people looking at three themes – loneliness and isolation, community support and services, healthcare and hospital discharge.
23.11.2022	Story writing with carers to represent their experiences and one big change they would like to see in services.

5. Co-producing Co-production

Co-production is one of the main principles of the Social Services and Well-being (Wales) Act 2014. Regional Partnership Boards have a responsibility to embed co-productive practice in our work.

At its core, co-production re-balances power structures to create an equal, reciprocal and trusting platform for people to find solutions together. In health and social care, this could mean somebody with a lived experience and a professional working together to improve a service.

As a RPB, we recognise the importance of co-production, and the value the practice can offer to the development and sustainability of services.

However, co-production can take time, and needs the right environment to work effectively. It's important we create the right approach to co-production, which provides space for positive and meaningful collaboration between those who use services and providers.

In 2019, we commissioned a project called 'Our Voice Matters' to identify barriers and suggest recommendations for best practice in co-production and engagement across Cwm Taf Morgannwg.

After undertaking research across the region, Our Voice Matters produced the following recommendations:

- The development of regional ownership and understanding of co-production through the co-creation of regional definitions for relevant terms, including but not limited to co-production and engagement.

- The development of a regional statement of intent for co-production (or co-production charter) and regional co-production strategy to help demonstrate and embed co-production across Health and Social Care services in Cwm Taf Morgannwg.

- Creation of a regional community of practice with the function to oversee and evaluate the implementation of regional co-production practices as detailed within the statement of intent and co-production strategy. This community of practices should also be space for sharing learning and good, emergent practice, through the creation of guides and toolkits, as well as celebrating success to inspire others.

- Development of a workforce and citizen support package to help train and embed the values of co-production for both service providers and users of services.

- To continue the development of a Regional Involvement Pathway that develops a mechanism for people to have a valued voice and for that voice to strengthen the work of projects and services being commissioned and delivered.

- To develop regional co-production criteria for commissioning/ funding of future projects and services, to be included as part of the funding application process. To develop a process for citizen engagement and co-decision making on reviewing and determining the success of local and regional service provider tenders and funding applications, against identified citizen and strategic priorities.

As part of our aspirations to recognise these recommendations and co-produce a regional co-production strategy, a series of work has been launched titled ‘Co-producing Co-production’.

The aim of this work is to bring a wide range of people together, including policy makers, services providers and people with lived experiences to co-design our future co-production journey as a region and to establish the core values and foundational principles that we would like to see realised through meaningful and beneficial engagement to transform and improve our health and social care services.

Launched as part of our 2022/2023 hackathon series, our co-producing co-production work has allowed us to co-create a new regional definition for the term. With over 150 individuals involved in the process our new definition is the starting point of a consistent and sustainable future in which meaningful engagement of both service providers and the users of our services can be used to generate positive change that benefits all.

Our new definitions reads as:

'Co-production positively transforms relationships between those who provide and receive services across Cwm Taf Morgannwg, by valuing lived experience and sharing power to influence and embed meaningful change.'

As we move into the next phase of our strategy development, our pilot co-analysis team of diverse members from across the region and statutory and third sectors will be looking to co-design a co-production charter and statement of intent, against which our regional co-production practices can be assessed. This in turn will create space and structure for recommendation three to be realised in the development of a regional community of practice for co-production and engagement to sit.

In the past 12 months, steps have also been taken against recommendation four, through the development of our flagship 'In This Together' training programme.

This four-module programme helps individuals to understand why citizen involvement is crucial to adding value to our work locally and regionally, and equipping both the workforce and citizens to facilitate and participate in meaningful conversations that build relationship, inspire action and ensure that feedback and communication loop.

Feedback from attendees has been positive and case studies are currently being developed to showcase the impact this training has had on service transformation across the region. Three more cohorts of In This Together training are planned for the 2023/2024 period and the development of a follow-on programme that looks more explicitly at co-production and generates space for piloting innovative engagement techniques is planned.

Whilst this body of work is evolutionary in its nature to embody co-production, the six outlined recommendations currently provide us with a framework in which to focus our efforts. Through annual reviewing we will ensure that these recommendations remain current and as recommendations are completed, we will look to expand our co-production reach and impact through, identifying opportunities for development and trialling new and regionally co-designed innovative engagement tools and techniques such as our hackathons. Our overall goal is to ensure citizen voice remains central to the work of the Regional Partnership Board and Health and Social Care services across Cwm Taf Morgannwg and that we are open to and active pursuing ways to promote our co-production work and ensure everyone involved in the process is valued meaningfully.

6. Communications

Engagement and co-production is only effective if supported by accessible and consistent communication.

We have utilised our website as a main communications platform to share updates, information on events and inspiring stories. Communication tactics have included the development of accessible films to showcase the work that has taken place, social media posts highlighting the importance of getting involved, and the utilisation of our stakeholder management platform to keep in touch with those who attend our events.

Notably, the work is gaining more profile and the songs and spoken word pieces created during our hack-a-thons were showcased at the Lleswyl Festival in February 2023. Lleswyl is a free-inclusive festival for people with chronic illness and was broadcast across Wales.

Between September and March, when undertaking activities to feed into our Regional Area Plan, our social media engagement rate increased by 11.1% (compared to same period last year). This shows more people are interested in the work we are doing and are taking action to be involved.

This is also reflected on our website, with our homepage page views increasing by 10.5%, and general user engagement increasing by 3%.

We also had a 75% increase in new users (supported by paid for advertisements when running an awareness campaign on the All Wales Dementia Care Pathway of Standards).

11%

Social media engagement

10.5%

Website homepage views

75%

New users

7. Governance

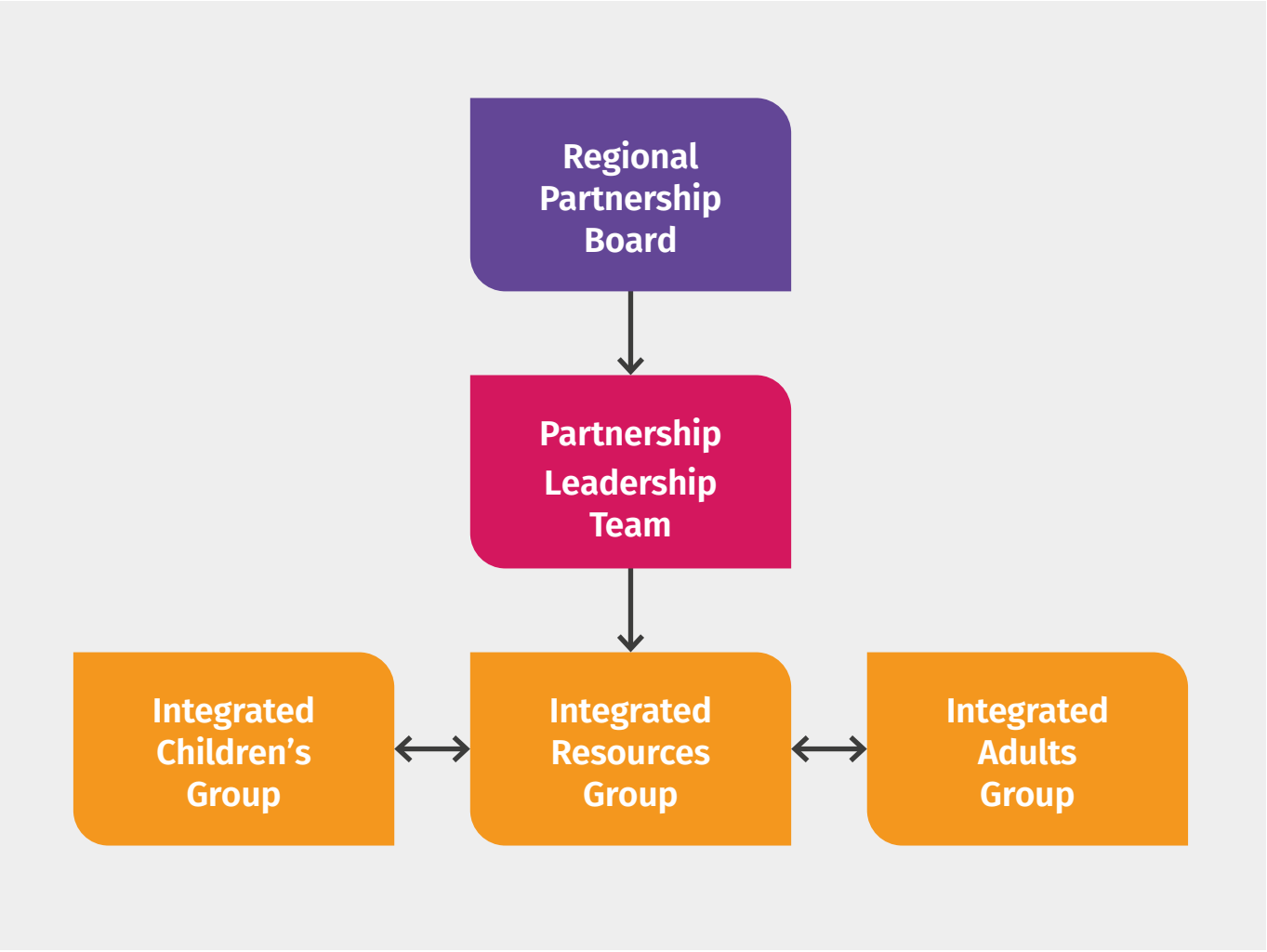
As noted in our introduction, the Cwm Taf Morgannwg Regional Partnership Board* was established to deliver the strategic intent set out in the Social Services and Wellbeing (Wales) Act 2014 specifically Part 9, to improve outcomes and wellbeing of people, as well as improving the efficiency and effectiveness of service delivery.

The RPB is the key leadership body to oversee all integration work across health and social care and to formally represent the interests of the local authorities, the health board and its key stakeholders. The RPB is responsible for monitoring progress and the ongoing delivery of integrated work programmes across the region.

The statutory objectives of the RPB are to:

- Respond to the Population Needs Assessment carried out in accordance with section 14 of the Act;
- Implement the plans for each of the local authority areas covered by the board, which local authorities and health boards are each required to prepare and publish under section 14A of the Act;
- Ensure the partnership bodies provide sufficient resources for the partnership arrangements, in accordance with their powers under section 167 of the Act; and
- Promote the establishment of pooled funds where appropriate

* Note the purpose of the board is also set out in Part 2 Code of Practice (General Functions).



Partnership maturity, governance and culture

Deliberate Design and Governance ensure governance arrangements remain fit for purpose and support the RPB to carry out its business efficiently and effectively.

Continually improve

Infrastructure arrangements to ensure partnership arrangements remain strong and partners can deliver on their partnership duties (under Part 2 /9 of Wellbeing Act)

Continue to drive forward

Innovation and improvement, utilising all available resources across the RPB (including but not limited to the Regional Integration Fund to support development and adoption of new sustainable models of health and wellbeing.

Develop and implement a partnership development programme based on a self-assessment maturity matrix framework that will offer a qualitative and measurable assessment of progress and opportunities for improved partnership culture and understanding, with a focus on coproduction.

8. Children and Young People

A Regional Partnership Board Statement of Intent for Children, Young People and their Families, was developed into a shared regional 'Strategy for Supporting Children, Young People and their Families' upon forming the new region of Cwm Taf Morgannwg.

Within Cwm Taf Morgannwg, Placement Commissioning Strategies are in place and Market Position Statements (MPS) which shape and inform commissioning arrangements for children looked after (CLA), identifying current demand, project future need for foster, residential and supported living for CLA. Despite there being a range of private framework and non-framework fostering and residential providers, the Children's Commissioning Consortium Cymru (4C)'s Regional Vacancy Snapshot Report in July 2020, identified insufficient suitable residential care at the point of need, for those CLA with the most complex needs. Also, there are no same day placement provision available when crisis intervention is required and at short notice.

Social care teams across the region also experience a number of unique young people where existing residential care placements aren't able to meet their complex mental health and emotional needs. These children are unable to be placed alongside other children, necessitating solo placements, due to risk, behaviours or vulnerabilities. Existing models cannot provide the specialist packages of care, tailored to the individuals, required to support their complex emotional and mental health needs, and in some cases where CAMHS interventions may not be the most beneficial, to achieve the best outcomes for them.

Not addressing these needs results in many of the following outcomes:

- Extremely challenging behaviour; physical violence, destruction of property
- Multiple placement breakdown, lack of stability and continuity of care
- Presentation of mental health symptoms, significantly impacting emotional wellbeing, diagnosed or undiagnosed
- Sexual harmful behaviour (SHB) and risks
- Trauma
- High levels multiple risk taking behaviours; self-harm, suicidal ideation, absconding, substance misuse or criminality.

Addressing this gap for this cohort of children and young people, who require highly specialised services and placements, is a focus for current and future development within the region.

8.1 Implementing the NEST Framework

Now more than ever, supporting people's emotional health and well-being is paramount to keeping society healthy and preventing the escalation of health and social care needs. With the impacts of the Covid-19 pandemic this is further realised with an increasing number of people of all ages, including children and young people, being identified as having emotional health and wellbeing support needs.

For further information regarding the roll out of the Regional NEST Framework Implementation Plan please click here.

8.2 Programme for Government: Eliminate private profit from the care of children looked after

The programme for Government included the following:

- Explore radical reform of current services for children looked after and care leavers.
- Eliminate private profit from the care of children looked after.
- Fund regional residential services for children with complex needs ensuring their needs are met as close to home as possible and in Wales wherever practicable.
- Strengthen public bodies in their role as 'corporate parent'.

This will impact directly on:

- Children's residential care including bespoke arrangements with for profit organisations
- Independent Fostering Agencies
- Agency social work and other staffing

A national 'Eliminating Profit' board has been established and mitigating the effects of the agenda feature within capital and revenue plans for the region.

8.3 Work programme

Under the direction of the Regional Children's Board, based on learning from the Population Needs Assessment and Market Stability Report a number of workstreams are being developed:

Pre-birth projects

Projects to support parents/mums during pregnancy either known to social care who have had first, second child removed, or at risk of having new born babies removed. Regional data and child looked after numbers demonstrate the need to support this area, due to increasing numbers of babies removed at birth or under 1 years old.

Parent Wellbeing Project

Need identified to support parent with trauma therapy to address their own wellbeing needs, in order to prevent child/2nd child/ren being removed. This proposal has come forward as a need to commission a piece of work to identify the level of need, research the evidence base regarding best practice and make recommendations on appropriate models or interventions. It should be noted that this project will look to provide direct intervention or trauma therapy for the adult. (It is put forward for consideration due to the essential relationship building that impacts directly on the child in order to avoid cycles of ACEs, rather than this project being considered from the Adults/Older Person RIF budget).

Parent- Infant relationships

The need to develop improved early relationships, bonding and attachment between parent and new-borns, in order to improve the neuro-developmental baby brain pathway, promote positive parenting and prevent future escalation of need/neglect etc.

Specialist Parenting Support for children with disabilities and children with additional needs

Behaviour management support for parents with children with neuro developmental challenges, disabilities, for both post-diagnosis and pre-diagnosis due to significant waiting times from point of referral to receiving clinical diagnosis.

Emotional wellbeing support for 8-11 year olds

Identified as a gap in provision.

Early Help Hub model

Universal access based on identified need for therapy support.

Domestic Violence/Abuse support

Intensive family intervention support, for families demonstrating commitment to address challenges and to remain together, working with both abuser and victim and children, with intensive 6 month support.

Social Care Workforce development

Proposals around systemic change to build on social care model of practice, to build workforce skills set, expertise and capacity to improve existing models of social work, which will lead to better outcomes for children and young people.

Accommodation needs

Proposals that sought funding for existing residential care facilities, and to develop trauma informed practice across children's residential care, and the need identified for respite facilities.

Our integrated approach to meeting the care and support needs of children and young people:

Children, young people and families in Cwm Taf live safe, healthy and fulfilled lives and that they are able to achieve their full potential by building resilient communities.

The shared principles that we will promote are to:

1. Work better in partnership with local children, young people, families and communities to help them achieve their personal well-being outcomes and build resilience.

2. Work positively with children, young people and families taking a strengths-based, co-production approach.

3. Take a place based approach to working collaboratively in and with communities to develop the best possible environment for them to thrive.

4. Focus our intensive support on those children and young people who need help to deal with significant adverse experiences.

9. Our integrated approach to meeting the care and support needs of older people

The ultimate aim of developing a new model of integrated services is to improve health, care and wellbeing across the Cwm Taf Morgannwg Region.

Redesigning a new integrated system that reduces fragmentation and enables services to operate more effectively together, improving individual and population outcomes.

There is a clear focus on redesigning the current system to support resilience within the community and delivering services at a local level where possible. Moving away from the more traditional acute models to focus on community putting the service user at the heart of service design.

With an aging population with growing complexity, to meet increase demand across health and social care we need to work better together, avoid duplication and ensure we make best use of resources.

Our vision is simple:

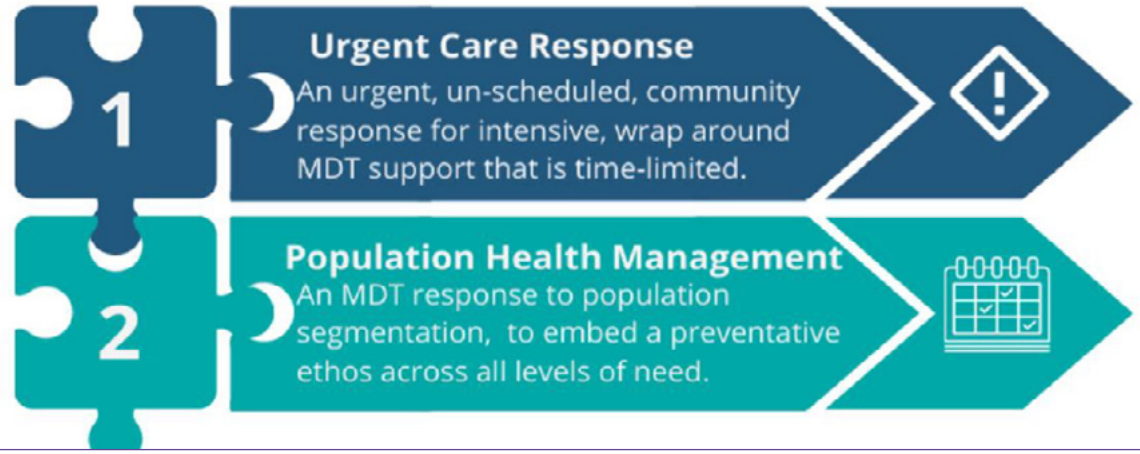
> ***Improving lives with seamless support for health, care and wellbeing.***

Services will be delivered at locality level where possible with multi-disciplinary teams bringing together existing support networks to better deliver seamless care under two integrated pathways, urgent Care Response and Population health management.

Pathway 1: Urgent community response

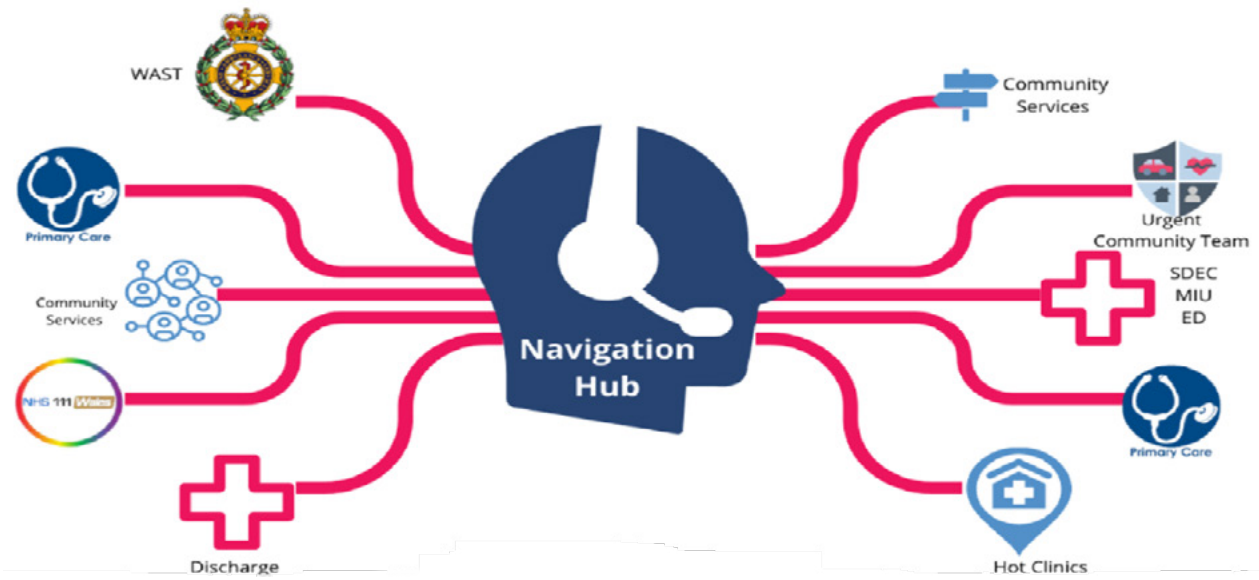
Time limited service provided my professionals from a range of backgrounds to support deterring health where recovery or rehabilitation is needed. This support will be provided at home if possible and will seek to stop needs escalating.

Integrated Pathways



Navigation Hub

This is key to co-ordinating resources and appropriate response. Effectively triaging individuals into services to best meet their needs.

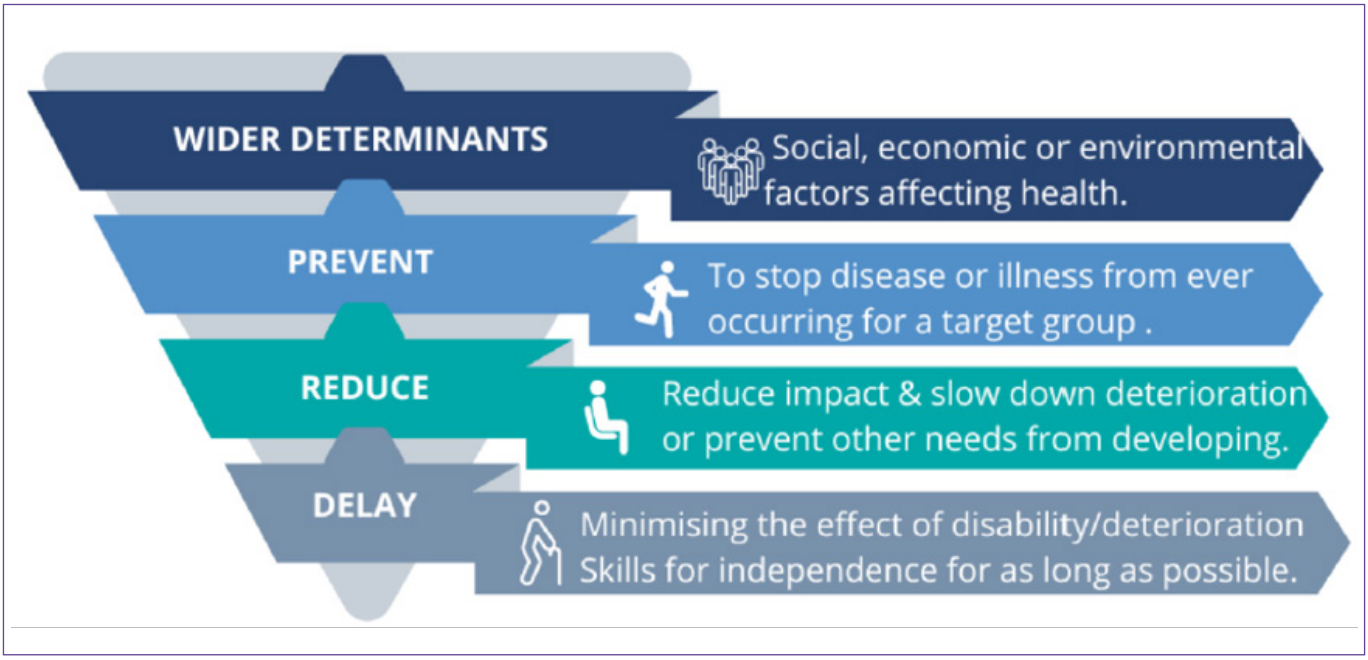


Pathway 2: Population Health Management

Cluster and locality access to a wide range of resources to support health and wellbeing. Help influence analysis, planning and delivery to meet local needs.

Community Networks

Structures around population groups and GP practices. Focus on local assess and resources to support holistic needs and deescalate need:



Workforce

Workforce is key to the success of an integrated model. Work force planning to ensure the right mix and numbers of workers with the right skills, behaviours, competencies and attributes to implement high quality services is needed.

A redesign of the system is underway. This will be a single vision for the region, underpinned by common performance data and governance structure.

10. Dementia

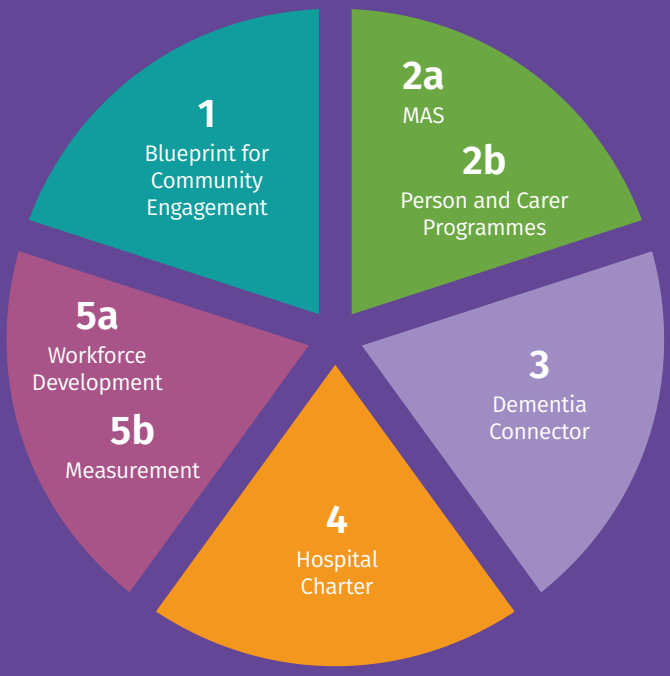
For Dementia there is a distinct national agenda and area of work under the Dementia Action Plan (DAP) and the All Wales Dementia Care Pathway of Standards.

Published in 2018 by Welsh Government, the four-year Dementia Action Plan (DAP 2018-2022) had ambitions to create a society without stigma; where people living with dementia continue to go about their day to day life with the wider public who are understanding and know how to provide support.

The DAP, which is currently undergoing an evaluation period, is supported by the standards published by Improvement Cymru in 2021 and a dementia specific Regional Integration Fund totalling £1.7M. Twenty standards for improvement across five themes were selected from over 100 possible measures as the most important for affecting change for people with dementia and their carers. Known as the All Wales Dementia Care Pathway of Standards, they fall under the following work stream areas; Community Engagement, Memory Assessment Services, Dementia Connector, Hospital Charter and Workforce & Measurement within CTM.

Read about the All Wales Dementia Care Pathway of Standards here.

Workstreams in CTM



Each work stream has responsibility for the delivery of a number of standards and has identified a set of priorities to complement their delivery as outlined below:

Work Stream 1 – Community Engagement

WS1 is responsible for the delivery of the following standards:

1a: Phase one: Community Engagement

1b: Phase two: local delivery plans

13: People living with dementia will have access when needed to relevant (and when accessing mental health services) dedicated services post diagnosis no matter their residence (listed) e.g. physiotherapy, dietetics

14: People living with dementia will have a current face to face appointment where a physical health review will be delivered in partnership by primary and secondary care

18: People living with dementia and their carers / families will have support and assistance to engage with appointments

The work stream has identified the following immediate priorities:

- Complete the community listening exercise
- Obtain a new chair for the work stream

Work Stream 2 – Memory Assessment Services

WS2 is responsible for the delivery of the following standards:

3: Memory Assessment Services (MAS) and Primary Care (GP) adopt READ Codes to capture diagnosis /MCI. Includes Inpatient

4: Learning Disability services will define a process to capture the total population of people living with Learning Disability and specifically Downs Syndrome to offer a cognitive wellbeing check

5: Health and social care services should provide the outcomes of an agreed set of completed assessment & interventions when referring to Memory Assessment services (where presenting need is indicated)

6: Memory Assessment Services within a 12 week period from point of referral provide a range of interventions to support diagnosis. Digital platforms and other adaptions and approaches may need to be considered

7: People access a contact that can provide emotional support throughout the assessment period and over the next 48 hours after receiving a diagnosis and ensure, following this period it is offered as required

8: People living with Mild Cognitive Impairment will be offered a choice of holistic services monitoring their physical, mental health and wellbeing

9: Within 12 weeks of receiving a diagnosis people living with dementia (after diagnosis) will be offered education and information on the importance of physical health activities to support and promote health

10: People living with dementia, carers and families will be offered learning, education and skills training.

The work stream has identified the following priorities:

- Development of a workshop to map what services are available across the area and make the connections
- The creation of the hub model across the region
- MAS services to be developed in Bridgend to provide parity of access.
- More stability in funding of the third sector particularly so that dementia groups in the community don't change or cease or turnover rapidly.
- Communication including the use of READ codes, language preferences (incl. D/deaf users) needs to be standardised and improved
- Strengthening links to social service particularly duty/intake is a priority to ensure services are provided holistically and referrals are appropriate
- Review and strengthen information governance arrangements between health, social care and third sector particular around consent
- Data gathering around MCI needs to be improved

In support of this within CTM we have also planned a MAS workshop to create the optimum diagnostic care and support pathway that provides a consistent offer across the whole of CTM. This will inform the creation of the Bridgend MAS team and will lead to quality improvements within the existing MAS structure across the old Cwm Taf footprint.

In order to ensure that this activity is undertaken in a coproduced way we are also seeking to engage the coproduction network to support this project so that we can ensure that lived experience of dementia from our citizens is utilised effectively alongside our professionals (including allied health professionals) to create the optimum MAS model across our region.

Work Stream 3 – Dementia Connector

WS3 is responsible for the delivery of the following standards:

12: People living with dementia and their carers will have a named contact (connector) to offer support, advice and signposting, throughout their journey from diagnosis to end of life.

15: Within 12 weeks of diagnosis will be offered support to commence planning for the future, including end of life care

The work stream has identified the following priorities:

- Implement the connector role across CTM by:
  - Creating job description and personal specification based on the requirements of the engagement activity
  - Mapping and gapping across CTM to see if there are posts in place that could meet this requirements identifying where roles could be reconfigured and what this would require
  - Identifying cost and potential funding for the role if required
  - Creating interview protocol for engagement with service users and carers if required
  - Feeding back to those with lived experience who have been involved in the engagement activity

Work Stream 4 – Hospital Charter

WS4 is responsible for the delivery of the following standards:

11: Wales will adopt the Dementia Friendly Hospital Charter with a regular review of implementation and outcomes

16: Organisations and care settings providing intensive dementia care, (this includes mental health and learning disabilities inpatient settings) provide Dementia Care Mapping in routine practice

19: Services will ensure that when a person living with dementia has to change / move between any settings or services, care, will be appropriately coordinated to enable the person to consider and adapt to the changed environment

The work stream has identified the following priorities:

- The implementation of the VIPS phased roll out
- The creation of a DCM team

This work stream has also been tasked with the health boards response to the cross party report on dementia services in hospital settings and implementing recommendations from this piece of work also falls under its remit.

Work Stream 5a – Workforce and Learning

WS5a is responsible for the delivery of the following standards:

17: All staff delivering care at all levels within all disciplines and settings, will have the opportunity to participate in person centred learning and development with support to implement into daily practice

The work stream has identified the following priorities:

- Improve engagement and coproduction through Learning and development hackathon / conference events
- Creation of a workforce learning and development plan

Work Stream 5b – Measurements

WS5b is responsible for the delivery of the following standards:

20: Working in partnership the region will deliver on the requirements of the agreed data items (measurement workbook (handbook)) for reporting and assurance

The work stream has identified the following priorities:

- Streamline the MAS data to ensure consistency
- Create system to record number of patients with dementia in order to comply with national audit (in patient settings and elsewhere)
- Support the other work streams with their data requirements

The dementia work streams complement the overarching vision of the region for services for older people and dementia and are working towards implementation of a three year dementia plan ultimately focused on:

- Compliance with the DAP and implementation of the first 20 standards
- Reconfiguration of services where required to achieve a regional consistency.
- Implementation of a coproduction approach across the region for dementia

11. Regional Integration Fund (RIF)

The Health and Social Care Regional Integration Fund (RIF) is a new five-year fund that will help to improve health and social care services.

11.1 What is the RIF aiming to do?

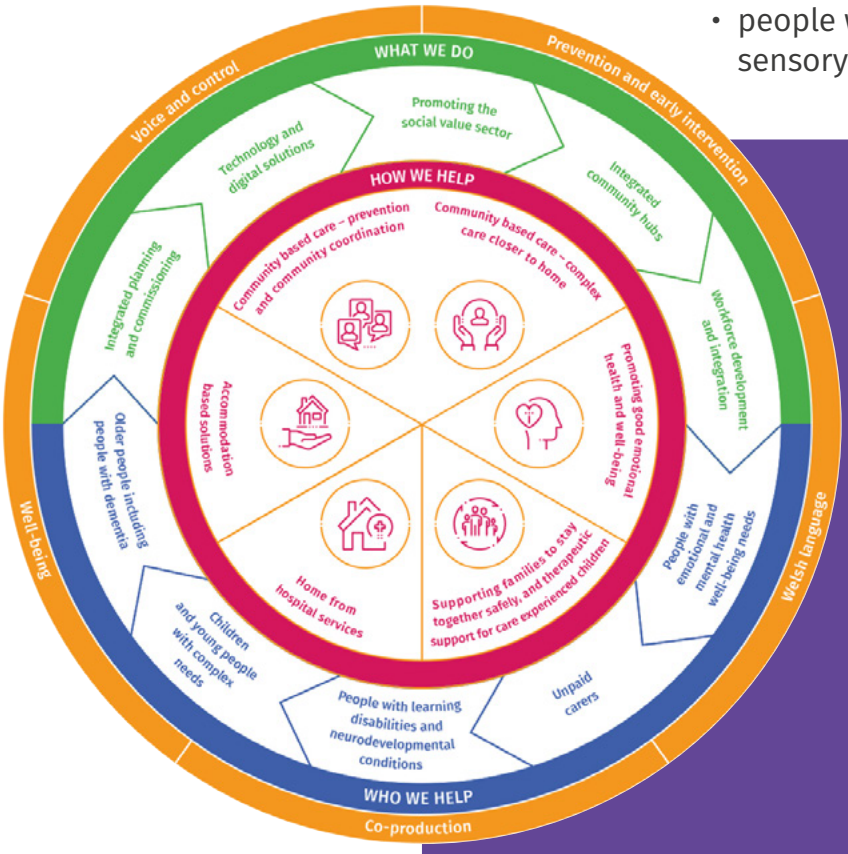
The RIF will help organisations working in health, social care and wellbeing to do the following things:

- Focus on prevention and tackle challenges at an early stage
- Work together to develop 'joined up' health and social care services
- Share experiences and learnings together through dedicated groups called 'communities of practice'
- Bring together staff from different organisations to deliver services

11.2 What services will the RIF support?

These models of care will need to meet the health, social care and wellbeing needs of our residents. This includes:

- people with learning disabilities
- unpaid carers
- autistic people, their families and carers
- people living with dementia
- older people
- children and young people
- people who access mental health services
- people with physical disabilities and sensory impairments



11.3 What are the models of care?

The six models of care that the RIF will support are as follows:

Community based care – prevention and community coordination

This includes community services that help to protect residents from longer term health or wellbeing problems, including befriending groups, community hubs, falls prevention, and access to wellbeing services.

Community based care – complex care closer to home

This will help to improve recovery following a period of ill health, helping people to be more independent in the long term. Support could include help at home from specialist teams who work in the community, and community rehabilitation.

Promoting good emotional health and well-being

Improving mental health and wellbeing in our communities is a priority. This will help create and improve services for both adults and young people who need emotional health and wellbeing support.

Supporting families to stay together safely, and therapeutic support for care experienced children

Health, social care and education partners will work together with families to help them stay together safely and prevent the need for children to become looked after.

Home from hospital services

Some people will always need treatment in a hospital environment, so this will help people to be discharged and recover at home safely and quickly. It also ensures those who do need acute care can access it easily.

Accommodation based solutions

It's vital people have warm, safe and supportive living environments. This includes developing independent living facilities, organising home adaptions and building accommodation for children with complex needs.

12. Capital Funding

Housing with care Capital Funding (HCF)

Welsh Government has provided 60M of national funding into new Housing with Care Capital Funding (HCF). The capital allocation for the Cwm Taf Morgannwg region is £8.729m per annum (2025/26 allocation to be confirmed).

Capital Investment can be made into three priority objectives:

Objective 1

Service users must hold tenancies

- Extra care housing (15-60 units) for older people with care needs.
- Supported living accommodation for adults with learning disability, or adults with mental illness or young people leaving care.

Objective 2

No tenancies

- New small scale (4-6 units) residential accommodation for children and young people.
- Short to medium term accommodation for adults with higher needs and/or behavioural challenges.
- Intermediate care settings e.g. step up/down, reablement/rehabilitation flats, training, respite for carers/cared for people.

Objective 3

Small scale projects:

- Repairs, refurbishments to existing housing with care/intermediate care settings, equipment, adaptations to existing homes, top up of Disabled Facilities Grants above £36,000, other small-scale projects, including digital aids and assistive technologies.

A regional capital board advise and give strategic direction to the RPB, regarding investing regional capital funding into identified capital projects and schemes that support the priorities for investment against the target client group of older people, those with dementia, people with learning difficulties, and neuro-developmental conditions, children with complex needs and carers.

In particular:

Development of a 5-10 year Capital Investment Strategy

To develop a regional Capital Investment Strategy, which translates into a regional 5-10 year capital plan for investment across Cwm Taf Morgannwg, using data identified through the population needs assessment, with particular focus on accommodation needs and solutions (beds). Identifying key priority projects for Housing with Care (HCF) and Integration and Rebalancing Care (ICRF) funding investments that promote: hospital discharge, step down facilities, independent living, supported living, eliminating profit agenda, developing integrated health and social care facilities and models.

You can see read the strategy here.

Management of Housing with Care Funding and Integration and Re-balancing Care funding

To review appropriate capital funding applications seeking regional funding, against agreed priorities for RPB endorsement, and management of HCF funds on an annual basis, management of any identified slippage and supporting the development of business cases to invest IRCF funding into regional schemes.

The CTM Population Needs Assessment, Market Stability Report, national policy drivers and local knowledge has suggested early potential areas for capital development:

- Extra Care Programme for older people
- Step Down / Step up accommodation / D2RA – hospital discharge schemes
- Supported accommodation for people with mental health & learning disabilities
- Reconfiguration of existing care home, increase capacity and more specialist nursing accommodation for older people
- Maesteg Community Development
- Primary care / H&WB spaces/ Community Hub expansion
- Nursing Home care - Dementia
- Navigation hub
- Children's Residential Care 'Eliminating Profit'


Lizzie
9

Aligining capital strategy to RIF 6 models of care:

Deliberate Design and Governance ensure governance arrangements remain fit for purpose and support the RPB to carry out its business efficiently and effectively.

Community Based Care – Prevention and Community Coordination

Theme:
Integrated Joint Models of Provision or Hubs (IRCF)

Emerging Capital Developments:

- Maesteg Community Development
- Primary care/H&WB spaces/ Community Hub expansion

Home from Hospital

Theme:
Older People – Hospital Discharge

Emerging Capital Developments:

- Step down/Step up accommodation/ D2RA
- Navigation Hubs

Community Based Care – Complex Care Closer to Home

Theme:
People with Learning Disabilities/Mental Health

Emerging Capital Developments:

- Mental Health and Learning Disabilities
- Supported accommodation on MH

Theme:
Older People – Specialist/ Other Care

Emerging Capital Developments:

- Reconfiguration of existing care home capacity
- Nursing Home Care – Dementia

Accommodation Based Solutions

Theme:
Older People – Promoting Independent Living

Emerging Capital Developments:

- Extra Care Housing Facilities

Theme:
Children Looked After/with Complex Needs

Emerging Capital Developments:

- Children's Residential Accommodation 'Eliminating Profit'

13. Welsh Government Policy Landscape

A Healthier Wales

A Healthier Wales: our Plan for Health and Social Care (2018) focused on strengthening community care services and set out the plan for a long-term future vision of a "whole system approach" to health and social care, focusing on health and well-being and preventing illness. The vision is supported by the Quadruple Aim outlined in the diagram below.

The Healthier Wales ambition is still evident in three major national programmes

- The Strategic Programme for Primary Care,
- The Urgent and Emergency Care Programme, and the
- Regional Integration Fund/ RPBs (see above)

The 'Further, Faster' – our mission to build an Integrated Community Care Service for Wales' seeks to accelerate integrated community services activity and plans to jointly develop and put in place a community care service and workforce model to make a significant positive impact on our system ahead of Winter 2023/24.

Establishing a comprehensive community care model ensures a full range of preventative and early intervention services are available locally. This will involve new delivery structures, moving the workforce and creating new roles so that, for example, community first responder services, more therapy and reablement workers, enhanced domiciliary care roles, community nursing and allied health professionals are the priorities for service and workforce development. Building on successful models service specifications will be developed nationally upon which to benchmark and model regional delivery.

The RPB therefore has an important role to play in delivering the further faster agenda. Flexing the existing governance structures and aligning planning and delivery there is an opportunity to achieve an agreed vision for integration for the region and meet the ambitions set by Welsh Government.

13.1 Six Goals for Urgent and Emergency Care

The six goals, co-designed by clinical and professional leads, span the urgent and emergency care pathway, and reflect the priorities in the Programme for Government 2021–2026 to provide effective, high quality and sustainable healthcare as close to home as possible, and to improve service access and integration.

There are a number of links and crossovers between the 6 goals programme and Regional Integration Fund (RIF) that have been mapped. The 6 goals board is aligned under the RPB Governance structure and there are multiple areas of work being delivered in support of the programme for government.

13.2 Accelerated Cluster Development

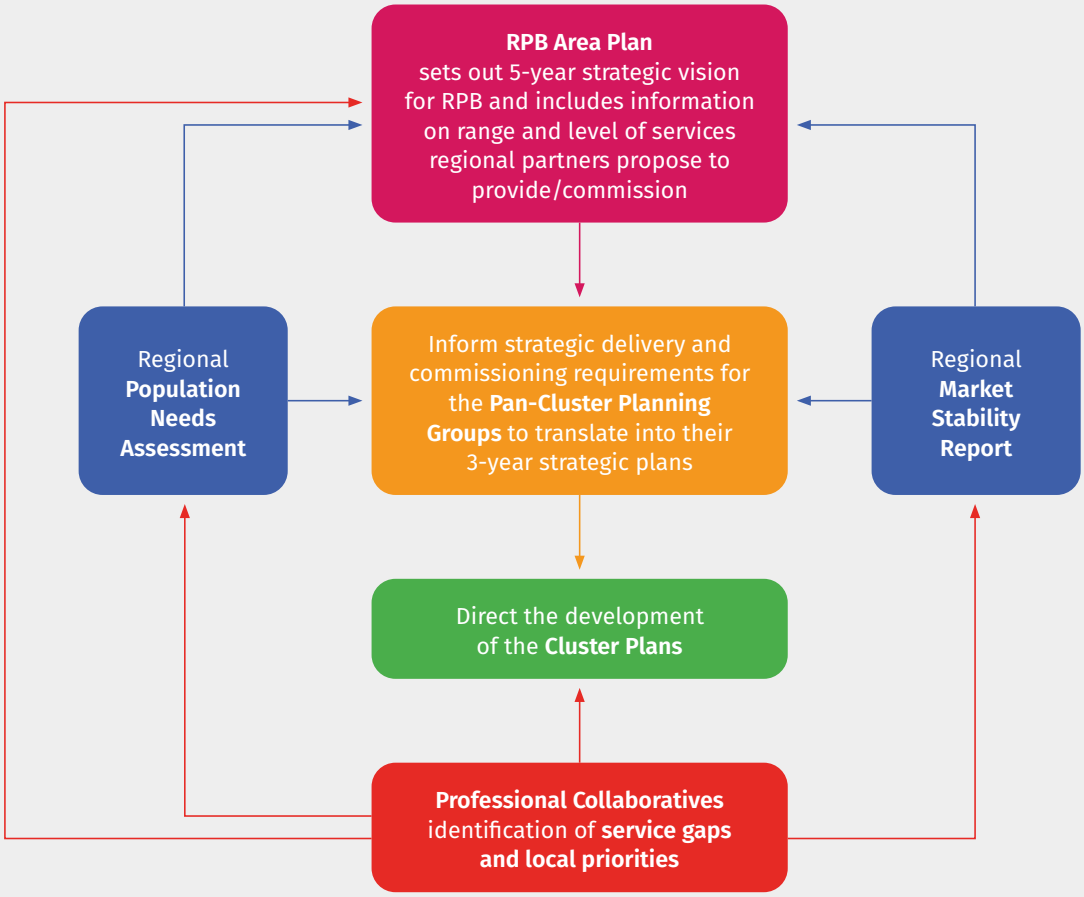
RPBs must take all opportunities to align their work with clusters. To support RPBs to do this, the Rebalancing Care and Support Programme includes a formal task and finish group on strengthening the planning system and one for collaborative service delivery. This will inform new legislative framework around RPBs within the Social Services and Wellbeing (Wales) Act.

It is important that Clusters, Pan Cluster Planning Groups and RPBs work closely ensuring that they offer greater value as a whole than just the sum of their parts. Without carefully designed and described alignment between cluster, pan cluster and regional planning and delivery mechanisms there is a potential risk of duplication of effort and even tension between partnership arrangements.

In 2022/2023, the Welsh Government's Minister for Health and Social Services launched a national programme to accelerate cluster-based working and strengthen links between clusters and the Regional Partnership.

In this model the role of the Regional Partnership Board is to provide oversight of Pan-Cluster Planning Group, planning and commissioning activity and to manage information flow between the clusters, health board and social care. These linkages as shown in the diagram below.

Relationship between RPBs and Pan-Cluster Planning Groups



The programme aligns with RIF place based care and focusses on:

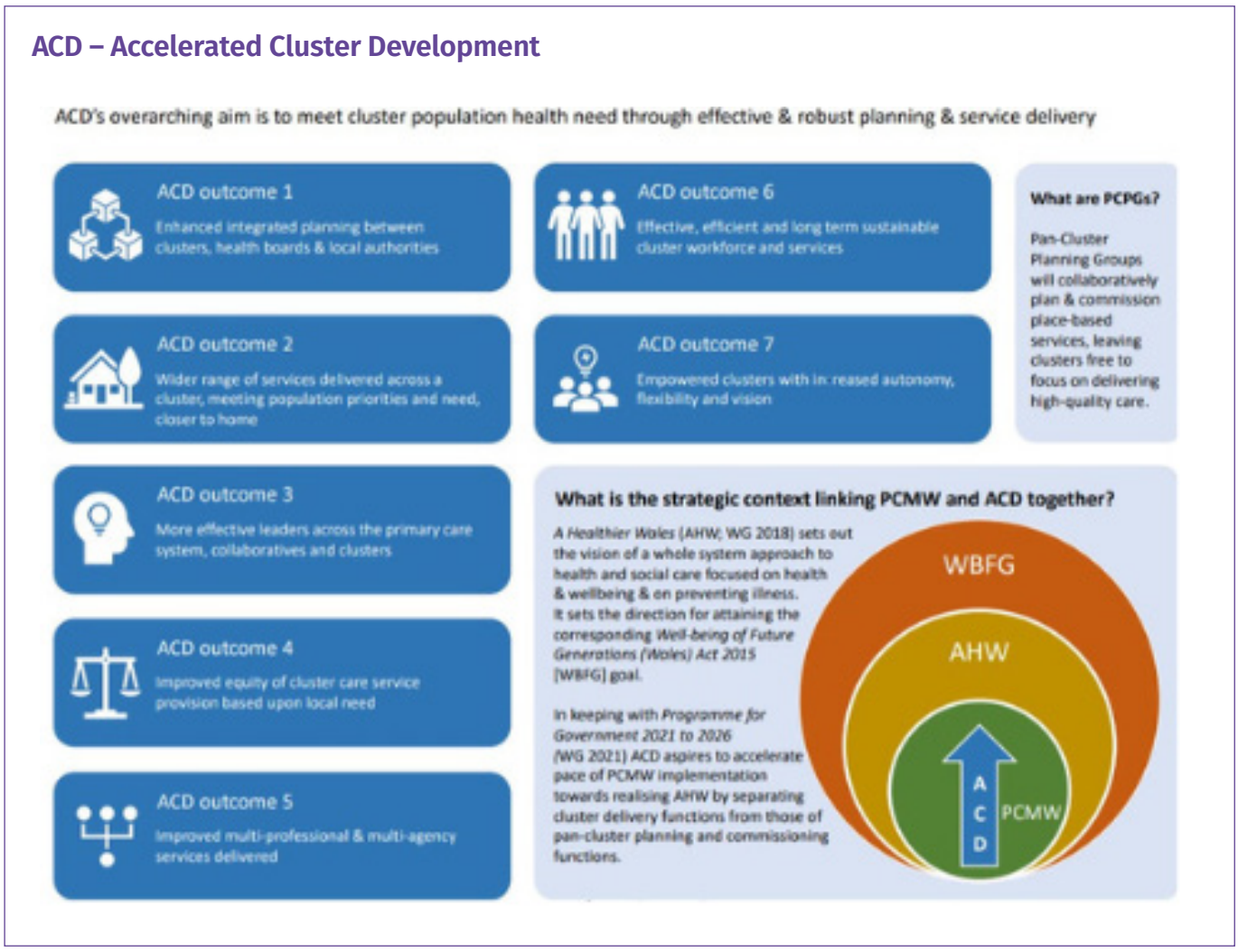
- Place-based care on cluster footprint.
- Community assets to support resilience and self-care.
- Connected communities
- Connected services
- Stable and sustainable primary care

The Cwm Taf Morgannwg area comprises of eight clusters – Rhondda; Taff Ely; Merthyr; North Cynon; South Cynon; Bridgend East; Bridgend West, and Bridgend North.

Accelerated Cluster Development, and the establishment of professional collaboratives, multi-profession clusters and strategic-level pan-cluster planning groups will continue to be a priority for 2023/24. Although there are eight clusters the pan cluster planning groups or 'Locality Planning Groups' are organised to be coterminous with the LA footprint. Therefore there are three Locality Planning Groups.

For further information information please click here.

In November 2021, the Strategic Programme for Primary Care (SPPC) launched the Advanced Cluster Development (ACD) programme and have described the ambitions of what ACD will deliver through seven outcomes as listed in the diagram below:



Essentially the aim is that the clusters will be the platform for:

- Supporting population health management to reduce inequalities
- Enabling personalised care to ensure care needs of our patients are met
- Reconfiguration of our community services
- Focus on continuous improvement and reducing variation

The Cwm Taf Morgannwg University Health Board (CTMUHB) vision which aligns to Accelerated Cluster development, is for an integrated community model of health, care and wellbeing, which will be the main delivery model for out-of-hospital health and social care services in CTMUHB.

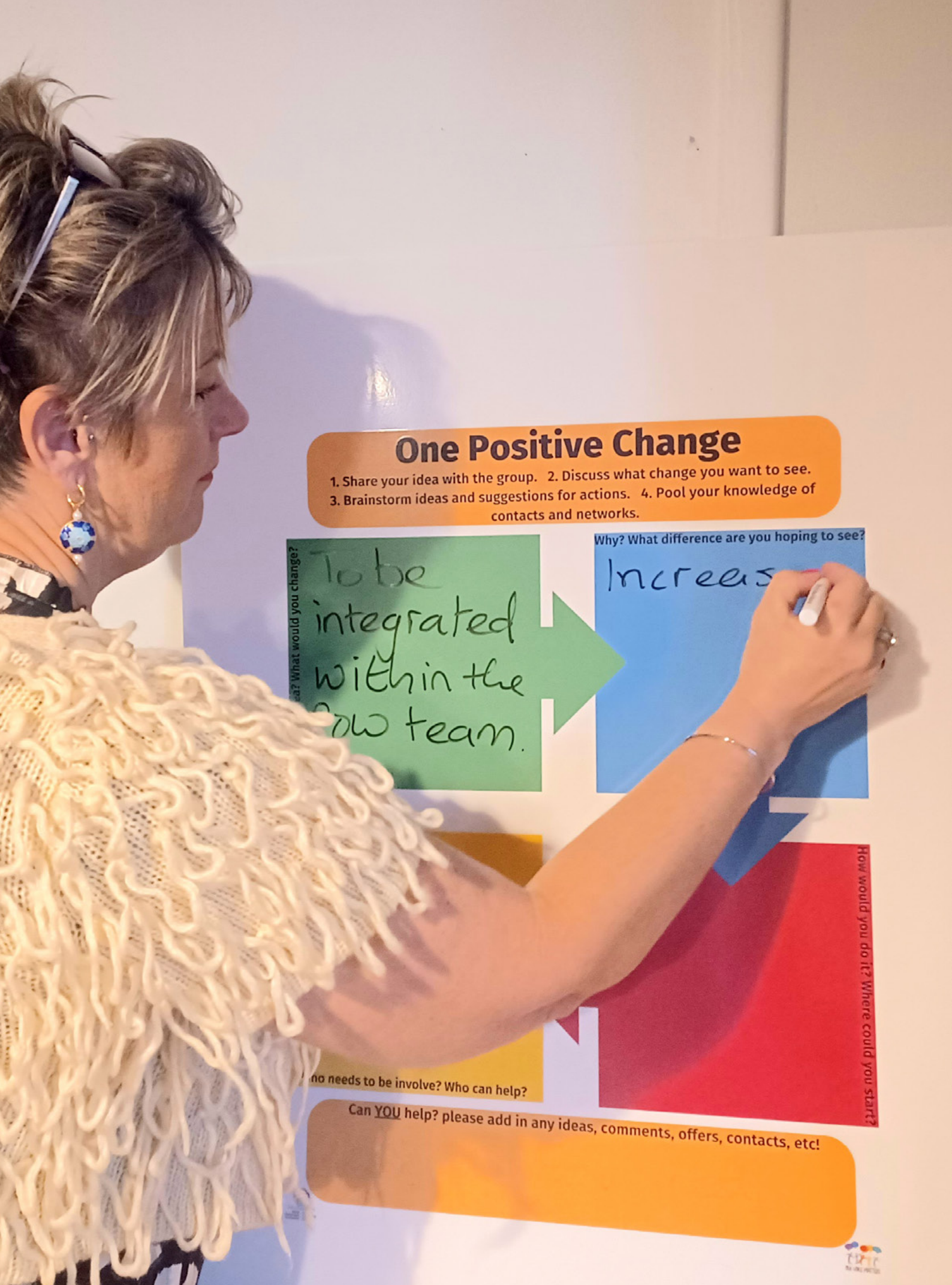
The integrated model will be built on the following principles:

- Consistent standards, outcomes, performance and monitoring through the Regional Partnership Board integrated structures
- Strong, resilient, co-terminus partnerships through Locality Planning Groups (or Pan Cluster Planning Groups)
- Effective and appropriate data and outcome monitoring, valuing time spent at home
- An integrated, supported and resilient workforce.
- Appropriate demand and capacity modelling that adapts resources accordingly
- Flexible and resilient working models
- Resilient resources, reflecting the shift to a community model built on a strong integrated workforce
- Provision based on local need with sustainable and effective resources

The approach taken in CTM in the first year of ACD has been through a planned series of engagement events/development sessions to support the change in thinking from where clusters are now to an integrated model of planning, service design and delivery.

During 2022, professional collaboratives started to be put in place. These are professional specific groups who meet on a cluster footprint to represent the service they can provide for their community based on the health needs. Initially the first professional collaboratives to be set up are based on the contractor professions and then other Primary Care based professions will emerge over 2022/2023.

The GP collaborative is formed from the original clusters supported by Cluster Development Managers. Pharmacists have already been working very effectively with clusters in a clinical capacity and this has been within the pharmacy contract since 2021. Eye Health Wales funded a pilot optometry collaborative in Taff Ely during 2022/23 which is now seen as an exemplar of an Optometry Collaborative across Wales and is the model being rolled out across CTMUHB.


One Positive Change
1. Share your idea with the group. 2. Discuss what change you want to see.
3. Brainstorm ideas and suggestions for actions. 4. Pool your knowledge of contacts and networks.
a? What would you change?
To be integrated within the ow team.
Why? What difference are you hoping to see?
Increas
How would you do it? Where could you start?
no needs to be involve? Who can help?
Can YOU help? please add in any ideas, comments, offers, contacts, etc!

14. Public Service Board

The Cwm Taf Morgannwg Public Services Board (PSB) brings together the previous PSBs in Cwm Taf, covering Merthyr Tydfil and RCT, and Bridgend to form one PSB for the Cwm Taf Morgannwg area.

The new board comprises of public bodies, who deliver services locally to improve the social, economic, environmental, and cultural well-being by setting objectives that will achieve the Well-being Goals outlined in the Wellbeing of Future Generations 2015 Wales Act.

The Wellbeing assessment provides the evidence base for this wellbeing plan, the data and information gathered has been used alongside what local communities and people have told us about life in Bridgend, Merthyr Tydfil, and Rhondda Cynon Taf.

The overarching theme of the Well-being Plan is 'A More Equal Cwm Taf Morgannwg' and that drives every aspect of the Public Services Board's work. Read the plan here.

15. Integrated Health and Social Care hubs

The programme for government included a commitment to develop integrated health and social care centres and hubs.

Funding has been made available to faciliate the development of seamless, integrated delivery of services through health and social care hubs to support the change in systems, processes, cultures, and behaviours will ensure hubs are more than buildings containing co-located services.

An agreed definition of a hub is being developed through a national Community of Practice, five broad levels of hub, as set out in the table below.

Building on existing capital and integrated developments a community hub regional programme will be developed and implemented.

Community wellbeing hub	**General health and wellbeing hub**	**Specific population group health and wellbeing hub**	**Health and care centre**	**Other** (not a hub within the programme)
Offering general wellbeing support, support with housing and employment, anti-poverty services to a geographic community	Offering general wellbeing services (as listed above) and specific health and wellbeing services e.g. leg clinic, mental health support, allied health professional outreach services	Offering health, care and wellbeing services for specific population groups and not open to the wider community population as a whole	Larger facility with substantive community and health and care services including GP practices, maybe part of accelerated clusters	Including blended types and health and care networks without a physical building
Focused on enhancing access and enhancing community facilities in small and/or rural populations	Operating either five or six days a week with smaller catchment population these facilities may host some clinical staff and also periodic additional multidisciplinary services	As above, but aimed at a particular group in the population, such as children, people with learning disabilities etc	A hub for primary and community services across a wider locality and catchment population	
Delivered in a shared accommodation and accessible on a flexible basis over an agreed number of days per week	Wellbeing services, either operated by the LA or third sector will be available on site		In addition to core and enhanced community services these facilities should provide a wide range of fixed community and health resources on substantive and/or sessional basis	
Facilities should be linked to a wider integrated health and care system so that all patients have access to a wide rrange of services and when they need it, but the facility will have the opportunity to be maintained by the local community under a cooperative mode, potentially with some light touch support from larger facilities	Likely to have public wellbeing resource access and digital consultation rooms		Diverse range of both clinical, community and commercial capacity, including pharmacy, care navigation and wider advisory services	
Members of the public particularly with the transport or mobility limitations should be able to access a range of digital resources and occasional visiting services at the facility			Accessible through a range of self-presenting and booked routes and should include a range of community resources to encourage the populations to engage with health improvement services	
			Facility assessable seven days per week, but some services would only be available on a booked basis during core office hours	

16. Workforce

Workforce development for ‘A Healthier Wales’. Creating a motivated and sustainable health and social care workforce.

One of the four quadruple aims outlined in the document, ‘A Healthier Wales: Our Plan for Health and Social Care’, is to have a motivated and sustainable health and social care workforce that delivers a truly seamless system of health and care. This calls for a fundamental shift in our understanding of who constitutes the workforce, and how we support the contribution that each individual makes. Requiring not only ‘greater parity of esteem’ between health and social care professionals, but also recognising and supporting the vital role played by the informal workforce of unpaid carers and of volunteers.

To support new models of care, health and social care services must strengthen the support, training, development and services available to the workforce, with a focus on building skills across a whole career and supporting their health and wellbeing.

New seamless models of health and care that emerge, require a clear and coherent approach to developing and planning the whole workforce. To meet this need, Welsh Government commissioned Health Education and Improvement Wales (HEIW) and Social Care Wales (SCW) to develop a long-term workforce strategy, in partnership with NHS and Local Government, the voluntary and independent sectors, as well as regulators, professional bodies, and education providers. The workforce strategy aims to address the Parliamentary Review’s call for joint regional workforce planning.

The workforce strategy also identifies dynamic leadership will be needed to instigate change, empower others and lead by example, as well as create conditions for continuous innovation and improvement, to drive up the quality and value of services.

17. Pooled Fund arrangements

The Partnership Arrangements (Wales) Regulations 2015 required partnership bodies within each regional partnership board area to establish and maintain pooled funds in relation to:

- The exercise of care home accommodation functions
- The exercise of family support functions.

The 2015 regulations (as amended by the Partnership Arrangements (Wales) (Amendment) Regulations 2017) require that if any of the partnership bodies decide to do things jointly in response to the population assessment, they must consider whether it is appropriate to establish and maintain a pooled fund.

Within Bridgend there has been a long-established Section 33 agreement and similar legal agreement in RCT and Merthyr Tydfil with regards to the Stay Well at Home service.

Pooled funds are a recognised way of:

- Achieving that integrated response
- The most vivid way of demonstrating a commitment to partnership working.
- The Welsh Government very strongly supports the development of pooled funds and there are clear requirements and expectations in the Act, Regulations and guidance.

18. Action Plan (2023-2027)

Our priorities for the next five years are detailed below.

These have been informed, influenced and shaped by our communities and professionals working in services. While the detail may adapt to reflect changes in needs, the priorities reflect the actions that are most important to those who live and work in Cwm Taf Morgannwg.

Progress against these actions will be updated via our website: **www.ctmregionalpartnershipboard.co.uk/ourpriorities**

1. Adults and older people – Deliverables and Outcomes

Co-produced priorities	What are we trying to achieve?	What will we do (actions)?	What difference will this make (impact)?
1.1 Older people and people with dementia will receive the support they need to remain in their home for as long as possible, or to move back home as quick as possible following a hospital admission.	• Improved continuity of health and social care services delivered to older people. • Improved choice and a sense of control when it comes to how, where and when they receive support from services. • Improved access to relevant information so older people are aware of support available before needs escalate.	• Implementation of Regional Optimum Model for Cwm Taf Morgannwg. • Further develop and implement our integrated approach to meeting the care and support needs of older people • Develop and implement regional approach to Falls Prevention • Expand Trusted Assessor Models • Deliver the ambition of 'Further Faster 'to build an Integrated Community Care Service for Wales • Support further community hub developments.	• Reducing unscheduled care admissions for people over 65 • People will remain active and independent in their homes and communities.
1.2 Older people and people with dementia will be able to participate in, contribute towards and access services within their communities.	• Improve the accessibility of health and social care services within communities across our region. • Develop inclusive communities, providing more opportunities for older people to participate in activities. • Improve sharing of information about and increase the number of social opportunities available older people.	• Our ambition is to shift services out of hospital to communities, and we want more services which stop people getting ill by detecting things earlier, or preventing them altogether. This will include helping people manage their own health, and manage long term illnesses. • Support individuals to remain active and independent engaging with voluntary sector partners. • Continue to support social prescribing and wellbeing support.	• People remain active and independent in their homes and communities.
1.3 People with dementia and their families will have access to the information, advice and guidance that they need.	• Improve the awareness across all relevant areas of the early signs of dementia. • Improve access to information so people better understand how they can support someone with dementia • Develop safe spaces so people can attend services and activities in their communities. • Develop a team around the individual approach. • Equity of support available across the region	• Implement the dementia Care Pathway of Standards. • Continue to promote Dementia Friendly Communities • Review commissioned dementia support.	• Better informed about what services/activities are available.

Co-produced priorities	What are we trying to achieve?	What will we do (actions)?	What difference will this make (impact)?
1.4 Older people and people with dementia will be supported to engage in their local community and have a quality of life where loneliness is minimised.	• Older people, including carers, will be considered as a valuable part of the health and social care received. • Improved social connectedness and encourage generational positive relationships. • More opportunities for older people to engage in community activities. • Improve access to community activities for people with sensory loss, physical disabilities or mobility issues. • Older people have access to information and advice about services and opportunities.	• Scope available services and identify gaps. • Co-produce solutions to meet identified needs.	• Older people feel more connected within their communities. • Reduced loneliness and isolation. • Increased take up of activities and support.
1.5 Older people and people with dementia will enjoy good health and wellbeing and supported to live independently for longer.	• Improve/increase the opportunities for home adaptions/modifications that will allow people to stay in their own homes longer. • Improved inclusion within their communities and feel they have a sense of purpose. • Increased opportunities to participate in physical activities tailored to older people's needs • Raise awareness and understanding of issues associated with mental health and well-being in older age. • Improve digital inclusion	• Continue investment in aids and adaptations through capital programme. • Seek innovative digital solutions to support people at home. • Engage with wider partnerships to better understand availability of activities	• Reducing unscheduled care admissions for people over 65 • Reducing the time spent in an acute hospital setting following an unscheduled care admission for people over 65.


TRANSPORT
TIME
TRAINS v BUSES
ON LIFTS
CLINICS
ARE AT

2. Learning disabilities – Deliverables and Outcomes

Co-produced priorities	What are we trying to achieve?	What will we do (actions)?	What difference will this make (impact)?
2.1 Suitable/appropriate transport infrastructure that will enable access to a range of services, including social and employment opportunities, that are available to people without a disability.	• Improve the options and accessibility to travel safely. • Increase the understanding and knowledge to safely access a range of travel options. • Ensure information is accessible and easy for people with a learning disability to understand.	• Increase opportunity for travel training and/or supported travel to allow. • Increase local cultural and social events for people with learning disabilities	• More people with a learning disability will be able to travel safely across the region • People with a learning disability will be more confident to travel. • More opportunities for people with a learning disability to engage.
2.2 Affordable and appropriate accommodation that supports people with a learning disability to live independently.	• Better understand the housing options for people with learning disabilities across the region. • Improve the housing options available for people with a LD across the region. • Improve the experience of people with a LD in the areas they live. • Better prepare people with a LD when transitioning to independent living.	• Review of housing options for people with a learning disabilities • Needs of people with a learning disability will be reflected in the regional capital programme. • Develop new properties in areas of high demand • Improve accessibility to the community services. • Review current transitional arrangements and make recommendations for improvement	• People with a learning disability will be better aware of accommodation options • Accommodation options better meet the need and demand of people with a learning disability • New build programmes are informed by people with a learning disability. • Improved access to community based provision. • Reduce the anxiety experienced by people with a LD when during transitional periods
2.3 A modern, accessible and appropriate respite offer.	• Better understand the issues with the existing model of respite care. • Improve the respite offer across the region. • Improve the booking system for respite care so people with an LD and their parents/carers can easily access and use. • Improve emergency respite care support.	• Review the current offer available across the region, including required staffing levels to deliver a modernised services. • Explore options for updating the booking system for those accessing respite. • Improve the information and support regarding emergency respite care options. • Utilise new short breaks money to meet the needs of carers across the region.	• People will have a choice of respite offer that best fits their needs and wants. • Provide reassurance to family's that adequate respite is available during emergencies. • Additional short break opportunities available to carers across the region.

Co-produced priorities	What are we trying to achieve?	What will we do (actions)?	What difference will this make (impact)?
2.4 Integrated health and social care services that support them through key transitional periods.	• Adequate time and thought is available to plan and deliver services for whole life transitions. • Maximise the opportunities for people with a LD to explore all possible options open to them.	• Increase learning disability training across health and social care.	• Increase understanding and empathy of staff when supporting people with a LD. • Reduce anxiety and provide opportunities to have a say in how services are provided.
2.5 Employment/ supported employment opportunities that enables them to reach their full employment/ voluntary potential.	Work with partners (e.g. PSB, etc.) to: • Improve the skills of people with a LD so they can utilise the opportunities that are available to them. • Improve understanding of the impact of paid work on benefits, to take advantage of opportunities as they arise. • Provide more employment and voluntary opportunities for people with a LD • Improve the accessibility to easily understood information so people with a LD are aware of the employment and voluntary opportunities that are available to them.	Ensure these priorities inform partner organisation plans: • Review current arrangements for organisations to access funding to make reasonable adjustments. • Explore options to increase resources available to organisations to secure employment or voluntary roles. • Develop supportive employment pathways to increase access to volunteering, apprenticeships etc. • Explore options to improve the advertising of volunteering, employment and placements to people with a LD.	• Improve understanding of the requirements needed to address the gaps in employment opportunities. • Increased opportunities for people with a LD to secure employment/volunteering. • People with an LD are able to reach their potential.
2.6 A community-based health, social care services, that they are able to access and promotes engagement in community life.	• Improve the accessibility of health and social care services within communities across our region. • Ensure timely access to specialist health services close to home, in the least restrictive manner. • Develop inclusive communities, providing more opportunities for people with a LD to safely participate in activities	• Ensure everyone has adequate opportunity to access them without the barriers of complications. • Review community based daytime opportunities. • Make sure community hubs are accessible and relevant to people with a learning disability.	• More inclusive communities, providing more opportunities for people with a LD to safely participate in activities. • People with a LD feel part of their communities. • Reduced stigma and discrimination.

3. Mental health and wellbeing – Deliverables and Outcomes

Co-produced priorities	What are we trying to achieve?	What will we do (actions)?	What difference will this make (impact)?
3.1 People misusing substances will be supported through enabling and encouraging them to reduce the harms they may be causing to themselves, their families and communities.	• Work with the APB to improve the integration of the services for substance use disorders across the continuum. • Improve the cohesion between substance misuse services and mental health support.	• Improve the knowledge of people across our communities about substance misuse issues and where to go/signpost if help and support is required. • Engage in discussions with relevant partners to improve the collaboration between substance misuse and mental health support.	• Improved access to services for people with substance misuse and mental health issues. • Reduce the harms caused by people with mental health and substance misuse issues.
3.2 People have access to a wide range of services, where they can access them, to reduce or mitigate against loneliness and isolation.	• Improved integration of services across our communities with a focus on combating loneliness and isolation. • Increase open access resources within local areas, that are available to whoever needs them. • Increase education and awareness of specific conditions that will improve inclusivity and encourage participants to engage.	• Increase access to universal/community based services/activities. • Extend the reach of the befriending network across the region	• Reduction in the amount of people who are lonely and or isolated • Increase access to community based services to vulnerable groups.
3.3 People across the region who are waiting for a diagnosis for a mental health condition have access to the support they need so they are able to 'wait well'.	• Mental health support services are better integrated, so people are not passed between multiple services without adequate help and support. • People are placed at the centre of care and support planning and receive the relevant services. • Key information is easily accessible so people are better aware of the services and provision available to them. • Improved access support, including self-referral and GP referral, to speed up potential diagnoses and allow people to start treatment earlier.	• Engage with voluntary sector to promote pre and post diagnostic support.	• People will be supported while they await an assessment and/or a diagnoses. • People will be better aware of the mental health and wellbeing services available to them. • People have an opportunity to be involved in decisions about the support they receive. • Maximise the use of voluntary sector/alternative support services available.

Co-produced priorities	What are we trying to achieve?	What will we do (actions)?	What difference will this make (impact)?
3.4 Deliver an improved whole system approach for providing mental health support across the region.	• Better understanding of the current scope and need of mental health support, from preventative to specialist. • Upskill staff/ professionals across the region so they can (appropriately) support people to achieve good mental health and wellbeing. • Improved specialist support for those experiencing mental health issues. • Reduce the waiting times for children and families for diagnoses of a neurodevelopmental disorder.	• Work with the Together for mental health board to support their planning and delivery.	• Better awareness of the need for support across the system. • Families are supported while they wait for a diagnoses. • Reduced waiting times for neurodivergence diagnosis

4. Carers – Deliverables and Outcomes

Co-produced priorities	What are we trying to achieve?	What will we do (actions)?	What difference will this make (impact)?
4.1 Unpaid carers will have access to the information they need to improve their knowledge of the services available and barriers to them accessing support are removed.	• Carers and the people they care for can speak to services and get appointments in a timely manner. • Improve understanding of a caring role, so support is available for carers pre-diagnosis, in the environment that suits best. • Better coordination of services supporting carers, with the needs of carers at the centre. • Improved recognition of carers as a key member of the caring team. • Modernisation of the respite offered across the region, providing more flexibility • Improve the educational outcomes for young people who have a caring role. • Increased opportunities for carers and the cared for to do activities.	• Extend the availability of in hospital support for carers. • Make sure the needs of carers are identified as part of hospital discharge planning. • Improve the awareness of wider professionals to increase the identification of people who may have a caring role. • Utilise new short breaks money to meet the needs of carers across the region. • Increase the awareness of the rights of carers including carers assessments. • Engage with carers to plan services that would directly support loneliness and isolation (working in Conjunction with Public Service Boards) • Improve information, advice and advocacy – good quality support is needed by carers to support their caring role especially in school and work environments • Improve Carers assessments – under used and under offered.	• Carers are identified sooner and are able to access appropriate support. • Additional short break opportunities available to carers across the region. • Carers and the cared for will realise the intended benefits from the services they receive.
4.2 Carers and the people they care for will be supported to enjoy good health and wellbeing and supported to maintain/improve their physical health.	• Protect the identify of a carer as a person in their own right including more support for carers to look after their own health and wellbeing. • Improved information available to carers so they are better informed of the services and activities available across the region. • Provide early intervention support, mitigating against a carers reaching crisis point.	• Develop the Carers board • Develop regional approach and strategy for supporting carers.	• Improved identification of carers • Improved mental health and wellbeing of carers. • Improve their ability to care for their loved ones.
4.3 Carers will have access to appropriate social, leisure, culture and fun activities wherever they live or whatever their circumstances.	• Increase the choice and availability of short term breaks available to carers. • Increase the reach of a 'Safe Space' scheme to communities across the region. Providing places for carers go to meet and befriend others.	• Develop robust plans for use of short breaks funding.	• Increase opportunities for carers to access activities in the community.

5. Children and young people – Deliverables and Outcomes

Co-produced priorities	What are we trying to achieve?	What will we do (actions)?	What difference will this make (impact)?
5.1 Improve the availability and variety of children's care home provision, to meet the identified gaps from across the region.	• Encourage providers to submit applications for capital funding to increase the children's care home provision. • Encourage providers to achieve the eliminating profit agenda from the social care accommodation market	• Supporting the Eliminating Profit agenda through capital programme.	• Increasing the sufficiency of suitable placements for children and young people in the region.
5.2 Improve the offer for young people to gain jobs and skills following formal education	• Outside of scope for RPB. Engage with wider partnerships to understand regional plans • Improved options and accessibility of post 16 pathways. • Young people will have the appropriate contracts in place to avoid exploitation. • Modernise the current regional arrangements for receiving careers advice.	• Work with relevant partnerships to understand barriers and work programmes underway.	• Young people to develop skills for long term employment.
5.3 Develop community space where children and young people can attend and feel safe.	• Improve availability and access to key information so young people are better aware of the services and provision available to them. • Improve public transport arrangements. • Co-design and deliver a community safe space scheme for young people.	• Work with relevant partnerships to develop safe community spaces.	• Increase access and availability across the region, so young people can travel and feel safe.

Co-produced priorities	What are we trying to achieve?	What will we do (actions)?	What difference will this make (impact)?
5.4 Deliver an improved whole system approach for providing mental health support to children and young people across the region.	• Better understanding of the mental health support available to young people, from preventative to specialist. • Improved knowledge of staff/ professionals across the region so they can (appropriately) support young people to achieve good mental health and wellbeing. • Improved specialist support for children and young people experiencing mental health issues. • Reduce the waiting times for children and families for diagnoses of a neurodevelopmental disorder.	• Implement the NEST/NYST Framework • Continue to invest in services to support Emotional Wellbeing of Children and Young People • Develop and enhance the prevention and early intervention services including loneliness and isolation.	• Improved mental health and wellbeing of children and young people. • Increased access to support.
5.5 Increase the availability and accessibility of sport, leisure, culture and fun activities for children and young people across the region.	• Not within the remit of RPB. Work with PSB to progress.	• Work with PSB and wider partnerships to deliver.	• Increased access to opportunities.
5.6 Behaviour support for children, young people and their families.	• Families to remain together. • Reduced pressure on statutory services.	• Implement the Children and young people RIF plan ensuring regional approach to supporting children and young people. • Enhance services that wrap around families to promote keeping families together • Develop community resources and support to prevent children needing to become looked after	• Families better supported to remain together.

6. Autism – Deliverables and Outcomes

Co-produced priorities	What are we trying to achieve?	What will we do (actions)?	What difference will this make (impact)?
Improve access and support	• Improve diagnosis and support for those with neurological conditions. • Promote access to support regardless of diagnosis both pre and post diagnosis.	• Review capacity and demand to provide and maintain the sustainability of appropriate • Support services to enable individuals with autism • Reduce the number of people waiting for a diagnostic assessment • Review support pre and post diagnosis • Improve child to adult transition services • Carry out more analysis to plan for the needs of the population living in the region. • Develop ASD Strategic Board to broaden scope to wider neurological conditions.	• Better access to support. • Reduction in escalating needs.

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