Partneriaeth Ranbarthol Gorllewin Morgannwg | West Glamorgan Regional Partnership

Appendix A

WEST GLAMORGAN REGIONAL PARTNERSHIP

AREA 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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1. Foreword

On behalf of the West Glamorgan Regional Partnership, I'm pleased to bring you our Area Plan for 2023-2027. This hugely important piece of work builds on the previous edition, which was published under our former guise of Western Bay (prior to Bridgend's move to the Cwm Taf Morgannwg region). is the culmination of several months of preparation and collaboration. It sets out clear themed objectives based on the findings of our most recent Population Needs Assessment and Market Stability Report, and I must applaud the phenomenal efforts of all those involved in these initiatives. The past few years have been tremendously challenging for us all, but I'm proud to say that colleagues across all partner organisations and those working with us on a voluntary basis have pulled out all the stops to help us map out this clear path for meaningful progress.

You will see that the Area Plan sets out the ways in which our work programmes deliver against key Welsh Government policies (A Healthier Wales, the Welsh Government Models of Care linked to the Regional Integrated Fund, and the Six Goals of Urgent and Emergency Care). The Plan also accounts for the gaps in service provision as highlighted in the Population Needs Assessment and Market Stability Report.

Devising the Area Plan has been an incredibly valuable exercise in that it gives us a thorough understanding of our position as a region and ensures everything we are delivering or plan to deliver aligns with local need as well as national principles. I'd like to extend my thanks to all those who have played a role in the development of this Plan and the initiatives that have helped shape it.

This will, of course, be an evolving document that will change and grow in tandem with the shifting health and social care landscape. We look forward to this next phase of our transformation journey and will keep refreshing the Area Plan to reflect our progress.

Emma Woollett

Chair of the West Glamorgan Regional Partnership Board

2. Introduction to the Area Plan and West Glamorgan Partnership

This Area Plan sets out how the West Glamorgan Regional Partnership Board will respond to the findings of the West Glamorgan Population Needs Assessment published on the 1st April 2022, which captured the health and social care needs of people across the West Glamorgan Region. It explains how the Local Authorities and the Health Board, with partners, will address the requirements of the Social Services and Well-being (Wales) Act 2014.

This document is the longer-term five-year plan (2023-2027) and includes the regional priorities to be overseen by the West Glamorgan Regional Partnership Board.

The second document (to be published later in the year) is the corresponding Action Plan, which is also a five-year plan (2023-2027), includes the key actions for the partnership to deliver, the timeline for delivery, along with the outcomes and impact those actions in delivering the regional priorities. This is a live plan and therefore iterative.

The former Western Bay Regional Partnership Forum was established on a non-statutory footing in 2014 to progress and oversee the work of the Western Bay Health and Social Care Programme. It also worked on the arrangements for implementing the Social Services and Well-being (Wales) Act 2014 (the Act). The Act came into effect on 6th April 2016 and introduced a statutory role for a Regional Partnership Board and specific responsibilities.

The Western Bay Regional Partnership Forum was reformed to become the Western Bay Regional Partnership Board (WB RPB) in July 2016 to meet Part 9 of the Act.

On 14th June 2018, Vaughan Gething, Cabinet Secretary for Health, and Social Services confirmed that, following consultation, that healthcare services for people in the area of Bridgend County Borough Council should be provided by Cwm Taf University Health Board (Cwm Taf) instead of Abertawe Bro Morgannwg University Health Board to align decision-making across health and local government.

This meant that from 1st April 2019, Bridgend County Borough Council regional partnership arrangements moved from the Western Bay Region to the Cwm Taf Region.

From 1st April 2019 the new Regional Partnership arrangements for West Glamorgan were established with the statutory partners, Neath Port Talbot County Borough Council, Swansea Council and Swansea Bay University Health Board.

The governance structure for the West Glamorgan Transformation Programme, can be found in Appendix 1**.**

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.

- Plan and deliver initiatives using social value models to enhance health and social care.
- 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.

West Glamorgan Vision and Aims

West Glamorgan Population Needs Assessment

The Social Services and Well-being (Wales) Act 2014 introduced a duty on Local Authorities and Health Boards to prepare and publish an assessment of the care and support needs of the population, including Carers who need support across the region.

In order to do this, the West Glamorgan region of Neath Port Talbot County Borough Council, Swansea Council, Swansea Bay University Health Board and

Third Sector partners considered these care and support needs against a set number of core themes. These are:

- Older People
- Children and Young People
- Mental Health
- Learning Disability
- Autism
- Carers who need Support
- Health and Physical Disability
- Sensory Impairment
- Violence against Women, Domestic Abuse and Sexual Violence

Preparing the Population Needs Assessment involved gathering information on well-being and the barriers to achieving well-being for people who need care and support, and their Carers. The exercise also considered what could prevent people from needing care and support in the first place, and what could be done to prevent this need from increasing.

To view the West Glamorgan Population Needs Assessment, please visit: West Glamorgan Population Needs Assessment 2022-2027

Development of the Area Plan

This Area Plan has been developed by reviewing the Population Needs Assessment's core themes and the gaps in provision that were identified as part of the information gathering exercises. Future work to address these gaps forms part of the plan, along with the findings of the Market Stability Report (also developed in 2022).

A review of the Population Needs Assessment and the Market Stability Report undertaken in the context of the new policies and guidance from Welsh Government (including the Models of Care linked to the Regional Integrated Fund and the Six Goal Programme) has served to reinforce the direction of travel for the region.

To view the full review of the gaps in service or identified services needs from the Population Needs Assessment and Market Stability Reports go to **Appendix 2** where each gap or service identified has an action identified to address the issue.

Additionally, the table identified where each action contributed to the policy agenda of "A Healthier Wales," Welsh Government Models of Care along with its enablers and the Six Goals of Urgent and Emergency Care.

The region has co-developed the Area Plan by working in tandem with partners to engage with the population on the priority areas. As highlighted in the Population Needs Assessment's Introductory Chapter, organisations have been mindful of consultation fatigue and the importance of ensuring engagement efforts are not duplicated across agencies.

This approach involved collaborating with the PSB Wellbeing Assessment engagement activities. The regional care and support component formed part of Neath Port Talbot's 'Let's Talk' campaign and Swansea's Assessment of Local Wellbeing public engagement exercises.

In addition to the above, we were able to further the conversation via our series of virtual 'Possibilities for People' public engagement events, two in person Emotional Wellbeing and Mental Health Summits (June and October 2022), and the Your Voice Advocacy 'Keep Me Healthy' Learning Disability Event (October 2022). These discussions solidified our thinking in terms of agreeing the themed areas that the region is focussing on.

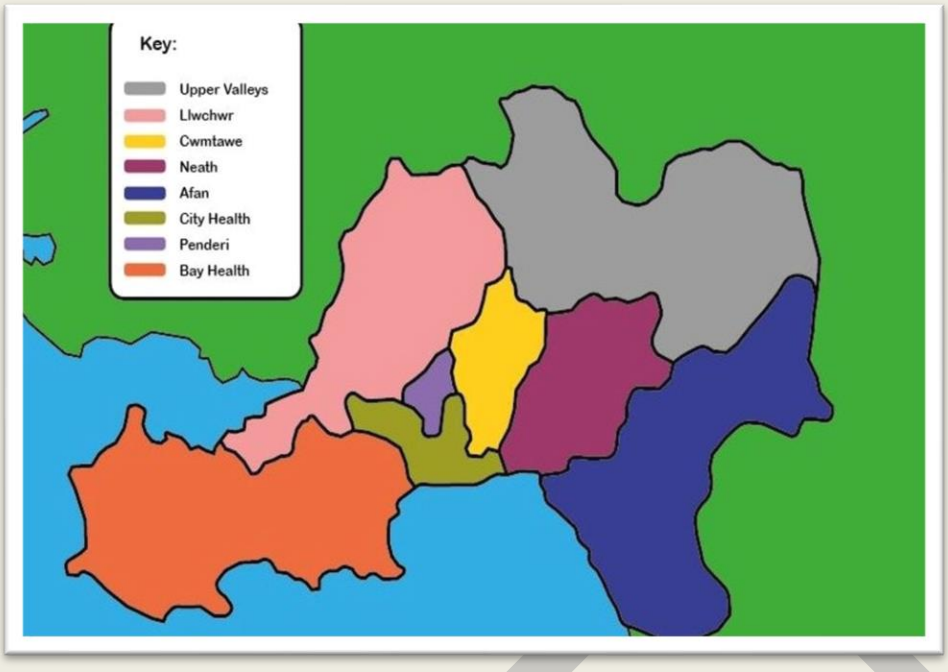
It is important to recognise that the work undertaken to date sets out a starting point for further, more detailed engagement on the region's priority areas. The breadth of the regional programme of work can be overwhelming, particularly for the wider population who may not be involved in this arena and whose awareness of the transformation agenda may be limited. To this end, we are/will be undertaking specific, targeted engagement on the priority themes and their practical implementation going forward.

Links to the national accelerated cluster development programme and Pan Cluster Plan

In 2022/2023, the Welsh Health Minister launched a national programme to accelerate cluster based working and strengthen links between clusters and the Regional Partnership.

"A cluster brings together all local services involved in health and care across a geographical area, typically serving a population between 25,000 and 100,000" - National Strategic Programme

Eight Local Cluster Collaboratives have been formed in the West Glamorgan region, and these include representatives from a series of professional collaboratives covering dental, pharmacy, optometry, community nursing, allied health professionals, and general medical practitioners. They also include third sector and mental health membership.



Local Cluster Collaboratives provide a very local form of partnership working to ensure a range of health and well-being services are organised and delivered for local communities as effectively as possible and that there is good join up between services.

An overarching Pan Cluster group has also been established, as required by the national programme, with representation from the Regional Partnership.

The programme is only currently in its transitional year. The cluster plans for 23/24 will focus on projects and services that will improve prevention of ill health and reduction of health inequalities, planned and unscheduled care, services for those with mental health problems or learning disabilities, and children and young people.

Joint work is underway to ensure we maximise opportunities to join up plans, priorities and actions going forward where it makes sense to do so and is likely to deliver better services and outcomes for local populations. This will include joint work on workforce planning and implementation of projects.

Themes identified for regional delivery

The following areas of work where partner organisations integrate to provide seamless services for the population will be addressed by the Regional Partnership:

- Older Adults
- Children and Young People
- Mental Health
- Learning Disability
- Autism

- Carers

Themes identified for local delivery

The following areas of work are being addressed locally by partner organisations as part of their core business, or through existing partnerships between organisations across the region:

- Health and Physical Disability – Core Business of Statutory Partners
- Sensory Impairment – Core Business of Statutory Partners
- Violence against Women, Domestic Abuse and Sexual Violence – Regional VAWDASV Group).

That said, where these themes have identified cross cutting areas for the region in terms of integrating services, they will be incorporated into this Area Plan and Action Plan for implementation.

Co-production in West Glamorgan

The region has a long history of working with Service Users and Carers to support its work.

During 2018/19, the Regional Partnership Board reviewed the programme and its governance. This review highlighted a number of areas of improvement in how we engage with citizens and to that end, from 1st April 2019, citizens have been represented on the Transformation Boards as well as the Regional Partnership Board.

In addition, we have also been striving to capture more Carer and Service User voices across the programme, therefore we have established a Carers Liaison Forum, a Housing Liaison Forum, and we are developing a Well-being and Learning Disability Forum. We have held a number of events to allow individuals to assist us to design the priorities of the programme and the associated projects.

We have a web page dedicated to co-production on our website which demonstrates the commitment to this principle across West Glamorgan.

Equalities and Human Rights in West Glamorgan

The Public Sector Equality Duty (PSED) was introduced by the Equality Act 2010 and places a duty on public bodies to eliminate unlawful discrimination and advance equality of opportunity on the basis of a series of protected characteristic groups. The West Glamorgan Regional Partnership Board is fully committed to the equalities agenda and ensuring due regard to the provisions of the PSED when developing and delivering services.

The Human Rights Act came into force in the UK in October 2000 and sets out sets out the fundamental rights and freedoms applicable to all citizens. People have a right to be heard, and this means involving them in shaping the services

they use. Further work will take place under the direction of the West Glamorgan Regional Partnership Board to ensure that people have their say when it comes to decisions that affect their personal well-being. Swansea became a Human Rights City; launched at the end of 2022.

Children have specific rights that are set out in the United Nations Convention on the Rights of the Child. In Wales, we must demonstrate the steps we take to listen to children and young people.

Persons with Disabilities have specific rights that are set out in the United Nations Convention on the Rights of Persons with Disabilities (CRPD). In Wales, we must demonstrate the steps we take to listen to and to respond positively to this group.

Links to Public Services Boards and Well-being Plans

There are two Public Services Boards in the West Glamorgan area, established by the Well-being of Future Generations (Wales) Act 2015. The purpose of the Public Service Boards is to improve the economic, social, environmental, and cultural well-being in their area, strengthening joint working across all public services in West Glamorgan. Public Services Boards have undertaken a 'Well-being Assessment' in parallel with the Population Assessment and are in the process of revising their Well-being Plans.

It is clear from the Well-being Plans that there are strong links between the priorities of each Public Services Board and those included within the regional Area Plan. All Public Services Boards reference four priority areas and whilst the specific details vary, there is a strong focus on these common themes:

- Ensuring children receive the best start in life during their early years
- Building strong communities that are resilient and safe
- Enabling citizens to live and age well within their communities and promote well-being
- Sustaining natural environments and reducing the carbon footprint.

Additionally, the Well-being Plans contain specific actions and areas of work that each Public Services Board will oversee. These actions are reflected within the Area Plan chapters and support integration of services both at a local and regional level. The regional cross-cutting themes and ethos of West Glamorgan Regional Partnership are particularly evident with reference to digital improvement, data sharing, partnership working, prevention and well-being. There is also a cross-cutting theme across all three Public Services Boards around the use of green spaces, which aligns with the Health and Physical Disability chapter within the Population Needs Assessment.

How will we monitor and review the plan?

Progress for the regional priorities in the Action Plan will be monitored on a quarterly basis at the Regional Partnership Board. Any issues will be escalated

through the West Glamorgan governance structure, as appropriate. Details of the West Glamorgan governance arrangements are included in **APPENDIX 1**.

Current Pooled Fund Arrangements

For some years, the Welsh Assembly Government has encouraged statutory organisations like Health Boards and Local Authorities to work together and develop joint funding arrangements often referred to as “pooled budgets,” “funds” or “Section 33 agreements”. A pooled budget is a mechanism by which the partners to the agreement each contribute to the delivery of the outcomes required by creating a discrete fund. The intention must be to enable flexibility in fulfilling the functions that are part of the pooled fund arrangement and therefore the use of these funds.

West Glamorgan already has several arrangements where funding from the Local Authorities and the Swansea Bay University Health Board have been pooled in order that services are integrated and seamless for service users.

These include:

- A Pooled Fund (Section 33 agreement) for Intermediate Care Services (Home First Programme) for the Swansea and Neath Port Talbot localities
- A Pooled Fund for Older Adults Care Homes (Section 33 agreement).
- A Pooled Fund (Section 33 agreement) for a Joint Equipment Store.

Information, Advice and Assistance (IAA)

IAA is organised and delivered locally, with a regional overview of the IAA position. Work is ongoing around linking the various IAA systems currently being utilised by all partners, which includes the Third Sector Infoengine system, the National Local Authority DEWIS platform and the Health Board’s 111 system.

Further information can be found in **APPENDIX 3**.

Welsh Language

West Glamorgan partners recognise the importance of the Welsh language and ensuring the needs of the Welsh speaking population are taken into account during service planning and delivery. This is organised locally by each of the statutory bodies, details of which are included in **APPENDIX 4**.

Social Value

Commitment to delivering health and social care based on a social value model approach, including promoting social enterprises, co-operatives, user-led services, and the Third Sector.

The West Glamorgan Regional Partnership funds the ‘Well-being Enterprise Development Support Project’ which is delivered by the two Councils for Voluntary Service. Officers support the development of Social and Micro Enterprises providing practical advice on the establishment, funding and running of new organisations to ensure a diverse and mixed economy of providers for the care and support needs of people across the region.

The project has strong links with the West Glamorgan Social Value Forum, which was established in 2019, in line with Welsh Government requirements. The Forum aims to support the development of a thriving social value sector and to help embed social value within the West Glamorgan programme. The ambition of the forum is to use the seven elements of a Social Value Model of Delivery as a framework for planning, funding, co-designing and evaluating project delivery and working towards the regional priorities.

Social Value Models of Delivery (sourced from 'Transforming Social Care', Cwmpas)

The Welsh Government's White Paper on rebalancing Care and Support sets out a vision for improving outcomes for people who need care and support and carers who need support. The paper seeks to rebalance the care and support market and outlines the system change needed:

- away from price towards quality and social value
- away from complexity towards simplification
- away from task-based practice towards an outcome-based practice
- away from reactive commissioning towards managing the market
- away from an organisational focus towards more effective partnership.

Social value approaches to commissioning will create an environment in which not-for-profit providers can grow, including co-operatives, whilst simultaneously encouraging all providers to develop their capacity for delivering social value.

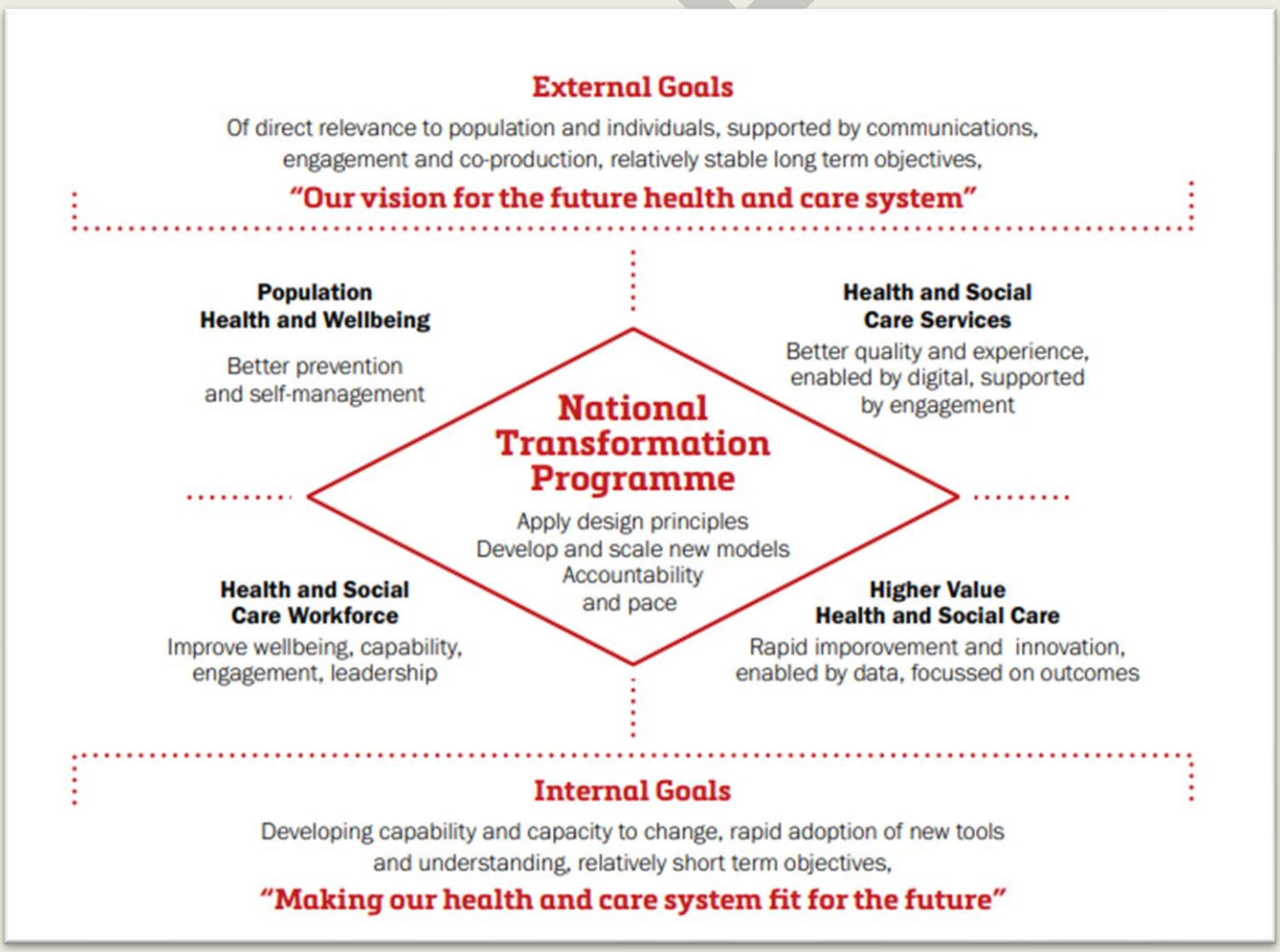
3. Strategic Policy

During the development of this Area Plan, the region has considered the Welsh Government Policies including:

- A Healthier Wales: Our Plan for Health and Social Care,
- Welsh Government Models of Care linked to the Regional Integrated Fund
- Six Goals of Urgent and Emergency Care.

A Healthier Wales

A Healthier Wales sets 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 Regional Partnership supports the delivery of these national goals through the delivery of its programme and has been used as a tool to ensure that each priority for the region contributes to the aims of the nation.

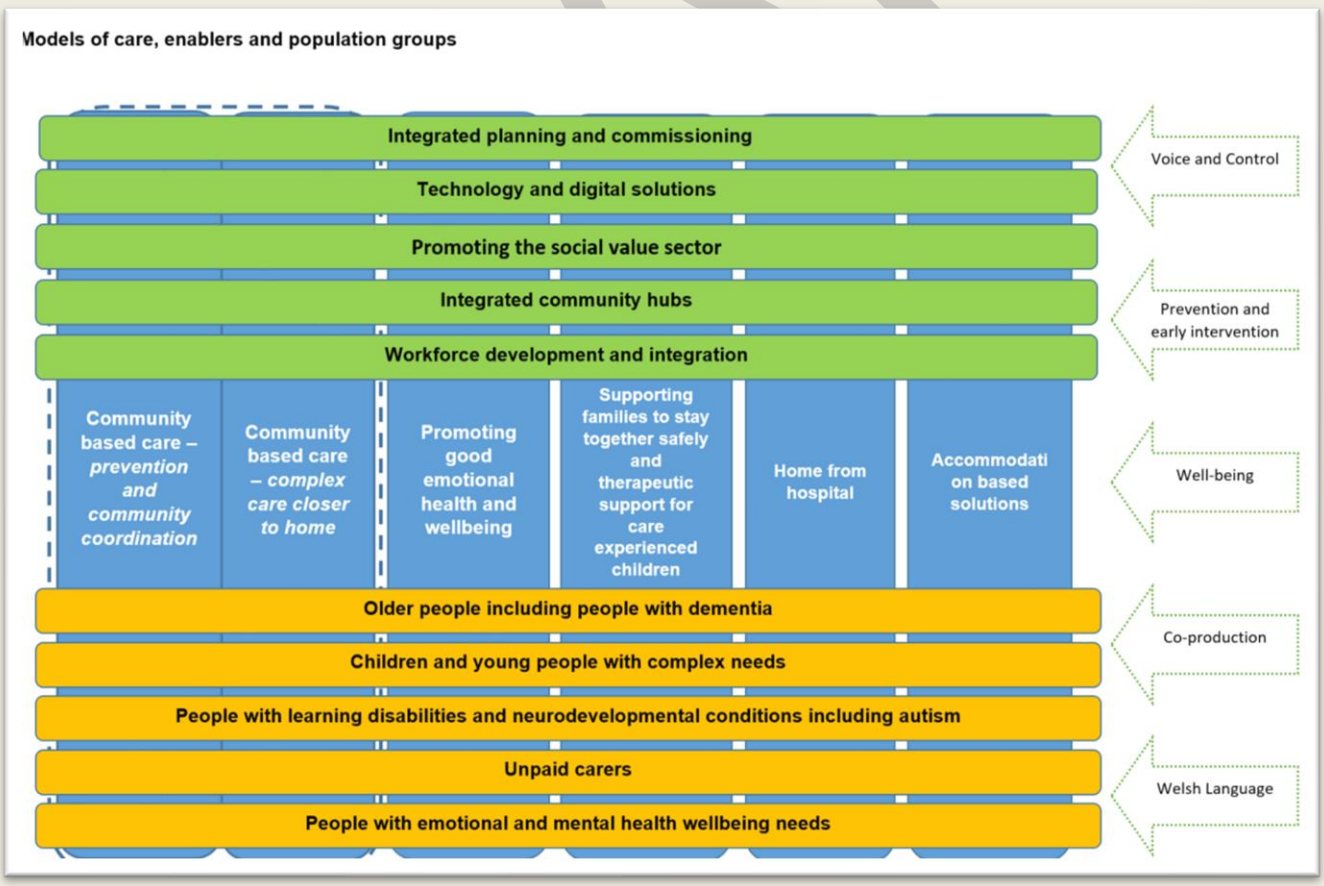


Welsh Government Models of Care

Welsh Governments aim is that by the end of the current five-year programme, Wales will have established and mainstreamed at least six new national models of integrated care so that citizens of Wales, wherever they live, can be assured of an effective and seamless service experience.

Regional Partnership Boards will have the flexibility to determine which projects and services align to which model of care but essentially all RPBs will need to ensure that:

- They invest in the development and embedding of the six priority models of care.
- That they are able to demonstrate that they are meeting the needs of all the priority population groups within each of the models of care
- That they are maximising the use of key enablers to ensure their models of care are innovative, integrated, and transformative.
- Across all population groups every opportunity is seized to increase the 'active offer' of integrated services through the medium of Welsh. Partners are able to 'shift' core resources to invest as match funding to ensure sustainable long-term delivery of new models of care.



A more detailed depiction of each of the Models of Care (above)

Community Based Care – Prevention and Community Coordination

There is a need to focus on prevention and early intervention to make services sustainable into the future and ensure better health and wellbeing outcomes for people. Section 15 of the SSWBA places statutory duties on local authorities to provide and arrange the provision of services to prevent or delay the development of care and support needs. Local authorities and local health boards must, when exercising their functions have regard to the importance of achieving these purposes in their areas. There is a need to build the resilience of the Welsh health and social care system by investing in preventative community services and supporting citizens to use these services to best effect. We are again looking to work closely with the local cluster collaboratives to promote/ accelerate prevention and community co-ordination.

To achieve this, it is vital that people are able to access the right information, advice and support they need, as quickly as possible and in the right place at the right time.

Community based care – complex care closer to home

The ‘Complex care closer to home’ model should support implementation of the Discharge to Recover and Assess Pathways, helping people to have their health and social care needs met as close to home as possible in a seamless and integrated way.

Promoting good emotional health and well-being

Regional Partnership Boards should consider their population needs assessments and determine the level of Emotional Health and Well-being services that they invest in across all ages of their population. This should complement but not replace Welsh Government investment in acute mental health services including the child and adolescent mental health service.

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

In keeping with the principle of prevention and early intervention they should work with families to help them stay together safely and prevent the need for children to become looked after. Models of care should be clearly integrated across partner organisations to provide a cooperative response for the families and children.

Home from hospital

Where possible care and support should be offered to help people stay well at home, and our national models of **Community based care** are designed to provide preventative care and where needed a rapid response to prevent the need for people to be conveyed to hospital. However, recognising that some people will always require acute assessment/ treatment in a hospital environment, it is vital that we create a national model of care that helps people be discharged to recover

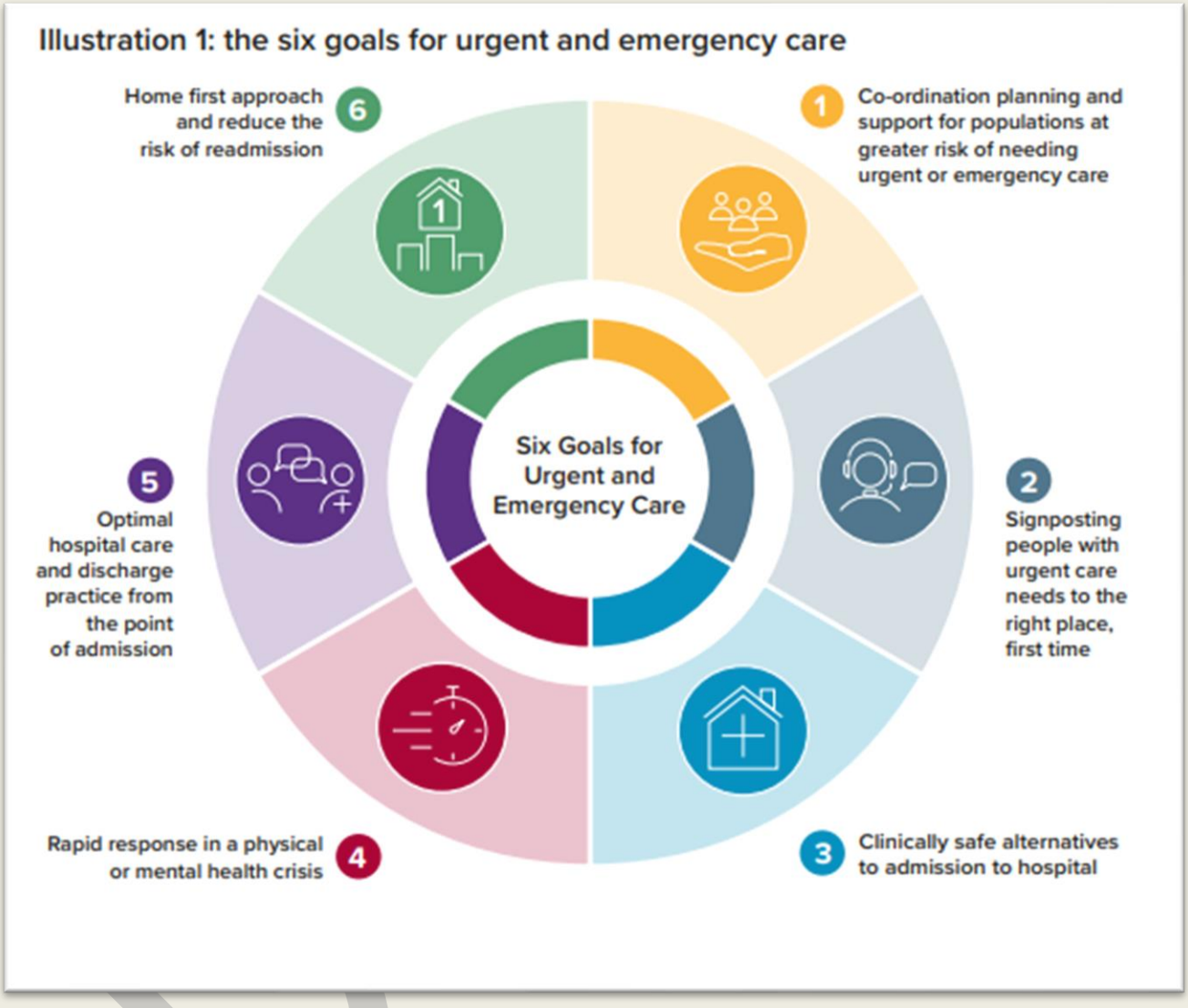
at home as quickly and safely as possible. This will also support the generation of capacity within health and care settings, ensuring that those who do need acute care can access it in a safe and timely manner.

Accommodation based solutions

Developing accommodation that can support people's independent living and have their care and support needs met in a domestic or residential environment is an important part of our health and care system. Linking with housing, registered social landlords, residential care providers and other key partners, including those who can support home adaptations will be vital to delivering this model of care.

Six Goals of 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.



The priorities, aligned to each of the six goals, should be considered as part of a whole-system and integrated approach. Some of our priorities have medium or longer-term timescales for implementation. This is in recognition of the well-rehearsed challenges faced by health and social care organisations regarding recruitment and retention, and the difficulty associated with managing increasing and complex levels of patient demand. Longer-term milestones also recognise sustainable and effective change cannot be achieved overnight or without focus on continuous learning, sharing, and improving.

The Regional Partnership has considered the six goals while developing this Area Plan and demonstrates the areas of work being delivered by the partnership in support of the programme for government.

- **GOAL 1: Coordination, planning and support for people at greater risk of Urgent and Emergency Care:**

  Health and social care organisations should work in collaboration with public service and third sector partners to deliver a coordinated, integrated, responsive health and care service, helping people to stay well longer and receive proactive support, preventative interventions, or primary treatment before it becomes urgent or an emergency.

- **GOAL 2: Signposting, information, and assistance**

  When people need or want urgent care, they can access a 24/7 urgent care service via the NHS 111 Wales online or telephone service where they will be given advice and, where necessary, signposted or referred to the right community or hospital-based service, first time. This will be achieved through the development of an integrated 24/7 urgent care service.

- **GOAL 3: Clinically safe alternatives to admission**

  People access appropriate and safe care close to home, and with as much continuity of care, as possible. Admission for ongoing care to an acute hospital bed should only occur if clinically necessary. Linked to Goals 1 and 2, and the establishment of an integrated 24/7 urgent care service, Health Boards.

- **GOAL 4: Rapid response in Crisis**

  Individuals who are seriously ill or injured or in a mental health crisis should receive the quickest and best response commensurate with their clinical need – and, if necessary, be transported to the right place for definitive care to optimise their experience and outcome.

- **GOAL 5: Optimal hospital care and discharge practice from the point of admission**

  Optimal hospital-based care provided for people who need short term, or ongoing, assessment or treatment for as long as it adds benefit to outcome, with a relentless focus on good discharge practice.

- **GOAL 6: Home first approach and reduce risk of admission**

  People will return home following a hospital stay – or to their local community with additional support if required – at the earliest and safest opportunity to improve their outcomes and experience, and to avoid deconditioning.

4. Cross Cutting Regional Priorities

Access and Transport

A consistent theme in the development of the Area Plan (emerging from the Population Assessment exercise) is the issue of transport and access to services.

For example, within the Older People chapter of the Population Needs Assessment, some of the 'lifestyle factors" included:

- **Community Transport:** Based on research where people struggle from rural areas to access services, it is to provide easy transport to critical health and social care services if the capability doesn't allow for a digital solution.
- **Access to Services:** Developing digital services for the majority will be a benefit for non-invasive treatments but the solution should not be used to replace services but be offered as an alternative until such times as the population are comfortably using.

Within the Older People chapter, 'changes we need to plan for' included:

- Work is underway to consider where strategic planning for transport could be considered and progressed regionally, with a view to address the issues highlighted within the Population Assessment being progressed as specific actions in the Area Plan.

Housing

Another consistent theme emerging from the Population Assessment and included in the Area Plan concerns the links between housing and health and social care. There were a considerable number of different housing issues captured from the core chapters, including:

- To support independent living, future planned housing and accommodation should be built to **Lifetime Homes Standards** building regulations. Housing should support healthy ageing and promote independence through homes that are well designed, excellent value, appropriately located and energy efficient. Early support through aids and adaptations, handyperson schemes and telecare are fundamental (Health & Physical disability)
- **Adaptations**: Smart Homes but also adaptations to existing homes to make them fit for the future for people who are living longer and getter older to encourage independence. (Older People)
- Develop provision for sustainable settings for CYP in need of support, linking in with learning disabilities and mental health support including the suitability of living accommodation. (CYP)
- Development of a range of accommodation options in the region for young people with complex needs going through transition; younger adults with complex needs (LD)
- Housing suitable for adults with mental health needs.

- The need to work strategically with new care home providers to develop a sustainable range of care home facilities across the region.
- Development of alternatives for older people awaiting placements / complex packages of care instead of remaining in hospital.

In order to address the significant number of issues raised, it has been acknowledged that a more strategic approach needs to be taken in relation to housing, health and social care in West Glamorgan.

Building on the work of the Regional Collaborative Committee for Supporting People and the former Swansea Bay University Health Board's Health and Housing Group, progress is being made to develop a West Glamorgan Regional Strategy for Housing, through the establishment of a Health, Social Care and Housing Group.

Data Collection and Information Sharing

The provision of Health and Social Care services requires the recording of essential information that creates and maintains individual care records. Such "record keeping" is often governed by professional standards, which are intended to outline the standards expected of professional staff. In addition, an expectation from effective integrated care is that information is easily shared between services so that staff have access to the right information at the right time. However, such ambitions are often frustrated by different methods of record keeping, which range from handwritten paper forms to separate electronic systems used by Local Authorities and Health Boards.

The inability to share information between health and social care is a frequent problem that has often frustrated the integration of services. West Glamorgan has recognised this issue and the potential to resolve this long-standing problem with the launch of the Digital Transformation for Health and Social Care (DTHSC) Programme.

The DTHSC Programme aims to bring together valuable data and information from different providers and services in order to enhance modelling and better predict demand on service and identify areas where service improvement is required in relation to integrated services. It provides an added focus on using digital technology to more accessibly capture outcomes for citizens, in order to understand what matters to the individual, as well as using this information to more broadly understand what matters to the region collectively, and informing, for example, the Population Needs Assessment. The programme is committed to collaborating with other regions across Wales to learn lessons and share best practice and successful innovations.

Digital Services to Support Better Care Delivery

For the Regional Partnership, we look at digital transformation as a key programme of change that spans across health and social care in the region.

Historically, IT-enabled change has been an important part of the delivery of transformation within our partner organisations (including Swansea Council, Neath Port Talbot Council and Swansea Bay University Health Board). This has included elements of regional change delivery that is IT-enabled, which can improve how we deliver our health and social care services.

However, these changes have often been developed in isolation to other initiatives and as a component of a specific change instead of being the driving force between transformation. Through the launch of the DTHSC Programme, the Region has committed to embedding digital services and solutions across the regional transformation programme appropriately to maximise on opportunities and benefits.

The impact of Covid-19 further highlighted the importance of enhanced digital technology to support health and social care delivery, from facilitating virtual assessments, to collection of time-critical data and deploying technology necessary to support agile working practices, all at considerable pace. Through reflection on this period the DTHSC Programme is taking stock of what was achievable, learning the appropriate lessons from this, and cementing digital transformation across the various work-streams as a key-enabler of transformational change, in order to move towards a more cohesive end-to-end process for our citizens and seamless, joined-up models of care for our workforce.

Workforce

West Glamorgan are developing a regional workforce strategy and action plan that sets out our strategic commitment as the West Glamorgan Regional Partnership for the next five years.

We will develop a West Glamorgan Workforce Programme to create the strategy and action plan to support the region in having a joined-up approach to the workforce challenges and opportunities across Health and Social Care

This strategy will need to support the principles of the Social Services and Well-being Act 2014, along with principles from A Healthier Wales and the Health Education and Improvement Wales (HEIW) Framework.

The programme will help to address the significant workforce issues that are experienced nationally and locally and seek to support integrated working across the sector.

The strategy will be a shared regional strategy which is clear about workforce analysis, planning and development resources and priorities, and how they will meet the wider regional transformation agenda. There are clear and paralleled workforce agendas as we move West Glamorgan further towards an integrated workforce.

The strategy will support the transformation of the workforce in the health and social care sectors where they are and can be integrated. These delivery models align to the requirements of the Social Services and Wellbeing (Wales) Act 2014,

A Healthier Wales, and the goals of the ‘Well-being of Future Generations (Wales) Act 2015’.

The strategy will support a longer-term workforce planning agenda, working in closer partnership with the independent sector and local communities to look to prevent the escalation of health and care problems and take a more joined-up approach.

The workforce strategy is not a static document and will continue to grow and develop alongside changes in the sector; having a workforce strategy that responds to the needs of the social care and the community health workforce.

5. Summary of Conclusions for the Area Plan

After a full and detailed review of the Population Needs Assessment and Market Stability Report which is located in Appendix 2. West Glamorgan has concluded that it will seek to address the following key issues though the implementation of its priorities:

Older Adults

- 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
- Strengthen the Discharge to Recover and Assess Pathways and ensure we support the individual in what matters to them
- Ensure safe and timely discharge from hospital
- Develop and enhance falls prevention care
- Reduce social isolation and loneliness
- Continue to make West Glamorgan a Dementia Friendly Region
- Develop and Enhance Prevention approaches to reduce the need for acute and long-term care
- Sustainable Care Provision
- High Quality Care Homes

Children and Young People

- Reduce social isolation and loneliness
- Continue to develop and implement the NEST/NYST Framework
- Develop and enhance the services to Emotional Wellbeing of Children and Young People
- Increasing the sufficiency of suitable placements for children and young people in the region
- Develop and enhance services that wrap around families to promote keeping families together
- Develop more community resources and support to prevent children needing to become looked after
- Develop and enhance the prevention and early intervention services
- Support the “Voice of the Child” being promoted across the programme to aid coproduction of services
- Develop housing solutions to support families, in particular in support of Children and Young People with Mental Health issues or a Learning Disability
- Ensure that planning is based on accurate data collection and demographics

Mental Health

- 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 such as poverty, substance misuse, unemployment, and digital exclusion
- Develop and enhance Mental Health links into the Cluster Networks
- Develop and Enhance prevention and low-level support services for people with Mental Health.
- Develop a CAMHS Telephone Single Point of Contact
- Ensure that planning is based on accurate data collection and demographics

Learning Disability

- Increase the uptake of Annual Health Checks of people with Learning Disabilities
- Increase and develop opportunities for employment for people with Learning Disabilities
- Reduce social isolation and loneliness
- Improve the child to adult transition services
- Develop a capital plan to develop accommodation for people with complex needs

Autism

- Review capacity and demand to provide and maintain the sustainability of appropriate support services to enable individuals with autism
- Ensure the groups are formed at a local level to support social interaction
- Ensure the groups are formed at a local level to support information and advice on channelling people with autism into work
- Reduce the number of people waiting for a diagnostic asessement
- 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.
- Carry out more analysis to plan for the needs of the population living in the region.
- 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.

Carers

- 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, providing then with opportunities to meet each other and engage with their communities.
- 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.
- Improve information on Direct Payments – difficult to navigate and under used for carers needs.
- Improve Communication – accessible information given at the right time. Training – consistent training for staff on how to work with carers. Funding – sustainable funding of carers services is needed.
- Develop engagement opportunities for carers to identify themselves, and be identified by supporting organisations such as young carers need to be recognised in educational settings

6. West Glamorgan Regional Priorities for 2023-2027

In response to the key conclusions drawn from the Population Needs Assessment and Market Stability Report, the West Glamorgan Regional Partnership Board has adjusted their priorities for the next five years.

Below is a more detailed explanation of each of the priorities:

Strengthening Communities

This priority focusses on how the statutory partners, third sector and volunteers will work collaboratively with and in communities. The partnership will adopt a strength-based and place-based model of prevention and community co-ordination. This will better support and promote good emotional health and wellbeing for individuals to remain living safe and well within their communities, without unnecessary recourse to statutory health and care services.

There will be a particular focus on:

- Support for carers of all ages
- Prevention and well-being services that support the delivery of a person-centred health and care approach
- Expanding the range of financially sustainable accommodation-based solutions for individuals who have or may develop care and support needs and reduce avoidable recourse to more institutionalised forms of care.

Transforming Health and Care Services at Home

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.

There will be a particular focus on:
Home from hospital services
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
Reducing unnecessary recourse to long term care for people over 65.

Transforming Emotional Wellbeing & Mental Health Services:

This priority focusses on the development of an increased range of opportunities and promoting good emotional health and wellbeing for children and adults who are struggling with their mental health and including dementia to access proportionate support across the continuum of need.

There will be a particular focus on:

Implementing a 'no wrong door' approach for access to emotional well-being and mental health support

Ensuring timely access to the right help, from the right person at the right time across the continuum of need

Increasing the range of opportunities for children and adults to access support that promotes emotional and psychological well-being and reduce avoidable recourse to specialist mental health services.

Transforming Complex Care

This priority focusses on the development of new models of financially sustainable and integrated health and community-based care that maximises the safety and independence of children and adults with complex needs, enabling them to live and be cared for closer to home, lead ordinary lives and avoids unnecessary recourse to more institutionalised forms of care.

There will be a particular focus on:

Establishing effective processes for joint assessment and care planning (including the associated funding arrangements) between the statutory partners that ensure a focus on the delivery of integrated health and care for children and adults with complex needs.

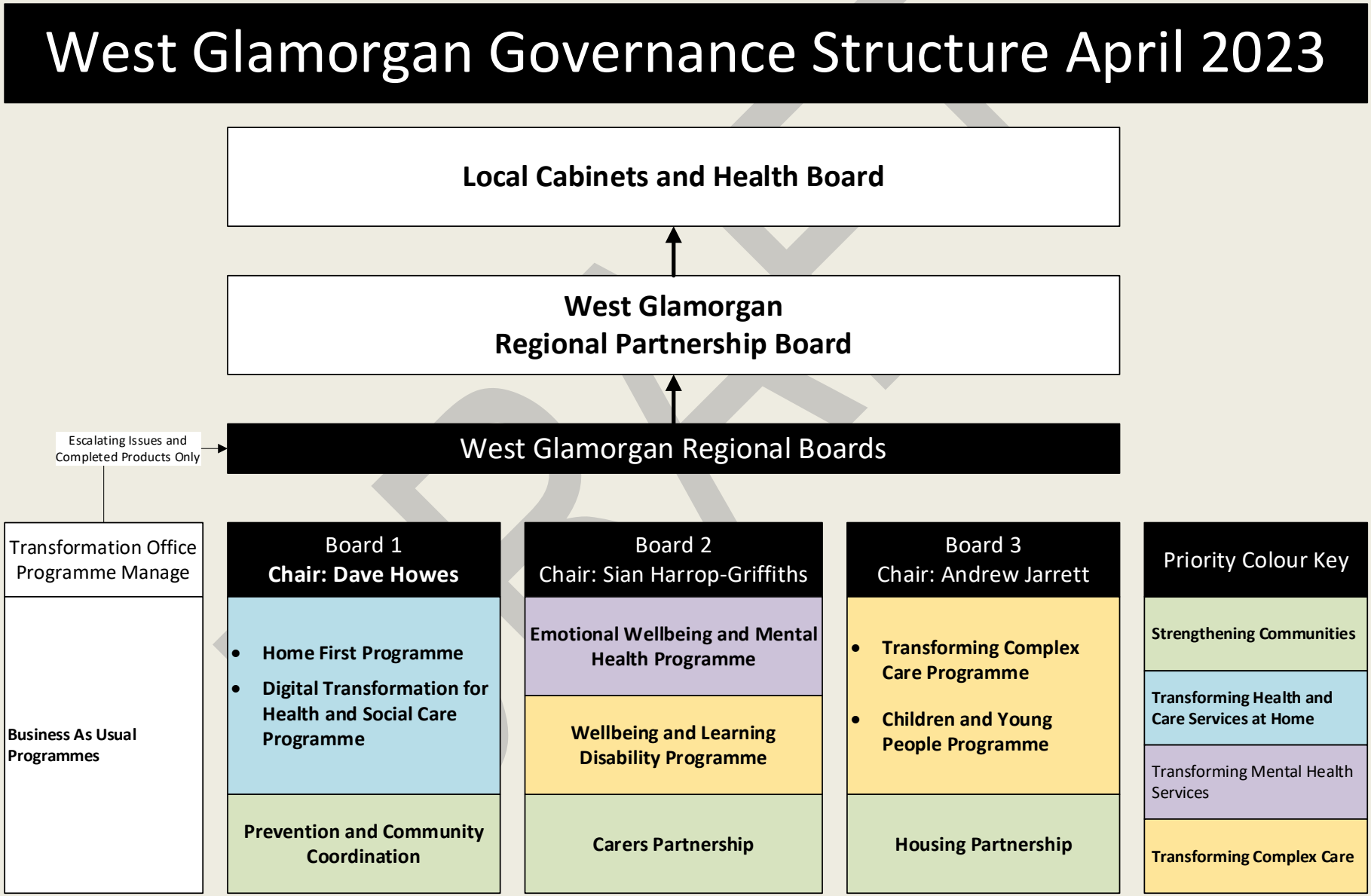
Improving the experience of an individual in the transition from children to adult services

Expanding the range of financially sustainable accommodation and care-based solutions for children and adults with complex needs and reduce avoidable recourse to more institutionalised forms of care

Expand the range of financially sustainable integrated health and care services across the continuum of need and support children to remain living safe and well within their families and communities.

Appendices

APPENDIX 1 - West Glamorgan Governance Structure



Appendix 2 - Population Needs Assessment and Market Stability Report

The table below highlights the gaps in service or identified services needs from the Population Needs Assessment and Market Stability Reports. Each gap or service identified has an action identified to address the issue.

Additionally, the table identified where each action contributed to the policy agenda of "A Healthier Wales," Welsh Government Models of Care along with its enablers and the Six Goals of Urgent and Emergency Care

Key for the Table

Quadruple Aim: A healthier Wales	Welsh Government Models of Care	Welsh Government Key Enablers	Six Goals of Urgent and Emergency Care
1. Population Health and Wellbeing – better prevention and self-management 2. Health and Social Care Services: Better quality and experience, enabled by digital, supported by engagement 3. Health and Social Care Workforce – Improve wellbeing, capability, engagement, leadership 4. Higher Value Health and Social Care – Rapid improvement and innovation enabled by data, focussed on outcomes	1. Place Based Care – Prevention and Community Co-ordination 2. Place Based Care – Complex Care Closer to Home 3. Promoting Good Emotional Health and Wellbeing 4. Supporting families to stay together safely and therapeutic support for care experienced children. 5. Home from Hospital 6. Accommodation Based Solutions	1. Digital and Technology Solutions 2. Promoting the social value sector 3. Integrated community hubs 4. Workforce development and integration 5. Integrated planning and commissioning	GOAL 1: Coordination, planning and support for people at greater risk of Urgent and Emergency Care: GOAL 2: Signposting, information, and assistance GOAL 3: Clinically safe alternatives to admission GOAL 4: Rapid response in Crisis GOAL 5: Optimal hospital care and discharge practice from the point of admission GOAL 6: Home first approach and reduce risk of admission

PNA Chapter	Gap or Service Need Identified by either PNA or MSR	Action Required	Quadruple Aim				Model of Care						Model of Care Enablers					Six Goals					
			1	2	3	4	1	2	3	4	5	6	1	2	3	4	5	1	2	3	4	5	6
Older Adults	1. It is predicted that by 2030, the over 65 population across West Glamorgan will exceed 89,215. Of these: • 25,667 will struggle with daily activities relating to personal care and mobility around the home that are basic to daily living (e.g., eating, bathing, dressing, toileting, etc). ADLs are activities that are important aspects of living independently (e.g., money management, cooking, shopping, etc • The number of adaptations, recorded in each local authority, delivered across West Glamorgan is 283, which has declined by half from 555 in 2018/19 to 283 in 2020/21.	Review capacity and demand to provide and maintain the sustainability of appropriate support services to enable individuals to remain independent and at home.	✓					✓			✓	✓	✓											
		Continuous improvement and learning of the commissioning of care homes to ensure consistent high quality and sustainable care home provision.		✓	✓	✓		✓				✓	✓										
		Based on the population increase in the over 65s cohort, services must be encouraged to embed preventative approaches earlier on in the life journey. This needs to enhance and build upon services currently provided by the Third Sector and requires further development.		✓	✓	✓	✓						✓										
	In 2015, 3,133 people in West Glamorgan had a diagnosis of dementia. By 2030 it is predicted that 7,098 will have dementia	Continue working towards a dementia friendly West Glamorgan, improving support and information for people with dementia, their family, and carers. Continue to develop the Dementia Action Plan and the Standards of Dementia services for the region	✓	✓	✓	✓		✓	✓			✓											
	9,959 people over 65+ were admitted to hospital in 2021	Identify capacity and demands for falls services. Review existing services in place to support falls.	✓	✓		✓	✓						✓										

PNA Chapter	Gap or Service Need Identified by either PNA or MSR	Action Required	Quadruple Aim				Model of Care						Model of Care Enablers					Six Goals					
			1	2	3	4	1	2	3	4	5	6	1	2	3	4	5	1	2	3	4	5	6
	from community and residential settings including those who have suffered falls.	Identify areas for improvement and transformation for example: increase the use of assistive technology to its fullest potential to ensure appropriate support is available to those at risk of falls.																					
	Loneliness and isolation can lead to physical and mental health problems, such as depression and increased risk of premature death. In a recent analysis more than 75% of women and a third of men over the age of 65 live alone.	Reduce social isolation and loneliness while maintaining independence, enabling individuals to engage with their communities. Engage with older people to plan services that would directly support loneliness and isolation (working in Conjunction with Public Services Boards)	✓	✓			✓						✓										
	The clinically optimised patients discharged from hospital are higher in 2021 compared to 2020. This links into the flow of patients out of hospital and to ensure there is capacity in the community care sector to provide the care they need to sustain a quality life.	Continue to develop the Discharge to Recover and Assess Pathways in line with Demand and available capacity. Continue to develop services that enable safe and timely discharge from hospital to home (or other appropriate residence e.g., step down beds in line with the West Glamorgan 'What Matters to Me Model') once medically fit providing appropriate reablement support.	✓			✓		✓			✓	✓	✓										
	The demand for respite services received by adults over 65+, had increased from 518 in 2016-17 to 1,061 in 2018-19	Continue to develop respite services and capacity available in line with demands.	✓		✓	✓																	
Children and Young People	Based on projections produced by Stats Wales in 2021, the population of those aged 0 - 15 years is expected to grow by approximately 2.5% by 2040	Continue to ensure projected population growth is reflected in future planning and modelling of services.	✓	✓	✓	✓	✓		✓	✓			✓ ✓				✓	✓					

PNA Chapter	Gap or Service Need Identified by either PNA or MSR	Action Required	Quadruple Aim				Model of Care						Model of Care Enablers					Six Goals					
			1	2	3	4	1	2	3	4	5	6	1	2	3	4	5	1	2	3	4	5	6
	from 66,692 to 67,635. An increase of 943. Source: PNA 2022-27																						
	"The 'Age and loneliness' insight found that 23.3% of those aged 16–24 reported being lonely compared to 10.5% of those aged 75+. Source: PNA 2022-27	Reduce social isolation and loneliness while maintaining independence, enabling individuals to engage with their communities	✓	✓			✓		✓	✓			✓	✓	✓		✓	✓	✓				
	In the year ending March 2020, 7 out of 10 (70%) children aged 10 to 15 years who experienced an online bullying behaviour said this was by someone from their school." Research shows that 36% of pupils with Special Educational Needs (SEND) experience frequent bullying, compared to 25% of those without. The Child and Adolescent Mental Health Service (CAHMS) have struggled to meet demand locally over recent months due to staffing and resources. They report the most prominent issues for CYP to be anxiety, suicidal thoughts/ ideation, and low mood. Young people have become socially isolated during the pandemic. This may further	To identify and recognise the factors that impact on Children and Young People (such as poverty, substance misuse, digital exclusion, etc.) which need to be addressed with our partners and stakeholders. Continue to take a regional, collaborative approach to the major transformation challenges, such as implementing the NEST/NYTH Framework across multiple sectors, services and organisations, specifically around universal prevention services and early intervention	✓	✓	✓	✓	✓		✓	✓			✓	✓	✓	✓	✓	✓	✓		✓		

PNA Chapter	Gap or Service Need Identified by either PNA or MSR	Action Required	Quadruple Aim				Model of Care						Model of Care Enablers					Six Goals					
			1	2	3	4	1	2	3	4	5	6	1	2	3	4	5	1	2	3	4	5	6
	enhance feelings of loneliness and social anxiety as we move out of the pandemic. This has had a severe impact on children and young people's mental health. Source: PNA 2022-27																						
	To identify and assess as early as possible those children who need care and support (including help to achieve emotional wellbeing and resilience). Source: PNA 2022-27	Continue to take a regional, collaborative approach to the major transformation challenges, such as implementing the NEST/NYTH Framework across multiple sectors, services and organisations, specifically around universal prevention services and early intervention to ensure that those children and young people who require care and support can access the right support at the earliest possible opportunity. Develop Emotional wellbeing support where there is a need to co-ordinate and shape well-being, mental health, counselling for under 18s, and post 18 services, including transition with all partners	✓	✓	✓	✓	✓		✓	✓		✓	✓	✓	✓		✓	✓	✓		✓			
	The number of new foster placements made within the boundaries of West Glamorgan as of 31st March 2021 is 177. This shows a decline in the previous year where it was 277. Source: PNA 2022-27	Both local authorities have an ambition to increase the number of carers registered with their own service so they can (i) meet more of the need for foster care locally, especially complex care needs, (ii) have stronger options to make more effective placement matching decisions, thus reducing the need to place out of county and ensure each placement is design for the needs of each CYP, and (iii) reduce the need to use independent agencies.	✓	✓		✓	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓	✓	✓		✓		

PNA Chapter	Gap or Service Need Identified by either PNA or MSR	Action Required	Quadruple Aim				Model of Care						Model of Care Enablers					Six Goals					
			1	2	3	4	1	2	3	4	5	6	1	2	3	4	5	1	2	3	4	5	6
	The latest data available for 2020/21 from the Child Protection Register records 98 children in Neath Port Talbot and 253 in Swansea. For Swansea, the figures are about the same as they had been pre-pandemic. For Neath Port Talbot, this figure has remained stable since 2019. Source: PNA 2022-27	Continue to take a regional, collaborative approach to the major transformation challenges, such as implementing the NEST/NYTH Framework across multiple sectors, services, and organisations, specifically around prevention and early intervention services to ensure families are supported to remain together in a healthy and happy environment. Ensuring wrap around services for families are made available which will prevent CYP needing to be placed on the Child Protection Register. Where children are not able to remain living with their parents, promoting keeping families together through the use of Special Guardianship Order.	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓		✓	✓	✓	✓	✓			
	The numbers of Looked after Children in 2020/21 may be impacted by the issues surrounding the impact of COVID-19 and is not a true reflection of actual figures. Swansea recorded 550 LAC, whereas Neath Port Talbot recorded 294. Source: PNA 2022-27	Preventing the need to become looked after by helping Children and Young People and families to use their individual and collective strengths and resources in their communities; and provide timely prevention and early intervention services prevents needs escalating and becoming critical. Where children are not able to remain living with their parents, promoting keeping families together through the use of Special Guardianship Order.	✓				✓		✓	✓		✓	✓	✓	✓		✓	✓	✓		✓			
	Co-production where further work is required to achieve effective and meaningful coproduction, and the need to develop the ability for CYP to shape the services they receive.	Embedding the principles of co-production and taking a range of approaches to participation and engagement with CYP (to identify and hear the 'voice of the child,' and understand their lived experiences, prioritising our programme of work based on the needs of our population);		✓			✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

PNA Chapter	Gap or Service Need Identified by either PNA or MSR	Action Required	Quadruple Aim				Model of Care						Model of Care Enablers					Six Goals					
			1	2	3	4	1	2	3	4	5	6	1	2	3	4	5	1	2	3	4	5	6
	Co-production with Gypsy Traveller communities also needs to be strengthened in order to empower people to contribute to service design and operation. Source: PNA 2022-27																						
	Youth Homelessness - In Swansea, the number of young people who presented to the youth homeless service between April 2015 – March 2020. were 485 presentations over the 5-year period. Source: PNA 2022-27	To develop Housing provision for sustainable settings for CYP in need of support, linking in with learning disabilities and mental health support. A strategic planning approach which incorporates the national, regional, and local priorities and activities across CYP services as well as the key dependencies with other areas of transformation (e.g., capital investment in accommodation solutions)	✓	✓	✓	✓	✓		✓			✓	✓	✓	✓	✓	✓	✓	✓	✓			✓		
	There are gaps in data collection where there is a need for information to understand the current numbers not only in the services provided but also in the assessment of the wider population. We need to develop and harness a culture of sharing data more easily and is accessible and it once source of the truth. We recognise it is critical to look beyond the numbers and use qualitative information to fully understand the needs of children and young people and those who care for them.	Work collaboratively on a regional basis and retaining a child centred approach to the most complex cases - including agreeing how packages of health, educational and social care support are jointly funded. Agree with partners revised data sets to ensure we are collecting the right data at the right time to accurately inform planning and service redesign	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓				✓	✓	✓	✓	✓	✓	✓	✓

PNA Chapter	Gap or Service Need Identified by either PNA or MSR	Action Required	Quadruple Aim				Model of Care						Model of Care Enablers					Six Goals					
			1	2	3	4	1	2	3	4	5	6	1	2	3	4	5	1	2	3	4	5	6
	Source: PNA 2022-27																						
Mental Health	Social Care Wales projections for the West Glamorgan area indicate a 65% increase in the number of people with dementia from 5,607 in 2020 to 8,661 in 2040. Source: PNA 2022-27	Use forecasting data of mental health inequalities and utilising the data taking a regional approach to the prevention of poor mental health. Recognising the factors that impact on mental health (such as poverty, substance misuse, employment, etc.) which need to be addressed with our partners and stakeholders. Continue to work regionally to implement the Wales Dementia Standards and Actions under the 5 national workstreams		✓			✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	Data from the GP Quality Outcome Framework indicates during 2018- 2019, 4,688 patients were registered on the mental health disease register (Stats Wales). The majority of these patients will be managing their mental health within the community setting, with support and input from family, the voluntary sector, primary care, social care and community teams. Source: PNA 2022-27	The provision of Mental Health link workers into Local Cluster Collaboratives continues to expand to jointly manage the level of need within the community and primary care. Continue to work with third sector organisations to plan and develop their services to support prevention and low-level mental health need. The launch of a second Mental Health 'Sanctuary Service' within the region.			✓		✓	✓	✓	✓		✓	✓	✓	✓	✓	✓		✓		✓		✓
	The latest information from Stats Wales indicates the largest referral avenue for young people attending counselling is through	Continue to develop CAMHS telephone single point of contact / referral line provides an open access service providing telephone advice, support, and referral triage.	✓			✓	✓		✓	✓		✓	✓		✓		✓	✓	✓	✓			✓

PNA Chapter	Gap or Service Need Identified by either PNA or MSR	Action Required	Quadruple Aim				Model of Care						Model of Care Enablers					Six Goals					
			1	2	3	4	1	2	3	4	5	6	1	2	3	4	5	1	2	3	4	5	6
	school staff and other education sources. Local data systems from SBUHB indicate the total number of referrals received by the Local Primary Mental Health Support Service [LPMHSS] for 2020/21 for children and young people was 489. Source: PNA 2022-27	Promote the tidy Minds service - a mental health and wellbeing website for young people in Neath Port Talbot and Swansea designed to help young people understand any negative feelings they may be experiencing and finding the right advice and support Develop and promote Kooth – a virtual counselling and support for children and young people who use the anonymous digital counselling and mental health support service. Work with regional partners to ensure that the principles of the NEST/NYTH Framework are incorporated across services																					
	Findings of a survey conducted by the Children's Commissioner for Wales indicated less than half of 12–18-year-olds (47%) felt confident in seeking mental health support from a mental health team in their area. Even fewer (39%) were confident to access counselling services offered through their school. Only 52% of these respondents felt confident to go to their own doctor for mental health support. Source: PNA 2022-27	See above	✓			✓	✓		✓	✓		✓	✓	✓	✓	✓	✓	✓	✓					
	The restrictions on seeing people, being able to go outside and worries about the health of family and friends affected mental health and loneliness was	See above	✓			✓	✓		✓	✓			✓	✓	✓	✓	✓	✓	✓				

PNA Chapter	Gap or Service Need Identified by either PNA or MSR	Action Required	Quadruple Aim				Model of Care						Model of Care Enablers					Six Goals					
			1	2	3	4	1	2	3	4	5	6	1	2	3	4	5	1	2	3	4	5	6
	a key contributor to poor mental health. More than half of adults (60% of those over 25) and three quarters of young people (74% of those aged 13-24) said that their mental health has worsened during the period of lockdown restrictions, from early April to mid-May (2021) Source: PNA 2022-27																						
	Gap in identifying all services provided across the partnership to identify gaps, threats, and opportunities, including regional commissioning. Gaps in data needed to inform future PNA development Source: PNA 2022-27	Work collaboratively and co-productively across the partnership to ensure that gaps are identified and agree a way forward		✓			✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Learning Disability	**Health Inequalities** People with a learning disability have worse health than people without a learning disability and are more likely to experience a number of health conditions (co-morbidities)	Increase uptake of the annual health checks with GPs	✓	✓	✓	✓			✓				✓						✓				
	Recovery from COVID-19 people with learning disabilities are more likely to contract COVID-19, have a more severe	Increase uptake of the annual health checks with GPs Increase opportunities in local communities with the support of third sector organisations	✓	✓	✓	✓	✓		✓					✓				✓	✓				

PNA Chapter	Gap or Service Need Identified by either PNA or MSR	Action Required	Quadruple Aim				Model of Care						Model of Care Enablers					Six Goals					
			1	2	3	4	1	2	3	4	5	6	1	2	3	4	5	1	2	3	4	5	6
	case of COVID-19, and are at least three times more likely than people without learning disabilities to die from COVID-19 Inequalities in health, wellbeing, social isolation, employment, and poverty that existed before COVID-19, along with separation from family and friends and changes to routines, may have been exacerbated during the COVID-19 pandemic																						
	Education, training, and recreation Some young people face a considerable change in how much support they receive after the age of 18 due to different thresholds rather than a sudden change in need There are limited opportunities for work and apprenticeships, with no supported employment opportunities – despite evidence suggesting this is particularly effective. Young people, parents and professionals all agree that young people with learning disabilities are still expected to slot into services that already exist, with	Improve child to adult transition services	✓	✓	✓	✓	✓		✓				✓				✓			✓				

PNA Chapter	Gap or Service Need Identified by either PNA or MSR	Action Required	Quadruple Aim				Model of Care						Model of Care Enablers					Six Goals					
			1	2	3	4	1	2	3	4	5	6	1	2	3	4	5	1	2	3	4	5	6
	limited options if that doesn't fit their needs.																						
	Social and economic well-being Disabled people in Wales were twice as likely as non-disabled people to live in a low-income household When the additional costs of disability are taken into account, 50% of working age disabled people in Wales were considered to be living in poverty 55% of disabled people in Wales were not in employment	Develop opportunities for employment working with organisations based in the region	✓	✓	✓	✓			✓					✓			✓						
	Suitability of living accommodation There is an increase year on year for accommodation for people with a learning disability. Residential placements have increased by 14% over the last 5 years. Supported living is the preferred option for people with a learning disability, however this is not available in high enough numbers for people with complex needs.	Development of a capital planning schedule of supported living schemes for people with complex needs across the region		✓		✓		✓			✓	✓				✓	✓						✓
Autism	In the West Glamorgan region, future projections for autistic people taken from the Social Care Wales data platform for the	Review, capacity, and demand to provide and maintain the sustainability of appropriate support services to enable individuals with autism	✓	✓	✓	✓							✓										

PNA Chapter	Gap or Service Need Identified by either PNA or MSR	Action Required	Quadruple Aim				Model of Care						Model of Care Enablers					Six Goals					
			1	2	3	4	1	2	3	4	5	6	1	2	3	4	5	1	2	3	4	5	6
	under 17-year-old age group suggest that this cohort will only rise by 0.5% from 1,382 in 2020 to 1,391 by 2040. Source: PNA 2022-27 In the West Glamorgan Region, the number of autistic people over the age of 18 in West Glamorgan, the projected figure for the same time period rises by 6.5% to 3712 by 2040 Source: PNA 2022-27 The number of referrals to the Western Bay Regional autism service solely for NPT and Swansea increased on the pandemic with the number being 257 compared with 68 one year earlier. Source: PNA 2022-27																						
	The National Autistic Society (NAS) are delivering a project aiming to create new social groups for autistic adults across Wales. In 2020-21, a survey of autistic adults in Wales was undertaken to find out about current opportunities for socialising and the potential for setting up new peer support groups. 70% of respondents said they would like to participate in a	Ensure the groups are formed at a local level to support social interaction	✓																				

PNA Chapter	Gap or Service Need Identified by either PNA or MSR	Action Required	Quadruple Aim				Model of Care						Model of Care Enablers					Six Goals					
			1	2	3	4	1	2	3	4	5	6	1	2	3	4	5	1	2	3	4	5	6
	group, and one in six would like to set up a group themselves. Source: PNA 2022-27																						
	The Disability Employment Gap is still too wide, with around half of disabled people in work, compared to over 80% of non-disabled people. But the autism employment gap is even wider, with just 22% autistic people reported in paid work. We are really worried that out of all disabled people, autistic people seem to have the worst employment rate. Source: PNA 2022-27	Ensure the groups are formed at a local level to support information and advice on channelling people with autism into work	✓																				
	In terms of mental health, autistic people are more likely to experience problems than the general population. Approximately 70%–80% of autistic children and adults experience mental health problems, most commonly depression and anxiety. Source: PNA 2022-27	Availability of preventative services that would enable autistic people in their daily lives	✓																				
	A 2019 report, Autism Act: 10 years on, showed 76% of autistic people have reached out for mental health support in the past five years, with only 14%	Need to provide appropriate and timely access to mental health and well-being services	✓																				

PNA Chapter	Gap or Service Need Identified by either PNA or MSR	Action Required	Quadruple Aim				Model of Care						Model of Care Enablers					Six Goals					
			1	2	3	4	1	2	3	4	5	6	1	2	3	4	5	1	2	3	4	5	6
	believing there are enough mental health services in their area to support their needs. Source: PNA 2022-27																						
	Transition to adulthood: A reference to the need for a systematic transition process, a lack of support for parents and support to handle the legal and financial procedures associated with young adults with profound intellectual disability reaching adulthood (18 years old). Source: PNA 2022-27	Improve child to adult transition services	✓	✓	✓	✓							✓										
	Of those children where the information is available, the number of children with an autistic spectrum disorder receiving care and support is increasing in the Region from 255 in 2016-17 to 310 for 2019-20. Source: PNA 2022-27	Further planning in terms of the requirements from the ALNWA Act around a fully inclusive education service needs to continue.	✓	✓	✓	✓																	
	The most significant gap identified in the development of the autism PNA chapter was the insufficient data for autism across all services. This means we are unable to clearly identify the gaps and demand for different services Source: PNA 2022-27	Ensure a mutual understanding and consistency across the partners in the way the data is recorded and analysed. Carry out more analysis to plan for the needs of the population living in the region. Engagement with people with autism and their carers to inform future developments for autism services.	✓	✓	✓	✓							✓										

PNA Chapter	Gap or Service Need Identified by either PNA or MSR	Action Required	Quadruple Aim				Model of Care						Model of Care Enablers					Six Goals					
			1	2	3	4	1	2	3	4	5	6	1	2	3	4	5	1	2	3	4	5	6
		Better sharing of information between partner organisations and people, particularly in terms of the services that are available across the region																					
Carers	Many unpaid carers struggle to balance work and caring for someone. Carers Wales estimates that 149,812 people in Wales have had to give up employment to care. Of those who have been able to stay in employment, 74,906 have had to reduce their working hours to support the people they care for. Source: PNA 2022-27	Provide increased short breaks/Respite - more innovative approaches are needed. Provide increased workplace support for carers			✓	✓							✓										
	Co-production – carers must be involved in co-designing services that meet their needs. Co-production must be embedded as per the Regional Co-production Framework. Source: PNA 2022-27 New developments and changes are co-produced with carers. Carers services are funded sustainably Carers are actively offered direct payments. Carers' positive and negative experiences are used to inform service improvements. Carers have responsive and flexible access to mental health and well-	Ensure that any services developed for carers are coproduced Ensure carers are involved in meaningful discussions about their needs and the people they care for (including young carers).	✓	✓																			

PNA Chapter	Gap or Service Need Identified by either PNA or MSR	Action Required	Quadruple Aim				Model of Care						Model of Care Enablers					Six Goals					
			1	2	3	4	1	2	3	4	5	6	1	2	3	4	5	1	2	3	4	5	6
	being services. Source: PNA 2022-27																						
	Carers have flexible and responsive respite opportunities. Carers have support with developing contingency plans. Carers have access to wellbeing workshops. Carers have workplace and educational support. Source: PNA 2022-27	Provide increased short breaks/Respite - more innovative approaches are needed. Provide young carers with support for tuition and homework clubs. Provide young carers with help choosing subject options and careers advice	✓	✓	✓	✓																	
	Carers have opportunities to meet each other. Carer led groups are commonplace. Source: PNA 2022-27	Reduce social isolation and loneliness for carers, providing then with opportunities to meet each other and engage with their communities. Engage with carers to plan services that would directly support loneliness and isolation (working in Conjunction with Public Services Boards) Ensure Young carers have opportunities where they can meet up with other young carers	✓	✓									✓										
	Carers are informed of their rights. Carers have dedicated and tailored information and advice portals/places across all statutory providers. Carers have information and advice about contingency planning. Carers are informed about Assessments and how they can be of benefit. Easy read options and minority languages are catered for appropriately. Source: PNA 2022-27	Improve information, advice, and advocacy – excellent quality support is needed by carers to support their caring role. Improve Carers assessments – under used and under offered. Improve information on Direct Payments – difficult to navigate and under used for carers needs. Ensuring direct payments work well and meet carers' needs Improve Communication – accessible information given at the right time. Training – consistent training for staff on how to work with	✓	✓	✓	✓							✓										

PNA Chapter	Gap or Service Need Identified by either PNA or MSR	Action Required	Quadruple Aim				Model of Care						Model of Care Enablers					Six Goals					
			1	2	3	4	1	2	3	4	5	6	1	2	3	4	5	1	2	3	4	5	6
		carers. Funding – sustainable funding of carers services is needed. Improve the information that is targeted at schools and employers about supporting the needs of carers and young carers																					
	Carers are recognised even if they do not self-identify. Carers are actively identified by organisations and staff supporting them. There is shared responsibility across and within organisations for identifying carers. Source: PNA 2022-27	Develop engagement opportunities for carers to identify themselves, and be identified by supporting organisations which includes the identification of young carers Develop a young carers leads network in educational settings Ensure young carers are identified in schools for signposting to early support.	✓	✓	✓	✓																	

APPENDIX 3 – Information, Advice and Assistance (IAA)

Neath Port Talbot County Borough Council

Neath Port Talbot CBC has worked with partners and imbedded the national well-being directory, DEWIS CYMRU; this works alongside the Family Information Service and with the directory used by the third sector, Infoengine. These platforms make it easier for citizens of Neath Port Talbot to access the information they require.

The Adults and Children's Single Point of Contact operate an integrated "front door" to the Social Services Health and Housing Directorate, where contact officers respond to queries from the public and appropriate information, advice and assistance is provided based on the needs of the caller.

Swansea Council

Swansea is implementing the national well-being directory, DEWIS CYMRU so that people can obtain information directly from the website in order to access a wider range of well-being care and support services. This national system, implemented locally, is expecting to build important links to the Family Information Service and Third Sector's Infoengine directories.

These developments are a part of an overall approach to providing information, advice and assistance that fits with the Council's approach to Corporate Contact, the Single Point of Contact in Child and Family Services and the Adult Common Access Point at the front door of community-based health and social care services.

Swansea Bay University Health Board

111 is the new free-to-call number for people to access general health and mental health advice from the correct professional in the quickest time possible and is part of a plan to improve urgent and unscheduled care.

The 111 Wales pilot was launched in October 2016 by Swansea Bay University Health Board and is live across the whole of the West Glamorgan region. Further enhancements to the NHS 111 service are planned throughout the next 12 months.

APPENDIX 4 – Welsh Language Services

Neath Port Talbot County Borough Council

Services will seek to match suitable members of Welsh speaking staff with a person/persons who would wish to discuss their well-being through the medium of Welsh.

Swansea Council

Swansea Council and Social Services recognises the importance of meeting the individuals' Welsh language needs, and we are committed to offering, providing, and developing Welsh language services. During the year, the Directorate has been working towards increasing capacity to deliver a bilingual service, as there is a current lack of capacity in the teams, reflected in the small number of fluent Welsh speakers.

Service plans and commissioning plans are tackling the challenges linked to increased citizen expectations, higher demand, and less resource. Work is still in progress both regionally, locally and within partnerships. These are informed by co-production with citizens, and any public facing events will be held with an 'active offer' in place. All such strategic plans are screened for Equalities considerations via an Impact Assessment, and contract specifications are reviewed regularly with providers and monitored routinely against a range of quality standards, including Welsh Language standards. Provider forums held with residential and domiciliary care sectors have helped to raise awareness of the Active Offer.

Swansea Bay University Health Board

Swansea Bay University Health Board is fully committed to providing a bilingual service and wants to improve the quality of the treatment, care and services people receive. We wish to ensure that people are treated with dignity and respect, and that we offer Welsh language services to people without them having to ask for them (in line with guidance within the Welsh Government's Strategic Framework "More than just words...." and The Active Offer).

APPENDIX 5 – Glossary of Acronyms

Glossary of Acronyms

Acronym	Full definition
BAME	Black, Asian and Minority Ethnic
CCN	Complex Care Needs
CCN	Commissioning for Complex Needs
CVS	Council for Voluntary Service
CWSA	Cluster Whole Systems Approach
CYP	Children and Young People
DCP	Discretionary Capital Programme
DTOC	Delayed Transfers of Care
EOI	Expression of Interest
H2H	Hospital 2 Home
HR	Human Resources
IAA	Information, Advice and Assistance
ICF	Integrated Care Fund
LD	Learning Disabilities
LGBTQ+	Lesbian, Gay, Bisexual, Transgender, Queer, Plus (the 'Plus indicates inclusion of all orientations and identities)
MAPSS	Multi-Agency Placement Support Service
MCP	Main Capital Programme
NPTCBC	Neath Port Talbot County Borough Council
ONA	Our Neighbourhood Approach
PNA	Population Needs Assessment
PSED	Public Sector Equality Duty
RBA	Results Based Accountability
RI&I	Research, Innovation & Improvement
RII	Research, Innovation and Improvement
RPB	Regional Partnership Board
SBUHB	Swansea Bay University Health Board
SC	Swansea Council
SCH&H	Social Care, Health & Housing
SMART	Specific, Measurable, Achievable, Relevant and Time-bound
SVF	Social Value Forum
TMHS	Transforming Mental Health Services
ToC	Theory of Change
ToR	Terms of Reference
TUC	Trades Union Congress
UNCRC	United Nations Convention on the Rights of the Child
VAWDASV	Violence Against Women, Domestic Abuse and Sexual Violence
WCCIS	Welsh Community Care Information System

Glossary of Terms

Term	Description
Benefits	We use the term '**Benefits**' to describe a measurable impact on an organisation or business, in our case primarily on our partner organisations. As opposed to Outcomes (which impact on People in general), a benefit will impact on the organisation in either a positive way (e.g. a reduction in operational running costs) or a negative way known as a Dis-benefit (e.g. changing a service may result in an increase in calls to a helpline or contact centre, which comes with an associated cost).
Business As Usual	We use the term '**Business as usual**' to mean a service provided by the Regional Partnership, either directly to our People or to the Regional Partnership Board and its partner organisations.
Capital Expenditure	The purchase or creation of assets that are intended to be used for a period of at least one year or more, including items such as land, buildings and equipment
Commissioning	We use the term '**Commissioner**' to represent an individual that plans the services that are needed by our People and ensures that they are available, including potentially paying for the service to be delivered by another individual or organisation. • We use the term '**Local Commissioning**' to mean when an organisation commissions a service either within their own local area or community, or only to their own Service Users directly. • We use the term '**Regional Commissioning**' to mean when the Regional Partnership (or another regionally-focused entity) commissions a service either across multiple areas or communities, or with the involvement of multiple organisations to reach a greater number of Service Users directly. • We use the term '**Tender**' to mean a written invitation to potential Service Providers who may be interesting in providing the services we commission. The Tendering Process means a series of tasks that allow Commissioners to identify the most suitable Service Provider and appoint them in a fair, open competition (usually resulting in a Contract being issued from the Commissioner to the successful Service Provider).
Continuous Improvement	We use the term '**Continuous Improvement**' to represent a process by which we are constantly checking to see if our service is delivering the right results (e.g. achieving the right outcomes for our People) and making changes where we believe they are needed. The difference between transformation and continuous improvement is that we ensure continuous improvement is built into the service so that it is always happening (and we do not have to wait until a certain time or when funding is available to make a change).
Dependencies	We use the term '**Dependencies**' to describe the link between different tasks or responsibilities. For example, we cannot deliver an event until we have created a plan so the two tasks are dependent (one has to be completed before the other can be started). This is especially important if different individuals or organisations are responsible for each task, as they need to know what is dependent on their work and what their work is dependent upon. Understanding and mapping dependencies can help us

	to manage the work to ensure that we can successfully deliver our Plans and achieve our Strategies.
Drivers	We use the term '**Drivers**' to describe the various influences on our transformation initiatives, providing a clear direction in terms of "why are we doing this". Strategic Drivers can include national policies, recommendations from major reviews, regionally co-produced strategies, legislation and other important factors. These Drivers not only motivated us to transform but provide clear rationale and boundaries within which we can deliver change.
Framework	We use the term '**Framework**' to describe "how we will manage our work" which enables us to deliver our Strategies. Frameworks provide us with the structures, processes and mechanisms that we can use repetitively across all of our areas of work. For example, a Communications Framework helps us to communicate consistently and in line with the same principles regardless of which Service, Programme, Project or Function we are delivering.
Function	We use the term '**Function**' to mean a service provided by the Regional Partnership Transformation Team that enables the partnership to operate. These are internal processes such as managing budgets and co-ordinating regional reporting which are necessary to enable us to work together and delivery our Portfolio of transformation initiatives.
Goals	We use the term '**Goals**' to describe the purpose of our transformation initiatives, in terms of what needs to be achieved and by when. We often use the SMART technique to ensure that our goals are described in a clear and effective way.
Indicators	We use the term '**Indicators**' to describe how we quantify the achievement of our Outcomes (e.g. if we delivered a change, what number or percentage of people did it help).
Issues	A previously uncertain event that is now certain to have an impact on some aspect of our work
Measures	We use the term '**Measures**' to describe how the changes we are delivering will impact on our Outcomes (e.g. if we delivered a change, how well did it work).
Mission	We use the term '**Mission**' to describe how we intend to move forward and achieve our Vision, either in terms of a clear task or a commitment to working in a specific way to ensure that we can successfully deliver the tasks needed.
Objectives	We use the term '**Objectives**' to describe the stated aims of an initiative to be achieved. This could include delivering a number of Outputs or implementing a number of tasks within a Plan. We often use the SMART technique to ensure that our Objectives are described in a clear and effective way.
Outcomes	We use the term '**Outcomes**' to describe a measurable impact on a key condition for some or all of our People (e.g. better wellbeing for carers). We may have lots of different initiatives contributing to a single Outcome over a long period of time.
Outputs	We use the term '**Outputs**' to describe something that is created by an initiative in order to help us achieve our Objectives. It could be a document, a process, an important message to be shared…anything that is created by a Programme or Project. Some of our outputs are co-

	produced in line with our **Regional Co-production Framework**. Other terms for Outputs include 'Products' or 'Deliverables'.
Plan	We use the term '**Plan**' to describe "how we will do it" in order to implement our Strategy and achieve our Vision for the future. The Plan is important to explain what action we plan to take in a way that everyone can understand what is going to happen and the impact of it happening. A Plan document combines information about the actions that will be taken during the life of the Programme or Project that is responsible for delivering it.
Portfolio	We use the term '**Portfolio**' to mean the totality of our investment in transformation. This means all of initiatives that we fund (regardless of their funding sources, timescales or resources) combined as a single collection of the following types of initiatives: • We use the term '**Programme**' to represent an initiative that delivers one or more Outcomes in line with our regional priorities and strategies. These initiatives are time-bound and usually take several years in total to complete (although some programmes are continuously refreshed with new Outcomes and timescales, these are known as "rolling programmes"). • We use the term '**Project**' to represent an initiative that delivers one or more Outputs that contribute to one or more Outcomes. These initiatives are time-bound and usually take between several months and two years to complete. • We use the term '**Work Package**' to represent a set of tasks and actions required to deliver an Output. Whereas a Programme or Project may have specific funding and resources assigned to it, a Work Package may not and would therefore need to be delivered within our funding and resource constraints. • We use the term '**Task & Finish Group**' to represent an initiative that is established to deliver a specific aim, task or Output. These initiatives are temporary and usually take weeks or months to complete.
Programme	A temporary structure responsible for implementation of a set of projects that will collectively deliver outcomes and strategic benefits
Project	A temporary structure responsible for delivering key outputs or changes that will contribute to achieving outcomes and strategic benefits
Revenue Expenditure	Expenditure incurred on day-to-day running costs which would include rent, utilities and salaries
Risks	An uncertain event that, if it happens, may have an impact on some aspect of our work
Schedule	We use the term '**Schedule**' to describe the tool we use for detailing the specific actions within the Plan including what tasks are required, who will do them, and when they will be started/finished. A Schedule is created for programmes and projects using our Project Server system
Section 33 agreement	A joint funding arrangement between organisations – often referred to as "pooled budgets" – which allow each organisation to contribute to achieving a shared outcome.
Service Manager	We use the term '**Service Manager**' to represent the individual who is accountable for a service, often the senior leader on a team within the Service Provider's organisation.

Service Provider	We use the term '**Service Provider**' to represent the individuals, organisations or groups who provide a service (in this case, generally a health or social care service).
Service User	We use the term '**Service User**' to represent the People who use the services provided by a Service Provider.
Social Value	The quantification of the relative importance that People place on the changes they experience in their lives
Strategy	We use the term '**Strategy**' to describe "what we plan to do" in order to achieve our vision for the future. A Strategy document combines various elements such as the mission, goals and drivers to describe the future state we want to achieve and why it is important. A strategy is not only about defining the scope and purpose of transformation, it is about engaging and inspiring the people who will help us to make that change happen.
The Act	The Social Services and Wellbeing (Wales) Act 2014
Tolerances	A set variance on key criteria against which change is delivered (e.g. Time, Cost, Quality, Scope)
Vision	We use the term '**Vision**' to describe how we see the future either in terms of our regional partnership, our key priorities for transformation or in specific programmes of work. A Vision Statement is a simple, clear and concise statement of what the future will look like which inspires us all to achieve our vision.
Workstream	We use the term '**Workstream**' to mean the structure for us to manage a number of programmes, projects, work packages and other activities related to a key theme or priority (such as Housing).