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**DELIVERING CHANGE TOGETHER**

**CYFLAWNI NEWID GYDA’N GILYDD**

**West Wales Area Plan 2018-2023**

**Foreword**

On behalf of the West Wales Regional Partnership Board, I am delighted to present our first Area Plan in which we set out how we will work as a partnership over the next five years to continue the transformation and integration of care and support in our region and address the issues identified in our recent Population Assessment.

We have intentionally structured our Plan around the principles of prevention and a single ‘care and support pathway’ which aims to help people of all ages stay independent within their communities and, if they need more formal care, to ensure that agencies work together to help those that can return home with appropriate support as soon as possible. For those needing longer term care our focus will continue to be on helping people reach their full potential and live fulfilling lives. These are the aims and values that underpin the Social Services and Wellbeing (Wales) Act.

Our Plan sets clear strategic objectives to which the Board will hold partners accountable. More detailed action plans are in place or are being developed to ensure that practical steps are taken to deliver the change that is required on the ground. We have provided links to these wherever possible.

We all have a stake in delivering transformation. A fundamental principle of the partnership is that people needing care and support and their carers – as well as wider communities – have a meaningful voice in shaping services and we will be looking to ensure that people are properly engaged as action plans are developed and implemented.

Committed professionals across the statutory, third and independent sectors provide high quality care and support to thousands of people in West Wales every day. Properly valuing our current staff and supporting them to develop new skills, as well as attracting new people to join the sector, are priorities for the partnership and we will be working at a regional level and nationally with colleagues in Social Care Wales to achieve this.

The landscape in which we operate is constantly changing. We will need to ensure that the objectives within our Plan fit with the anticipated response from Welsh Government to the recent Parliamentary Review of Health and Social Care in Wales. Similarly, they will need to support the implementation of Hywel Dda University Health Board’s Transforming Clinical Services Programme. Therefore we aim to refresh the Plan on a regular basis. Updates will be available via a new on-line Data Portal which also contains a vast range of information on our population and the care and support that is delivered across West Wales. This data will also be updated regularly to help us monitor the impact of this Plan and ensure that we remain on track.

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**Sue Darnbrook**

Chair, West Wales Regional Partnership Board

**Section 1: Overview**

**West Wales Care Partnership**

The West Wales Care Partnership brings together partners from local government, the NHS, third and independent sectors with users and carers with the aim of transforming care and support services in the region.

The West Wales region covers the area of Hywel Dda University Health Board and includes the council areas of Carmarthenshire, Ceredigion and Pembrokeshire. Our region is predominantly rural and is the second most sparsely populated region in Wales. Covering approximately one quarter of the landmass of Wales, the region’s population was estimated to be 384,000 in 2016.

The work of the West Wales Care Partnership is overseen by a Regional Partnership Board. Membership of the Board is provided in Appendix 1.

Further information on the Partnership and what it does can be found [here.](http://www.google.co.uk/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&cad=rja&uact=8&ved=0ahUKEwiZwOzbkffWAhVRahoKHU4EAh8QFggoMAA&url=http%3A%2F%2Fwww.wwcp.org.uk%2F&usg=AOvVaw2QmGbobojn_QYZT850GISL)

**Population Assessment**

In March 2017 we published our first [Population Assessment](http://www.wwcp.org.uk/wp-content/uploads/2017/03/West-Wales-Population-Assessment-March-2017.pdf). Required under Section 14 of the Social Services and Wellbeing (Wales) Act, this assessment was carried out jointly by the three local authorities and Hywel Dda University Health Board, with input from users, carers and colleagues in the third and independent sectors. It provides a detailed analysis of care and support needs, and support needs of carers in the region, the range and level of services required and the extent to which those needs are currently being met. We were required by Welsh Government to look at the specific needs of the following population groups:

* Children and Young People
* People with Physical Disabilities
* People with a Learning Disability and people with Autism
* People with a Mental Health condition
* Older people
* People with a sensory impairment
* People involved in Substance Misuse
* People experiencing Violence Against Women, Domestic Abuse and Sexual Violence

We also considered generic population health needs within the community.

Our Population Assessment contained a number of overarching recommendations in relation to how care and support should be provided in the future. These were as follows:

**OR1** We should remain focused on respecting people’s dignity and protecting them from neglect and abuse

**OR2** Services should be available in Welsh for all who need them

**OR3** Prevention – delaying or reducing the need for ongoing care and support – should underpin all we do and we need to help communities to help themselves

**OR4** We must recognise the contribution of carers and provide them with appropriate support

**OR5** The transition between children’s and adult’s services needs to be handled appropriately to make sure young adults continue to get the support they need to live independent and fulfilled lives

**OR6** We must involve users, carers, service providers and wider communities in the planning and delivery of care and support

**OR7** We should be bold and radical in changing the way services are provided

**OR8** We need an integrated approach to commissioning and delivery of services and look to pool our resources where possible to ensure we make best use of available budgets and join services up at the point of delivery

Section 2 provides a summary of the issues we identified in relation to each of the population groups, including identified gaps and areas for improvement.

**The Area Plan**

Section 14A of the Social Services and Wellbeing (Wales) Act requires us to produce an Area Plan setting out how we will work together to address the findings and recommendations of our Population Assessment. It also needs to provide details of our approach to prevention, Information, Advice and Assistance, development of alternative delivery models and how we will deliver services through the medium of Welsh.

Our Plan is an important document that provides a clear framework for partners for integrating and transforming care and support and a public statement of our intentions, to which users, carers and communities more generally are invited to hold us to account. We have to produce an Area Plan every five years.

Whilst it focuses on the care and support needs of people in West Wales, our Plan has been informed by a number of important national drivers. These are as follows:

**The Social Services and Wellbeing (Wales) Act 2014**, which provides a legislative framework for care and support based on the principles of:

* Supporting people to achieve their own wellbeing
* Putting people at the centre of their care and support and giving them a voice in terms of the support they receive
* Involving people in the design and delivery of services
* Developing preventative services that help prevent, delay or reduce the need for care and support
* Promoting not for profit delivery models, and
* Requiring collaboration across agencies in the provision of care and support and integration of key services including services for older people with complex needs, children with complex needs, people with a learning disability and carers, including young carers

**The Wellbeing of Future Generations (Wales) Act 2015**, which sets out 5 ways of working for public bodies:

* **Long term** – Balancing short-term needs with the need to safeguard the ability to also meet long-term needs
* **Prevention** – How acting to prevent problems occurring or getting worse may help public bodies meet their objectives
* **Integration** – Considering how public bodies’ wellbeing objectives may impact on each of the wellbeing goals, on their objectives, or on the objectives of other public bodies
* **Collaboration** – Acting in collaboration with any other person (or different parts of the body itself) that could help the body to meet its wellbeing objectives
* **Involvement** – The importance of involving people with an interest in achieving the wellbeing goals and ensuring that those people reflect the diversity of the area which the body serves.

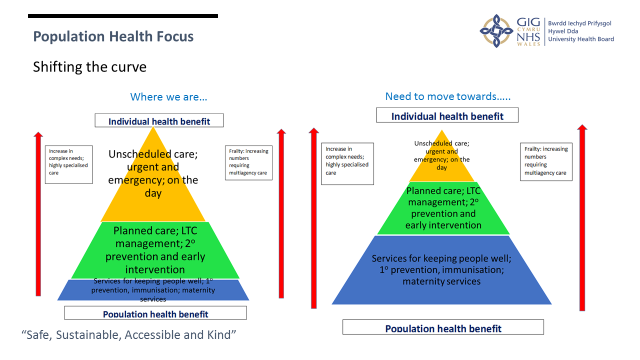
**The Parliamentary Review of Health and Social Care in Wales**, which reported in January 2018 calls for a seamless system of care for Wales, organised around the individual and their family and underpinned by the ‘Quadruple Aim’ of health and care staff, volunteers and citizens working together to deliver clear outcomes; improved health and wellbeing; a cared for workforce; and better value for money.

**Prosperity for All**, the Welsh Government’s national strategy, which sets out how the objectives set for the current term of the National Assembly for Wales will be delivered and identifies longer-term foundations for the future. Five priority areas are identified, which include:

* **Early years** – recognising that an individual’s childhood experiences play a significant part in shaping their future and are crucial to their chances of going on to lead a healthy, prosperous and fulfilling life
* **Social care** – highlighting the centrality of compassionate, dignified care in maintaining strong communities and helping people to stay independent and healthy for longer and emphasising the economic importance of the care sector
* **Mental health** – recognising that one in four people in Wales will experience mental ill health at some point in their lives and the importance of getting the right treatment at an early stage and raising awareness in order to prevent long term adverse impacts

The strategy also highlights **the need for agencies to work more closely, on a consistent regional basis**, to maintain resilience and responsiveness of services in the future.

In terms of local needs, our Population Assessment identified a number of common challenges and opportunities across the different population groups. It demonstrated that a collaborative, preventative approach based on improving population health and reducing and delaying the need for care and support is going to be crucial if we are to help people achieve positive outcomes, remain independent and live fulfilled lives within our communities. We have strong foundations on which to build although it is clear that we need to accelerate the pace of change. This will require a fundamental shift in the balance between community-based, preventative support and acute services and an associated change in funding priorities. This shift is illustrated in the following diagram, developed by Hywel Dda University Health Board but applicable across health and social care.

Figure 1

**An integrated care and support pathway**

In view of this we have structured our Plan to span the needs of the entire population around a **co-produced, preventative approach to care and support**. This approach has emerged from a model developed to shape and monitor impact of our Integrated Care Fund (ICF) programme in West Wales and aligns with national principles underpinning seamless, integrated, locality-based care. It aims to support people to:

1. **Stay well and independent within the community** (for example through making information available in accessible formats which enables people to make appropriate choices and maintain personal health and wellbeing, understanding the value from a young age of regular exercise, healthy eating and the need to socialise regularly, linking people with well-being hubs and informal support within their communities and further development of supported living services) – **Prevention Stage 1**
2. **Maintain independence through provision of targeted support that prevents the need for people to be admitted to hospital or long-term residential care, or supports timely discharge** (such as domiciliary care, housing adaptations, ‘turnaround’ services at the front door of hospitals and rapid response services,‘step-up’, ‘step-down’ and reablement services, extra care,supporting families and parents to reduce adverse childhood experiences (ACE) which can have life- long effects, building on the work of the Integrated Family Support Service to work with and support the most vulnerable children and families in Wales) – **Prevention Stage 2**
3. **Provision of appropriate, outcomes-focused long-term care and support** (for example providing ongoing health and/ or social care in residential settings with a focus on supporting independence, building on strengths and improving outcomes for individuals over time, work to reduce unnecessary use of care) – **Prevention Stage 3**

**Transforming Clinical Services**

These principles also underpin a fundamental review of healthcare services in West Wales being taken forward through Hywel Dda University Health Board’s **Transforming Clinical Services Programme**. This programme is underpinned by four key objectives:

* Improving the quality of care
* Meeting the changing needs of patients
* Making resources go further
* Joining up services

Following extensive engagement with staff, partners, service users, carers and the public during the Spring and Summer of 2017 a number of options for organising and delivering healthcare in the future have been developed and these will be consulted upon further in the Spring of 2018, prior to formal adoption of the preferred model in July. All of these models are based on the core principles of improving population health, prevention and self-care and include the establishment of ‘community hubs’ providing a range of integrated health and care services aimed at helping people stay well within their communities.

The Transforming Clinical Services Programme provides a unique opportunity for health, social care, partners in the independent and third sectors – working with users and carers - to develop the seamless care system envisaged in the Parliamentary Review that fits with the needs of people in West Wales. The Objectives within this Plan reflect the aims of the programme and signal a shared strategic intent to deliver transformational change. Detailed implementation plans will be developed once the way forward has been agreed.

**Regional priorities**

Our Plan also reflects **eight regional priorities** that have been adopted by the Regional Partnership Board. These fit into three categories:

**ENABLERS OF CHANGE – improving core processes and building capacity to deliver transformation**

* Regional Workforce Strategy
* Integrated commissioning
* Implementation of the Welsh Community Care Information System (WCCIS)

**TRANSFORMING KEY SERVICES – integrating models of care for different population groups**

* Transforming Mental Health and Learning Disability Services

**CROSS-CUTTING THEMES – areas of change that span different population groups**

* Information, Advice and Assistance
* Carers
* Service integration and pooled funds
* Welsh Language

Section 3 of the Plan provides a high level Delivery Plan containing a range of objectives grouped under the 3 stages of our preventative approach, with an additional section detailing objectives in relation to our ‘enablers’. For each objective we indicate which population groups will be affected by the planned change (linking directly back to the Chapters in our Population Assessment and the summary information contained in Section 2), and which of the eight regional priorities apply. We also cross-refer each objective to the overarching recommendations within our Population Assessment.

**Meeting local needs**

In developing the Plan, we have sought to strike the right balance between a regional focus and local delivery. As partners we are committed to ensuring that wherever people live in West Wales they can be assured of consistent standards and a common joined-up approach to their care and support. Service standards will be developed in partnership with users, carers and providers and will reflect best practice in our region, other parts of Wales and further afield. To achieve economies of scale we will continue to work regionally to achieve sustainability in our markets and in the commissioning and delivery of specialist services such as for those for children with complex needs.

However, this does not mean that all services will look exactly the same in all areas. Our Population Assessment recognises the rich diversity of our region, which includes post-industrial areas with significant social deprivation, rural and coastal communities. The way in which services are organised, funded, delivered and accessed must reflect the particular needs of such communities. Such an approach aligns with the aims of the Welsh Government’s Plan for a Primary Care Service for Wales. We are therefore committing within the Plan to a localised approach, looking for opportunities to integrate and pool resources at the lowest level possible. This combination of regional consistency and local delivery reflects the recommendations of the Parliamentary Review and the ethos underpinning the Transforming Clinical Services Programme.

**Links with other programmes**

The Delivery Plan is supported by a wide range of more detailed implementation plans. These are referenced within the Plan and links are provided where available. They include single agency and collaborative plans. Some are statutory, for example the Regional Strategy for Violence Against Women, Domestic Abuse and Sexual Violence, the Commissioning Strategy for Drug and Alcohol Misuse, Together for Mental Health Strategy and the Health Board’s Integrated Medium Term Plan.

Specific initiatives supported through the ARCH (A Regional Collaboration for Health) programme such as the Llanelli Wellness and Life Science Village at Delta Lakes will be key in helping deliver our vision for services serving the whole region. The largest ever regeneration project in South West Wales, this programme will improve the health and wellbeing of people in our region and create up to 2000 jobs. Proposals include:

* An Institute of Life Science with laboratory and clinic space and an incubation facility for business start-up, research and development
* A Wellness Hub incorporating a new ‘state-of-the-art’ sports and leisure centre
* A Community Health Hub offering a range of health and wellbeing services and facilities for education and training.
* A Wellness Hotel
* An Assisted Living Village

The ambitious project – which will see an investment of more than £200million - is being led by Carmarthenshire County Council in partnership with Hywel Dda and Abertawe Bro Morgannwg University Health Boards and Swansea University.

It is also a key project for the Swansea Bay City Region and is earmarked to receive £40million as part of the £1.3billion City Deal funding.

Mechanisms are also in place to ensure alignment between our Plan and the work programme of the Mid Wales Health Care Joint Committee.

We will ensure that updated versions of implementation plans are made available as they are developed and adopted. This will help make sure the Plan stays relevant and provides an up-to-date picture of progress.

**A wider approach to wellbeing**

Some of the issues and challenges that were identified within our Population Assessment require action beyond the remit of the Regional Partnership Board. Examples include the need to consider how public transport might be improved to make it easier for people in rural communities to access the care and support that is available. In relation to these we have liaised with the three Public Service Boards (PSBs) in the region, which have responsibility for improving economic, social, environmental and cultural wellbeing in their areas by strengthening joint working across public services. Under the Wellbeing of Future Generations (Wales) Act, PSBs are required to produce Wellbeing Plans for their areas, informed by Wellbeing Assessments, and we have sought to ensure such wider issues are picked up as the Wellbeing Plans are implemented. Similarly, we have identified where our Area Plan will help address issues pertinent to the wellbeing of people in need of care and support identified within the Wellbeing Assessments. Areas of the three wellbeing plans that clearly link with the priorities and objectives of our Area Plan are set out in Figure 2 below.

Figure 2

|  |  |  |
| --- | --- | --- |
| Carmarthenshire Wellbeing Plan | Ceredigion Local Wellbeing Plan | Wellbeing Plan for Pembrokeshire |
| **Healthy Habits**   * People have a good quality of life, and make healthy choices about their lives and environment   **Early intervention**   * To make sure that people have the right help at the right time; as and when they need it   **Strong connections**   * Strongly connected people, places and organisations that are able to adapt to change   **Prosperous People and Places**   * To maximise opportunities for people and places in both urban and rural parts of our county | **Community resilience**   * Create conditions for communities to support individuals from all backgrounds to live fulfilling, independent lives   **Individual resilience**   * Enable every child to have the best start in life * Enable people to create and grasp opportunities and meet challenges throughout their lives * Enable people to live active, happy and healthy lives | **Resourceful communities**   * Build on our existing strengths and create resourcefulness and capacity to prevent communities weakening or fracturing * Ensure communities are involved and given the opportunity and support to identify and develop solutions which are right for them   **Tackling rurality**   * Re-examine traditional models of service delivery to meet the needs of rural communities |

Moving forward, we will continue to work closely with the PSBs to monitor achievement of shared and respective objectives.

**Welsh language**

When undertaking our Population Assessment we were required to consider how care and support services will be provided through the medium of Welsh. This is an important consideration for our region as the proportion of Welsh speakers is considerably higher in Carmarthenshire and Ceredigion than in Wales as a whole. This is not the case in Pembrokeshire, although it is still vital that services are available in Welsh for people within the community for whom Welsh is the language of choice.

Figure 3

Proportion of Welsh speakers in West Wales

|  |  |
| --- | --- |
|  | Percentage of Welsh Speakers (over the age of 3) |
| Carmarthenshire | 44% |
| Ceredigion | 47% |
| Pembrokeshire | 19% |
| West Wales | 37% |
| Wales | 19% |

A range of initiatives are in place across the region to improve availability of care and support services through the medium of Welsh and that the requirements of the Welsh Language (Wales) Measure 2011 and the ‘More than Just Words’ Framework are fully met. To support further developments in this area we have adopted the Welsh language as an additional cross-cutting theme. We will establish a regional Welsh Language Forum, in addition to those already in place in each local authority area, which will facilitate sharing of practice and generate cross-regional initiatives as appropriate. This new forum will report on a regular basis to the Regional Partnership Board.

**Measuring outcomes**

A key aspiration within the Act is that services across the statutory, independent and third sectors work in partnership to build on people’s strengths and abilities and enable them to maintain an appropriate level of independence and realise their personal goals. To support this, Welsh Government has developed a National Outcomes Framework for people who need care and support and for carers needing support. This Framework includes a series of national wellbeing outcomes which these groups should expect in order to lead fulfilled lives. These are as follows:

| **What well-being means** | **National well-being outcomes** |
| --- | --- |
| Securing rights and entitlements  Also for adults: Control over day-to-day life | |  |  | | --- | --- | | **N1** I know and understand what care, support and opportunities are available and use these to help me achieve my well-being.  **N2** I can access the right information, when I need it, in the way I want it and use this to manage and improve my well-being.  **N3** I am treated with dignity and respect and treat others the same.  **N4** My voice is heard and listened to.  **N5** My individual circumstances are considered.  **N6** I speak for myself and contribute to the decisions that affect my life, or have someone who can do it for me. | | |  |  | |
| Physical and mental health and emotional well-being  Also for children: Physical, intellectual, emotional, social and behavioural development | **N7** I am healthy and active and do things to keep myself healthy.  **N8** I am happy and do the things that make me happy.  **N9** I get the right care and support, as early as possible. |
| Protection from abuse and neglect | **N10** I am safe and protected from abuse and neglect.  **N11** I am supported to protect the people that matter to me from abuse and neglect.  **N12** I am informed about how to make my concerns known. |
| Education, training and recreation | **N13** I can learn and develop to my full potential.  **N14** I do the things that matter to me. |
| Domestic, family and personal relationships | **N15** I belong.  **N16** I contribute to and enjoy safe and healthy relationships. |
| Contribution made to society | **N17** I engage and make a contribution to my community.  **N18** I feel valued in society. |
| Social and economic well-being  Also for adults: Participation in work | **N19** I contribute towards my social life and can be with the people that I choose.  **N20** I do not live in poverty.  **N21** I am supported to work.  **N22** I get the help I need to grow up and be independent.  **N23** I get care and support through the Welsh language if I want it. |
| Suitability of living accommodation | **N24** I live in a home that best supports me to achieve my well-being. |

Outcomes are also being developed at a regional level, to measure the impact of services and build on the national framework. The framework will be supported by specific performance measures, to help us monitor progress. This work has begun in support of our ICF programme, which reflects the national framework and will enable robust scrutiny of delivery and we will be adopt the framework during 2018-19. The framework will be supported by a comprehensive data bank developed following the Population Assessment and through which we will look to standardise data sets in relation both to the population and services across the Region.

In Section 2 we link each objective to relevant National Outcomes and will update the Plan to include regional outcomes as these are finalised.

**Resources**

To ensure that we meet the objectives set out in the Plan, partner agencies will need to fundamentally change the way they do things and shift resources to support new service models. For example, we will expect to see spend on long term care reducing as further investment is made in preventative services (as set out in Figure 1). However, we also have dedicated funding through the Welsh Government’s Integrated Care Fund (ICF), which is provided to support delivery of the Regional Partnership Board’s responsibilities in relation to transformation and integration. In West Wales we receive around £7.5 million a year and expect this to continue at least until 2021. We will continue to use a small proportion of the ICF to fund regional programme management capacity in support of our priorities, whilst the remainder will support the ongoing implementation of new service models at both regional and local level. We will also look to use forthcoming additional Capital ICF funding to support large-scale, long-term investment in regional delivery of specialist services.

Significant funding is also available through the Welsh Government’s Primary Care Fund which both supports Primary, Community and Preventative health initiatives as well as the 7 Localities in developing new ways of working to keep people at home, help them stay independent and develop greater resilience within integrated Primary Care Services. In West Wales this amounts to £3.406m of Primary Care Funding and a further £1.296m of direct cluster funding. Using this funding creatively, and aligning the cluster programmes with initiatives funded through the ICF and other priorities within our Area Plan, will help optimise the resources available and deliver a cohesive and joined up approach to care and support.

Alongside resources from the ICF and local budgets, we will also be making use of an allocation from the £1million announced recently by the Minister for Children and Social Services to enable Local Health Boards to work with a range of partners in enhancing the lives of carers. The focus for this funding will be on:

* Supporting carers to have reasonable breaks from caring to lead fulfilled lives
* Identifying and recognising carers
* Providing information, advice and assistance to carers where and when they need it

**Governance**

As required under Part 9 of the Act, the Regional Partnership Board will continue to promote integration across a range of service areas, ensure its constituent agencies provide sufficient resources to support the partnership arrangements and ensure that all partners work effectively together to improve outcomes for people. A key role will be scrutinising the delivery of our Area Plan and making sure that it aligns with other plans in place across the respective agencies.

The Act also enables Regional Partnership Boards to develop and coordinate formal and informal partnership arrangements to support delivery of its priorities. With this in mind, and in anticipation of forthcoming Local Government legislation, we are looking to establish a Joint Committee which will bring together senior representatives from the 3 local authorities and Hywel Dda University Health Board with delegated authority to make key decisions regarding changes to services and pooling of resources. Aimed at streamlining decision-making and increasing transparency and accountability, the Joint Committee will be further supported by an Executive Board of senior officials from the statutory partner agencies which will oversee the operational delivery of partnership arrangements.

We will also continue to work to formalise links between the West Wales Care Partnership, the three PSBs and other statutory forums such as the Mental Health Partnership Board and Dyfed Area Planning Board for Substance Misuse.

**A co-productive approach**

In producing our Population Assessment and the Area Plan we have taken opportunities to engage with providers, service users and carers, to ensure that our priorities reflect their views and opinions as far as possible. However, genuine co-production needs a bolder approach to change. As a partnership we are committed to working with users, carers, families, advocates and citizens in general to make sure that people get the right care and support that meets their needs and aspirations. Appropriate means of ensuring this will be identified for each of our workstreams and the Regional Partnership Board will also look to scrutinise other relevant programmes across West Wales in terms of the extent to which they are co-produced.

In addition to user and carer representation on the Regional Partnership Board, we will establish a regional **Citizens’ Panel** through which we will look to engage with a cross-section of the public in planning, delivering and reviewing services. A new strategic **Provider Forum** will also be established and used to help us engage meaningfully with service providers across the statutory, independent and third sectors in developing and delivering new approaches to care and support.

Such approaches will complement changes to practice through which, increasingly, individuals will participate meaningfully in creating their own care and support plans, which will require us to work innovatively with users, carers and providers. We will also continue to promote Direct Payments as a means of increasing user voice and control.

**Equalities impact assessment**

It is important that we assess the likely impact of our Plan on protected groups within the population. To assist with this we have undertaken a high-level Equalities Impact Assessment which is included in Appendix 2. This will be supplemented by more detailed assessments in respect of the various supporting implementation plans.

**Section 2: Summary of issues by population group**

**2.1 Carers**

**What the Population Assessment told us**

* Around 1 in 8 people in West Wales, many of them young people, are providing unpaid care with a significant proportion providing between 20 to 50+ hours of unpaid care per week
* The provision of unpaid care is becoming increasingly common as the population ages, with an expectation that the demand for care provided by spouses and adult children will more than double over the next thirty years
* Based on a national calculation conducted by carers UK and Sheffield University in 2015, the cost of replacing unpaid care in West Wales can be estimated at £924m. This exceeds the NHS annual budget for the region

**Gaps and areas for improvement we identified**

|  | **Relevant Objectives within the Delivery Plan** |
| --- | --- |
| Raising the profile and public understanding of carers and embedding good practices around identification, information, consultation and benefits advice | 1.11 |
| Developing appropriate access to a range of information, advice and assistance, including carers information services and training, which supports all the key stages in the caring journey | 1.13 |
| Ensuring that carers and their families are able to access services through their language of choice and that the offer through the medium of Welsh is available | 1.13 |
| Enhancing assessment and care planning processes to ensure carers are involved in decisions about the cared for person including discharge planning | 2.8; E8 |
| Developing consistent, integrated commissioning and procurement processes that are based on co-production principles, which involve user-led community-based groups and fora in the design and delivery of services | 1.12 |
| Increasing use of direct payments by developing community based supply chains that co-produce new models of service delivery such as carer co-operatives | 1.12 |
| Developing integrated Community Transport Schemes and other concessions on a regional footprint to provide a more consistent service that is aligned with Direct Payments, Voucher schemes and other community schemes | Referred to PSBs |
| Addressing accommodation issues for those caring for older people or people with learning disabilities needing to move home from an inappropriate property, or needing support with adaptations, equipment, repairs and improvements, lettings policies, alarms and telecare technologies | 1.11 & 1.13 |
| Integrating carers impact assessment into planning processes for infrastructure programmes such as transport, housing, and technology developments and other relevant community programmes | 1.11 |

**How we will take this work forward**

A regional Carers Development Group is in place with representatives from all partner agencies. Reporting to the Regional Partnership Board, this Group will oversee implementation of relevant objectives within the Delivery Plan.

**2.2 Children and young people**

**What the Population Assessment told us**

* Children and young people make up approximately 22.2% of the population in the West Wales region. The number of young people is expected to stay relatively stable over the next 15 years
* The region has a lower number of Looked After Children (LAC) than the national average
* Care and support needs span a wide range from universal, through early intervention, multiple needs and remedial intervention
* Partner agencies have adopted a broadly consistent continuum of care and support for children and families with a focus on prevention
* Areas for improvement include further development of preventative and early intervention services, building on established programmes such as Family Information Services, Families First and Team Around the Family; refocusing managed care and support to promote independence and wellbeing; improving multi-agency working and improved collaboration across the region to bring services to a consistent level and standard
* Collaborative action should also be considered to address strategic challenges such as reducing budgets, workforce development and the establishment of user-led preventative services

**Gaps and areas for improvement we identified**

|  | **Relevant Objectives within the Delivery Plan** |
| --- | --- |
| Developing appropriate access to a range of information, advice and assistance that directs families with children and young people to relevant care and support within communities | 1.3; 1.4; 1.15 |
| Enhancing assessment and care planning processes to ensure that citizens have a genuine voice when agreeing outcomes and the support needed to achieve them | 1.16; 2.1; E8 |
| Ensuring that children, young people and their families are able to access services through their language of choice and that the ‘active offer’ through the Welsh medium is available | Welsh language |
| Developing community-based, user-led, co-produced services that support families with children and young people to become more resilient and develop a range of skills including life skills | 1.15; 1.16; 1.18 |
| Reconfiguring commissioning processes for high cost, low volume care and support packages for children with complex needs, to deliver consistent cost-effective services that ensure best outcomes for service users | 3.5 |
| Improving the support offered for family relationships, particularly for new parents or parents who are experiencing stress due to other factors such as imprisonment or disability | 1.15 |
| Enhancing accommodation and meeting accommodation support needs of young people leaving care or following custodial sentences | Insert |
| Improving integration between children’s services, mental health and learning disability and access to mental health services at an early stage | 1.19 |
| Reducing the number of placement moves for LAC and reducing reliance on residential care | 1.16 |
| Improving joint planning between CAMHS and learning disability services, to ensure equitable service provision for children with neuro-developmental conditions via the ‘Together for Children’ programme | 1.17 |
| Developing links between Integrated Family Support Services (IFSS) and other council services such as adult care and housing as well as community-based services, to help families back to independence and enable them to function effectively within their communities | 2.9 |
| Improving access to child sexual health services | Insert |
| Adopting consistent methodology such as Signs of Safety to underpin care and support across the region | 1.17 |
| Developing a consistent, outcomes-based performance framework for children and young people’s services across the region | TBC |

**How we will take this work forward**

A regional Children’s Service Group is being established with representatives from all partner agencies. Reporting to the Regional Partnership Board, this Group will oversee implementation of relevant objectives within the Delivery Plan, working where appropriate with other forums such as the Regional Adoption Committee and IFSS Lead Officer’s Group.

**2.3 Health and physical disability**

**What the Population Assessment told us**

* Although life expectancy in West Wales is slightly above the national average, there are higher levels of people who are obese or overweight
* There are significant areas of deprivation in the Region, focused in parts of Llanelli, Cardigan and Pembroke Dock
* In spite of generally healthier lifestyles than Wales in general, there are challenges to be addressed including higher levels of alcohol consumption in Ceredigion
* A significant proportion of people in the 18-64 age group will not be accessing care and support directly to address specific needs. However, they will benefit from general public health information and programmes aimed at encouraging healthy lifestyles and reducing risks to their health brought about by factors such as smoking and obesity.
* A range of ‘accelerating factors’ have been identified within people’s environments that might increase the likelihood of them developing an ongoing health condition, or aggravate the effects of existing conditions, and against which mitigating action should be taken. These include unemployment, low wages and poor housing conditions
* Neurological conditions are the most common cause of serious disability and have a major, but often unrecognised, impact on people’s lives and care and support services
* The contribution of care and support services must be complemented by a range of collaborative approaches to improve people’s social, economic, environmental and cultural wellbeing
* Public Health has an important role in providing the population with general information and advice on healthy life choices and support in areas such as diet and smoking cessation. This needs to start in the early years but should be sustained where possible across the range of age groups.

**Gaps and areas for improvement we identified**

|  | **Relevant Objectives within the Delivery Plan** |
| --- | --- |
| Developing appropriate access to a range of information, advice and assistance including Dewis Cymru and Infoengine, and advocacy services relevant to health and social care needs at all key life stages | 1.3; 1.4 |
| Developing consistent, integrated regional services that are accessible and respond to population need | Whole Plan |
| Improving the early identification, treatment and management of preventable and chronic conditions including diabetes, heart disease and respiratory illness, to improve long term wellbeing and reduce complications | 1.1 |
| Ensuring effective interventions and pathways for prevention, treatment and management of obesity and childhood obesity are routinely available and systematically implemented | 1.1 |
| Improving early identification and treatment of risk factors associated with health inequality | 1.1 |
| Strengthening transition arrangements between children and young people’s services and adult services | Insert |
| Developing community-based, user-led, co-produced services that prevent isolation, promote independence and support people to become more resilient and manage their own conditions | 1.2; 2.3; 3.1; E5 |
| Increasing use of assistive technology, such as telecare to transform domiciliary care and supported living services | 1.5 |
| Improving flexibility to deliver step up and down provision to respond to changing needs | 2.2 |
| Establishing a regional Neuro Rehabilitation Group | Insert |

**How we will take this work forward**

Hywel Dda University Health Board is committed to working with partners to improve health outcomes for those who live in, work in, or visit West Wales. A population health approach, which seeks to embed prevention and early intervention, underpins the Health Board’s Transforming Clinical Services programme. In the medium to longer term, a Public Health and Wellbeing Strategy will be developed, under the auspices of Health Board’s Health Strategy Committee, developing cross-cutting plans and processes to ensure effective delivery of strategic aims in this area.

The Strategy will need to ensure ‘fit’ across the wider system, and effective partnership working across sectors and agencies providing care and support, will be crucial in maximising impact and improving the health of the West Wales population.

**2.4 Learning Disability and Autism**

**What the Population Assessment told us**

* There are an estimated 1,483 people over 18 with a moderate or severe learning disability in West Wales (2015 figures), representing just under 0.5% of the total adult population and comparable with other parts of Wales
* This number is expected to rise over the next two decades, but in proportion with overall population growth
* A more significant rise of 33% in people over 75 with a moderate or severe learning disability is predicted over the same period
* Data relating to the incidence of autism is not collected routinely; however between January 2013 and November 2015 there were 265 referrals to diagnostic services and the between April and November 2016 was 99. In Ceredigion and Pembrokeshire (where data is collected) there were 40 and 113 open cases at the time of the Population Assessment
* The way in which the needs of people with a Learning Disability are met has changed over the last twenty years. People who would historically have been placed in institutional care are increasingly being supported to live in their communities. Health and social care services along with the third sector collaborate to maximise the independence and potential of those who use our services.

**Gaps and areas for improvement we identified**

|  | **Relevant Objectives within the Delivery Plan** |
| --- | --- |
| Improving the recognition, diagnosis and the treatment and management of people with neurodevelopmental disorders including ASD and ADHS | 1.9; 2.7 |
| Empowering people with a learning disability to decide who provides their support and what form that support takes | 1.20; 1.21; 2.11 |
| Strengthening pathways back to local communities through developing local education, volunteering and work opportunities in communities, making the necessary adjustments for people with a learning disability | 1.20; 2.12 |
| Increasing access and availability of appropriate, suitable local housing and accommodation to enable people with a learning disability to live as independently as possible, in a place of their choice | 2.12 |
| Developing consistent, integrated commissioning and procurement processes that are based on co-production principles, which involve user-led community-based groups and fora in the design and delivery of services | 1.20; 2.11; 3.8; E5 |
| ‘Right-sizing’ existing packages of care to ensure they meet current needs, facilitate personal development, increase independence and deliver cost-effective services that ensure best outcomes for service users | 2.12 |
| Developing a consistent, outcomes-based performance framework for service delivery across the region, utilising data to support future planning and commissioning | 3.8 |

**How we will take this work forward**

A regional Learning Disability Programme Group is in place with representatives from all partner agencies. Reporting to the Regional Partnership Board, this group will oversee delivery of the relevant Objectives within the Delivery Plan.

**2.5 Mental Health**

**What the Population Assessment told us**

* According to the Mental Health Foundation in any year one in four of us experience a mental health problem, yet three quarters of people with mental health problems receive no treatment
* In West Wales 25% of people over 16 have a common mental health disorder (2013-14 figures). Incidence of a range of mental health disorders is expected to increase in the period to 2030. Around 75% of those with a mental health issue suffer from common disorders such as depression, anxiety disorder, panic disorder, obsessive-compulsive disorder and post-traumatic stress disorder
* The incidence of early onset dementia (prior to the age of 65) is slightly higher in West Wales than in the country as a whole, although the figure is expected to decrease over the next 20 years
* Significant number of people will require support with respect to our mental health throughout our lives whether this is low intensity support for difficulties such as low level anxiety /depression or longer term support
* Mental illness can develop from a number of factors including social traumas, illegal drug use and genetic predisposition. Mental health does not discriminate and can affect anyone often leading to debilitating conditions.
* Early intervention is crucial and this can take the form of providing information or referral to community or third sector services. Admissions to inpatient services may occur in extreme situations, where the individual cannot be treated in the community and presents a risk to themselves and/or others
* It has been estimated that the economic and social costs of mental health problems in Wales is estimated to be £7billion a year

**Gaps and areas for improvement we identified**

|  | **Relevant Objectives within the Delivery Plan** |
| --- | --- |
| Improving prevention and early intervention services, alternatives to hospital admission and access to services, especially for those in crisis | 1.22; 1.23; 2.14 |
| Developing an outcome focused and ‘risk-enablement’ approach to service provision to support a flexible approach | 1.22; 1.23; 2.14 |
| Improving access to advice and support for service users and carers, including welfare rights and involvement in care and treatment | 1.22 |
| Developing 24 hour direct access to alternative provision for those in crisis where hospital admission is not the best option | 2.14 |
| Improving service user experience and conveyancing in relation to S136 of the Mental Health Act for those detained in police custody | N/A  Taken forward through Transforming Mental Health Implementation Plan |
| Developing co-produced services and community networks to support people in building confidence and skills using peer support and/or mentoring | 1.22 |
| Developing a flexible and responsive workforce across health and social care to successfully deliver new models of mental health service | 1.7; 3.2; E1 |
| Addressing the lack of transport links within rural areas, which add to the difficulty of accessible service delivery and recruitment challenges | Referred to PSBs |

**How we will take this work forward**

A regional Mental Health Programme Board is in place which has responsibility for taking forward the Together for Mental Health Programme and has a strong link to the University Health Boards Transforming Clinical Services programme. Links between this Board and the Regional Partnership Board are being established.

**2.6 Older People**

**What the Population Assessment told us**

* The proportion of older people (aged over 65) is higher in West Wales than in Wales as a whole (21.3% compared with 18.6%)
* An increase of approximately 60% in the numbers of people over 65 in West Wales is predicted by 2035
* An even higher rate of increase in the number of people over 85 in West Wales – 122% - is predicted over the same period
* Disability-free life expectancy is rising more slowly than life expectancy, suggesting an increased need for care and support over time
* Significantly higher numbers of older people undergo emergency admission to hospital in West Wales than the population as a whole with a similar discrepancy in the number of people receiving inpatient care for chronic conditions
* Rates of dementia in older people are also set to rise, with particularly high projections in North Carmarthenshire and Pembrokeshire
* Rurality can be an accelerating factor in exacerbating the needs of older people, due to social isolation, higher levels of deprivation and poor access to services

**Gaps and areas for improvement we identified**

|  | **Relevant Objectives within the Delivery Plan** |
| --- | --- |
| Developing appropriate access to a range of information, advice and assistance including Dewis and advocacy services relevant to health and social care needs at relevant stages for health and social care | 1.3; 1.4 |
| Improving anticipatory care across the health, social care and other sectors to avoid escalation of need | 1.1; 2.2 |
| Improving the management of and support for people affected by dementia | Insert |
| Reducing the reliance on residential and nursing care in favour of lower level, preventative and wellbeing services | 1.1; 2.2; E5 |
| Developing community-based, user-led, co-produced services that prevent isolation; promote community connectivity, well-being and resilience and support people to remain independent for longer in their own communities | 1.2; E5 |
| Enhancing assessment and care planning processes to ensure older people and their carers are involved in decisions about them, including discharge planning | 2.1; E8 |
| Ensuring that older people and their families are able to access services through their language of choice and that the offer through the medium of Welsh is available | Welsh language |
| Achieving a consistent, integrated approach to frailty across the region that aligns with regional frailty and dementia strategies and pathway | Insert |
| Developing consistent, integrated commissioning and procurement processes based on co-production principles, which involve older people, user-led community-based groups and fora in the design and delivery of services, to achieve market sustainability | E5 |
| Improving and standardising levels of telehealth and telecare across the region | 1.5 |
| Addressing the lack of transport links within very rural regions, which add to the difficulty of accessible service delivery and recruitment challenges | N/A Referred to PSBs |
| Growing an integrated approach to quality assurance and contract monitoring of care homes to identify and address emerging concerns and prevent placement breakdown | 3.11 |

**How we will take this work forward**

Information to follow

**2.7 Sensory impairment**

**What the Population Assessment told us**

* Sensory impairment can be a significant life-limiting condition and its incidence increases with age
* In West Wales numbers of those over 75 with moderate or severe visual impairment and registerable eye conditions is set to rise significantly over the next two decades
* Numbers of people with a moderate or severe hearing impairment are set to increase by 32% and 42% respectively over the same period
* Early identification, prevention and improving access to mainstream services are vital in maintaining wellbeing for those with a sensory impairment

**Gaps and areas for improvement we identified**

|  | **Relevant Objectives within the Delivery Plan** |
| --- | --- |
| Raising the profile and public understanding of sensory impairment and the NHS Low Vision Service and embedding good practices around identification, information, consultation and integration of other related services | 1.25 |
| Developing appropriate access to a range of information, advice and assistance that addresses the needs and barriers to accessing services, which can prevent those with sensory impairment accessing vital healthcare | 1.3; 1.4; 1.25 |
| Developing specific consistent support and services such as interpretation, translation, lip reading, talking therapies, rehabilitation and clinics for ophthalmology and glaucoma to ensure they are available and accessible across the region | Insert |
| Increasing use of direct payments to ensure people can exercise genuine choice and control over the care and support they receive | Insert |
| Developing community-based, user-led, co-produced services that prevent isolation; promote community connectivity, well-being and resilience and support people to remain independent for longer in their own communities | 1.2; 1.25; E5 |
| Addressing the lack of transport links within very rural regions, which add to the difficulty of accessible service delivery | Referred to PSBs |

**How we will take this work forward**

Need to insert something here

**2.8 Substance misuse**

**What the Population Assessment told us**

* The percentage of adults drinking over recommended guidelines and binge drinking is falling and is below the Welsh average
* There are regional variations in relation to alcohol-related admissions to hospital with decreases in Ceredigion and Pembrokeshire between 2014-15 and 2015-16 but increases in Carmarthenshire over the same period
* The proportion of people successfully completing drug treatment in West Wales is above the Welsh average, at 79%
* Children in Need cases related to familial substance misuse are lower than the Welsh average, with Ceredigion and Pembrokeshire having the lowest proportions in Wales

**Gaps and areas for improvement we identified**

|  | **Relevant Objectives within the Delivery Plan** |
| --- | --- |
| Ensuring that children, young people and families are able to access services through their language of choice and that the offer through the medium of Welsh is available | To be inserted |
| Increasing use of direct payments to ensure people can exercise genuine choice and control over the care and support they receive | To be inserted |
| Establishing a more co-ordinated and coherent approach to drug and alcohol misuse education and awareness raising for young people across schools and for those who are not in education, employment and training (NEET) | To be inserted |
| Establishing clear and coherent treatment options for young people and their families with drug and alcohol problems to provide a more holistic approach to prevention and early intervention ensuring that there is a clear link to the Adverse Childhood Experiences (ACE) agenda | To be inserted |
| Developing clear pathways between services for service users with co-occurring substance misuse and mental health | To be inserted |
| Re-evaluating treatment options for young people aged between 18-25 years old and older people with alcohol issues | To be inserted |
| Improve data and information sharing arrangements between partners involved in reducing harm in the night time economy | To be inserted |
| Development of housing options and reintegration opportunities within the community for recovering service users | To be inserted |
| Establish, develop, implement and manage a robust process for the review of both fatal and non-fatal overdoses including the rollout of the distribution of Naloxone across hospital sites | To be inserted |
| Ensure clear pathways between services for service users with co-occurring substance misuse and mental health issues | To be inserted |
| Developing consistent, integrated commissioning and procurement processes based on co-production principles, which involve service users, carers, young carers, parents or significant others, user-led community-based groups and fora in the design and delivery of services | To be inserted |

**How we will take this work forward**

The Dyfed Area Planning Board for Substance Misuse will take this work forward through a regional commissioning strategy. Links are being established between this Board and the Regional Partnership Board.

**2.9 Violence Against Women, Domestic Abuse and Sexual Violence**

**What the Population Assessment told us**

* 1.4 million women and 700,000 men aged 16-59 report experiencing incidents of domestic abuse in England and Wales.
* Younger women aged 16-24 are most at risk and a woman is killed every 2.4 days in the UK, with 148 UK women killed by men in 2014
* Extrapolating this data to Wales shows that 11% women and 5% men a year experience ‘any domestic abuse’, while rates of ‘any sexual assault’ in the last year were also higher for women (3.2%) than men (0.7%)
* Approximately 124,000 women, men, boys and girls over the age of 16 in Wales, have been the victim of a sexual offence
* There has been a 26% increase in the number of recorded sexual offences involving children under 16 in Wales in the past year. Figures have more than doubled in the last decade (Bentley et al, 2016). Last year the rate of recorded sexual offences against children under 16 in Wales was 3.3 per 1000 children
* In 2011 an estimated 137,000 girls and women were living with consequences of FGM in the UK and in 2011 an estimated 60,000 girls under the age of 15 were living in the UK who were born to mothers from FGM practising countries and therefore could be at risk of FGM. It is estimated there are 140 victims of FGM a year in Wales
* 80% of cases dealt with by the Forced Marriage Unit involved female victims; 20% involved male victims. It is estimated there are up to 100 victims of forced marriage a year in Wales
* Domestic Abuse alone costs Wales £303.5m annually. This includes £202.6m in service costs and £100.9m to lost economic output. If the emotional and human cost is factored in there are added costs of £522.9m.

Later work undertaken following publication of the Population Assessment and in preparation for the Regional VAWDASV Strategy indicates that:

* In the Dyfed Powys area (which includes West Wales):
* 18,000 people aged between 16 - 59 had, on average, been victims of Domestic Abuse each year throughout 2013 – 2016
* 6.8% of the local population are estimated to have experienced abuse in the last year 10.3% of the Female population 3.3% of the Male population (ONS Police Crime Survey 2016)
* Between March 2013 and March 2015 there were 6 Domestic Homicides in Dyfed Powys
* During July 2016 to June 2017 1373 cases were discussed at the Multi Agency Risk Assessment Conferences (MARACs). This amounts to 63 MARAC cases discussed per 10,000 adult female population, which is higher than the national average, and higher than the recommended 40
* In 2016/17 Dyfed Powys Police recorded:
  + 4635 incidents of domestic abuse
  + 69 sexual offences crimes including rape
  + 405 stalking / harassment crimes

**Gaps and areas for improvement we identified**

|  | **Relevant Objectives within the Delivery Plan** |
| --- | --- |
| Raising the profile and understanding of violence against women, domestic abuse and sexual violence, including among vulnerable groups such as Black and Ethnic Minorities, disabled people, the LGBT community, older people, refugees and migrants | N/A  Refer to VAWDASV Strategy |
| Embedding good practices around identification, information, consultation and integration of other related services | 2.17 |
| Earlier identification of violence against women, domestic abuse and sexual violence | N/A  Refer to VAWDASV Strategy |
| Enhancing education about healthy relationships and gender equality, ensuring a consistent regional approach | N/A  Refer to VAWDASV Strategy |
| Ensuring professionals are trained to provide consistent effective, timely and appropriate responses to victims and survivors | 1.25 |
| Provide victims with equal access to appropriately resourced, consistent high quality, needs led, strength based, gender responsive services | N/A  Refer to VAWDASV Strategy |
| Developing community-based, preventative initiatives that increase awareness, provide information and facilitate access to services | N/A  Refer to VAWDASV Strategy |
| Increasing survivor engagement in the planning, delivery and monitoring of services | N/A  Refer to VAWDASV Strategy |
| Developing and implementing an integrated pathway for all forms of violence against women, domestic abuse and sexual violence | N/A Refer to VAWDASV Strategy |
| Increased focus on perpetrators, holding them to account for their actions and providing opportunities, through intervention and support, to change their behaviour | N/A  Refer to VAWDASV Strategy |

**How we will take this work forward**

The enactment of the Violence Against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015 requires the public sector in Wales to work together in a consistent and cohesive way to improve the outcomes for individuals and their families subjected to Violence against women, Domestic Abuse or Sexual Violence.

In 2018 Mid and West Wales will publish its first joint strategy to tackle Violence against Women, Domestic Abuse and Sexual Violence; outlining how the region will support victims and survivors, tackle perpetrators, ensure professionals have the tools and knowledge to act, increase awareness of the issues and help children and young people to understand inequality in relationships and that abusive behaviour is always wrong.

The strategy aims to provide a framework that will improve the planning, coordination and collaboration of responses and, furthermore, support the integration and transformation of service delivery; enabling a step change in action to achieve a sustainable reduction in violence and abuse, improve outcomes for all individuals and families affected and prevent such abuse from happening in the first place.

The strategic direction for VAWDASV sits with the Mid and West Wales Safeguarding Executive.

A Violence against Women, Domestic Abuse and Sexual Violence Strategic Group, accountable to the regional Safeguarding Executive has been established to provide a governance structure to develop, approve and monitor the regional arrangements for Violence against Women, Domestic Abuse and Sexual Violence.

The Regional Partnership Board will work closely with the Mid and West Wales Safeguarding Boards to agree formal reporting arrangements for VAWDASV enabling us to strengthen effective partnership working and identify opportunities to align work plans around early intervention and preventative services.

**Section 3: Delivery plan**

**Prevention Stage 1: Stay well and independent within the community**

| **Objective** | **Timeframe** | **Strategic priority** | **Population Groups** | **Links to Overarching Recs/**  **Areas for Improvement** | **Links to National Outcomes** | **Implementation Plan/s** |
| --- | --- | --- | --- | --- | --- | --- |
| **1.1** Develop a shared, Health and Wellbeing Strategy for the region which embeds prevention and reduces health inequalities through mainstream action across the whole system | 2018-19 | IAA and prevention | All | OR3  OR7 | N1, N2, N3, N4, N5, N6, N7, N8, N9, N13, N14, N17, N19, N22 | Insert link/s |
| **1.2** Establish regional preventions framework based on effective local practice and aimed at building community resilience | 2018-2019 | IAA and prevention | All | OR3  OR7 | N1, N2, N4, N5, N6, N7, N8, N9, N13, N14, N17, N18, N19, N22 | Insert link/s |
| **1.3** Establish and implement regional standards for IAA services | 2018-2020 | IAA and prevention | All | OR3  OR7 | N1, N2, N3, N4, N5, N6, N7, N8, N9 | Insert link/s |
| **1.4** Embed and promote Dewis and Infoengine as primary service portals, linked to the NHS 111 service and local Family Information Services | 2018-2020 | IAA and prevention | All | OR3  OR7 | N1, N2, N3, N4, N5, N6, N7, N8, N9 | Insert link/s |
| **1.5** Establish and implement regional strategy for Technology Enabled Care (TEC) | 2018-2020 | IAA and prevention | All | OR3  OR7 | N7, N8, N9, N14, N22, N24 | Insert link/s |
| **1.6** Enhance out of hours provision across the region | 2018-2020 | IAA and prevention | All | OR1  OR7 | N1, N2, N4, N8 | Insert link/s |
| **1.7** Develop Technology Enabled Care to support independence within the community | 2018-2020 | IAA and prevention | All | OR1  OR7 | N1, N2, N4, N8 | Insert link/s |
| **1.8** Deliver integrated training and development programme to support practice around IAA and preventions | 2018-2020 | IAA and prevention/ Workforce Development | All | OR3  OR7 | N1, N2, N3, N4, N5, N6, N7, N8, N9 | Insert link/s |
| **1.9** Establish regional advocacy service for adults | 2020 | IAA and prevention | All adults | OR1  OR6  OR7  OR8 | N1, N2, N3, N4, N5, N6, N10, N12 | Insert link/s |
| **1.10** Ensure adults and children with autism, who do not have a learning disability or mental health problems, receive appropriate IAA and signposting to relevant support and services in the community through the development and implementation of a regional Integrated Autism Service, | 2018-2023 | IAA and prevention | Autism | OR3  OR7 | N1, N2, N3, N4, N9, N15, N17, N18, N19 | Insert link/s |
| **1.11** Raise awareness of carers through Carer Aware/ Young Carer Aware e-learning programmes, training and workforce development and the Investors in Carers Scheme, to ensure needs are identified and appropriate support provided | 2018-2022 | Carers | Carers | OR3  OR4 | N1, N2, N4, N5, N6, N9, N11, N12, N18 | Insert link/s |
| **1.12** Ensure appropriate levels of respite and support services for carers, developed using a co-produced approach | 2018-2023 | Carers | Carers | OR1  OR3  OR4  OR6  OR7 | N1, N2, N4, N5, N6, N9, N11, N12, N18 | Insert link/s |
| **1.13** Ensure carers have access to appropriate IAA to support them in their role | 2018-2023 | Carers | Carers | OR3  OR4  OR7 | N1, N2, N4, N5, N6, N9, N11, N12, N18 | Insert link/s |
| **1.14** Support the wellbeing of carers and former carers through supporting them to build and maintain emotional resilience | 2018-2023 | Carers | Carers | OR1  OR3  OR4  OR6  OR7 | N1, N2, N4, N5, N6, N9, N11, N12, N18 | Insert link/s |
| **1.15** Develop community resilience and strengths-based early intervention and prevention initiatives to provide appropriate support for children and families, working with the third sector and focusing on the four wellbeing outcomes for children and young people | 2018-2023 | IAA and prevention | Children and Young People | OR1  OR3  OR7 | N1, N2, N4, N5, N6, N7, N8, N9, N13, N14, N17, N18, N19, N22 | Insert link/s  Include VAWDASV |
| **1.16** Implement ‘The Right Help at the Right Time for Children, Young People and their Families’ regional threshold framework which includes support to reduce Adverse Childhood Experiences (ACEs) | 2018-2020 | IAA and prevention | Children and Young People | OR3  OR5  OR7 | N1, N2, N3, N4, N5, N6, N7, N8, N9,N10, N11, N12, N13, N14 | Insert link/s |
| **1.17** Implement the ‘Signs of Safety’ Practice Framework across the Region. |  |  | Children and Young People | OR1 | N1, N10, N11, N12 | Insert link/s |
| **1.18** Implement the Child Poverty Strategy for Wales within West Wales | 2018-2023 | IAA and prevention | Children and Young People | OR3  OR7 | N7, N8, N9, N16, N17, N18, N20 | Insert link/s |
| **1.19** ensure preventative services meet the needs of children and young people with Mental Health problems through the Together for Children and Mental Health Strategy for child and adolescent mental health | 2018-2023 | IAA and prevention/ Transforming Mental Health Services | Children and Young people | OR1  OR3  OR5  OR6  OR7 | N1, N2, N4, N5, N6, N7, N8, N9, N13, N14, N17, N18, N19, N22 | Insert link/s |
| **1.20** Ensure community-based preventative support is optimised for people with a Learning Disability, drawing on regional Statement of Intent and Model of Care and Support | 2018-2023 | IAA and prevention/ Transforming LD services | Learning Disabilities | OR3  OR7 | N1, N3, N4, N5, N9 | Insert link/s |
| **1.21** Ensure IAA provision supports people with a Learning Disability in accessing appropriate care and support and enhances their access to generic services | 2018-2023 | IAA and prevention/ Transforming LD Services | Learning Disabilities | OR3  OR7 | N1, N2, N3, N4, N5, N9 | Insert link/s |
| **1.22** Ensure preventative services meet the needs of people with Mental Health problems through the Together for Mental Health Strategy within the Region | 2018-2023 | Transforming Mental Health Services | Mental Health | OR1  OR3  OR5  OR6  OR7 | N1, N2, N4, N5, N6, N7, N8, N9, N13, N14, N17, N18, N19, N22 | Link/s to plans |
| **1.23** Provide single regional contact number for people with Mental Health problems with links to specialised local information and to generic IAA provision in the region | 2018-19 | IAA and prevention/  Transforming Mental Health Services | Mental Health | OR3  OR7 | N1, N2, N3, N4, N5, N6, N7, N8, N9 | Insert link/s |
| **1.24** Ensure IAA and preventative services meet the needs of people with dementia through delivery of the Regional Dementia Strategy | 2018-2022 | IAA and prevention | Older People | OR1  OR3  OR7 | N1, N2, N4, N5, N6, N7, N8, N9, N10, N13, N14, N17, N18, N19, N22 | Insert link/s |
| **1.25** Ensure needs of people with sensory impairment are addressed through:   * Piloting the Sensory Loss Friendly Award and rolling out across health and social care * Sharing learning from the HDUHB Communication Support Service and applying good practice across health and social care * Undertaking a regional review of services for people with a sensory impairment with a view to enhancing services | 2018-2023 | IAA and prevention | Sensory impairment | OR1  OR3  OR6 | N1, N2, N3, N5, N7, N8, N9 | Insert link/s |
| **1.26** Ensure preventative and IAA services meet the needs of people experiencing VAWDASV | 2018-2023 | IAA/ prevention | VAWDASV | OR1  OR3  OR6 | N1, N2, N10, N11, N12 | Insert link/s |

**Prevention Stage 2:** **Maintain independence through provision of targeted support that prevents the need for people to be admitted to hospital or long-term residential care, or supports timely discharge**

| **Objective** | **Timeframe** | **Strategic priority** | **Population Groups** | **Links to Overarching Recs/**  **Areas for Improvement** | | | **Links to National and Outcomes** | **Implementation Plan/s** |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **2.1** Implement consistent, multi-disciplinary approach to assessment and care planning across the region, supported by WCCIS, to ensure a focus on individual outcomes and preserving independence | 2018-2020 | IAA and prevention/ Service Integration and Pooled Funds/ WCCIS | All | OR6 | | | N1, N2, N3, N4, N5, N6, N7, N8, N9, N10, N18, N22, N24 | Insert link/s |
| **2.2** Develop integrated community care model through locality-based community hubs, providing proactive low level care, step-up facilities and joined up management of chronic conditions, reducing admissions to hospital or long term care and supported by pooled fund arrangements | 2018-2022 | IAA and prevention/ Service Integration and Pooled Funds | All | OR3  OR6  OR7  OR8 | | | N1, N2, N3, N7, N9, N10, N12 | Insert link/s |
| **2.3** Ensure multi-agency community-based support and step-down facilities are available to facilitate timely discharge | 2018-2020 | IAA and prevention | All | OR3  OR4  OR6  OR7 | | | N1, N5, N6, N7, N8 | Insert link/s |
| **2.4** Deliver integrated training and development programme to support improved practice in targeted care and services | 2018-2020 | Workforce Development | All | OR3  OR7  OR8 | | | All | Insert link/s |
| **2.5** Review arrangements for Integrated Community Equipment Stores and implement regional model, including consideration of pooled fund arrangements | 2019-2020 | Service Integration and Pooled Funds | All | OR3  OR4  OR7  OR8 | | | N7, N8, N9, N24 | Insert link/s |
| **2.6** Review service contracts and consider single regional contract with pooled fund arrangements | 2020-2023 | Integrated commissioning/ Service Integration and Pooled Funds | All | OR1  OR6  OR7  OR8 | | | N7, N9, N22, N24 | Insert link/s |
| **2.7** Implement Care and Support At Home Strategy in West Wales | 2018-2022 | Integrated Commissioning/ Service Integration and Pooled Funds/ Workforce | All adults | OR1  OR6  OR7  OR8 | | | N3, N4, N5, N6, N7, N8, N9, N10, N24 | Insert link/s |
| **2.8** Ensure adults and children with autism and a learning disability or mental health problem receive appropriate, coordinated, targeted care and support through the development and implementation of a regional Integrated Autism Service | 2018-2023 | IAA and prevention | Autism | | OR1  OR3  OR6  OR7 | | N1, N2, N3, N4, N5, N6, N7, N8, N9, N13, N14, N17, N18 | Insert link/s |
| **2.9** Ensure appropriate carer involvement in assessment process and that carers are offered their own assessment | 2018-2020 | IAA and prevention  Carers | Carers | OR3  OR6 | | | N1, N2, N4, N5, N6, N9, N11, N12, N18 | Insert link/s |
| **2.10** Deliver and consolidate regional arrangements for the Integrated Family Support Service (IFSS), working in partnership with other services to maximise opportunities for children and young people to remain or be rehabilitated to their families. Arrangements to include pooled funding as required by the SSWBWA | 2018-2022 | Service Integration and Pooled Funds | Children and Young People | OR1  OR3  OR7  OR8 | | | N1, N3, N4, N5, N6, N7, N8, N9, N10, N11, N12, N18, N24 | Insert link/s |
| **2.11** Ensure targeted support meets the needs of children and young people with mental health problems through the Together for Mental Health Strategy | 2018-2022 | Transforming Mental Health Services | Children and Young people | OR1  OR3  OR5  OR7  OR8 | | | N1, N2, N3, N4, N5, N6, N7, N8, N13, N14, N22 | Insert link/s |
| **2.12** Ensure appropriate, integrated step-up models of care are available when needed for people with a Learning Disability, drawing on the regional Model of Care and Support | 2018-2023 | Transforming LD services | Learning Disabilities | | OR3  OR6  OR7 | N5, N7, N8, N9 | | Insert link/s |
| **2.13** Reduce residential packages for people with learning disability in favour of supported living schemes and improve access to opportunities within the wider community | 2018-2023 | Transforming LD services | Learning Disabilities | OR3  OR6  OR7 | | | N5, N7, N8, N9 | Insert link/s |
| **2.14** Ensure targeted support meets the needs of people with mental health problems through the Together for Mental Health Strategy | 2018-2022 | Transforming Mental Health Services | Mental Health | OR1  OR3  OR7  OR8 | | | N1, N2, N3, N4, N5, N6, N7, N8, N13, N14, N22 | Link/s to plans |
| **2.15** Establish community Mental Health Services across the region, incorporating 24/7 Community Mental Health Centres and Central Assessment and Treatment Units | 2020-21 | Transforming Mental Health Services | Mental Health | OR1  OR3  OR7  OR8 | | | N1, N2, N3, N4, N5, N6, N7, N8, N13, N14, N22 | Insert link/s |
| **2.16** Ensure targeted care and support services meet the needs of people with dementia through delivery of the Regional Dementia Strategy | 2018-2022 | IAA and prevention/ Service Integration and Pooled Funds | Older People | OR1  OR3  OR7  OR8 | | | N1, N2, N3, N7, N9, N10, N12 | Insert link/s |
| **2.17** Ensure assessment and care planning approach identifies and records users with a sensory impairment and facilitates referrals to appropriate services | 2018-2020 | IAA and prevention/ Service Integration and Pooled Funds/ WCCIS | Sensory Impairment | OR1  OR6 | | | N1, N3, N4, N5, N6 | Insert link/s |
| **2.18** Ensure assessment and care planning approach identifies and records users with VAWDASV and facilitates referral to appropriate services | 2018-2020 | IAA and prevention/ Service Integration and Pooled Funds/ WCCIS | VAWDASV | OR1  OR3 | | | N1, N3, N4, N5, N6, N9, N10, N11, N12 | Insert link/s |

**Prevention Stage 3: Provision of appropriate, outcomes-focused long-term care and support**

| **Objective** | **Timeframe** | **Strategic priority** | **Population Groups** | **Links to Overarching Recs/**  **Areas for Improvement** | | | **Link to National Outcomes** | **Implementation Plan/s** |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **3.1** Ensure IAA arrangements support people to make informed choices about their long-term care | 2018-2020 | IAA and prevention | All | OR3  OR7 | | |  | Insert link/s |
| **3.2** Deliver integrated training and development programme to support improved practice in delivery of long term care | 2018-2020 | Workforce Development | All | OR3  OR7  OR8 | | |  | Insert link/s |
| **3.3** Embed the Regional Adoption Service | 2018 and onwards | Children’s Services | Children and Young People | OR1  OR7  OR8 | | |  | Insert link/s |
| **3.4** Ensure long term care and support meets the needs of children with mental Health problems through the Together for Mental Health Strategy | 2018-2022 | Children’s Services/ Mental Health | Children and Young people | OR1  OR3  OR5  OR7  OR8 | | |  | Insert link/s |
| **3.5** Establish regional complex needs service, utilising regional resources where appropriate | 2021-2022 | Service integration and pooled funds | Children and Young people | OR1  OR3  OR5  OR7 | | |  | Insert link/s |
| **3.6** Adopt single regional Contract and service specification for older people’s care homes, supported by relevant policies and consistent approach to quality assurance and escalating concerns | 2018 | Service integration and pooled funds | Older People | OR1  OR7  OR8 | | |  | Insert link/s |
| **3.7** Where people with a Learning Disability require ongoing care and support, ensure assessment is based around individual outcomes, they play a part in all decisions about their care and they are able to live their lives within their communities, maintaining social and family ties and other connections that are important to them | 2018-2023 | Transforming LD services | Learning Disabilities | | OR3  OR6  OR7 |  | | Insert link/s |
| **3.8** Develop regional contract and service specification for homes for people with a Learning Disability, supported by relevant policies and consistent approach to quality assurance and escalating concerns | 2019-2020 | Service integration and pooled funds/ Transforming LD Services | Learning Disabilities | OR1  OR7  OR8 | | |  | Insert link/s |
| **3.9** Establish regional pooled fund for care homes for people with a Learning Disability | 2019-2020 | Service integration and pooled funds/ Transforming LD Services | Learning Disabilities | OR8 | | |  |  |
| **3.10** Ensure long term care and support meets the needs of people with Mental Health problems through the Together for Mental Health Strategy | 2018-2022 | Mental Health | Mental Health | OR1  OR3  OR7  OR8 | | | Insert link/s | Insert link/s |
| **3.11** Establish regional pooled fund for older people’s care homes, based on shadow arrangements in place from April 2018 | 2019-2020 | Service integration and pooled funds | Older People | OR8 | | |  | Insert link/s |
| **3.12** Ensure long term care and support services meet the needs of people with dementia through delivery of the Regional Dementia Strategy | 2018-2022 | Transforming Older People’s Services | Older People | OR1  OR3  OR7  OR8 | | |  | Insert link/s |

**Enablers**

| **Objective** | **Timeframe** | **Strategic priority** | **Population Groups** | **Links to Overarching Recs/**  **Areas for Improvement** | **Links to National Outcomes** | **Implementation Plan/s** |
| --- | --- | --- | --- | --- | --- | --- |
| **E1** Establish regional workforce strategy, with a view to:   * Improving recruitment and retention rates by working together to promote care and support as a positive career choice * Developing integrated roles across health and social care * Developing integrated workforce development programmes to support delivery of emerging service models, supported by pooled funding arrangements where appropriate * Embedding the National VAWDASV Framework * Reviewing existing workforce development capacity across the Region with a view to possible further integration * Maintaining robust, shared data on workforce to inform future activity | 2018-2022 | Workforce Development | All | OR7  OR8 |  | Insert link/s |
| **E2** Establish regional strategic commissioning strategy, supported by evidence-based statements of intent and Market Position Statements for all population groups to support the further integration of commissioning across health and local authorities. | 2018-2019 | Integrated commissioning | All | OR3  OR4  OR5  OR6  OR7  OR8 |  | Insert link/s |
| **E3** Establish a regional ‘Innovations Forum’ bringing together commissioners and providers to support transformation of services and address key issues and challenges | 2018 | Integrated commissioning | All | OR7  OR8 |  | Insert link/s |
| **E4** Establish consistent regional approach to fee setting across population groups | 2019-2020 | Integrated commissioning | All | OR8 |  |  |
| **E5** Support the further development of social enterprise, cooperatives and user-led services, with the aim establishing new user-led organisations | 2018-2020 | Integrated commissioning | All | OR3  OR6  OR7  OR8 |  | Insert link/s |
| **E7** Deliver integrated training and development programme to support improved commissioning practice | 2018-2020 | Integrated commissioning | All | OR7  OR8 |  | Insert link/s |
| **E8** Implement the Welsh Community Care Information System across the region, drawing on experience in Ceredigion and consolidating local pilots run jointly with health | 2018-2020 | Implementing WCCIS | All | OR6  OR8 |  | Insert link/s |

**Monitoring delivery**

The Regional Partnership Board will receive regular updates on the delivery of the Plan and, where appropriate, supporting implementation plans. The Regional Partnership Board’s Annual Reports will also update on progress with implementation. Regional outcomes and performance measures will be used as a basis for tracking progress. Opportunities will be taken to refresh the Plan, for example where national policy developments require a new approach and where initial activities have been completed and need to proceed onto the next stage. Regular updates will also be available on the West Wales Care Partnership’s website ADD LINK

**Appendix 1**

**West Wales Regional Partnership Board – Membership (March 2018)**

|  |  |
| --- | --- |
| Sue Darnbrook (Chair) | Strategic Director, Care, Protection & Lifestyle |
| Jonathan Griffiths | Director of Social Services, Pembrokeshire County Council |
| Steven Griffiths | Carer representative |
| Councillor Tessa Hodgson | Cabinet Member for Social Services, Pembrokeshire County Council |
| Councillor Catherine Hughes | Cabinet Member for Care, Assurance and Housing Services, Ceredigion County Council |
| Sarah Jennings | Executive Director of Governance, Communications and Engagement, Hywel Dda University Health Board |
| Hazel Lloyd Lubran | Chief Officer, Ceredigion Association of Voluntary Organisations |
| Melanie Minty | Policy Officer, Care Forum Wales |
| Jake Morgan | Director of Communities, Carmarthenshire County Council |
| Jill Paterson | Executive Director of Primary Care, Community and Long-term Care, Hywel Dda University Health Board |
| Bernadine Rees OBE | Chair, Hywel Dda University Health Board |
| Alan Thomas | User representative |
| Cathryn Thomas | Social Care Wales |
| Councillor Jane Tremlett (Vice Chair) | Executive Board Member for Social Care and Health, Carmarthenshire County Council |
| James Tyler | User representative |
|  |  |

**Appendix 2**

**Equalities Impact Assessment**