



**DELIVERING CHANGE
TOGETHER**

**CYFLAWNI NEWID
GYDA'N GILYDD**

**West Wales Area Plan
2018-2023**

Contents

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.

Sue Darnbrook

Chair, West Wales Regional Partnership Board



How we have structured our Area Plan

Our Area Plan is in three sections:

Section 1: Overview

This section provides information on statutory requirements in relation to the production of Area Plans, the West Wales Care Partnership and its priorities and the approach we took to developing our Plan.

Section 2: Summary of issues by population group

This section summarises key findings within the Population Assessment in relation to different population groups and the gaps and areas for improvement we identified. For each of these we highlight the relevant objectives within our Delivery Plan or, where appropriate, reference separate plans through which those specific issues are being addressed.

Section 3: Delivery plan

This section contains high level objectives which will be taken forward collaboratively on behalf of the RPB over the coming period. Where possible links are provided to more detailed implementation plans. These detailed plans may change over time and we will refresh our Plan regularly to reflect these changes.

Indicative timescales for delivery of our objectives are also provided, with 'short term' meaning a timescale of 1 to 2 years and 'medium term' 3 to 5 years. Again these timescales may be modified over time and any changes reflected as the Plan is refreshed.

Section 1: Overview

1.1 West Wales Care Partnership

The West Wales Care Partnership (WWCP) 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 WWCP is overseen by a Regional Partnership Board (RPB). Current membership of the Board can be found via the following link [Insert](#).

Further information on the WWCP and what it does can be found [here](#) [Insert link](#).

1.2 Population Assessment

In March 2017 we published our first Population Assessment [Insert link](#). 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 (HDUHB), 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:

- Carers
- 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.

1.3 The Area Plan

Section 14A of the 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. We have to produce an Area Plan every five years.

The West Wales Area Plan has been produced jointly by the three Local Authorities and HDUHB and other partners in the region. This collaborative approach will continue as we deliver against our shared objectives, ensuring that we achieve consistency where possible across the region and develop integrated and sustainable care and support to people in West Wales.

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 intentionally made the Plan succinct so that it is accessible to the range of people and organisations that have an interest in how care and support is provided now and how we want to change it in the future.

1.4 National context

Whilst it focuses on the care and support needs of people in West Wales, our Plan is 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

Link:

<https://www.google.co.uk/url?sa=t&rct=j&q=&esrc=s&source=web&cd=4&cad=rja&uact=8&ved=0ahUKEwju05aCo9>

1.5 Regional priorities

Our Plan reflects **eight regional priorities** that have been adopted by the RPB. These have been shaped by the national policy context, statutory requirements under the Act and the findings of our Population Assessment.

Our regional priorities fit into three categories, as set out in Figure 1 below:

Figure 1

ENABLERS OF CHANGE – improving core processes and building capacity to deliver
<ul style="list-style-type: none">• 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
<ul style="list-style-type: none">• Transforming Mental Health and Learning Disability Services
CROSS-CUTTING THEMES – areas of change that span different population groups
<ul style="list-style-type: none">• Information, Advice and Assistance/prevention• Carers• Service integration and pooled funds• Welsh Language

Comprehensive work programmes are in place in support of each of the objectives and key deliverables from these are reflected in the objectives set out in our Delivery Plan.

1.6 Prevention

Prevention is a core theme within the Act and the principle already underpins many models of care and support in place across the region. Prevention essentially means meeting people's needs in the community before they reach crisis point and, for those receiving care and support, preventing escalation of their needs by focusing on their abilities and helping them to be as independent as possible for as long as possible. This approach is proven to improve outcomes for people and help ensure their well-being. It also helps optimise available resources by reducing demand for formalised care, thus making services more sustainable.

This requires shifts in the way in which statutory agencies deliver care and support. The three local authorities and HDUHB are actively involved in reconfiguring services and testing new approaches, in many cases through programmes supported by the Welsh Government's Integrated Care Fund (ICF). Examples include:

- Increasing the use of step-up and step-down facilities to prevent the need for admission to hospital and enable people to go home sooner
- Increasing the range of reablement services which provide targeted support to people following a stay in hospital or temporary escalation in care and support needs, to help them get back to full independence as quickly as possible

- Providing turnaround services at general hospitals to reduce the number of admissions and facilitate earlier discharge

Other partners such as the third sector also have a key role to play in prevention, for example by developing low level support networks within communities which can help people to remain connected and to stay independent for as long as possible. In West Wales we have a proud record of innovative practice in this area, which includes:

- Cross-sector 'home from hospital' schemes which bring together statutory and third sector agencies to provide wraparound support and ensure people's home environments are appropriate for their needs following discharge
- Establishment of 'third sector broker' or 'community connector' roles which help raise awareness of care and support available within local communities and support the development of new initiatives at local level

Not surprisingly, prevention is one of the strategic priorities adopted by the RPB. To ensure that our approach to prevention is as effective as possible, we are committed to reviewing arrangements across the region, identifying proven practice across Wales and the UK and developing a regional preventions framework based on shared quality standards.

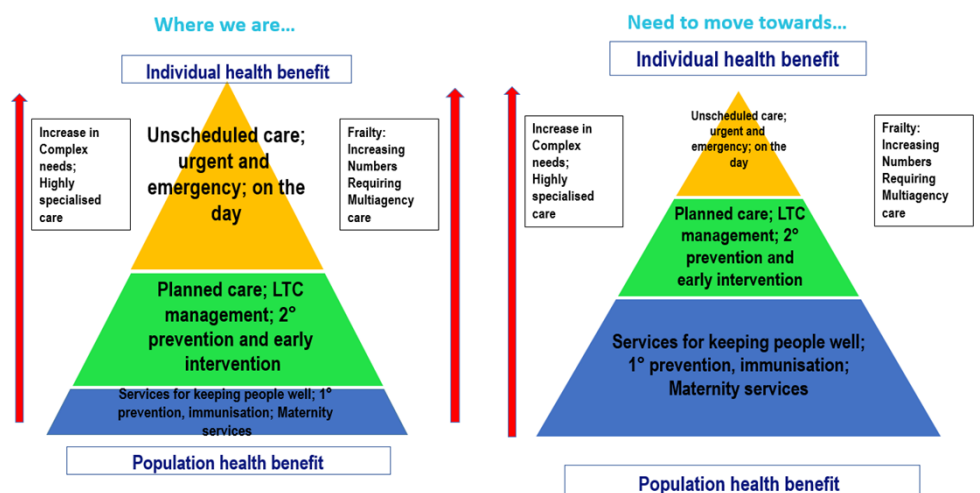
We will actively support the development of alternative delivery models, including social enterprises, cooperatives and user-led services, building on existing activity in the region and pooling expertise of local and national partners.

More information on our objectives is contained within the Delivery Plan in Section 3.

1.7 An integrated care and support pathway

In terms of care and support 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 Figure 2 below, which has been developed by HDUHB but is applicable across health and social care.

Figure 2



In view of the cross-cutting nature of many of our challenges and opportunities, we have structured our Plan to span the needs of the entire population through a **co-produced, preventative approach to care and support**, reflected in a **staged care and support pathway**. This approach aligns with our commitment to prevention outlined above and national work that is underway to develop consistent models of seamless, integrated, locality-based care.

Our care and support pathway 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 (ACEs) 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**

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 the 'enablers' within the RPB's priorities. 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 set out in 1.5 above apply. We also cross-refer each objective to the overarching recommendations within our Population Assessment.

1.8 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.

1.9 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 (VAWDASV), 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 £200 million - is being led by Carmarthenshire County Council in partnership with HDUHB 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 £1.3 billion City Deal funding.

Mechanisms are also in place to ensure alignment between our Plan and the work programmes of the Mid Wales Health Care Joint Committee, Supporting People and regional safeguarding boards for children and adults.

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.

1.10 Transforming Clinical Services

These principles also underpin a fundamental review of healthcare services in West Wales being taken forward through HDUHB'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.

1.11 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 RPB. Examples include developing ways of making it easier for people in rural communities to access the care and support that is available. In these instances we will work 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 will seek 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 and

will work with PSBs to align activity as necessary. Areas where the themes of the wellbeing plans and the Area Plan overlap include healthy habits, early intervention, strong connections and prosperous people and places (Carmarthenshire); community resilience and individual resilience (Ceredigion); and living and working, resourceful communities and tackling rurality (Pembrokeshire).

Links to the three wellbeing plans are provided below:

Insert

1.12 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

	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 improvements 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 enable a collaborative approach, achieve consistency in terms of services available in Welsh, facilitate sharing of practice and generate cross-regional initiatives as appropriate. This new forum will report on a regular basis to the RPB.

1.13 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 set out in Figure 4 below.

Figure 4

What well-being means	National well-being outcomes
<p>Securing rights and entitlements Also for adults: Control over day-to-day life</p>	<p>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.</p>
<p>Physical and mental health and emotional well-being Also for children: Physical, intellectual, emotional, social and behavioural development</p>	<p>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.</p>
<p>Protection from abuse and neglect</p>	<p>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.</p>
<p>Education, training and recreation</p>	<p>N13 I can learn and develop to my full potential. N14 I do the things that matter to me.</p>
<p>Domestic, family and personal relationships</p>	<p>N15 I belong. N16 I contribute to and enjoy safe and healthy relationships.</p>
<p>Contribution made to society</p>	<p>N17 I engage and make a contribution to my community. N18 I feel valued in society.</p>
<p>Social and economic well-being Also for adults: Participation in work</p>	<p>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.</p>
<p>Suitability of living accommodation</p>	<p>N24 I live in a home that best supports me to achieve my well-being.</p>

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.

1.14 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 ICF, which is provided to support delivery of the RPB'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 £1.296 million 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 £1 million 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

In keeping with the requirements of Part 9 of the Act we will explore opportunities for pooling budgets across health and local authorities to support delivery of the integrated approaches outlined in this Plan and ensure available resources are used as efficiently and effectively as possible.

1.15 Governance

As required under Part 9 of the Act, the RPB 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 Plan and making sure that it aligns with other plans in place across the respective agencies.

The Act also enables RPBs 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, supported by regional scrutiny arrangements, which will bring together senior representatives from the 3 local authorities and HDUHB 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 Committee will also oversee the operational delivery of formal partnership agreements. .

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

1.16 A co-productive approach

When undertaking our Population Assessment we undertook a comprehensive engagement exercise in which we worked with the three PSBs which were consulting on their wellbeing assessments at the same time. Our Assessment noted a number of key messages coming from the engagement, which included a survey distributed to households in the region and a series of follow-up consultation events. These messages included:

- A significant number of people identifying as having caring issues
- Around a third of respondents stating they had a health issues that affected their wellbeing
- Many people receiving care and support directly from their families
- Reported problems with care and support including care visits at unsuitable times and at infrequent intervals, long waiting list for local authority care, changes in benefits lessening people's ability to pay for care privately and unmet need for emotional support and practical help following slips and falls
- The need to ensure information and advice in relation to care and support is readily available and accurate
- The value of supporting people and communities to help themselves
- The importance of having access to preventative services including gym facilities
- The need to ensure availability of services in people's language of choice
- The need to put people at the heart of care and support and to improve access to services

These views and concerns have been reflected in the themes and objectives of the Area Plan. In producing the Plan we took further opportunities to engage with a range of people to ensure that our priorities reflect their views and opinions as far as possible. For example, we have discussed its contents with users, carers and representatives of the third and independent sectors on the RPB and engaged with a number working groups comprising a range of stakeholders to ensure that it reflects shared intentions and draws on existing effective practice.

However, genuine co-production requires a bolder approach and should not start and finish at planning stage. 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 RPB 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 RPB, we will establish new **regional arrangements** for **engaging with a cross-section of the public** in planning, delivering and reviewing care and support services. These will complement mechanisms already in place at regional and local levels. A new strategic **Innovations Forum** will also be established 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 and achieving social value.

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.

1.17 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 available via the following link **Insert**. 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	1.10
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	1.12
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	1.12
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	1.11
Increasing use of direct payments by developing community based supply chains that co-produce new models of service delivery such as carer co-operatives	1.11
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	N/A For further discussion with 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	1.10 & 1.12
Integrating carers impact assessment into planning processes for infrastructure programmes such as transport, housing, and technology developments and other relevant community programmes	1.12

How we will take this work forward

A regional Carers Development Group is in place with representatives from all partner agencies. Reporting to the RPB, 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; 1.14
Enhancing assessment and care planning processes to ensure that citizens have a genuine voice when agreeing outcomes and the support needed to achieve them	1.15; 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	N/A For consideration by regional Welsh language forum
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	1.14; 1.15; 1.17
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	1.14
Enhancing accommodation and meeting accommodation support needs of young people leaving care or following custodial sentences	N/A For further discussion with PSBs
Improving integration between children's services, mental health and learning disability and access to mental health services at an early stage	1.18

	Relevant Objectives within the Delivery Plan
Reducing the number of placement moves for LAC and reducing reliance on residential care	1.17
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	1.16
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	1.16
Developing a consistent, outcomes-based performance framework for children and young people's services across the region	N/A Address through regional outcomes framework

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 RPB, 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

	Relevant Objectives within the Delivery Plan
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

HDUHB 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 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 ADHD	1.8; 2.7
Empowering people with a learning disability to decide who provides their support and what form that support takes	1.19; 1.20; 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	1.19; 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	1.19; 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 RPB, this group will oversee delivery of the relevant Objectives within the Delivery Plan.

A regional Strategy Group is in place to oversee the implementation of the Integrated Autism Service (IAS) in West Wales.

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	1.21; 1.22; 2.14
Developing an outcome focused and 'risk-enablement' approach to service provision to support a flexible approach	1.21; 1.22; 2.14
Improving access to advice and support for service users and carers, including welfare rights and involvement in care and treatment	1.21
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 Take 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	1.21

	Relevant Objectives within the Delivery Plan
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	N/A For further discussion with 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 RPB 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	N/A For consideration by regional Welsh language forum
Achieving a consistent, integrated approach to frailty across the region that aligns with regional frailty and dementia strategies and pathway	1.1; 1.2; 1.3; 1.4; 1.5; 1.8; 1.23; 2.1; 2.2; 2.3; 2.5; 2.7; 3.1; 3.12; E1; E2; E3; E5; E8

	Relevant Objectives within the Delivery Plan
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 For further discussion with 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	1.24
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; 1.24
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; 1.24; E5
Addressing the lack of transport links within very rural regions, which add to the difficulty of accessible service delivery	N/A For further discussion with PSBs

How we will take this work forward

Information to follow

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. However over 22% of the population drink at harmful levels
- 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

More recent data that has become available since completion of the Population Assessment shows trends which are of concern and require appropriate remedial action:

- During 2016–17, the HDUHB area saw the largest increase in rates of alcohol related hospital admissions for an alcohol specific condition across Wales. Carmarthenshire had an admission rate of 375 individuals per 100,000 population, an increase in 25% since 2015-16 and an increase of 46% since 12-13. Ceredigion has seen an increase of 13% since 2015-16 and Pembrokeshire an increase of 3%
- Alcohol attributable hospital admissions in Carmarthenshire in 2016-17, have increased by 12% compared to 2015-16 and by 27% over the past 5 years. Ceredigion has increased by 8% in the past year and by 19% compared to admission rates five years ago. There has been no change in Pembrokeshire rates since 2015-16 but there has been an increase of 9% since 2012-13
- In 2016 /17 there were 1197 referrals for alcohol treatment (compared to 1137 in 2015-16) and 978 referrals for drug treatment

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	N/A Refer to Area Planning Board (APB) Prevention Plan Link to follow
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)	N/A Refer to APB Prevention Plan Link to follow
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	N/A Refer to APB Prevention Plan Link to follow
Developing clear pathways between services for service users with co-occurring substance misuse and mental health	N/A

	Relevant Objectives within the Delivery Plan
	Refer to APB Treatment and Harm Reduction Plan Link to follow
Targeting prevention, early intervention and treatment interventions to reduce harm to older people (50 plus) with alcohol problems	N/A Refer to APB Treatment and Harm Reduction Plan Link to follow
Development of housing options and reintegration opportunities within the community for recovering service users	N/A Refer to APB Treatment and Harm Reduction Plan and Drug-Related Death Action Plan Link to follow
Establishing, developing, implementing and managing a robust process for the review of both fatal and non-fatal overdoses including the rollout of the distribution of Naloxone across hospital sites	N/A Refer to APB Treatment and Harm Reduction Plan and Drug-Related Death Action Plan Link to follow
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	N/A Refer to APB Treatment and Harm Reduction Plan Link to follow

How we will take this work forward

The Dyfed APB for Substance Misuse will take this work forward through a regional commissioning strategy, based on the following vision:

- People will be healthier and experience fewer risks as a result of alcohol and drug use
- Fewer adults and young people will use drugs or drink alcohol at levels that are damaging to themselves or others
- Individuals will be able to recover from problematic drug and alcohol use and improve their health, wellbeing and life chances
- Alcohol and drug prevention, treatment and support services will be accessible, high quality, evidence based, timely and continually improving
- The family members and children of people misusing alcohol and drugs will be safe, well supported and have improved life chances

Links are being established between the APB and the RPB to help facilitate a joined up approach in this area.

2.9 Violence Against Women, Domestic Abuse and Sexual Violence (VAWDASV)

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 Female Genital Mutilation (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	2.18
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	1.26
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 RPB 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	Short term	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	Short term	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	Short term	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	Short term	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)	Short term	IAA and prevention	All	OR3 OR7	N7, N8, N9, N14, N22, N24	Insert link/s
1.6 Enhance and standardise out of hours provision across the region	Medium term	IAA and prevention	All	OR1 OR7	N1, N2, N4, N8	Insert link/s
1.7 Deliver integrated training and development programme to	Medium term	IAA and prevention/	All	OR3 OR7	N1, N2, N3, N4, N5, N6, N7, N8, N9	Insert link/s

Objective	Timeframe	Strategic priority	Population Groups	Links to Overarching Recs/ Areas for Improvement	Links to National Outcomes	Implementation Plan/s
support practice around IAA and preventions		Workforce Development				
1.8 Establish regional advocacy service for adults	Short term	IAA and prevention	All adults	OR1 OR6 OR7 OR8	N1, N2, N3, N4, N5, N6, N10, N12	Insert link/s
1.9 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,	Short term	IAA and prevention	Autism	OR3 OR7	N1, N2, N3, N4, N9, N15, N17, N18, N19	Insert link/s
1.10 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	Medium term	Carers	Carers	OR3 OR4	N1, N2, N4, N5, N6, N9, N11, N12, N18	Insert link/s
1.11 Ensure appropriate levels of respite and support services for carers, developed using a co-produced approach	Medium term	Carers	Carers	OR1 OR3 OR4 OR6 OR7	N1, N2, N4, N5, N6, N9, N11, N12, N18	Insert link/s

Objective	Timeframe	Strategic priority	Population Groups	Links to Overarching Recs/ Areas for Improvement	Links to National Outcomes	Implementation Plan/s
1.12 Ensure carers have access to appropriate IAA to support them in their role	Medium term	Carers	Carers	OR3 OR4 OR7	N1, N2, N4, N5, N6, N9, N11, N12, N18	Insert link/s
1.13 Support the wellbeing of carers and former carers through supporting them to build and maintain emotional resilience	Medium term	Carers	Carers	OR1 OR3 OR4 OR6 OR7	N1, N2, N4, N5, N6, N9, N11, N12, N18	Insert link/s
1.14 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	Medium term	IAA and prevention	Children and Young People/ Substance Misuse	OR1 OR3 OR7	N1, N2, N4, N5, N6, N7, N8, N9, N13, N14, N17, N18, N19, N22	Insert link/s Include VAWDASV
1.15 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)	Short term	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
1.16 Implement the 'Signs of Safety' Practice Framework across the Region.	Short term		Children and Young People	OR1	N1, N10, N11, N12	Insert link/s

Objective	Timeframe	Strategic priority	Population Groups	Links to Overarching Recs/ Areas for Improvement	Links to National Outcomes	Implementation Plan/s
1.17 Implement the Child Poverty Strategy for Wales within West Wales	Medium term	IAA and prevention	Children and Young People	OR3 OR7	N7, N8, N9, N16, N17, N18, N20	Insert link/s
1.18 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	Medium term	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
1.19 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	Medium term	IAA and prevention/ Transforming LD services	Learning Disabilities	OR3 OR7	N1, N3, N4, N5, N9	Insert link/s
1.20 Ensure IAA provision supports people with a Learning Disability in accessing appropriate care and support and enhances their access to generic services	Medium term	IAA and prevention/ Transforming LD Services	Learning Disabilities	OR3 OR7	N1, N2, N3, N4, N5, N9	Insert link/s
1.21 Ensure preventative services meet the needs of people with Mental Health problems through the Together for Mental Health Strategy within the Region	Medium term	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

Objective	Timeframe	Strategic priority	Population Groups	Links to Overarching Recs/ Areas for Improvement	Links to National Outcomes	Implementation Plan/s
1.22 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	Short term	IAA and prevention/ Transforming Mental Health Services	Mental Health	OR3 OR7	N1, N2, N3, N4, N5, N6, N7, N8, N9	Insert link/s
1.23 Ensure IAA and preventative services meet the needs of people with dementia through delivery of the Regional Dementia Strategy	Medium term	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
1.24 Ensure needs of people with sensory impairment are addressed through: <ul style="list-style-type: none"> • 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 	Medium term	IAA and prevention	Sensory impairment	OR1 OR3 OR6	N1, N2, N3, N5, N7, N8, N9	Insert link/s

Objective	Timeframe	Strategic priority	Population Groups	Links to Overarching Recs/ Areas for Improvement	Links to National Outcomes	Implementation Plan/s
1.25 Ensure preventative and IAA services meet the needs of people experiencing substance misuse issues	Medium term	IAA/ prevention	Substance misuse	OR1 OR3 OR6	N1, N2, N10, N11, N12	Insert link/s
1.26 Ensure preventative and IAA services meet the needs of people experiencing VAWDASV	Medium term	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	Medium term	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	Medium term	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	Medium term	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	Medium term	Workforce Development	All	OR3 OR7 OR8	All	Insert link/s

Objective	Timeframe	Strategic priority	Population Groups	Links to Overarching Recs/ Areas for Improvement	Links to National and Outcomes	Implementation Plan/s
support improved practice in targeted care and services						
2.5 Review arrangements for Integrated Community Equipment Stores and implement regional model, including consideration of pooled fund arrangements	Short term	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 for Integrated Community Equipment Stores	Short term	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	Medium term	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	Short term	IAA and prevention	Autism	OR1 OR3 OR6 OR7	N1, N2, N3, N4, N5, N6, N7, N8, N9, N13, N14, N17, N18	Insert link/s

Objective	Timeframe	Strategic priority	Population Groups	Links to Overarching Recs/ Areas for Improvement	Links to National and Outcomes	Implementation Plan/s
implementation of a regional Integrated Autism Service						
2.9 Ensure appropriate carer involvement in assessment process and that carers are offered their own assessment	Short term	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	Short term	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	Medium term	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	Medium term	Transforming LD services	Learning Disabilities	OR3 OR6 OR7	N5, N7, N8, N9	Insert link/s

Objective	Timeframe	Strategic priority	Population Groups	Links to Overarching Recs/ Areas for Improvement	Links to National and Outcomes	Implementation Plan/s
regional Model of Care and Support						
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	Medium term	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	Medium term	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	Medium term	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	Medium term	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	Medium term	IAA and prevention/ Service	Sensory Impairment	OR1 OR6	N1, N3, N4, N5, N6	Insert link/s

Objective	Timeframe	Strategic priority	Population Groups	Links to Overarching Recs/ Areas for Improvement	Links to National and Outcomes	Implementation Plan/s
a sensory impairment and facilitates referrals to appropriate services		Integration and Pooled Funds/ WCCIS				
2.18 Ensure assessment and care planning approach identifies and records users experiencing VAWDASV and facilitates referral to appropriate services	Short term	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	Short term	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	Medium term	Workforce Development	All	OR3 OR7 OR8		Insert link/s
3.3 Embed the Regional Adoption Service	Short term	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	Medium term	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	Short term	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	Short term	Service integration and pooled funds	Older People	OR1 OR7 OR8		Insert link/s

Objective	Timeframe	Strategic priority	Population Groups	Links to Overarching Recs/ Areas for Improvement	Link to National Outcomes	Implementation Plan/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	Short term	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	Short term	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	Short term	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	Medium term	Mental Health	Mental Health	OR1 OR3 OR7 OR8	Insert link/s	Insert link/s

Objective	Timeframe	Strategic priority	Population Groups	Links to Overarching Recs/ Areas for Improvement	Link to National Outcomes	Implementation Plan/s
problems through the Together for Mental Health Strategy						
3.11 Establish regional pooled fund for older people's care homes, based on shadow arrangements in place from April 2018	Short term	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	Medium term	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
<p>E1 Establish regional workforce strategy, with a view to:</p> <ul style="list-style-type: none"> • 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 	Medium term	Workforce Development	All	OR7 OR8		Insert link/s

Objective	Timeframe	Strategic priority	Population Groups	Links to Overarching Recs/ Areas for Improvement	Links to National Outcomes	Implementation Plan/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.	Short term	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	Short term	Integrated commissioning	All	OR7 OR8		Insert link/s
E4 Establish consistent regional approach to fee setting across population groups	Short term	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	Medium term	Integrated commissioning	All	OR3 OR6 OR7 OR8		Insert link/s
E7 Deliver integrated training and development programme to support improved commissioning practice	Short term	Integrated commissioning	All	OR7 OR8		Insert link/s

Objective	Timeframe	Strategic priority	Population Groups	Links to Overarching Recs/ Areas for Improvement	Links to National Outcomes	Implementation Plan/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	Medium term	Implementing WCCIS	All	OR6 OR8		Insert link/s

Monitoring delivery

The RPB will receive regular updates on the delivery of the Plan and, where appropriate, supporting implementation plans. The RPB'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 WWCP's website at www.wwcp.org.uk