BWRDD PARTNERIAETH RHANBARTHOL
CAERDYDD A'R FRO
CARDIFF & VALE
REGIONAL PARTNERSHIP BOARD

Health & Social Care
Regional Integration Fund

Cardiff and Vale RPB Strategic Plan

DECHRAU'N DDA
STARTING WELL

BYW'N DDA
LIVING WELL

HENEIDDIO'N DDA
AGEING WELL

Llywodraeth Cymru
Welsh Government

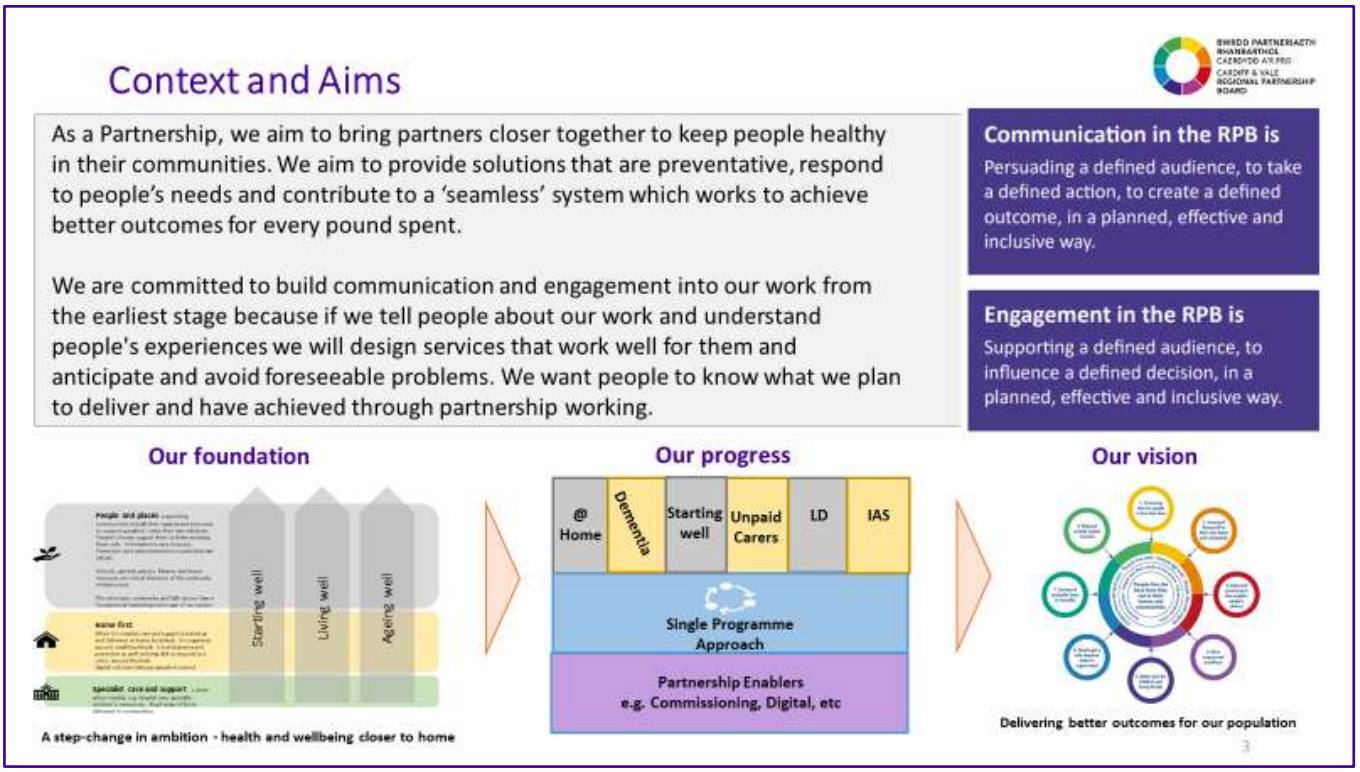
Regional infrastructure

Posts / type of roles	Indicate if role was previously under ICF or TF	Number of posts / roles (FTE)	Monetary cost (£m)	WG contributions
Senior Leadership	ICF	2wte	0.219	
Information and Commissioning	ICF	2.8wte	0.189	
Partnership Coms and Engagement Officer	ICF / Transformation	1wte	0.043	
Partnership Support	ICF	2wte	0.068	
Financial reporting support	ICF	Non pay	0.08	
Coms, engagement and translation	ICF/Transformation	Non pay	0.151	
		Total	**0.750**	**100%**
Match Funding				
Includes: - Financial Leadership and support - Regional Information Group Membership - Partner-specific commissioning lead time - Communications line management support - Facilities and associated infrastructure (incl. IT) - Digital and information governance development support - Procurement; - Legal / corporate support; - Human Resources; - PA support.	n/a		**0.250**	

Regional continuous engagement strategy

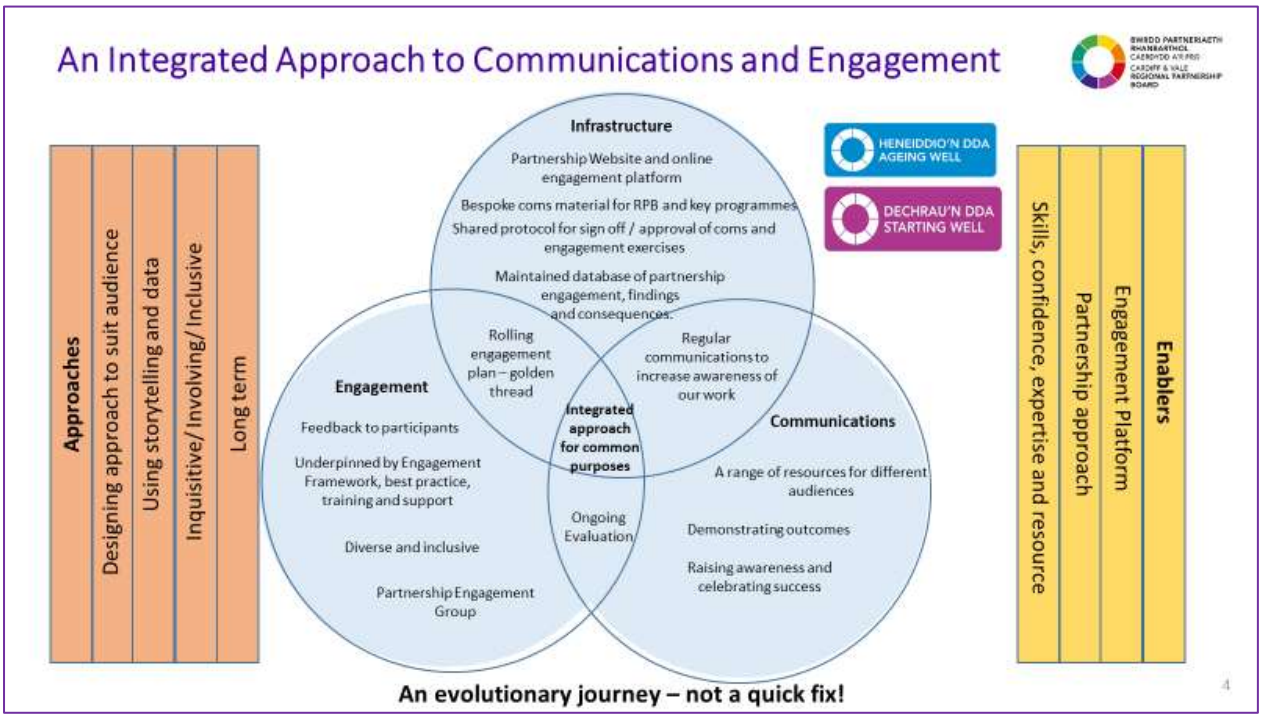
No	Criterion
1	*Facilitate a more joined-up approach across regions on engagement.*
2	*Design, develop and evaluate a cross-sector continuous engagement plan for each region until March 2023.*
3	*Find innovative ways to reach communities beyond those who are regularly or keenest to be involved, including harder-to-reach groups.*
4	*Use the latest digital tools and platforms for engagement.*
5	*Identify practical ways to collaborate across regions.*

Cardiff and Vale RPB has a detailed communications and engagement strategy which has been developed and initiated across the region in 2021-22. An overview of our approach can be summarised as follows:



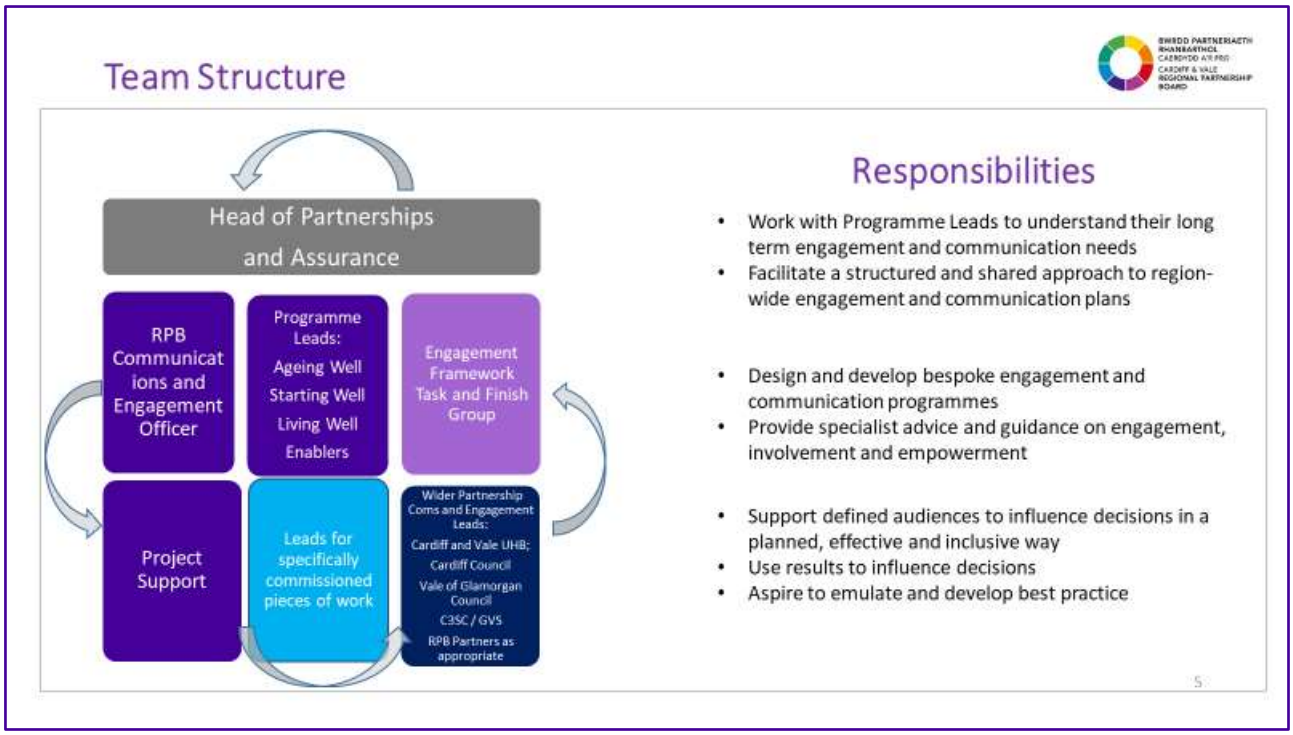
The Strategy is based upon key findings and recommendations from work facilitated by third sector partners to develop a region-wide engagement framework and is split into three separate sections:

1) Delivery of a prioritised engagement plan focused on key priority areas in our work programmes to encourage a culture of continuous engagement and involvement;
2) A communications delivery plan to spread, share and celebrate the work of our programmes;
3) Comprehensive infrastructure to support delivery of these plans, utilising a variety of digital innovation and ensuring that we make best use of existing resources from across our RPB membership.



Our coms and engagement strategy is supported with RPB funding for a full time Communication and Engagement Officer who sits within the Cardiff and Vale UHB Communications Team but is accountable to the RPB. This arrangement allows the Officer to plays a key role within the RPB partnership team whilst benefiting from ongoing support and development from a specialist coms team. The Officer also has a fundamental responsibility to develop a strong network of contacts with coms and engagement officers in all RPB partner organisations. Together this network is then able to develop and deliver shared, prioritised plans for both engagement and communications. Shared tools and resources will be available from 31 March 2022 to support a consistent approach to engagement and ensure that the results of engagements are easily accessible to all.

In addition, our Coms and Engagement Officer is already a member of an informal network of colleagues in similar roles from across the various regions who meet on a monthly basis to share plans, ideas and best practice. Their aim is to build a unified and consistent voice to explain the role and achievements of the RPBs.

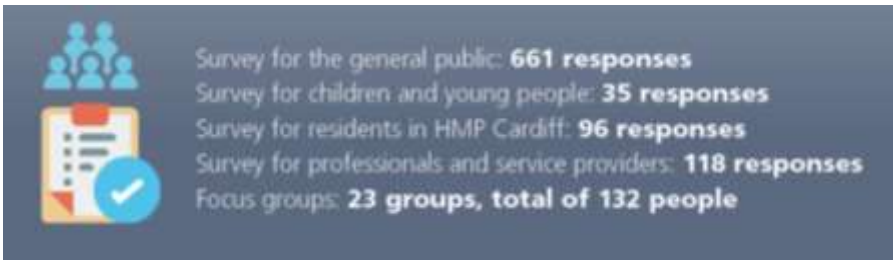


Wherever possible the RPB aims to utilise digital innovation to enhance it coms and engagement capabilities. In the last year, we have re-designed our Partnership website and are in the process of establishing a digital platform for engagement as part of our infrastructure plan. We have also invested in a number of digital case studies to showcase our work.

A couple of digital examples…

Get me Home V2 - YouTube https://vimeo.com/541392872/89cddf27e1

Our plans are carefully tailored to ensure that we actively seek to engage with community groups who may find it harder to engage with us. For example, we undertook specialist engagement as part of the Population Needs Assessment including reaching people in secure estates, where HMP Cardiff supported us to deliver a tailored survey directly to their prison population. We received almost 100 responses and were able to here directly some of the challenges they faced, as well as some of the excellent work that is being undertaken in HMP Prison.



We have begun our engagement for Ageing Well by holding regular direct engagements with a panel of older people. This will be supported by an engagement programme that is designed to reach people with a diverse range of voices and experiences. We will work with partners to build relationships with citizens and ensure that they have the capacity to engage. Our Starting Well Programme will focus on infants, children and young people who are particularly affected by our work, including vulnerable infants, children and young people across the partnership priorities (emotional and mental health, wellbeing, disability). A series of coproduced resources will ensure that these voices can be heard by decision-makers.

In addition, we seek to ensure that communication and engagement resources are shared across all elements of the RPB portfolio. The following diagrams list the agreed Engagement and Communication priorities for 2022 onwards:

Proposed Priority Engagement Areas for 2022 - onwards

1. **Population Needs Assessment**: targeted discussions to understand the care and support needs of 12 priority population groups to inform a refresh of the 2017 Population Needs Assessment

2. **Ageing Well: @Home – adults**: opportunity to test the key priority areas of the @Home programme with local citizens, seeking guidance on key issues such as cluster development, intermediate care, health and wellbeing centres, the Vale alliance and the development of single access points. This would include the involvement of carers and people with dementia.

3. **Capital**:
   - **CRI 'Chapel'** – engagement with local people on a proposed name for the new facility which has been developed within the previous CRI chapel building;
   - **Vale Smart House** – engagement with people with learning disabilities to ensure that the technology provided within the smart house will meet the needs of residents.

4. **Starting Well:**
   - **Children with Disabilities / additional needs – building on existing conversations to inform the ongoing development of** specific service areas relating to the project;
   - **Children and Young People with emotional, wellbeing and mental health needs** opportunity to test key priority areas and seek guidance on key issues relating to key issues including the safe accommodation, Whole schools approach, integrated service delivery, crisis intervention services and implementation of NEST/NYTH project.

5. **Commissioning – Market Stability Report:**
   - Engagement with **people who self fund or who are in receipt of Direct Payments** to help inform their present and future needs for care home provision;
   - Engagement with **care providers** to inform an annual sufficiency report, providing an overview of changes in need and provision.

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RPB Communications Detailed Delivery Plan 2022 onwards

Area	Output	Outcome
Starting Well	NEST/Nyth promotional video – focussing on building what already exists	Raise awareness of service change amongst staff Item for inclusion in AR
Starting Well	Transition Protocol/ event 14.3.21 Need pre and post coms Others bringing case studies	Communicate what has been achieved so far
Starting Well	Family group conferencing/reunification (Delayed due to capacity until late 2022)	Resource for families about how service works
Starting Well	Early Help Co-location of mental health support at the front door	Film/blog for funders and stakeholders: Showcase 'thinking together' conversations Demonstrate streamlined referral process
General	Carers Gateway Celebration of work	Promotional film showing how services work together to support carers of all ages Incorporating younger/older case study
Ageing Well	Accelerated Cluster work using SW Cluster Combination of staff interview and statistical impact of new approach	Film aimed at professional stakeholders and funders
Capital	Capital funding for third sector small projects	Film promoting impact of capital grants for small scale projects
Living Well	Integrated Autism Service	Film promoting IAS for funders and stakeholders
Living Well	Smart House (Vale) Tech support (C&V)	Films promoting services for Annual Report and performance monitoring
Ageing Well	@Home looking forward	Film setting out AW Plans for the future
Other resources	Pull up stands Polo shirts (Dementia team)	Resources for future work
RPB	Regional Outcomes Framework	Training/promotional film Planners to remind people to use
Ageing Well	Films/blogs featuring a range of dementia initiatives	Films promoting work for performance monitoring and promotional purposes

The implementation of this strategy means that the RPB is well positioned to deliver a comprehensive engagement and involvement plan to support the successful implementation of our Regional Integration Fund.

Population Needs Assessments

The region is in the process of finalising its latest Population Needs Assessment (PNA), the final draft of which will be presented to the Regional Partnership Board in May 2022. The draft emerging recommendations have been mapped against the priority programmes identified within the RIF and an overview of these initial results is provided in ***Annex B***. A RAG status has been used to show where recommendations already align with programme priorities and also where there may be gaps which require to be considered as part of escalation funding plans in the future.

This initial exercise highlights that the majority of recommendations within the draft PNA are already contained within the scope of appropriate RPB priority programmes for specific beneficiaries. However, a number of recommendations remain outstanding where further assessment and discussion is required and these are summarised in the table below.

Population Needs Assessment – gap analysis

Population Group	Potential Gap Recommendation	RIF Beneficiaries	? Programme Link
Older People	Further develop existing collaborations to provide high quality end of life care	Older people / people with Dementia	Ageing Well
Physical Disability	Various including service provision, training, employment and cultural.	Subset of all beneficiary groups	Living Well
Mental Health	Various including work to reduce the long term impact of COVID-19, and addressing demand through collaborative service re-design and innovation.	Subset of all beneficiary groups	Living Well
Unpaid Carers	Strengthen clear pathways for carers assessments including capturing first language needs and flexible respite provision	Unpaid Carers	Unpaid Carers / Living Well
Sensory loss and impairment	Increasing shared awareness of basic needs alongside provision of specialist support, monitoring and ensuring equity of access.	Subset of all beneficiary groups	Living Well
Violence Against Women, Domestic Abuse, and Sexual Violence	Increasing shared awareness of basic needs alongside provision of specialist support, monitoring and ensuring equity of access.	Subset of all beneficiary groups	Living Well
Substance Misuse	Increasing shared awareness of basic needs alongside provision of specialist support, monitoring and ensuring equity of access.	Subset of all beneficiary groups	Living Well
Secure Estate	Increasing shared awareness of basic needs alongside provision of specialist support, monitoring and ensuring equity of access.	Subset of all beneficiary groups	Living Well
Asylum Seekers and refugees	Increasing shared awareness of basic needs alongside provision of specialist support, monitoring and ensuring equity of access.	Subset of all beneficiary groups	Living Well
Veterans	Increasing shared awareness of basic needs alongside provision of specialist support, monitoring and ensuring equity of access.	Subset of all beneficiary groups	Living Well

These findings will be taken into consideration as together, partners consider shared priorities for the focused use of Acceleration Funding in 2022-23 and beyond.

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CARDIFF & VALE REGIONAL PARTNERSHIP BOARD

Annex A
Cardiff and Vale Regional Partnership Board

Strategic Partnership	Strategic Programme	Strategic Project	FUNDING ENABLER		MODELS OF CARE						Nationally defined strategic enablers			
			Revenue	Capital*	Community Based Care - Prevention & Comm Co-ord	Community Based Care - Complex Care Closer to Home	Emotional Health and Wellbeing	Families Staying Together & Therapeutic Support for CEC	Home From Hospital	Accommodation Based Solutions	Workforce	Digital	RIIC	Commissioning
Ageing Well	At Home	Access	yes		yes	yes	yes		yes	yes	yes	yes	yes	yes
		Intermediate Care	yes		yes	yes	yes		yes	yes	yes	yes	yes	yes
		Accelerated Clusters	yes		yes	yes	yes				yes	yes	yes	yes
		Health and Wellbeing Centres		yes	yes	yes	yes		yes	yes	yes	yes	yes	yes
		Vale Alliance	yes		yes	yes	yes		yes	yes	yes	yes	yes	yes
		Hospital to Home	yes			yes			yes	yes	yes	yes	yes	yes
	Dementia Strategy	Assessment and Diagnosis	yes		yes	yes	yes				yes	yes	yes	yes
		Dementia Friendly Region	yes		yes	yes	yes		yes		yes	yes	yes	yes
		Team Around the Individual	yes		yes		yes	yes			yes	yes	yes	yes
		Home from Hospital	yes		yes		yes	yes			yes	yes	yes	yes
		Dementia Care Training	yes		yes	yes	yes	yes	yes	yes	yes	yes	yes	yes
Starting Well	Emotional health and wellbeing	Prevention and wellbeing	yes		yes		yes	yes			yes	yes	yes	yes
		Access	yes		yes	yes	yes	yes	yes		yes	yes	yes	yes
		Right support, right time, right person	yes		yes	yes	yes	yes	yes	yes	yes	yes	yes	yes
		CYP with complexity of need	yes	yes		yes	yes	yes	yes	yes	yes	yes	yes	yes
	Complex health and disabilities	Prevention and wellbeing	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes
		Access	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes
		Right support, right time, right person	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes
		CYP with complexity of need	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes
	Enabling Starting Well	PARK: Multi-Agency Learning (enabler workstream for CYP	yes		yes	yes	yes	yes			yes	yes	yes	yes
Living Well	Learning Disabilities	Fit for my future	yes		yes	yes	yes	yes		yes	yes	yes	yes	yes
		Right support, right time, right person	yes		yes	yes	yes	yes		yes	yes	yes	yes	yes
		Accommodation Solutions	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes
	Carers	Access	yes		yes	yes	yes	yes	yes		yes	yes	yes	yes
		Young Carers	yes		yes	yes	yes	yes			yes	yes	yes	yes
		Adult Carers	yes		yes	yes	yes	yes	yes		yes	yes	yes	yes

Annex B PNA Recommendations

			Models of Care						Beneficiaries				
	Links to ROF	**Existing RPB Programme/Project**	Place based care - prevention and	Place based care - complex care closer to	Promoting good emotional health and w…	Preventing children entering care	Home from Hospital	Accommodation based solutions	Older people including people with	Children and young people with complex	People with learning disabilities and	Unpaid carers	People with emotional and mental health
Children and Young People													
Cardiff and Vale University Health Board and Cardiff and the Vale of Glamorgan Local Authorities to:													
• Adopt the NEST Framework and No Wrong Door approach	1. Increased time to live life > reduced waiting time 6. Safe response when in need > decreased delays	Starting Well	x		x	x				x	x (CYP)		x (CYP)
• (1) Strengthen actions to ensure information is accessible to children and young people; (2) and they are invited to co-produce services so they are person-centred, and help children and young people feel valued (tender out is all about)	3. Environment that enables choice > Increased access to relevant information, advice, assistance and support	Starting Well			x					x	x (CYP)		x (CYP)
• Monitor emerging literature on long COVID in children and young people (who to be decided - RPB BI?)	6. Safe response when in need > increased understanding of need	ROF	x							x	x (CYP)	x	x (CYP)
Cardiff and Vale University Health Board to:													
• Continue to promote preventative strategies including routine immunisations (outside of RPB remit)	2. Increased living well in their own home and community > staying healthy and well	UHB-specific	x	x	x	x		?		x	x (CYP)	?	x (CYP)
• Continue to develop partnerships with Education services and embed the whole school approach to emotional health and wellbeing (need already being addressed by EWMH)	3. Environment that enables choice > Increased preventative care and early intervention	Starting Well	x		x	x				x	x (CYP)		x (CYP)
• Increase funding available to mental health services for children and young people (25) (potential need to be included in planning framework)	6. Safe response when in need > decreased delays	Starting Well	x		x	x				x	x (CYP)	?	x (CYP)
• Target waiting list times, especially for children and young people's mental health services (potential need to be included in planning framework)	1. Increased time to live life > reduced waiting time 6. Safe response when in need > decreased delays	Starting Well	x		x	x				x	x (CYP)	?	x (CYP)
• Develop Integrated Model for Emotional Health and Well-being for Cardiff and Vale (need already being addressed by EWMH)	4. More empowered workforce > effective integrated teams	Starting Well	x		x					x	x (CYP)	?	x (CYP)
Children and Young People with Complex Needs													
Cardiff and Vale University Health Board, Cardiff and the Vale of Glamorgan Local Authorities, education providers, and third sector to:													
• Promote universal and targeted early intervention and preventative services including parental support	3. Environment that enables choice > increased preventative care and early intervention	Starting Well	x	x	x	?		?		x			
• Undertake training to increase awareness and promote services accessible and comfortable for children and young people with neurodevelopmental disorders (RPB but not quite there)	3. Environment that enables choice > increased access to relevant information, advice, assistance and support AND increased preventative care and early intervention	Starting Well CLD8 - Enhanced educational interface-autism ND planning tool 2022 onwards	x	x	x			?		x			
• Work to ensure the T4CYP 2 programme is fully embedded	??? 7. Decreased avoidable harm or mortaility	Starting Well		x				x		x			
Cardiff and Vale University Health Board and Cardiff and the Vale of Glamorgan Local Authorities to:													
• Share good practice and learning	??? 4. More empowered workforce > right tools and equipment 6. Safe response when in need > decreased delays	Starting Well	x	x	x	x	x	x		x			
• Address data gaps	??? 4. More empowered workforce > right tools and equipment 6. Safe response when in need > decreased delays	Starting Well											
• Address gaps in service provision	??? 7. Decreased avoidable harm or mortaility	Starting Well	x	x	x	x	x	x		x			
• Promote early help and preventative approaches in line with T4CYP 2	3. Environment that enables choice > Increased preventative care and early intervention	Starting Well	x	x	x	x		x		x			
• Embed the NEST framework and No Wrong Door approach	1. Increased time to live life > reduced waiting time 6. Safe response when in need > decreased delays	Starting Well	x		x					x			
• Address the increasing waiting list for assessment	1. Increased time to live life > reduced waiting time 6. Safe response when in need > decreased delays	Starting Well	x	x	x	?		?					
Regional Partnership Board to:													
• Lead on development and implementation of an integrated model for children and young people's emotional health and wellbeing	4. More empowered workforce > effective integrated teams	Starting Well	x	x	x	x	x	x		x	x (CYP)	?	x (CYP)
Children Looked After													
Cardiff and Vale University Health Board and Cardiff and the Vale of Glamorgan Local Authorities to:													
• (1) Continue to foster a culture whereby children looked after feel valued and listened to; (2) are informed of choices available to them; (3) and can influence decisions about their care	??? 7. Decreased avoidable harm or mortaility 3. Environment that enables choice > Increased access to relevant information, advice, assistance and support	Starting Well and individual partners.	x	x	x	x	x	x		x	x (CYP)	?	x (CYP)
• Promote a preventative approach to prevent needs arising or escalating	3. Environment that enables choice > Increased preventative care and early intervention	Starting Well and individual partners.	x	x	x	x		?		x	x (CYP)	?	x (CYP)

• Ensure that children looked after have timely access to health and education services that they need, in order to meet statutory education requirements, close the inequalities gap, and promote their well-being (92)	1. Increased time to live life > reduced waiting time 5. Better start for C&YP > increased educational outcomes 6. Safe response when in need > decreased delays	Individual partners	x	x	x	x	?	?		x	x (CYP)	?	x (CYP)
• Develop of an integrated working model to promote seamless transition between services, including actions to be taken when children go missing from care, and interaction with the criminal justice system (92)	4. More empowered workforce > effective integrated teams 5. Better start for C&YP > reduced involvement with criminal justice system	Starting Well and individual partners.	x	?	x			x		x	x (CYP)	?	x (CYP)
Cardiff and the Vale of Glamorgan Local Authorities to:													
• Develop additional placements close to home for children and young people	5. Better start for C&YP > increased family living arrangements and permanent attachments	Starting Well and individual partners.	x	?	x	?	?	x		x	x (CYP)		x (CYP)
• Orientate services to be person-centred, building trust and rapport with children and young people, promoting a sense of value through co-production	??? 7. Decreased avoidable harm or mortality	Starting Well and individual partners.			x					x	x (CYP)		x (CYP)
Older People													
Cardiff and the Vale of Glamorgan Local Authorities, Cardiff and Vale University Health Board, and private providers to:													
• Recognise the diversity of the "older people" group and provide services to meet the needs of such a diverse group, including transport options	???	Ageing Well and individual partners.	x	x	x		?	x	x			x	
• Continue to embed the Cardiff and Vale Rehabilitation Model	2. Increased living well in their own home and community > increased time at home AND increased support delivered at or as close to home as possible	Ageing Well and wider UHB work.	x	x			x	?	x				
• Further develop existing collaborations to provide high quality end of life care	2. Increased living well in their own home and community > dying with dignity 4. More empowered workforce > effective integrated teams	Not included currently.		x	x		x		x				
• Integrate care and support services to enable older people to live independently and well at home for as long as possible, for example, through the @home programme	2. Increased living well in their own home and community > increased time at home AND increased support delivered at or as close to home as possible	Ageing Well - @ Home programme	x	x	x		x	x	x				
• Promote the use of Dewis Cymru to increase awareness of available support services	3. Environment that enables choice > Increased access to relevant information, advice, assistance and support	Partner-specific.	x		x			x	x				
Cardiff and the Vale of Glamorgan Local Authorities to:													
• Support new building developments to meet the needs of an ageing population, and increase the provision of a variety of accommodation options to enable older people to make informed choices on where and how they live	2. Increased living well in their own home and community > positive physical environment	ICF Capital plan and individual partners.						x	x				
• Implement the Housing Adaptations Strategic Framework; and ensure existing properties are appropriate, safe, and support older people's independence	2. Increased living well in their own home and community > positive physical environment AND increased time at home AND increased support delivered at or as close to home as possible	ICF Capital plan and individual partners.	x				x	x	x				
• Apply urban design standards and accessibility criteria when redesigning existing infrastructure, for example, increasing the time for people to cross the road at a light-controlled pedestrian crossing (106)	2. Increased living well in their own home and community > positive physical environment	Partner-specific.	x		x				x				
Cardiff and Vale University Health Board and Primary Care to:													
• Promote the Royal College of General Practitioners 'Tackling loneliness. A community action plan for Wales' amongst health care providers and partners to raise awareness of loneliness, and advise how lonely patients can be identified and supported (106)	2. Increased living well in their own home and community > increased positive relationships	Ageing Well and Partner-specific.			x				x			x	x
Healthy Lifestyles and Long Term Conditions													
Cardiff and the Vale of Glamorgan Local Authorities, Cardiff and Vale University Health Board, and policy makers to:													
• Anticipate the impact of demographic change on future service demands	6. Safe response when in need > increased understanding of need	ROF	x	x	x	x	x	x	x	x	x	x	x
• Consider the impact of socio-economic disadvantage on service users, and how services can be provided in a way to reduce inequities, in line with the Socio-Economic Duty	??? inequality or inequity not addressed by ROF, but should it be?	ROF	x	x	x	x		x	x	x	x	x	
Cardiff and the Vale of Glamorgan Local Authorities and housing providers to:													
• Further progress accommodation solutions that meet the needs of the service users	2. Increased living well in their own home and community > positive physical environment	ICF Capital Plan and partner-specific	?	?				x	x	x	x	x	x
Cardiff and Vale University Health Board to:													
• Improve access to services, with a focus on mental health services	1. Increased time to live life > reduced waiting time 6. Safe response when in need > decreased delays	ROF	?	?	x		?		x	x	x	x	x

• Continue to develop and strengthen preventative health services	3. Environment that enables choice > Increased preventative care and early intervention	SW - SPA in UHB and Whole School App												
Policy makers to:														
• Use the Triple Challenge lens to inform policies and strategies around issues impacted by Brexit, COVID-19 and climate change, such as food systems and diet (65)	??? 2. Increased living well in their own home and community > staying healthy and well	PSB / Partner specific	x	x				x	x	x	x	x	x	x
Physical Disability														
All agencies to:														
• Undertake training on disability equality	??? inequality or inequity not addressed by ROF, but should it be?	Individual partner plans in place but may require consideration as RPB priority.			x				x	x	x	x	x	x
• Ensure services are accessible to disabled people; including accessible information	3. Environment that enables choice > Increased access to relevant information, advice, assistance and support	Individual partner plans in place but may require consideration as RPB priority.			x				x	x	x	x	x	x
• Reaffirm social model of disability (73)	7. Decreased avoidable harm or mortality > XXX	Individual partner plans in place but may require consideration as RPB priority.			x			?	x	x	x	x	x	x
• Work towards a positive and inclusive culture for disabled people	???	Individual partner plans in place but may require consideration as RPB priority.	x	x	x			x	x	x	x	x	x	x
• Increase awareness of job opportunities for disabled peoples, and how to apply for reasonable adjustments with improved links to Access to Work.	???	Individual partner plans in place but may require consideration as RPB priority.			x			?						
• Increase availability of training for disabled people to further their independence, such as travel training (112)	2. Increased living well in their own home and community > increased time at home AND increased safety and security	Individual partner plans in place but may require consideration as RPB priority.			x			?	x	x	x			x
Cardiff and the Vale of Glamorgan Local Authorities and housing providers to:														
• Continue to promote independent living	???	Ageing Well, Learning Disabilities, Carers, Starting Well and Individual partner plans.	?	?	x		?	X	x	x	x	?	x	
Cardiff and Vale University Health Board to:														
• Continue to consider mental health alongside physical health in service developments	4. More empowered workforce > effective integrated teams	Partner-specific.	x		x		?	?	x	x	x	x	x	
Learning Disability														
Third sector, Cardiff and Vale University Health Board and Cardiff and the Vale of Glamorgan Local Authorities to:														
• Continue to base services on co-production; individual care and support plans should also be co-produced	??? 7. Decreased avoidable harm or mortality	Learning Disabilities Programme	?	?	x	?		?			x			
• Focus services towards what is important for the individual, such as encouraging an active independent lifestyle, and promotion of friendships	2. Increased living well in their own home and community > staying healthy and well AND increased positive relationships	Learning Disabilities Programme	?		x						x			
• Build on existing provision to provide opportunities for work and activities, as per the Cardiff and Vale of Glamorgan Joint Commissioning Strategy (78)	???	Learning Disabilities Programme			x						x			
• Ensure information provided is accessible and jargon free to improve service access and maximise their impact	3. Environment that enables choice > Increased access to relevant information, advice, assistance and support	Learning Disabilities Programme			x						x			
• Identify and mitigate against inequities amongst people with learning disability (further clarification req'd)	??? inequality or inequity not addressed by ROF, but should it be?	Learning Disabilities Programme	x	x	x	x		x			x			
Cardiff and the Vale of Glamorgan Local Authorities to:														
• Continue to promote the "community first" approach when planning placements and accommodation	2. Increased living well in their own home and community > increased support delivered at or as close to home as possible	Learning Disabilities Programme CLD5, CLD13, CLD3	x	x	x			?			x			
Cardiff and Vale University Health Board to:														
• Continue to improve uptake of annual health checks and screening	2. Increased living well in their own home and community > staying healthy and well	Learning Disabilities Programme CLD11,	x								x			
Autism														
Third sector, Cardiff and Vale University Health Board and Cardiff and the Vale of Glamorgan Local Authorities to:														
• Continue to develop opportunities for co-production, and the involvement of autistic people in decisions around their care and support plans	??? 7. Decreased avoidable harm or mortality	IAS	?	?	x	?		?		?	x			
• Improve data collection to better understand the number of autistic people, and associations with socio-economic deprivation and language needs.	??? 4. More empowered workforce > right tools and equipment 6. Safe response when in need > decreased delays	ROF									x			
• Embed the Code of Practice in the delivery of Autism Services	??? 7. Decreased avoidable harm or mortality	IAS	?	?	x			?			x			
• Develop inclusive recruitment, for example, through the Disability Confident Scheme (187) or Positive About Working with Autism Programme (71)	???	Partner specific			x						x			
• Improve wider societal awareness of autism and develop a supportive culture	???	Partner specific			x						x			
Cardiff and the Vale of Glamorgan Local Authorities to:														

• Develop accessible and flexible respite services	1. Increased time to live life > reduced waiting time 6. Safe response when in need > decreased delays	IAS	x	x		?		x			x		
Cardiff and Vale University Health Board to:													
• Reduce waiting list times for assessment by the Integrated Autism Service	1. Increased time to live life > reduced waiting time 6. Safe response when in need > decreased delays	IAS			x						x		
Adult Mental Health													
All agencies to:													
• Develop data systems to address the gaps in our knowledge	??? 4. More empowered workforce > right tools and equipment 6. Safe response when in need > decreased delays	Individual partner plans in place but may require consideration as RPB priority.	?	?	x	?	?	?					x
• Monitor the evolving understanding of the impact of COVID-19 on mental health	tbc	Individual partner plans in place but may require consideration as RPB priority.	?	?	x								x
• Support housing transition to avoid homelessness for mental health service users	6. Safe response when in need > decreased delays	Individual partner plans in place but may require consideration as RPB priority.			x			x					x
Cardiff and Vale UHB and Cardiff and Vale of Glamorgan Local Authorities to:													
• Commission enhanced peer support services to promote independence	6. Safe response when in need > decreased delays	Individual partner plans in place but may require consideration as RPB priority.			x								x
• Redesign mental health services so that waiting times decrease and there is easy access to mental health services when in a crisis	6. Safe response when in need > decreased delays	Individual partner plans in place but may require consideration as RPB priority.	x	x	x		?						x
• Co-produce meaningful outcome measures with mental health service users	National priority.	Individual partner plans in place but may require consideration as RPB priority.			x								x
• Assess the efficacy of novel interventions, for example in the Recovery College	6. Safe response when in need > decreased delays	Individual partner plans in place but may require consideration as RPB priority.	?		x			?					x
Third sector to:													
• Promote independence and advocacy for people with mental health conditions	6. Safe response when in need > decreased delays	Individual partner plans in place but may require consideration as RPB priority.			x								x
Cognitive Impairment including Dementia													
All agencies to:													
• Increase service user and carer input into service developments and their own person centred care plans	??? 7. Decreased avoidable harm or mortality	Dementia DAP			x				x			x	
• Ensure that individual needs are person-centred	??? 7. Decreased avoidable harm or mortality	Dementia DAP	x	x	x		x	x	x			x	
• Tailor the needs of unpaid carers of people living with dementia so that they have appropriate respite	1. Increased time to live life > reduced waiting time 6. Safe response when in need > decreased delays	Carers	x		x			x	?			x	
• Have clear care, coordinated pathways for people with a progressive diagnosis so, individuals are not lost in the system	4. More empowered workforce > right staffing AND right tools AND effective integrated teams (others???)	Dementia DAP							x			x	
Cardiff and the Vale of Glamorgan Local Authorities to:													
• Develop the capacity of residential and nursing homes to accommodate the future needs of people living with dementia, both in terms of increased bed numbers and also dementia-friendly environments	6. Safe response when in need > decreased delays	Commissioning		x	x			x	x				
• Support the needs of unpaid carers, who are often older people themselves, through the provision of information, advice and support	3. Environment that enables choice > Increased access to relevant information, advice, assistance and support	Carers							x			x	
• In partnership with the third sector and Cardiff and Vale UHB, to further develop local communities to become dementia friendly	6. Safe response when in need > decreased delays	Dementia Strategy	x		x				x			x	
Cardiff and Vale University Health Board and Primary Care to:													
• Support further developments in Primary Care through training and development to ensure that both physical and mental health needs are met for people living with dementia.	4. More empowered workforce > right tools and equipment AND effective integrated teams	Dementia Strategy	x	x	x				x			x	
• Provide a personalised care pathway for a person living with dementia and their carer so that people can link in with support as needed	6. Safe response when in need > decreased delays ??? 7. Decreased avoidable harm or mortality	Dementia Strategy and Evaluation	x						x			x	
Adult Unpaid Carers													
All agencies, in partnership to:													
• Review the need for an updated carers directory, which is updated regularly and available digitally, and publicise widely	3. Environment that enables choice > Increased access to relevant information, advice, assistance and support	Unpaid Carers (Third Sector/Carers Gateway)	x		x							x	
• Provide respectful care that is culturally appropriate, with training where needed	4. More empowered workforce > effective integrated teams	Unpaid Carers											
Cardiff and the Vale of Glamorgan Local Authorities to:													
• Strengthen clear pathways for carers assessments within local authorities following a "what matters" conversation	??? 7. Decreased avoidable harm or mortality	Individual partner plans in place but may require consideration as RPB priority.	x		x							x	

• Capture first language needs in carers assessments	3. Environment that enables choice > Increased access to relevant information, advice, assistance and support	More extensive baseline assessment required - may require consideration as RPB priority.			x							x		
• Consider flexible respite needs for unpaid carers	1. Increased time to live life > reduced waiting time 6. Safe response when in need > decreased delays	More extensive baseline assessment required - may require consideration as RPB priority.	x	x	x			x				x		
Cardiff and Vale University Health Board to:														
• Review the pathway for mental health support to unpaid carers, so that waiting time decreases	1. Increased time to live life > reduced waiting time 6. Safe response when in need > decreased delays	More extensive baseline assessment required - may require consideration as RPB priority.			x							x		
Employers to:														
• Adopt reasonable adjustments for people with caring responsibilities so that worthwhile employment is maintained and finances for unpaid carers are optimised	tbc	More extensive baseline assessment required - may require consideration as RPB priority.			x							x		
Sensory Loss and Impairment														
All agencies, in partnership, to:														
• Increase awareness of specialist and support services to improve signposting (257); and improve joined working	3. Environment that enables choice > Increased access to relevant information, advice, assistance and support 4. More empowered workforce > effective integrated teams	More extensive baseline assessment required - may require consideration as RPB priority.	x		x			x	x	x	x	x	x	
• Promote awareness and normalisation of British Sign Language (BSL)	???	More extensive baseline assessment required - may require consideration as RPB priority.			x				x	x	x	x	x	
• Anticipate the increase in prevalence of hearing and sight loss in the future	??? 4. More empowered workforce > right tools and equipment 6. Safe response when in need > decreased delays	More extensive baseline assessment required - may require consideration as RPB priority.	x		x			x	x	x	x	x	x	
• Increase opportunities for consultation and co-production	??? 7. Decreased avoidable harm or mortaility	More extensive baseline assessment required - may require consideration as RPB priority.	?	?	?	?	?	?	x	x	x	x	x	
• Sign up to the Disability Confident Scheme (187) and develop inclusive recruitment. The D/deaf community (encompassing people who have profound hearing loss and use BSL (Deaf), as well as people who have hearing loss (deaf)) need more D/deaf and BSL users professionals embedded in services to ensure they are represented and that communication is not a barrier	4. More empowered workforce > right staffing AND right tools and equipment AND effective integrated teams (others???)	More extensive baseline assessment required - may require consideration as RPB priority.			x				x	x	x	x	x	
Cardiff and Vale University Health Board and Cardiff and the Vale of Glamorgan Local Authorities to:														
• Undertake Deaf Awareness training for staff to improve the culture for service users, and co-workers who may have hearing loss	4. More empowered workforce > right tools and equipment	More extensive baseline assessment required - may require consideration as RPB priority.			x				x	x	x	x	x	
• Increase the number of Rehabilitation Officers for Visually Impaired people in line with recommendations (258)	4. More empowered workforce > right tools and equipment	More extensive baseline assessment required - may require consideration as RPB priority.	x		x				x	x	x	x	x	
• Design physical activity strategies and plans to increase D/deaf-friendly and D/deaf aware opportunities	??? 2. Increased living well in their own home and community > staying healthy and well	More extensive baseline assessment required - may require consideration as RPB priority.	x		x				x	x	x	x	x	
Cardiff and Vale University Health Board and Primary Care to:														
• Improve recording of Deaf people as Deaf in medical records so BSL interpreters can be appropriately booked (257), improving referrals, and experience of health care	??? 4. More empowered workforce > right tools and equipment 6. Safe response when in need > decreased delays	Partner-specific action							x	x	x	x	x	
• Take additional action to promote equity of access to healthcare services for D/deaf people compared to non-disabled people	??? inequality or inequity not addressed by ROF, but should it be?	Partner-specific action	x	x	x				x	x	x	x	x	
• Support the newly established Inclusive Recruitment Team who ensure that they work to the Themes and Goals of the Disability Confident Scheme	???	Partner-specific action			x				x	x	x	x	x	
Violence Against Women, Domestic Abuse, and Sexual Violence														
All agencies to:														

• Strengthen the availability of existing services to provide person-centred care with seamless and timely transition between agencies, for example, through supporting inter-agency communication	4. More empowered workforce > effective integrated teams	More extensive baseline assessment required - may require consideration as RPB priority.	x	x	x	x	?	x	x	x	x	x	x	x
• Continue to improve awareness amongst victims, bystanders, and service providers on the recognition and management (including signposting) of VAWDASV	???	More extensive baseline assessment required - may require consideration as RPB priority.	x		?				x	x	x	x	x	x
• Continue to deliver the required elements of the National Training Framework to all relevant staff and build on successes of Ask & Act and routine enquiry	4. More empowered workforce > right tools and equipment AND effective integrated teams (others???)	More extensive baseline assessment required - may require consideration as RPB priority.	x		x	?	?		x	x	x	x	x	x
• Improve the multi-agency response to identified risk factors, such as ACEs, through increasing understanding of factors that increase risk and an awareness of the lived experiences	4. More empowered workforce > effective integrated teams	More extensive baseline assessment required - may require consideration as RPB priority.	x		x	x			x	x	x	x	x	x
• Continue to monitor evolving trends in forms of abuse and ensure services anticipate changes in demand	??? 4. More empowered workforce > right tools and equipment 6. Safe response when in need > decreased delays	More extensive baseline assessment required - may require consideration as RPB priority.	x		x	x		x	x	x	x	x	x	x
• Ensure continued investment in specialist support services and required delivery of high quality, needs-led, strengths-based and trauma-informed person-centred provision	4. More empowered workforce > effective integrated teams 6. Safe response when in need > decreased delays	More extensive baseline assessment required - may require consideration as RPB priority.	x		x	x		?	x	x	x	x	x	x
• Increase practitioners' knowledge and understanding of perpetrator behaviour(s) to ensure that the accountability for the abusive behaviour remains with the perpetrator(s)	4. More empowered workforce > right tools and equipment AND effective integrated teams (others???)	More extensive baseline assessment required - may require consideration as RPB priority.			x	x			x	x	x	x	x	x
Cardiff and the Vale of Glamorgan Local Authorities to:														
• Further develop target hardening and move on accommodation opportunities, so spaces are available in refuges for those who need it, and minimise disruption to victims who wish to stay at home	2. Increased living well in their own home and community > increased support delivered at or as close to home as possible AND positive physical environment 6. Safe response when in need > decreased delays	Partner-specific action	x		x	x		x	x	x	x	x	x	x
• Maintain, and where possible extend, a range of interventions to target known and potential perpetrators of abuse	???	Partner-specific action,	x						x	x	x	x	x	x
Substance Misuse														
All agencies to:														
• Take action to ensure services are accessible to the service user, with a focus on provision of face to face support and a reduction in the reliance on digital access for awareness of services, and service provision	3. Environment that enables choice > Increased access to relevant information, advice, assistance and support	More extensive baseline assessment required - may require consideration as RPB priority.	x		x				x	x	x	x	x	x
• Monitor trends relating to alcohol and substance misuse in order to anticipate service needs, including misuse of over the counter drugs and the purchasing of on-line supplies of drugs	??? 4. More empowered workforce > right tools and equipment 6. Safe response when in need > decreased delays	More extensive baseline assessment required - may require consideration as RPB priority.	x						x	x	x	x	x	x
• Increase signposting of those in need, through awareness across the system of support provided by other services including public, private and third sector	3. Environment that enables choice > Increased access to relevant information, advice, assistance and support	More extensive baseline assessment required - may require consideration as RPB priority.	x		x				x	x	x	x	x	x
• Increase awareness of Dewis Cymru, a website which enables individuals to find local and national organisations and services (256)	3. Environment that enables choice > Increased access to relevant information, advice, assistance and support	More extensive baseline assessment required - may require consideration as RPB priority.	x						x	x	x	x	x	x
• Support the harm reduction agenda through		More extensive baseline assessment required - may require consideration as RPB priority.							x	x	x	x	x	x
○ Increasing coverage of needle and syringe programmes (291)	6. Safe response when in need > decreased delays	More extensive baseline assessment required - may require consideration as RPB priority.	x						x	x	x	x	x	x

○ Strengthen blood borne virus screening (291)	6. Safe response when in need > decreased delays	More extensive baseline assessment required - may require consideration as RPB priority.	x						x	x	x	x	x		
○ Continue to build partnership services to increase the provision of Take Home Naloxone (292)	4. More empowered workforce > effective integrated teams	More extensive baseline assessment required - may require consideration as RPB priority.	x						x	x	x	x	x		
Cardiff and the Vale of Glamorgan Local Authorities to:															
• Work together with housing providers to identify those at risk of homelessness, and enable people to remain in accommodation (293)	6. Safe response when in need > decreased delays	Partner-specific action.	x					x	x	x	x	x	x		
Cardiff and Vale University Health Board and Primary Care to:															
• Continue to develop mental health support provided alongside substance misuse support and treatment (293) to improve client outcomes	4. More empowered workforce > effective integrated teams	Partner-specific action.	x		x				x	x	x	x	x		
• Increase routine alcohol screening in Primary and Secondary Care to identify hazardous and harmful drinking behaviours	2. Increased living well in their own home and community > staying healthy and well	Partner-specific action.	x		x				x	x	x	x	x		
Secure Estate															
All agencies to:															
• Develop a culture of person-centred services, with increased voice for the person in prison	??? 7. Decreased avoidable harm or mortaility	More extensive baseline assessment required - may require consideration as RPB priority.	x		x				x	x	x	x	x		
• Adopt an ACE- or trauma-informed approach to support those with ACEs, and reduce the risk of children with ACEs becoming offenders	5. Better start for C&YP > reduced involvement with criminal justice system	More extensive baseline assessment required - may require consideration as RPB priority.	x		x	x				x	x		x		
• Consider the recommendations of the Cardiff Youth Justice Health Needs Assessment (95)	tbc	More extensive baseline assessment required - may require consideration as RPB priority.	x		x	?				x	x		x		
Prison health services to:															
• Develop healthcare registers of long term conditions, which will enable appropriate reviews and referrals in line with national best practice	4. More empowered workforce > right tools and equipment	Partner-specific action.	x	x	x				x	x	x	x	x		
• Primary mental health services to continue to build and develop existing services to manage the increased demand	6. Safe response when in need > decreased delays	Partner-specific action.	x	?	x				x	x	x	x	x		
Cardiff and Vale University Health Board to:															
• Develop systems which facilitate the sharing of health information from prison health services to primary and secondary health care providers	??? 4. More empowered workforce > right tools and equipment	Partner-specific action.							x	x	x	x	x		
Cardiff and the Vale of Glamorgan Local Authorities and housing providers to:															
• Strengthen Local Authority housing pathways to plan release from prison and facilitate transition from HMP Cardiff (and other establishments) to community settings	4. More empowered workforce > effective integrated teams	Partner-specific action.						x	x	x	x	x	x		
• Provide more suitable housing options which increase the chance of successful reintegration into the community and employment, and reduce the risk of re-offending	2. Increased living well in their own home and community > positive physical environment	Partner-specific action.						x	x	x	x	x	x		
Asylum Seekers and Refugees															
All agencies to:															
• Provide training and ongoing support for all professionals working with asylum seekers, refugees, and undocumented migrants to improve quality of service provision within a trauma informed approach. To include rights, signposting, and access to care, support, and translation services	4. More empowered workforce > right tools and equipment	More extensive baseline assessment required - may require consideration as RPB priority.	x		x				x	x	x	x	x		
• Improve data collection; for example, better data coding	??? 4. More empowered workforce > right tools and equipment	More extensive baseline assessment required - may require consideration as RPB priority.							x	x	x	x	x		
• Work towards co-location of health with other services such as mental health, benefits/ accommodation providers/third sector services for those who are most vulnerable, for example, destitute asylum seekers, undocumented migrants and those who moved in and out of the asylum system	4. More empowered workforce > right facilities AND effective integrated teams	More extensive baseline assessment required - may require consideration as RPB priority.	x		x				x	x	x	x	x		
• Multi-agency liaison; for example, dispersal linked to health and social services to improve continuity of care and support	4. More empowered workforce > effective integrated teams	More extensive baseline assessment required - may require consideration as RPB priority.	x	x	x				x	x	x	x	x		

• Facilitate integration and community cohesion (340)	2. Increased living well in their own home and community > increased positive relationships	More extensive baseline assessment required - may require consideration as RPB priority.			x				x	x	x	x	x	
○ Identify and build upon local community support for refugees and asylum seekers; which has been successful in other areas (340)	??? 2. Increased living well in their own home and community	More extensive baseline assessment required - may require consideration as RPB priority.	x		x				x	x	x	x	x	
○ Increase awareness amongst asylum seekers and refugees, including children and young people, of the language, culture, and heritage in Wales (340)	???	More extensive baseline assessment required - may require consideration as RPB priority.			x				x	x	x	x	x	
Cardiff and the Vale of Glamorgan Local Authorities and housing providers to:														
• Encourage landlords to rent to refugees through formal support providers (341)	2. Increased living well in their own home and community > positive physical environment	Partner-specific action.						x	x	x	x	x	x	
Cardiff and Vale University Health Board to:														
• Consider different models of primary care to overcome known barriers to healthcare, for example, walk in clinics; opportunistic provision of care such as screening, vaccination and contraceptive services for those service users who are the most vulnerable and despite flexibility, would continue to struggle to fit in to the current model of care, for example destitute or failed asylum seekers, undocumented migrants and those who move in and out of the asylum system	??? 4. More empowered workforce > effective integrated teams	Partner-specific action.	x						x	x	x	x	x	
Armed Forces Service Leavers (Veterans)														
All agencies to:														
• Consider the needs of veteran families, including children, of current and former armed forces service personnel	???	More extensive baseline assessment required - may require consideration as RPB priority.	x					x	x	x	x	x	x	
Ministry of Defence/ Armed Forces and Cardiff and the Vale of Glamorgan Local Authorities to:														
• Develop clearer pathways for veterans to support the transition into civilian life	6. Safe response when in need > decreased delays	Partner-specific action.	x		x				x	x	x	x	x	
• Consider development of a veterans ID card to give priority status to certain public services	6. Safe response when in need > decreased delays	Partner-specific action.			x				x	x	x	x	x	
Cardiff and Vale University Health Board to:														
• Await the outcome of the all Wales review into the Royal College of GPs' Veterans Friendly Practice accreditation programme and consider the recommendations	???	Partner-specific action.							x	x	x	x	x	
• Increase healthcare professionals' understanding of veterans' needs and priority status through, for example, Welsh Government promotional material designed for Primary Care (360), and continuing to strengthen links between healthcare staff and the Armed Forces Champions	??? 4. More empowered workforce > right tools and equipment	Partner-specific action.	x		x				x	x	x	x	x	

BWRDD PARTNERIAETH RHANBARTHOL CAERDYDD A'R FRO
CARDIFF & VALE REGIONAL PARTNERSHIP BOARD

Health & Social Care Regional Integration Fund

Starting Well Programme

DECHRAU'N DDA
STARTING WELL

Llywodraeth Cymru
Welsh Government

National Models of Care – Strategic Vision

Community-based care – Prevention and community coordination

The region endorses Welsh Government's commitment to community-based care with the following outcomes:

1) People's well-being needs are improved through accessing co-ordinated community-based solutions.
2) Local prevention and early intervention solutions support people to avoid escalation and crisis interventions.

In line with these aspirations, the Starting Well programme aims to deliver the following commitments for children and young people in Cardiff and the Vale of Glamorgan:

- Prevention and Wellbeing
- Access

Community-based care – complex care closer to home

Cardiff and Vale RPB support Welsh Government's commitment to community-based care by providing complex care close to home so that:

1) People are more involved in deciding where they live while receiving care and support
2) Complex care and support packages are better at meeting the needs of people and delivered at home or close to home

In line with these aspirations, the Starting Well programme aims to deliver the following commitments for children and young people in Cardiff and the Vale of Glamorgan:

- Prevention and Wellbeing (Complex health needs and disability)
- Access (Complex health needs and disability)
- Children and young people with complexity of need (Emotional wellbeing and mental health)

Promoting good emotional health and wellbeing

Our region is keen to ensure that:

1) People are better supported to take control over their own lives and well-being
2) People have improved skills, knowledge and confidence to be independent in recognising their own well-being needs

In line with these aspirations, the Starting Well programme aims to deliver the following commitments for children and young people in Cardiff and the Vale of Glamorgan:

- All project areas within the emotional wellbeing and mental health programme:
- Prevention and wellbeing
- Access
- Right support, right time, right person
- Complex care for children and young people

Preventing children entering care and supporting children to remain with their families

Our region is committed to ensuring:

1) Families get better support to help them stay together

2) Therapeutic support improves and enhances the well-being of care experienced children

In line with these aspirations, the Starting Well programme aims to deliver the following for children and young people in Cardiff and the Vale of Glamorgan, to support emotional wellbeing and mental health and children and young people with complex illness and disability:

- Access
- Right support, right time, right person

Home from hospital

Our region is committed to ensuring that:

- People go home from hospital in a timelier manner with the necessary support in place at discharge
- People have a better understanding of the discharge process and are more involved in pre and post discharge planning

In line with these aspirations, the Starting Well programme aims to deliver the following for children and young people in Cardiff and the Vale of Glamorgan with complex illness and disability:

- Access
- Right support, right time, right person

The following project from both programmes:

- Complex care for children and young people

Accommodation based solutions

Cardiff and the Vale region will ensure that:

1) People are more involved in the design of accommodation to meet their needs
2) People have more choice about where they live and with whom

In line with these aspirations, the Starting Well programme aims to deliver the following commitments for children and young people in Cardiff and the Vale of Glamorgan:

- Complex care for children and young people

Programme title

Cardiff and Vale of Glamorgan Starting Well Programme

Priority Models of Care for the programme

Priority model of care	Select	DAP*
Community-based care – Prevention and community coordination	Yes	No
Community-based care – complex care closer to home	Yes	No
Promoting good emotional health and wellbeing	Yes	No
Preventing children entering care and supporting children to remain with their families	Yes	No
Home from hospital	Yes	No
Accommodation based solutions	Yes	No

Programme - Executive summary

The Cardiff and Vale of Glamorgan Starting Well Partnership is the main delivery vehicle for delivering partnership priorities for infants, children and young people and their families and carers across the region. This partnership has evolved following a comprehensive review of governance arrangements for our RPB to ensure that, as partners, we are well placed to deliver against key priorities for this group of our population.

The SWP is one of three new programme delivery partnerships which will enable the RPB to give particular focus to improving outcomes for people at different stages in their lives.

It has taken forward a number of existing priorities within our previous children and young people's partnership, in addition to setting out the wider ambition of transforming the way services are delivered for infants, children and young people.

Previously, the Regional Partnership Board has established a number of key service innovations utilising the Integrated Care Fund (ICF) and Transformation Fund with a view to improving the lives of infants, children and young people, specifically:

- Embedding Family Group Conferencing
- Delivering regional and integrated services to young people on the edge of care
- Embedding a framework and delivering services and support that work towards reunification and reduction of children and young people within the care system, with support to families to maintain caring responsibilities
- Integrating assessment and planning processes for children and young people with disabilities and multiple health needs
- Strengthening transition support across child and adult services for young people with ALN
- Embedding psychological approaches to supporting children and young people with learning disabilities
- Strengthening access points to services with specialist skills to enable timely referrals (Mental Health/Disability)
- Targeted support to enable successful transitions for young people with neurodiversity
- Support for families with children with neurodiversity and ADHD
- Psychology services and in reach to develop resilience within schools for children and young people with emotional and well-being needs

The end of the ICF and Transformation Funds, combined with the introduction of the new Regional Integration Fund has allowed us to undertake a thorough overhaul of all previous service delivery investment against these newly agreed aspirations and the six national care models. This has resulted in a new programme where the outcomes of those initial workstreams have been re-aligned to form a foundation for the next phase in innovative service development for infants, children and young people and their families and carers. Over the next 5 years, the Starting Well programme will deliver:

i. Strengthening preventative and universal services to respond to need within locality and neighbourhoods
ii. Joining up access points to services to deliver a No Wrong Door
iii. Ensuring services are available at the right time, in the right place and delivered by the right person through embedding the NEST/NYTH approach
iv. Responding collectively to provide solutions that are required to support infants, children and young people who present with complex issues/multiple needs that require a partnership response.
v. Providing an integrated response to infants, children and young people with disabilities and illness where additional complexities require a partnership response.

A schematic demonstrating the links between this programme and the respective models of care outlined within the RIF guidance is provided at Annex A. Further explanatory detail showing the links between the Starting Well programme and the national models is provided in section 1 of this document.

Programme - Business case

Aims and Objectives

Over the next 5 years, the Starting Well programme will deliver two major programmes of work for infants, children, young people, families and carers under the following programme headings.

- Emotional wellbeing and mental health
- Children and young people with complex health and disability

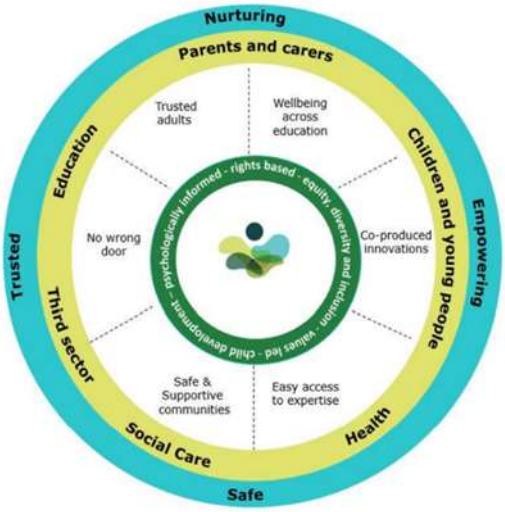
Both programmes have an emphasis on a community-based wellness model of support for all infants, children and young people that is facilitated and delivered by an integrated, seamless system.

Each programme is set out into 4 projects to take forward the following:

- Prevention and wellbeing - focussed on improving preventative and universal services in meeting the needs of the population of children and young people as needs arise, reducing the need for referrals into services where needs can be met within local services and within people's neighbourhoods
- Access – focussed on ensuring that people reach the right place when asking for help. This project will deliver the Cardiff and Vale of Glamorgan 'No Wrong Door' and streamline access points into services when people ask for help
- Right support, right time, right person- focussed on ensuring services are equipped to respond to need and to 'hold on' and continue to support young people instead of 'referring on'. This will include the development of support to embed the trusted adult approach across services, and the additional workforce development required to build a resilient workforce in supporting young people.
- Complex care for children and young people – focused on addressing the service delivery gaps for children and young people who require a multiagency response or specialist approach, ensuring provision is available across the region for those young people who are at risk of placement breakdown or entering care.

These key areas will be supported through 2 further enabler projects & the implementation of the NEST/NYTH framework:

i. Workforce development and training to include trauma informed approaches and positive behaviour support
ii. Digital Care Region programme.



The programme seeks to embed previous projects funded through the ICF and transformation as a foundation of the new programme of works outlined. This can be shown in the two programme plans below:

Starting Well Programme Map 22-23:

Prog 1: Emotional wellbeing and mental health programme

	Prevention & wellbeing: keep infants, children, young people and their families well and independent in the first place	Access: Access to support and help that is simple, proportionate and timely. Simplifying access across services. National priority	**Right Support, Right Time, Right Person, Right Reach** (integrated, locality-based care model).	**Children & young people with a complexity of need**
Project	CLD10 Parents with LD (beneficiaries are CYP at risk of entering care) CLD2.1 Family First Advice line enhancement to enable signposting for ALN	CRP1 Early Help Plus: (missing middle). T6 Resilience access in schools which will move to delivery the WSA via CAMHS in-reach.	CR1 Family group conferencing CR4.1 Re-unification Vale CR4.2 Re-unification Cardiff	CR2 ARC (step down) CR3 EnFys -
Embedding	i. NO practitioners at front door to strengthen Early Help Plus ii. ii. Develop Thinking Together (psych-led) across region into Vale. (CH Charity Application – Social prescribing confirmed as a matched contribution to the programme)		Care navigation across EWB/MH system. Expansion of CAMHS parent support worker function ii. Developing and testing locality-based integrated care model iii Phase 2: delivery elements of the EHWB programmes Digital care region: shared digital record as a programme enabler	
Accelerating		i. Growth of Early Help Plus: EWB practitioner ii. Enhanced and integrated web-based resource building on CVUHB website & apps to support engagement iii. NEST gaps: to be defined. Iv. Transition support development (spans into Living Well). 16-25 group.		i. Joint Recovery Service (safe accommodation): ii. Integrated assessment and care planning (joint safety plan roll-out). iii Develop respite element of Adolescent Resource Centre (foster-related). iv Capital resource to support accommodation of staff in delivery of service model

Multi-Agency Learning (enabler workstream for CYP MH - links to workforce development and integration and culture shift. Includes development of trusted adult role as part of NEST)

Trauma informed approaches

NEST across the ages (up to 25)

Embedding approaches for range of needs across the system.

Digital Care Region programme e.g apps, webs, shared care records etc, WSA and info sharing across systems at front door

Prog mgt

Programme delivery capacity:
Consultant project manager;
Project Manager 1.0 B7
Starting Well Prog Manager 0.8 1.0 B5/G6 Starting Well outcome monitoring officer

Releasing leadership capacity:
Project manager B6 CVUHB 1.0
Strategic lead 3 mth PYE – Cardiff
Strategic lead- Vale 1.0

This programme map outlines the 4 projects within the programme for all children and young people, and the additional areas of development for children with disabilities and illness.

The Emotional wellbeing and mental health programme is a wellness model approach to mental health and wellbeing that ensures a wider scope of coverage from prevention through to specialist support.

This programme is built on the principles and practice outlined within the NEST/NYTH framework across the whole system with coproduction and infants, children and young people at the centre.

The children and young people with complex illness and disability programme covers the *additional* focussed areas of priority which are specific to this area. These includes interface with the programme for people with learning disabilities but also seeks to embed an inclusive ethos across the Starting Well Programme.

Links between the Starting Well programme and associated national models of care are articulated clearly within section 1 of this document and also in Annex A.

Baseline Position

The Cardiff and Vale population needs assessment references the population needs and assets in place for infants, children and young people within the children and young people and the learning disability section

A refresh of the Cardiff and Vale PNA conducted in 2021/22 has highlighted these additional areas of focus:

- Adopt the NEST/NYTH framework and No Wrong door
- Strengthen information and opportunities for co-production
- Monitor the impact of Long COVID 19 on children and young people
- Delivery of the Whole School Approach
- Continue to strengthen preventative and universal services, including parental support
- Further invest into mental health services for young people up to 25 years
- Reduce waiting times in mental health services
- Embed an integrated model for delivering emotional health and well-being services

- Develop an integrated working model to promote seamless transition between services, including actions to be taken when children go missing from care, and interaction with the criminal justice system
- Develop additional placements close to home for children and young people

Reflections on the impact of COVID 19 are captured within the refreshed PNA, with an increase in infants, children and young people and their families and carers seeking additional support with emotional health and well-being needs. Also noted are the existing challenges of waiting lists, national staff shortages and COVID 19, and the impact these have had on the direct delivery of support for young people with emerging and complex mental health needs.

Schools across the region are projecting a population increase, in particular within additional learning needs and the growth in numbers of children and young people with ALN requiring a placement within a specialist provision.

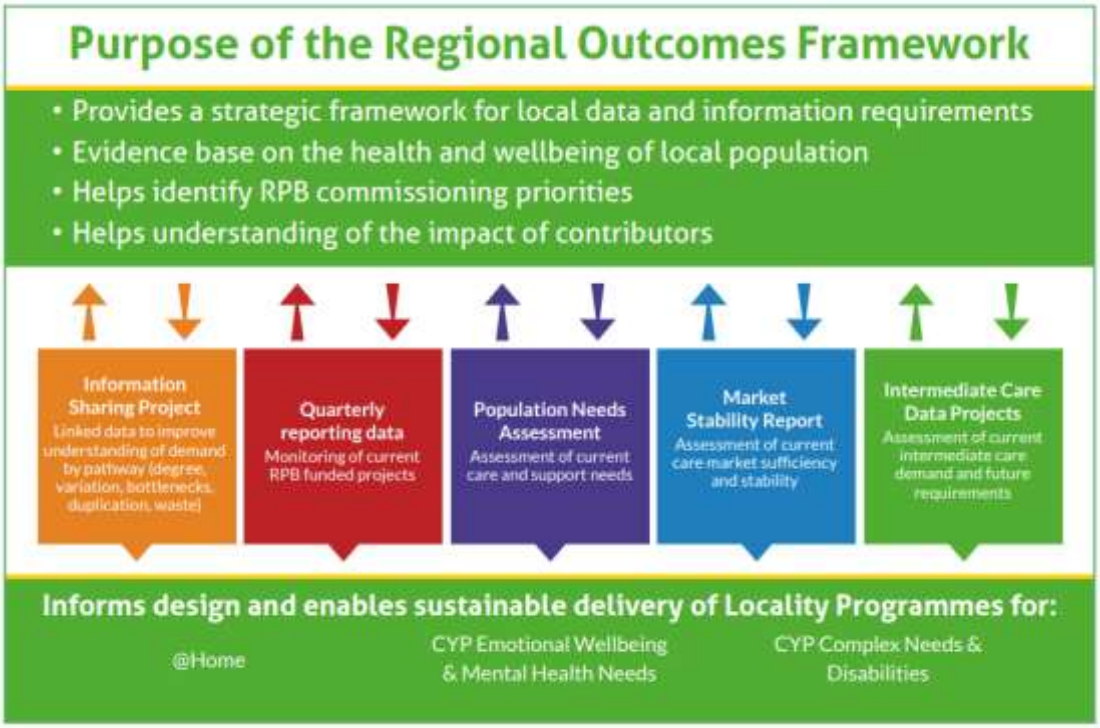
Cardiff and the Vale of Glamorgan have both seen increases in numbers of children looked after and registrations on the child protection register, with the continued challenge of limited placements and availability and the ongoing reliance on out of area placements in meeting needs.

Benefits Realisation:

Cardiff and Vale Regional Partnership Board has a Regional Outcomes Framework (ROF) to which all our outcomes regionally align and that also articulate what we want to achieve for the whole population which includes infants, children and young people and their families/carers. Those outcomes are:

- Reduced wasted system resource
- Increased time for people to live their lives
- Increased living well in their own home and community
- Improved environment that enables people's choices
- Better start for children and young people
- Decreased avoidable harm or mortality
- People get a safe response when in urgent need
- More empowered workforce.

The ROF has been developed over a period of years and is currently being used to chart progress against these outcomes for adults only. Over the next year, it is the intention to introduce data charting outcomes for other priority population groups including infants, children and young people.



At an operational level, the region has positive experience of utilising Results Based Accountability to measure key performance outcomes for individual projects. This has enabled projects to demonstrate proof of concept and attract sustainable resources where outcomes monitoring has evidenced positive change. There are a number of examples of this within the Starting Well Programme. This methodology will continue to be utilised in the formation and delivery of all projects across the RIF programme portfolio. Qualitative information will be gathered via our Engagement Delivery Framework outlined within the Strategic Plan in addition to our work with the social value sector and stakeholder forums within the Starting Well Programme.

Additionally, each of our projects is focussed on delivering capability which will improve the lives of infants, children, young people and their families and contribute to the following key quantifiable metrics which will indicate whether benefits are being realised:

- Reducing the numbers of children looked after
- Reducing the waiting times for access to services
- Reducing the number of delayed transfers of care for children and young people

Plans for sustainability:

This programme is a key priority for the Regional Partnership Board's Starting Well Partnership which has already agreed the proposed overall delivery plan. Partners have already demonstrated their commitment to the Starting Well programme through the provision of match resources to support its work in 2022-23 as outlined in the project briefs below. The region has initiated work to develop a Memorandum of Understanding, completion of which will set a clear commitment to working collaboratively across the partnership to support the RIF aims and objectives. We are working with the Health Board Director of Finance and Local Authority Section 151 Officers to develop our roadmap for the ongoing development of sustainable funding streams over the remaining 4 years and how we work with Welsh Government to taper the match funding of resource requirements.

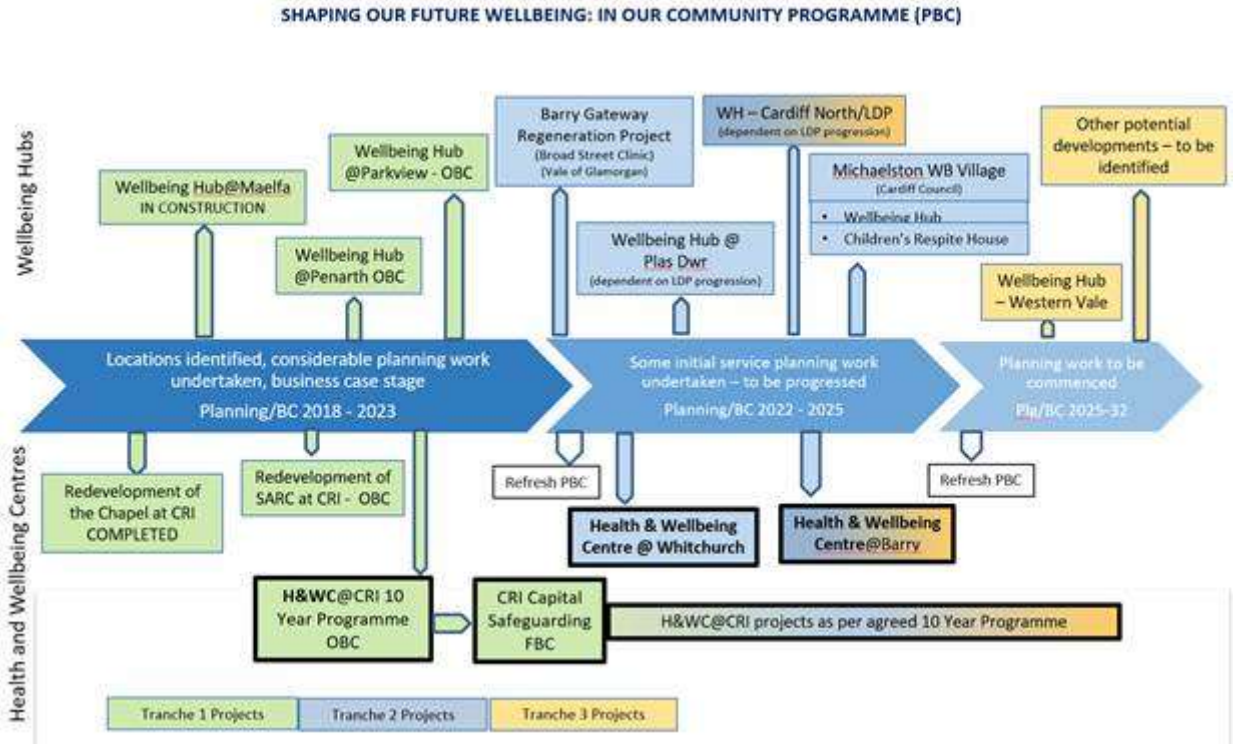
Our programmes will bring together the legacy ICF / Transformation Fund projects, triangulating them with core funded services that align to our programmes and accelerated services to deliver our programme aspirations and contribute to the development of the six national care models. By taking this approach we will be able to use the RIF to transform our core services.

Programme - Key enablers

Select which of the key enablers will maximise the delivery of the programme, using the free text box to describe how this will be achieved.

Key Enablers	Select
Integrated planning and commissioning	
Integrated planning and commissioning are fundamental to the delivery of all programmes within the RIF programme portfolio. The Starting Well programme enables partners to work together to take forward jointly agreed priorities for this population through a centrally provided management structure which works alongside operational teams to design, support and deliver new ways of working. This ongoing commitment to integrated planning will be informed by the findings of the region-wide Population Needs Assessment and the Market Stability Report which are under development currently. The Starting Well programme is also contributing to a region-wide exercise which will identify shared capital development priorities in preparation for emerging capital funding provision in 2022 onwards. We will work with the Cardiff and Vale Regional Commissioning Board to ensure there is an equitable approach to integrated planning and commissioning across projects. The region is committed to developing opportunities for integrated commissioning. In relation to the Starting Well programme, this is particularly relevant for the following project: Safe Accommodation: a Joint Recovery Service for children and young people requiring wraparound support. This is a new service which will provide an integrated response to young people requiring support to be safely discharged from hospital following an episode of emotional distress.	✓

Technology enabled care	
This is an enabler for the whole Starting Well programme. The digital infrastructure is fundamental to the delivery of all programmes within the RIF programme portfolio. Specific investment in this area will be sought via the Digital Care Region improvement programme to take forward a prioritised delivery plan. This will enable delivery of shared care records to reduce the duplication across the system and embedding a 'tell us once' approach to improve the experience of children, young people and their families.	✓
Promoting the social value sector	
The social value sector is fundamental to the delivery of all programmes within the RIF programme portfolio. All partner organisations have existing and ongoing relationships with the third sector who provide a range of services across the region and this programme builds on this. The social value sector plays a key role in the Starting Well Programme with representatives from Llamau and Barnardo's on the Starting Well Partnership board and programme delivery arrangements. A stakeholder engagement group is being established within the Emotional Health and Well Being programme to enable a wider reach of engagement for the social value sector. This will include both the delivery of the programme and embedding approaches for infants, children and young people in the implementation of the NEST/NYTH framework Promoting the social value sector is particularly relevant in the following projects: • Family group conferencing – third sector delivery working in partnership with local authorities to enable families to reach solutions through facilitation • Safe Families – third sector approach to providing family based short breaks • Vale Family Support Service – match funded service which has added value to provide additional support to those families in need of additional support to enable re-unification • Young Carers (see Carers programme) The Starting Well programme is committed to supporting that 20% of the overall RIF is utilised to promote social value.	✓
Integrated community hubs	
The development of integrated community hubs will be led by the @Home programme utilising capital funding to complete feasibility plans by early 2023. All priority groups within the RIF programme portfolio will be able to make use of these hubs upon their completion. The Health Board's *Shaping our Future Wellbeing: In our Community* (SOFW:IOC) programme business case has been developed with partners and was endorsed by Welsh Government (2019) and the subsequent capital business cases and WG investment seeks to support the development and reconfiguration of community infrastructure to create a network of Locality Health and Wellbeing Centres (H&WCs) and smaller cluster-based Wellbeing Hubs (WHs) across Cardiff and Vale that support the above objective. The overall vision is summarised in the diagram below with the work driven through both the @Home programme and the SOFW:IOC delivery board	✓



Planning work commissioned in the last quarter of 2021/22 with the use of ICF capital funding will inform the development of the proposals for the Barry Health and Wellbeing Centre/hospital, the new H&WBC for the North Cardiff locality and the opportunities created through the development of Michaelson Wellbeing Village which may have a particular focus on services for children and young people. There is a very pressing need to develop the plans for primary and community services in North Cardiff because of the speed at which housing developments are progressing in the area.

Workforce development and integration

Workforce and organisational development is fundamental to the delivery of all programmes within the RIF programme portfolio. Specific investment in a Workforce and OD specialist will be included within the Partnership Support plans as part of our acceleration proposal.

✓

Programme - Priority population groups

Select both the primary and secondary beneficiaries of the programme by priority population group, using the free text box to describe the particular impacts this will have. Please also indicate if the beneficiaries are supported using DAP funding.

Priority population groups	Primary	Secondary	DAP
Older people including people with dementia			
Children and young people with complex needs	✓		
To provide a system-wide approach to all infants, children and young people with a range of needs which present as complex and require a multi-agency and multi-system response to enable a seamless and integrated approach to care delivery.			
People with learning disabilities and neurodevelopmental conditions including autism*	✓	✓	
To provide a system-wide approach to all infants, children and young people which is *inclusive* of learning disabilities and neurodevelopmental conditions and neurodiversity. To embed an integrated care model across partners for infants, children and young people with disabilities and complex health needs, including learning disability.			
Unpaid carers*	✓	✓	
To provide support to parents and siblings of infants, children and young people who require care and support - Also see separate Carers Programme.			
People with emotional and mental health wellbeing needs	✓	✓	
To provide a system-wide approach to infants, children and young people who have or may develop emotional and mental health wellbeing needs. To embed an integrated care model across partners for infants, children and young people with emotion health, wellbeing and mental health needs			

Other beneficiaries

If there are other stakeholders benefiting from the programme, please provide this detail below.

Parents, paid carers and siblings - where support for parental well-being requires dovetailing with the support required for children and young people by taking a holistic, systems approach to assessing and meeting needs. For example, addressing sources of parental trauma which may have a positive impact on the trauma informed delivery of services for young people.

Total programme cost and match funding projection

Provide a breakdown of the total programme cost, Welsh Government contribution, partner monetary and resource match including costs attributed to support unpaid carers and / or social value sector delivery. You can find more information on match funding in the guidance notes.

Total cost of Programme	Welsh Government contribution	Partner match monetary	Partner match resource	% support for unpaid carers	% for social value sector delivery
£ 3.511m	£ 2.458m	£0	£ 1.053m	2%	19%

Its current contribution within the embedding fund equates to an overall total of and this will be further expanded where possible through the use of acceleration funding.

Programme resource and management details

Provide a summary of the planned resource and roles required to deliver this specific programme. These roles are 100% funded via the RIF and will accounted for within the allocated fund.

Posts / type of roles	Estimated FTE	Costs
Starting Well Programme Delivery capacity	1.8	
EMHWB Improvement and Development Manager	1.0	
CWD Improvement and Development Manager	1.0	
Administrative support Band 4	1.0	
	Total	£0.294m
Releasing leadership capacity - Vale	1.0	
Releasing leadership capacity - Cardiff	1.0	
Releasing leadership capacity - UHB	1.0	
	Total	£0.134m
		£0.428m

Project plans

In this section, outline each project that will contribute towards the successful delivery of the associated National Models of Care. For the purposes of the investment proposal you will need to provide:

- Information on all sections within the table below.
- Repeat the table for each project being put forward.
- Indicate if the project will be delivered using DAP funding in the summary.
- For Dementia project, outline which strand the project relates to DAP or Memory Assessment Services/Diagnostic Support in the summary.

Title of project to support model of care (programme)

Prevention and wellbeing

Models of care the project will contribute towards

- Promoting good emotional health and well-being
- Community-based care – prevention and community coordination

Project Summary

This project focusses on prevention and early approaches to supporting infants, children and young people and their families within their communities and neighbourhoods. The intention is to enable universal services to be able to meet needs as they arise, and 'hold on' to the children and young people they work with. We will develop further 'Thinking together' conversations which bring together multi-agency practitioners to find solutions and move forward without the need to 'scattergun' refer into multiple services and feel confident when they do need to refer on.

This programme starts with a wellness model where prevention and wellbeing activity happens in communities for all infants, children and young people and entry to statutory services is only in a response to need that cannot be managed in a community setting. This will help the region to implement the principles of the NEST Framework, including the development of trusted adult roles who are supported to "hold on" to an infant, child or young person they work with, rather than refer on to other services.

This will mean that children and families will experience a shift from a service-led model to an integrated system that wraps around the individual, like a nest wraps around a bird.

Within this project, the focus remains on community-based care and coordination of assets to prevent the need for additional support where needs can be met within the community.

Focussed mental health workers and neurodevelopment practitioners will be hosted within our early help services to reduce the need for referral into specialist services and encourage early conversations as needs emerge. This triage approach is hoped to reduce referrals where these are not needed and strengthen the workforce supporting people within their neighbourhoods. Where referrals are required, these will be strengthened through access to these workers and knowledge with referrals reaching the right place at the right time.

Since 2018, over 560 families have been supported through the Families First Advice Line (FFAL). Since 2019 over 250 multi agency, psychology-led thinking together conversations have supported solutions for young people.

Impact of these further developments would be measured through qualitative information gathering through our engagement framework with children and young people and families. In addition, using RBA the programme

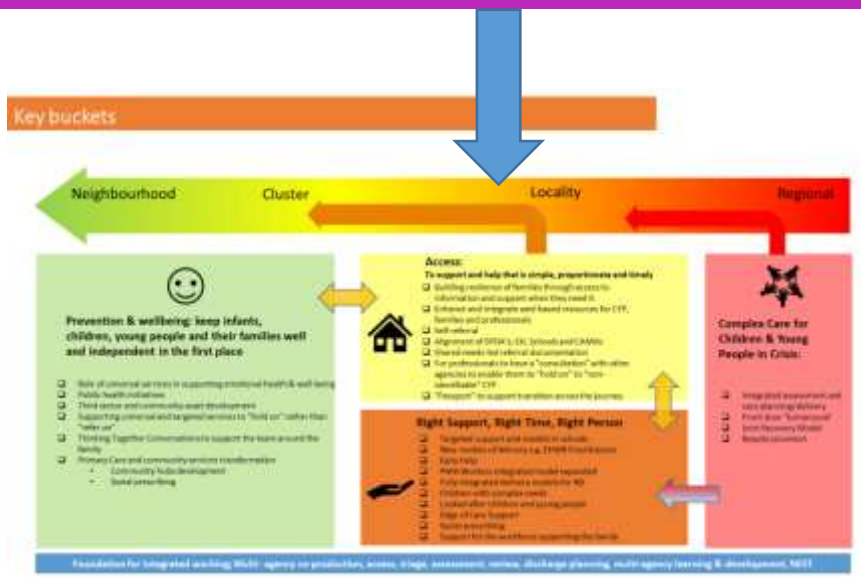
would continue to measure demand across service areas to ensure preventative services are resourced to meet need as it arises.

The partnership brings an additional social prescribing project into this workstream through recently obtained Health Charity resources and also has a number of third sector providers working with leads to secure future opportunities through big lottery funding.

Priority population group
People with emotional and mental health wellbeing needs Children and young people with complex needs People with learning disabilities, neurodiverse and neurodevelopmental conditions including autism Unpaid carers
Key enablers
All five enablers will support delivery in this area
New or existing investment
Combination of new and existing investment
Estimated total cost
£0.183m

Start date (show phases if possible)	**Describe Phases.**
01.04.2022 All embedding elements have already commenced	Embedding projects will build on existing delivery

Title of project to support model of care (programme)
No Wrong Door
Models of care the project will contribute towards
Community-based care – prevention and community coordination [Community-based care – complex care closer to home] Promoting good emotional health and well-being (EH&WB)
Project Summary



Cardiff and the Vale of Glamorgan are committed to delivering a No Wrong Door for children and young people. To help us in delivering our message of how our services will work to deliver a no wrong door, the following video has been developed with young people. This demonstrates the core fundamentals of this project area within this programme of work:
English - https://youtu.be/5zicHSQ4vzQ
Welsh - https://youtu.be/WWwAO0ANCro

Previous models of support that were funded through ICF and Transformation grants worked to improve access to early help services. Projects such as the resilience project and early help plus piloted additional capacity at key points in the system to highlight the benefits of a no wrong door approach for children and young people.

Resilience Project Press Release Aug 20

Since commencing in 2019, these projects were successful. There have been clear benefits to colocation of teams and integrated ways of working that has supported the development of a team around the worker approach which has been identified as good practice in the Cardiff and the Vale of Glamorgan implementation of the NEST Framework.

This project aims to build on the successes achieved and spread and scale this way of working across organisations, building capacity and resilience within the system to enable young people to reach the right service regardless of where they ask for help from. We also want to ensure that emotional mental health and wellbeing information for infants, children, young people and families is easily accessible and that the region is addressing any gaps identified through our implementation of the NEST Framework.

Working in this way will mean that all children, young people and families who move towards services for additional support experience a joined-up system that wraps around them and their needs. They will also be empowered to easily access good quality information on emotional wellbeing in a central location.

The anticipated outcomes of working in this way will be:

- Better start for children and young people
- Increased time for people to live their lives
- Increased living well in their own home and community
- Improved environment that enables people's choices
- More empowered workforce.
- Reduced wasted system resource

New developments within this project will align to key areas of focus within the NEST Framework.
Cardiff and the Vale of Glamorgan has developed an engagement framework. We are building on this to create links with the social value sector to support us to engage with infants, children, young people and their families. We will use these links to coproduce positive change across the Starting Well programme and ensure that people's voices are central to planning and decisions. Our approach to engagement is illustrated here:

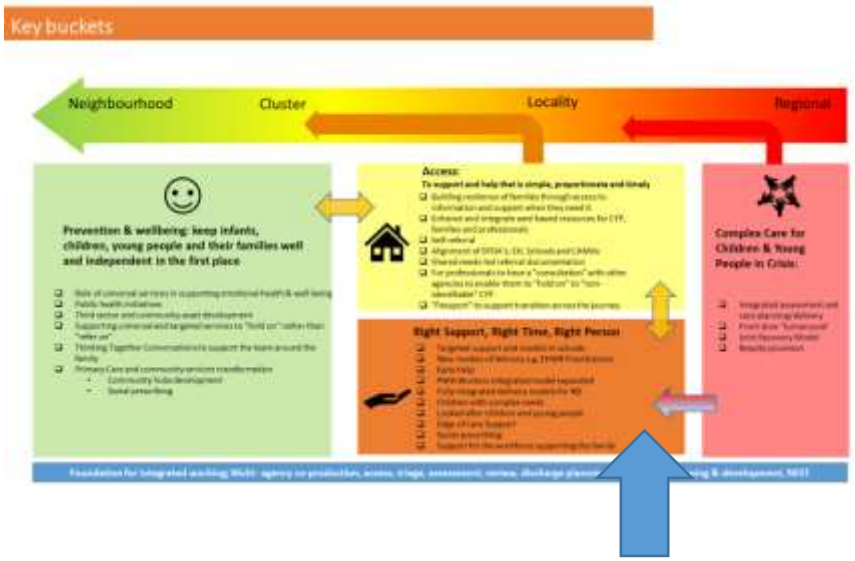
We will ensure expertise is easy to access for infants, children, young people and their families through joint working with digital enablers to scale existing web-based resources and to create new access routes, including through the development of apps.

We will use these to strengthen referral pathways and to initiate a move towards a self-referral approach across the system that empowers children, young people and their families to access the support they want, how they want and when they want.

Priority population group
People with emotional and mental health wellbeing needs Children and young people with complex needs People with learning disabilities, neurodiverse and neurodevelopmental conditions including autism Unpaid carers
Key enablers
All five enablers will support delivery in this area
New or existing investment
Combination of new and existing investment
Estimated total cost
£0.295m

Start date (show phases if possible)	**Describe Phases.**
01.04.2022 All embedding elements have already commenced	Embedding projects will build on existing delivery

Title of project to support model of care (programme)
Right support, right time, right person
Models of care the project will contribute towards
Promoting good emotional health and well-being (EH&WB) Supporting families to stay together safely, and therapeutic support for care experienced children
Project Summary



This project focusses on ensuring the right support can be accessed, when it is needed, and delivered by the right person. This project builds on the successes of regional approaches to keeping families, who were in or on the edge of the care system, together through regionally commissioned services and roll-out of shared models with localised delivery methods.

COVID 19 has had a significant impact on the delivery methods in supporting families, with a move to supporting families through change that was unplanned for at the outset of project. It has been a challenge to fully understand the impact due to changing family need, impact of school closures and online learning and reprioritisation of resources. Mobilising a skilled workforce during this time has been equally challenging, with limitations in the availability of time to train staff, or the ability to bring groups of staff together.
Where outcomes have been captured, these give a strong message. Numbers of children have been reunified with families, family group conferences have yielded family-based solutions and drawing on community assets through the introduction of community conferencing.

Since 2019, 430 children, young people and families that have received support to empower family networks to identify and resolve issues and by working to reunify children with families wherever possible.
This project builds on these approaches to implement an integrated locality-based care model that will become fully amalgamated across the partnership within the next five years. This will include a range of skilled staff that will work across the exiting systems in place, creating links across services and removing barriers to joint ways of working. We will build on the success of introducing a social worker within CAMHS by regionalising and embedding a workforce that can support a wider range of needs. Alongside this, additional social work assistants that can support families to understand and care for their children with neurodiversity and disabilities, supporting to build resilience within family units and reduce the risk of family breakdown through implementation of positive behaviour support.

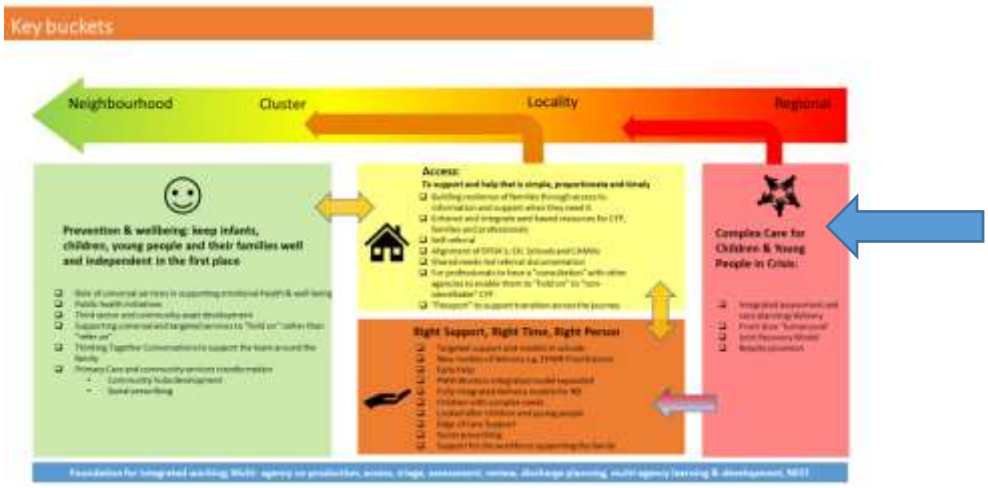
This project will deliver a consistent care model that will mean that families will receive an equitable, person-centred approach across the region by developing and testing locality-based integrated care models.

We anticipate the following outcomes:

- Increased living well in their own home and community
- Improved environment that enables people's choices
- Better start for children and young people
- Decreased avoidable harm or mortality
- People get a safe response when in urgent need
- More empowered workforce.

Priority population group	
People with emotional and mental health wellbeing needs Children and young people with complex needs People with learning disabilities, neurodiverse and neurodevelopmental conditions including autism Unpaid carers	
Key enablers	
All five enablers will support delivery in this area	
New or existing investment	
Combination of new and existing investment	
Estimated total cost	
£1.310m	
Start date (show phases if possible)	**Describe Phases.**
01.04.2022 All embedding elements have already commenced	Embedding projects will build on existing delivery

Title of project to support model of care (programme)
Complex Care for Children and young people (Edge of/In Care/Placement breakdown)
Models of care the project will contribute towards
Promoting good emotional health and well-being Community-based care – complex care closer to home Home from hospital Supporting families to stay together safely, and therapeutic support for care experienced children Accommodation based solutions
Project Summary



This project aims to support children and young people who require support that is specialist when other arrangements have not been able to meet needs.

The existing project has delivered the 'ARC' service for children and young people on the edge of care, providing a regional option to supporting people within their communities who would have previously required a short-term placement during times of crisis/placement breakdown. Since 2019, this service has supported over 150 young people to remain within their family/community through a community-based wrap around support mechanism for families and young people. The intention is to strengthen this service, building therapeutic support into the delivery methods and access to direct therapeutic sessions for individual young people.

This project has also seen the development and expansion of therapeutically led services for children in care and who are adopted. The Enfys service supports children and young people to remain within placements, reducing the number of placement 'move ons' and enabling children and young people to remain within their home safely, whilst developing resilient care workers who become a young person's 'trusted adult'. Adopting a trauma informed approach, this service has provided direct support to over 100 young people and offered therapeutic consultation to practitioners supporting over 200 young people and families since 2019.

This model of support directly informs the programme of work supporting the Cardiff and Vale Safe Accommodation project which aligns therapeutic approaches across accommodation solutions and within community services for children who present with a range of complex needs.

COVID 19 has highlighted gaps in the region's response to the specific support needs of some children and young people, in particular the ability to meet the needs of children and young people who present in distress to

emergency services, and require support to return home. In some instances, young people remain in hospital in the absence of local provisions that can manage high risk, responding to high levels of emotional distress.
This project seeks to align psychological approaches across our specialist support offers. This will provide consistency in the therapeutic response young people can expect and facilitate easy transition between any services young people may engage with. This will enable the system response needed to move young people back toward universal models of support from specialist wherever possible as part of a wellness model approach to emotional mental health and wellbeing.

We want to enable as many children, young people and families as possible to be supported in-region through additional capacity in the services that have already demonstrated positive outcomes and through the creation of local support offers for complex needs and specialist respite that prevents family breakdown.

The outcomes related to this project include:

- Reduced wasted system resource
- Increased time for people to live their lives
- Increased living well in their own home and community
- Improved environment that enables people's choices
- Better start for children and young people
- Decreased avoidable harm or mortality
- People get a safe response when in urgent need
- More empowered workforce.

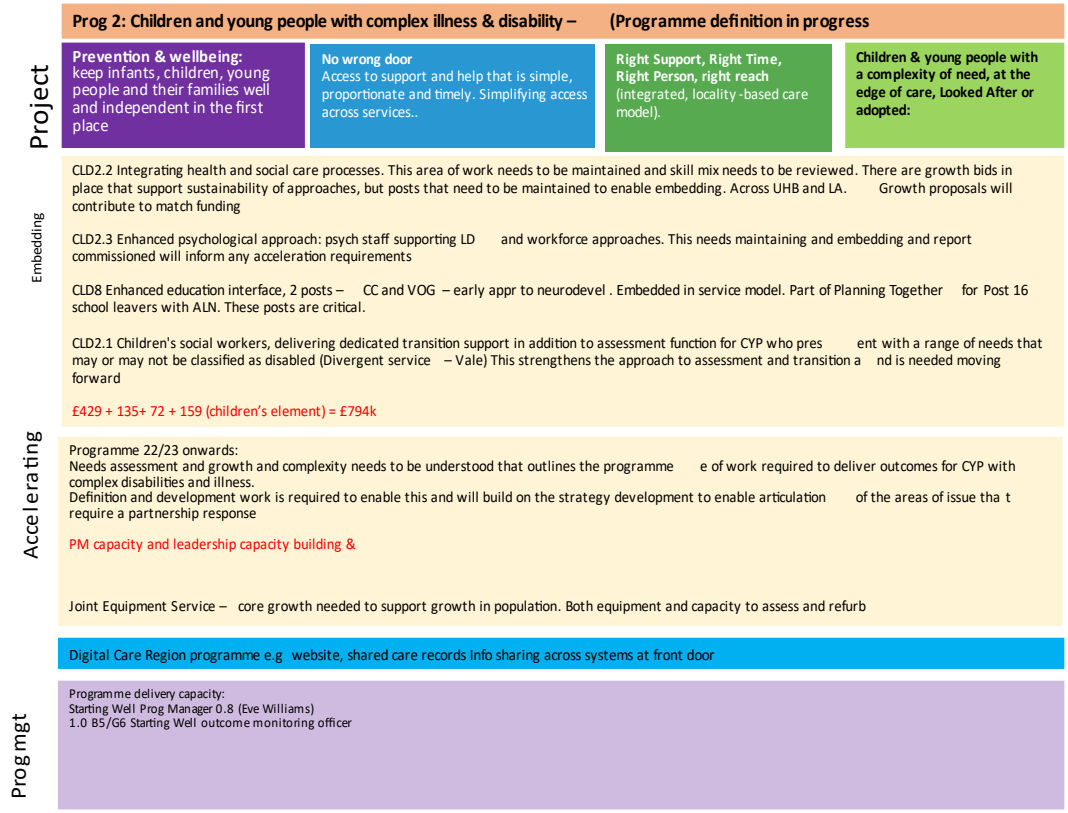
Details to follow on acceleration projects that will deliver the complete programme, including any that align to the capital plan.

Priority population group
People with emotional and mental health wellbeing needs Children and young people with complex needs Unpaid carers
Key enablers
All five enablers will support delivery in this area
New or existing investment
Combination of new and existing investment
Estimated total cost
£0.778m Capital resource – accommodation solutions and housing a workforce

Start date (show phases if possible)	**Describe Phases.**
01.04.2022 All embedding elements have already commenced	Embedding projects will build on existing delivery

Title of project to support model of care (programme)
Children with Complex Health Needs and Disabilities
Models of care the project will contribute towards
Community-based care – complex care closer to home Supporting families to stay together safely, and therapeutic support for care experienced children Community-based care – prevention and community coordination
Project Summary
Across the Starting Well Programme, Children with Complex Health needs and Disabilities are seen as children first and where outlined are included within the programme of works supporting emotional health and well-being. This project outlines the developments that are specific to delivering outcomes to CYP where disability is the main presenting need. ICF has previously supported an enhanced approach to transition, development of integrated processes for those with complex health needs and increased psychological support to CYP with learning disabilities. The aim of these projects was to improve access to care and support in a timely way and reduce duplication in assessment and care planning. A number of projects have been embedded across the partnership where these have proved successful, including additional support at first point of contact and supporting early intervention. A number of new processes have been embedded across systems which has improved the access and experience of CYP and their families. We have developed a strategy, coproduced with CYP, families and stakeholders which is in draft form but sets out partnership principles and priorities to address. These projects have seen improved outcomes for CYP, such as access to blended diets and enhanced local provisions to enable them to remain close to home. So far, the programme of support has reached in excess of 850 additional children, young people and young adults with disabilities across the life span of ICF. We are seeking to build on these successes by embedding further the additional workforce than enables delivery of 'Planning for my Future' a regional transition protocol launched in March 2022. This includes the workforce that supports planning for young people requiring support into adulthood, including embedding person-centred approaches. We also seek to embed further psychological and therapeutic approaches that are specific to children with disabilities through the continuation of PBS and additional psychology services which support families to build resilience. We plan to maintain and expand through match funding, the integrating health and social care work through the recruitment of additional nurses and social workers to enable early access to assessment and services where these are needed. This will enable CYP to receive support at the right time, in the right place. We will continue to embed approaches across education settings for CYP on the neurodevelopmental pathway, with a particular focus on supporting CYP through transition into adulthood. This will provide earlier planning and support for CYP who do not require ongoing support from adult services but who may need support transitioning into college. We will be seeking to confirm the strategy for CYP with disabilities and will seek to accelerate a development piece which enables partners to articulate future priorities that require a partnership response in delivering this.

DRAFT Starting Well Programme Map 22-23:



Priority population group

Children and young people with complex needs
People with learning disabilities, neurodiverse and neurodevelopmental conditions including autism
Unpaid carers

Key enablers

All five enablers will support delivery in this area

New or existing investment

Combination of new and existing investment

Estimated total cost

£0.945m

Start date (show phases if possible)	Describe Phases.
01.04.2022 All embedding elements have already commenced	Embedding projects will build on existing delivery

Regional investment model

Select the funding element which the project will be set against. Repeat the table and rationale below for each project.

Title of project to support model of care (programme)	
Starting Well Programme	
Funding elements	**Select**
Element 1 - Acceleration funding year 1	✓
Element 1 - Acceleration funding year 2	
Element 2 - Embedding fund year 1	✓
Element 2 - Embedding fund year 2	
Element 2 - Embedding fund year 3	
Element 3 - Legacy integrated pooled fund	
Element 4 – National priorities (Dementia and Memory Assessment Services/ Diagnostic Support)	

Provide the rationale for the element selected.

Embedding Acceleration to follow.

Delivery partners

Include details of local LHBs, local authorities, third sector and other providers that will support in the delivery of the projects. In this section you will also need to explain what they bring to the project by means of match contribution. This can be evidenced by either monetary or resource match. Repeat the table below for the number of projects being put forward.

RPBs will be expected to invest a **minimum of 20%** of their RIF allocation in delivery through social value sector organisations. RPBs should be connecting closely with their social value forums to ensure the wider sector can be engaged in the planning, design and delivery of these Models of Care. The information provided below will help aggregate the social value sector involvement at programme level.

Title of project to support model of care (programme)				
Starting Well Programme				
Delivery Partners	**Welsh Government contribution**	**Partner match monetary**	**Partner match resource**	**Total funding required**
Region	£2.458m	0	£1.053m	£3.511m

BWRDD PARTNERIAETH RHANBARTHOL CAERDYDD A'R FRO
CARDIFF & VALE REGIONAL PARTNERSHIP BOARD

Health & Social Care Regional Integration Fund

Unpaid Carers

BYW'N DDA LIVING WELL

Llywodraeth Cymru
Welsh Government

National Models of Care – Strategic Vision

The primary purpose of the Health and Social Care Regional Investment Fund is to build on the learning and development undertaken by the Integrated Care Fund and the Transformation Fund and to establish and embed six new National Models of Integrated Care by 2027.

Provide a summary below of how the programmes and projects within this document will collectively deliver the associated National Models of Care and wider commitments of A Healthier Wales. Please attach the Programme and projects matrix table in annex A to support your narrative.

It's recognised that the strategic vision may not be fully scoped in year one and will evolve each year as projects are delivered and outcomes are realised.

Community-based care – Prevention and community coordination

The region endorses Welsh Government's commitment to community-based care with the following outcomes:

1) People's well-being needs are improved through accessing co-ordinated community-based solutions.
2) Local prevention and early intervention solutions support people to avoid escalation and crisis interventions.

In line with these aspirations, the Carers Strategy programme aims to deliver the following commitments for 'unpaid carers' in Cardiff and the Vale of Glamorgan:

- Adult carers - To identify and recognise carers for the vital contribution they make to the community and the people they care for, and in doing so enable carers to have a life alongside caring
- Young carers - Young carers are really important to us, to the communities where they live and to the people they care for. We want to know if you care for someone, so that we can help you and the person you care for, and make sure you have time to do things for yourself

Unpaid carers play a key role in *community-based care – prevention and community coordination*, this programme aims to ensure carers are recognised and supported in their role.

Community-based care – complex care closer to home

Cardiff and Vale RPB support Welsh Government's commitment to community-based care by providing complex care close to home so that:

1) People are more involved in deciding where they live while receiving care and support
2) Complex care and support packages are better at meeting the needs of people and delivered at home or close to home

In line with these aspirations, the Carers Strategy programme aims to deliver the following commitments for 'unpaid carers' in Cardiff and the Vale of Glamorgan:

- Adult carers - To identify and recognise carers for the vital contribution they make to the community and the people they care for, and in doing so enable carers to have a life alongside caring
- Young carers - Young carers are really important to us, to the communities where they live and to the people they care for. We want to know if you care for someone, so that we can help you and the person you care for, and make sure you have time to do things for yourself

Unpaid carers play a key role in *community-based care – complex care closer to home*, this programme aims to ensure carers are recognised and supported in their role.

Promoting good emotional health and wellbeing

Our region is keen to ensure that:

1) People are better supported to take control over their own lives and well-being
2) People have improved skills, knowledge and confidence to be independent in recognising their own well-being needs

In line with these aspirations, the Carers Strategy programme aims to deliver the following commitments for 'unpaid carers' in Cardiff and the Vale of Glamorgan:

- Adult carers - To identify and recognise carers for the vital contribution they make to the community and the people they care for, and in doing so enable carers to have a life alongside caring
- Young carers - Young carers are really important to us, to the communities where they live and to the people they care for. We want to know if you care for someone, so that we can help you and the person you care for, and make sure you have time to do things for yourself

Unpaid carers play a key role in *promoting good emotional health and wellbeing*, this programme aims to ensure carers are recognised and supported in their role.

Preventing children entering care and supporting children to remain with their families

Our region is committed to ensuring:

1) Families get better support to help them stay together
2) Therapeutic support improves and enhances the well-being of care experienced children

In line with these aspirations, the Carers Strategy programme aims to deliver the following commitments for 'unpaid carers' in Cardiff and the Vale of Glamorgan:

- Adult carers - To identify and recognise carers for the vital contribution they make to the community and the people they care for, and in doing so enable carers to have a life alongside caring
- Young carers - Young carers are really important to us, to the communities where they live and to the people they care for. We want to know if you care for someone, so that we can help you and the person you care for, and make sure you have time to do things for yourself

Unpaid carers play a key role in *preventing children entering care and supporting children to remain with their families*, this programme aims to ensure carers are recognised and supported in their role.

Home from hospital

Our region is committed to ensuring that:

1) People go home from hospital in a timelier manner with the necessary support in place at discharge
2) People have a better understanding of the discharge process and are more involved in pre and post discharge planning

In line with these aspirations, the Carers Strategy programme aims to deliver the following commitments for 'unpaid carers' in Cardiff and the Vale of Glamorgan:

- Adult carers - To identify and recognise carers for the vital contribution they make to the community and the people they care for, and in doing so enable carers to have a life alongside caring
- Young carers - Young carers are really important to us, to the communities where they live and to the people they care for. We want to know if you care for someone, so that we can help you and the person you care for, and make sure you have time to do things for yourself

Unpaid carers play a key role in *home from hospital*, this programme aims to ensure carers are recognised and supported in their role.

Accommodation based solutions

Cardiff and the Vale region want to ensure that:

1) People are more involved in the design of accommodation to meet their needs
2) People have more choice about where they live and with whom

In line with these aspirations, the Carers Strategy programme aims to deliver the following commitments for 'unpaid carers' in Cardiff and the Vale of Glamorgan:

- Adult carers - To identify and recognise carers for the vital contribution they make to the community and the people they care for, and in doing so enable carers to have a life alongside caring
- Young carers - Young carers are really important to us, to the communities where they live and to the people they care for. We want to know if you care for someone, so that we can help you and the person you care for, and make sure you have time to do things for yourself

Unpaid carers play a key role in *accommodation-based solutions*, this programme aims to ensure carers are recognised and supported in their role.

Programme title

Please provide the programme title. If an element of the programme is moving from ICF/TF funding into the RIF, also include the previous programme title, if different.

Cardiff and Vale of Glamorgan Unpaid Carers Strategy Delivery Programme

Priority Models of Care for the programme

All programmes within the Regional Integration Fund (RIF) must contribute to at least one of the six Models of Care. Select the models of care which the programme will contribute to. Indicate if the programme uses Dementia Action Plan (DAP) funding in the column provided.

Priority model of care	Select	DAP*
Community-based care – Prevention and community coordination	✓	
Community-based care – complex care closer to home	✓	
Promoting good emotional health and wellbeing	✓	
Preventing children entering care and supporting children to remain with their families	✓	
Home from hospital	✓	
Accommodation based solutions	✓	

* the Cardiff and Vale Dementia programme Investment Proposal lists the use of all DAP funding with the exception of one project which sits in our carers strategy programme

Programme - Executive summary

Previously, the Regional Partnership Board has established a number of key service innovations utilising the Integrated Care Fund (ICF) and Transformation Funding with a view to improving the lives of unpaid carers, specifically:

- Carers gateway – a centralised support and signposting service
- Young carers in schools – supporting schools to identify and support young carers
- Dementia carers information and support program

In the last year, the RPB undertook a comprehensive review of its governance arrangements to ensure we are in a position to drive change effectively across the region. As part of this process we identified the need to bring together a group of existing Partnerships for specific priority population groups into a virtual Living Well Partnership. This arrangement is still very much in its infancy but it is anticipated that unpaid carers and the Carers Board that is already in place should be supported and enabled through the RIF to take forward a new and innovative plan to drive forward enhanced opportunities for unpaid carers to receive the care and support they need as close to their own home as possible as they commence through the different stages in their lives.

The carers board is in the process of reviewing its strategy in line with 7 key priorities which are illustrated below:

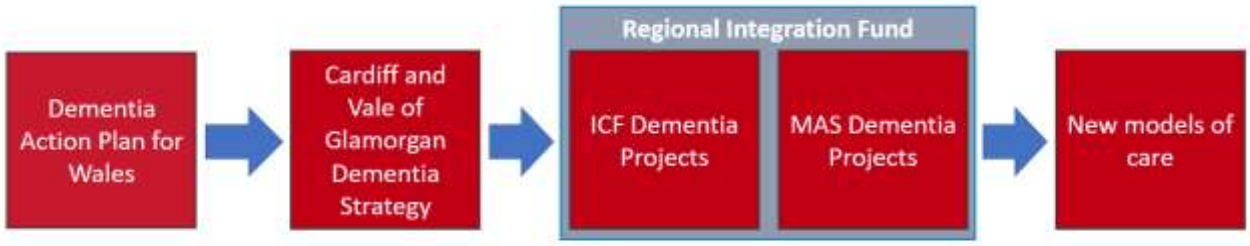
The Cardiff and Vale Carers Strategy Programme is the vehicle for the region's Carers Board to deliver these aspirations.

The demise of the ICF and Transformation Funds, combined with the introduction of the new Regional Investment Fund has allowed us to undertake a thorough overhaul of all previous service delivery investment against these newly agreed aspirations and the six national care models. This has resulted in a new programme where the outcomes of those initial workstreams have been re-aligned to form a foundation for the next phase in innovative service development for unpaid carers.

A schematic demonstrating the links between this programme and the respective models of care outlined within the RIF guidance is provided as Annex A. Further explanatory detail showing the links between the Carers Strategy programme and the national models is provided in section 1 of this document.

Dementia Action Plan (DAP) summary

The Cardiff and Vale Dementia Programme is the delivery vehicle for the region's Dementia Action Plan (DAP).



An external evaluation is currently being undertaken to:

- Understand how well the region has progressed towards achieving DAP priorities so far;
- Capture a baseline assessment of where the current DAP aligns with the newly launched All Wales Dementia Care Pathway of Standards and to identify any gaps which must now be taken into account;
- Identify areas in Dementia care which need further support or development as a result of the COVID-19 pandemic;
- Compare the DAP with the emerging findings of the region's Population Needs Assessment, again with a view to ensuring that key priorities are included within the revised DAP.

The outcome of this evaluation will help the region to inform priorities for recurrent funding from October 2022 and beyond. The resulting Dementia Programme will ensure that recurrent funding is aligned to meet the needs of people living with Dementia and their carers across the region through a delivery plan that dovetails with the wider RIF and anticipated capital programmes as appropriate.

Programme - Business case

Aims and Objectives

Unpaid carers play a vital role in ensuring the people they care for stay safe and well in their own homes and communities. There are many reasons why people become unpaid carers and they are often family of the people they care for. Due to this, carers often feel isolated and are unaware of the support available. Without accessing or being aware of the support available, the carer support can breakdown which may result in unplanned admissions or requirement of long-term support such as residential support. These may be avoidable if the carer has access to the information and support to enable them to continue in their caring role.

Cardiff and Vale of Glamorgan is committed to the Welsh Government national priorities to improve the lives of unpaid carers. The National Priorities are as follows:

1. Priority one: Identifying and valuing unpaid carers – all unpaid carers to be valued and supported to make an informed choice about the care they provide and to access the support they need whilst caring and when the caring role comes to an end.
2. Priority two: Providing information, advice and assistance – it is vital all unpaid carers have access to the right information and advice at the right time and in an appropriate format.
3. Priority three: Supporting life alongside caring – all unpaid carers must have the opportunity to take breaks from their caring role to enable them to maintain their own health and well-being and have a life alongside caring.
4. Priority four: Supporting unpaid carers in education and the workplace – employers and educational / training settings should be encouraged to adapt their policies and practices, enabling unpaid carers to work and learn alongside their caring role.

Over the next 5 years, the Carers Strategy delivery programme will deliver the following vision for unpaid carers in the region:

- Adult carers: *"To identify and recognise carers for the vital contribution they make to the community and the people they care for, and in doing so enable carers to have a life alongside caring"*
- Young carers: *"Young carers are really important to us, to the communities where they live and to the people they care for. We want to know if you care for someone, so that we can help you and the person you care for, and make sure you have time to do things for yourself"*

The vision and a set of key priorities were developed by the regional unpaid carers board through a series of engagements with key stakeholders and unpaid carers to ensure it reflects their needs and the positive system changes they would like to see. The seven priorities identified for the region are as follows:

A demonstration of how previous projects will now be embedded within the foundation of the new programme plan is provided below:

Unpaid Carers Programme Map 22-23

Project	Access Providing contact support and signposting for unpaid carers	Young Carers Support and respite for young carers	Adult Carers Support and respite for adult unpaid carers
Embedding	OP11 Carers Gateway	CLD14 Young Carers project (Cardiff) Young carers in school (national carers grant)	MAS4 Dementia carers support and information programme
Accelerating	Assessments (statutory duty)	Coordinating regional approach	Discharge support & advocacy (national carers grant) LD parent carers

Links between the Carers Strategy programme and associated national Models of care are articulated clearly within section 1 of this document and also in Annex A.

Baseline Position

Our latest Population Needs Assessment (due for publication in 2022) contains a chapter on unpaid carers which outlines a number of priority areas which the unpaid carers strategy programme aims to address, specifically:

- Review the need for an updated carers directory, which is updated regularly and available digitally, and publicise widely
- Provide respectful care that is culturally appropriate, with training where needed

- Strengthen clear pathways for carers assessments within local authorities following a “what matters” conversation
- Capture first language needs in carers assessments
- Consider flexible respite needs for unpaid carers
- Review the pathway for mental health support to unpaid carers, so that waiting time decreases
- Employers should adopt reasonable adjustments for people with caring responsibilities so that worthwhile employment is maintained and finances for unpaid carers are optimised

This programme also builds on our priorities highlighted through our area plan, specifically:

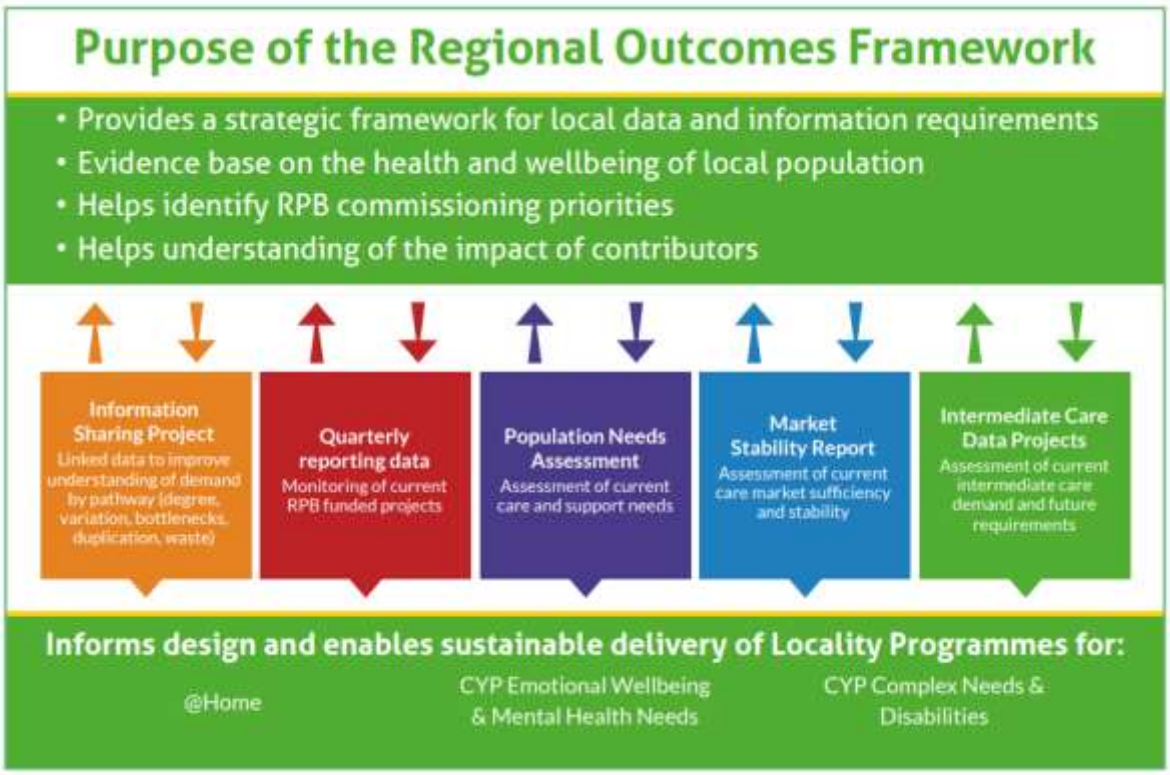
- AYC1.1: Identify and implement a carer engagement model based on best practice
- AYC1.2 Improve physical and emotional support for young carers, including emergency and pre-planned respite and reducing the risk of Adverse Childhood Experiences (ACEs)
- AYC1.3: Improve physical and emotional support for adult carers, including emergency and pre-planned respite
- AYC1.4: Involve carers, including young carers, in the planning of hospital admission and discharge if the person they care for is in hospital
- AYC1.5: Provide easily accessible information to carers and relatives in a range of formats and languages, through existing information points, such as primary care and libraries.
- AYC1.6: Raise awareness around caring and carers among public and health and social care professionals, (e.g. adopting an approach similar to Making Every Contact Count), to ensure that carers are identified as early as possible and all involved are aware of their rights as a carer

Benefits Realisation:

Cardiff and Vale Regional Partnership Board has a Regional Outcomes Framework (ROF) to which all our outcomes regionally align and that also articulate what we want to achieve for the whole population which includes unpaid carers). Those outcomes are:

- Reduced wasted system resource
- Increased time for people to live their lives
- Increased living well in their own home and community
- Better start for children and young people
- Improved environment that enables people's choices
- Decreased avoidable harm or mortality
- People get a safe response when in urgent need
- More empowered workforce.

The ROF has been developed over a period of years and is currently being used to chart progress against these outcomes for adults only. Over the next year, it is the intention to introduce data charting outcomes for other priority population groups.



At an operational level, the region has positive experience of utilising Results Based Accountability to measure key performance outcomes for individual projects. This methodology will be utilised in the formation and delivery of all projects across the RIF programme portfolio. Qualitative information will be gathered via our Engagement Delivery Framework outlined within the Strategic Plan.

Plans for sustainability:

This programme is a key priority for the Regional Partnership Board's Living Well Partnership which has already agreed the following overall delivery plan. Partners have already demonstrated their commitment to the Carers Strategy programme through the provision of match resources to support its work in 2022-23 as outlined in the project briefs below.

The region has initiated work to develop a Memorandum of Understanding, completion of which will set a clear commitment to working collaboratively across the partnership to support the RIF aims

and objectives. We are working with the Health Board Director of Finance and Local Authority Section 151 Officers to develop our roadmap for the ongoing development of sustainable funding streams over the remaining 4 years and how we work with Welsh Government to taper the match funding of resource requirements.

Our programmes will bring together the legacy of ICF / Transformation Fund projects, triangulating them with core funded services that align to our programmes and accelerated services to deliver our programme aspirations and contribute to the development of the six national care models. By taking this approach we will be able to use the RIF to transform our core services.

Programme - Key enablers

Select which of the key enablers will maximise the delivery of the programme, using the free text box to describe how this will be achieved.

Key Enablers	Select
Integrated planning and commissioning	✓
The Carers Strategy programme enables partners to work together to take forward jointly agreed priorities for this population through a centrally provided management structure which works alongside operational teams to design, support and deliver new ways of working. This ongoing commitment to integrated planning will be informed by the findings of the region-wide Population Needs Assessment and the Market Stability Report which are under development currently. The Carers Strategy programme is also contributing to a region-wide exercise which will identify shared capital development priorities in preparation for emerging capital funding provision in 2022 onwards. The region is committed to developing opportunities for integrated commissioning. This is particularly in relation to commissioning and utilising the third sector for the Carers Strategy programme by all partners across the region.	
Technology enabled care	✓
In relation to the Carers Strategy programme, this is particularly relevant for the following projects: • Access – identifying and enabling carers to access information, support and services. • Young carers – enabling shared records for young carers who may be more vulnerable, and also how they may be supported by health and social services. Digital infrastructure is fundamental to the delivery of all programmes within the RIF programme portfolio. Specific investment in this area will be sought via the Digital Care Region Improvement Programme to take forward a prioritised delivery plan.	
Promoting the social value sector	✓

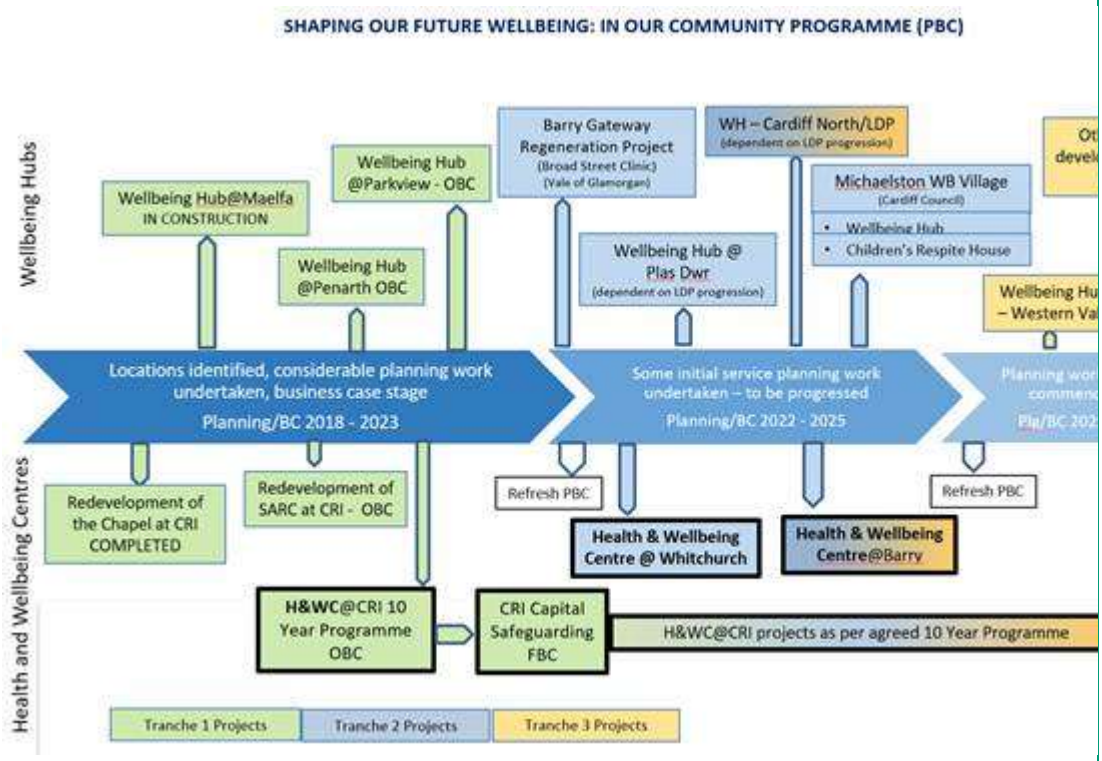
The social value sector plays a key role with representatives from Carers Strategy organisations on its Partnership board and programme delivery arrangements.

Promoting the social value sector is particularly relevant in the unpaid carers strategy programme which utilises the third sector to provide support and services for carers.

Integrated community hubs

The development of integrated community hubs will be led by the @Home programme utilising capital funding to complete feasibility plans by early 2023. All priority groups within the RIF programme portfolio will be able to make use of these hubs upon their completion.

The Health Board's *Shaping our Future Wellbeing: In our Community* (SOFW:IOC) programme business case has been developed with partners and was endorsed by Welsh Government (2019) and the subsequent capital business cases and WG investment seeks to support the development and reconfiguration of community infrastructure to create a network of Locality Health and Wellbeing Centres (H&WCs) and smaller cluster-based Wellbeing Hubs (WHs) across Cardiff and Vale that support the above objective. The overall vision is summarised in the diagram below with the work driven through both the @Home programme and the SOFW:IOC delivery board



Planning work commissioned in the last quarter of 2021/22 with the use of ICF capital funding will inform the development of the proposals for the Barry Health and Wellbeing

Centre/hospital, the new H&WBC for the North Cardiff locality and the opportunities created through the development of Michaelson Wellbeing Village which may have a particular focus on services for children and young people. There is a very pressing need to develop the plans for primary and community services in North Cardiff because of the speed at which housing developments are progressing in the area.	
Workforce development and integration	
Workforce and organisational development is fundamental to the delivery of all programmes within the RIF programme portfolio. Specific investment in a Workforce and OD specialist will be included within the Partnership Support plans as part of our acceleration proposal.	✓

Programme - Priority population groups

Priority population groups	Primary	Secondary	DAP
Older people including people with dementia		✓	
By providing support and services for unpaid carers, including those who support *older people including people with dementia*.			
Children and young people with complex needs		✓	
By providing support and services for unpaid carers, including those who support *children and young people with complex needs*.			
People with learning disabilities and neurodevelopmental conditions including autism*		✓	
By providing support and services for unpaid carers, including those who support *people with learning disabilities and neurodevelopmental conditions including autism*.			
Unpaid carers*	✓		✓
This programme is solely focussed on providing direct support for *unpaid carers* by providing access to support and services to enable carers to provide care.			
People with emotional and mental health wellbeing needs		✓	
By providing support and services for unpaid carers, which supports good *emotional and mental health wellbeing needs*, such as with respite. This programme will also support unpaid carers of *people with emotional and mental health wellbeing needs.*			

Other beneficiaries

If there are other stakeholders benefiting from the programme, please provide this detail below.

Total programme cost and match funding projection

Provide a breakdown of the total programme cost, Welsh Government contribution, partner monetary and resource match including costs attributed to support unpaid carers and / or social value sector delivery. You can find more information on match funding in the guidance notes.

EMBEDDING:

Total cost of Programme	Welsh Government contribution	Partner match monetary	Partner match resource	% support for unpaid carers	% for social value sector delivery
£0.339	£ 0.237	£ 0	£0.102	100%	100%

ACCELERATING:

Total cost of Programme	Welsh Government contribution	Partner match monetary	Partner match resource	% support for unpaid carers	% for social value sector delivery
£tbc	£ tbc	£ tbc	£ tbc	£ tbc	£ tbc

Programme resource and management details

Provide a summary of the planned resource and roles required to deliver this specific programme. These roles are 100% funded via the RIF and will accounted for within the allocated fund.

Posts / type of roles	Estimated FTE	Costs
RPB Team support – strategic planning, project support, reporting and coms / engagement.		

Project plans

In this section, outline each project that will contribute towards the successful delivery of the associated National Models of Care. For the purposes of the investment proposal you will need to provide:

- Information on all sections within the table below.
- Repeat the table for each project being put forward.
- Indicate if the project will be delivered using DAP funding in the summary.
- For Dementia project, outline which strand the project relates to DAP or Memory Assessment Services/Diagnostic Support in the summary.

Title of project to support model of care (programme)
Access
Models of care the project will contribute towards
Community-based care – prevention and community coordination; community-based care – complex care closer to home; promoting good emotional health and wellbeing; preventing children entering care and supporting children to remain with their families; home from hospital
Project Summary
Unpaid carers play a vital role in ensuring the people they care for stay safe and well in their own homes and communities. Unpaid carers can often feel isolated and often do not identify themselves as carers and therefore may be unaware of the full breadth of support and services available to them. A breakdown of carer support can put stress on both the carer and the person they care for, often requiring crisis intervention. Since March 2020, Cardiff and Vale of Glamorgan have piloted a Carers Gateway which provides a centralised resource for care and support for unpaid carers. Carers Trust Southeast Wales have provided this service for the last 2 years with the following aim: *To improve the quality of life for unpaid carers, and the cared for, in Cardiff and the Vale, helping them sustain their caring role and enhance their ability to have a life outside caring. It will do this by making it easier for unpaid carers to access information about support and services in the region.* The Carers Gateway has achieved this through supporting unpaid carers with: • Understanding what support is available for carers • Signposting and supporting carers to access local services • Identifying new services that are needed to help carers • Raising awareness on the issues carers face • Providing training and development opportunities for carers • Developing the network of services in the region. Over the next 2 years we are hoping to continue to embed this service as part of the community and ensure that the services is promoted and linked to some of the key services within the Health Board and Local Authorities. Through an improved network it is hoped that the service can continue to support unpaid carers in their role and reduce the pressures on statutory services.

In addition, Cardiff and vale shall look at potential ways of expanding the service to provide greater levels of support with assessments and programmes of support provided by the service itself.	
Priority population group	
Unpaid carers	
Key enablers	
Integrated planning and commissioning; technology and digital solutions; promoting the social value sector; integrated community hubs; workforce development and integration	
New or existing investment	
Existing	
Estimated total cost	
£0.182m	
Start date	
2022-23 – phase 1 **2023-24-onward**	-retendering of the Carers Gateway and assess options for development with the Unpaid Carers Board -develop Access including how the Carers Gateway and carer assessments are connected/interwoven

Title of project to support model of care (programme)
Young Carers
Models of care the project will contribute towards
Community-based care – prevention and community coordination; community-based care – complex care closer to home; promoting good emotional health and wellbeing; preventing children entering care and supporting children to remain with their families; home from hospital
Project Summary
The 2011 census showed that Wales had the highest proportion of carers under the age of 18 in the UK and it was calculated that there are approximately 30,000 carers under the age of 25 in Wales. The likelihood is however that the number is far higher since processes for identifying young carers are often under developed. The Children Act 1989 placed a duty upon Local Authorities to provide an assessment of need for Young Carers within their Local Authority. More Recently The Social Services and Wellbeing Act Wales 2014 (referred to as The Act in this document) has strengthened the offer to Young Carers. Through ICF funding, Cardiff and Vale implemented a Young Carers project in 2018 which piloted the use of a centralised coordinator to support young carers in Cardiff. The service was delivered by the YMCA and aimed to: • Provide dedicated support for young carers, including identifying and supporting newly identified young carers • Deliver activities and sessions to support young carers in their role • Provide respite activities for young carers and support life alongside caring In addition, through the Carers Grant funding, the region has implemented a 'Time 4 Me' young carers in schools project, which built on the work of the YMCA to improve the skills of teachers and the support available through schools for young carers. As part of the national scheme, the project supported accreditation of Carer Friendly schools and also provided access to respite services for young carers. Over the next two years, overseen by the Unpaid Carers Board, and aligned to the Unpaid Carers Strategy, Cardiff and Vale of Glamorgan would like to develop a regional approach to young carers, which will provide an equitable offer across the region whilst taking in emerging requirements of the national Carers Grant.
Priority population group
Unpaid carers
Key enablers
Integrated planning and commissioning; technology and digital solutions; promoting the social value sector; integrated community hubs; workforce development and integration
New or existing investment
Existing
Estimated total cost
£0.157m

Start date	
2022-23 – phase 1 **2023-24-onward**	-through the Unpaid Carers Board, to develop a regional approach to young carers and the support available -to continue to develop services and access to support for young carers

Title of project to support model of care (programme)	
Adult Carers	
Models of care the project will contribute towards	
Community-based care – prevention and community coordination; community-based care – complex care closer to home; promoting good emotional health and wellbeing; preventing children entering care and supporting children to remain with their families; home from hospital	
Project Summary	
An integral part of the commitment from the region in its priorities for unpaid carers is to improve the information and support available to unpaid carers. This is because the role of an unpaid carer may be unplanned, and the systems which support carers can be complex. Unpaid carers are often family members and in many situations be required to support the person they care for in making decisions about their care or finances. All of which can add to the stress of their role. In 2021, a programme was set up by the Alzheimer's Society for unpaid carers of people living with dementia. This 6-week programme provided a broad range of advice and information for their role as an unpaid carer. This approach supported the work of Carers Gateway (see Access) and also helped to reduce isolation for the unpaid carer, by providing a network of other people who were caring for someone with dementia. In the next 2 years, Cardiff and Vale would like to review the support available for parents of people with learning disabilities; it is felt that developing a similar approach would provide positive outcomes for this group of unpaid carers. Alongside this development, Welsh Government have stated the importance of providing support for carers, when the person they care for discharged from hospital. This difficult time can be stressful for many unpaid carers and so the region is committed to developing hospital-based support in this area through the Carers Grant and will be piloted in 2022-23.	
Priority population group	
Unpaid carers	
Key enablers	
Integrated planning and commissioning; technology and digital solutions; promoting the social value sector; integrated community hubs; workforce development and integration	
New or existing investment	
Existing	
Estimated total cost	
Included within Dementia Action Plan	
Start date	
2022-23 – phase 1	-review and alignment of adult carer support projects, with analysis of any gaps in available support, pilot a discharge support project -development of areas of support and if successful spread the discharge support

2023-24-onward	

Regional investment model

Select the funding element which the project will be set against. Repeat the table and rationale below for each project.

Title of project to support model of care (programme)	
Cardiff and Vale of Glamorgan Unpaid Carers Strategy Programme	
Funding elements	**Select**
Element 1 - Acceleration funding year 1	
Element 1 - Acceleration funding year 2	
Element 2 - Embedding fund year 1	✓
Element 2 - Embedding fund year 2	
Element 2 - Embedding fund year 3	
Element 3 - Legacy integrated pooled fund	
Element 4 – National priorities (Dementia and Memory Assessment Services/ Diagnostic Support)	✓

Provide the rationale for the element selected.

Embedding – with exception of the schemes below, we will be looking to embed the projects described in this document.

National priorities – the *young carers in schools project* is currently funded through the national £1m carers grant, and we will be utilising this funding for the *discharge support* work. The *dementia carer information and support programme* is funded by the DAP funding.

Delivery partners

Include details of local LHBs, local authorities, third sector and other providers that will support in the delivery of the projects. In this section you will also need to explain what they bring to the project by means of match contribution. This can be evidenced by either monetary or resource match. Repeat the table below for the number of projects being put forward.

RPBs will be expected to invest a **minimum of 20%** of their RIF allocation in delivery through social value sector organisations. RPBs should be connecting closely with their social value forums to ensure the wider sector can be engaged in the planning, design and delivery of these Models of Care. The information provided below will help aggregate the social value sector involvement at programme level.

Title of project to support model of care (programme)				
Delivery Partners	**Welsh Government contribution**	**Partner match monetary**	**Partner match resource**	**Total funding required**
CAVUHB	£0.044m		£0.102m	£0.339m
Third sector	£0.295m			

BWRDD PARTNERIAETH RHANBARTHOL
CAERDYDD A'R FRO
CARDIFF & VALE REGIONAL PARTNERSHIP BOARD

Health & Social Care Regional Integration Fund

Learning Disabilities

BYW'N DDA LIVING WELL

Llywodraeth Cymru
Welsh Government

National Models of Care – Strategic Vision

Community based care – Prevention and community coordination

The region endorses Welsh Government's commitment to community-based care with the following outcomes:

1) People's well-being needs are improved through accessing co-ordinated community-based solutions.
2) Local prevention and early intervention solutions support people to avoid escalation and crisis interventions.

In line with these aspirations, the Learning Disabilities programme aims to deliver the following commitments for people with learning disabilities in Cardiff and the Vale of Glamorgan:

- Implementing a programme of modernisation (community-based solutions)
- Providing the right support at the right time

Community based care – complex care closer to home

Cardiff and Vale RPB support Welsh Government's commitment to community-based care by providing complex care close to home so that:

1) People are more involved in deciding where they live while receiving care and support
2) Complex care and support packages are better at meeting the needs of people and delivered at home or close to home

In line with these aspirations, the Learning Disabilities programme aims to deliver the following commitments for people with learning disabilities in Cardiff and the Vale of Glamorgan:

- Providing the right support at the right time
- Development of local and regional Accommodation solutions

Promoting good emotional health and wellbeing

Our region is keen to ensure that:

1) People are better supported to take control over their own lives and well-being
2) People have improved skills, knowledge and confidence to be independent in recognising their own well-being needs

In line with these aspirations, the Learning Disabilities programme aims to deliver the following commitments for people with learning disabilities in Cardiff and the Vale of Glamorgan:

- Ensuring the service offer for people is fit for their future
- Embedding an inclusive community-based approach

Preventing children entering care and supporting children to remain with their families

Our region is committed to ensuring:

1) Families get better support to help them stay together
2) Therapeutic support improves and enhances the well-being of care experienced children

In line with these aspirations, the Learning Disabilities programme aims to deliver the following commitments for people with learning disabilities in Cardiff and the Vale of Glamorgan

- Ensuring the service offer for people is fit for their future (as young people reach adulthood)
- Providing the right support at the right time (to ensure care experience young people with learning disabilities are supported into adulthood)

Home from hospital

Our region is committed to ensuring that:

1) People go home from hospital in a timelier manner with the necessary support in place at discharge
2) People have a better understanding of the discharge process and are more involved in pre and post discharge planning

In line with these aspirations, the Learning Disabilities programme aims to deliver the following commitments for people with learning disabilities in Cardiff and the Vale of Glamorgan

- Implementing a programme of modernisation (community-based solutions)
- Providing the right support at the right time (to enable planned discharge from hospital)

Accommodation based solutions

Cardiff and the Vale region want to ensure that:

1) People are more involved in the design of accommodation to meet their needs
2) People have more choice about where they live and with whom

In line with these aspirations, the Learning Disabilities programme aims to deliver the following commitments for people with learning disabilities in Cardiff and the Vale of Glamorgan:

- Embedding accommodation solutions across the region

Programme title

Cardiff and Vale of Glamorgan Learning Disabilities Programme

Priority Models of Care for the programme

Priority model of care	Select	DAP*
Community based care – Prevention and community coordination	√	
Community based care – complex care closer to home	√	
Promoting good emotional health and wellbeing	√	
Preventing children entering care and supporting children to remain with their families	√	
Home from hospital	√	
Accommodation based solutions	√	

* the Cardiff and Vale Dementia programme Investment Proposal lists the use of all DAP funding

Programme - Executive summary

The Cardiff and Vale of Glamorgan Learning Disability Partnership (LDP) is the main delivery vehicle for delivering partnership priorities for adults with learning disabilities and their families and carers across the region. This partnership been embedded following a comprehensive review of governance arrangements for our RPB to ensure that, as partners, we are well placed to deliver against key priorities for this group of our population.

The Learning Disabilities programme is hosted within the Living Well Partnership, one of three new programme delivery partnerships which will enable the RPB to give particular focus to improving outcomes for people at different stages in their lives.

The LDPB is a well-established partnership which has developed the Joint Commissioning Strategy for Adults with Learning Disabilities 2019-2024. This strategy outlines the key priorities for people with learning disabilities across the region, and areas of development required to improve outcomes for people. Our strategy has been co-produced with citizens and informs our intentions in setting out the wider ambition of transforming the way services are delivered for people with learning disabilities.

Previously, the Regional Partnership Board has established a number of key service innovations utilising the Integrated Care Fund (ICF) with a view to improving the lives of people with learning disabilities, specifically:

- Embedding additional transition social workers to enable timely transfer into adult services from child services;
- Development of a regional multi-agency transition protocol;
- Supporting the transition of young people with complex needs from education to day opportunities;
- Strengthening transition support across child and adult services for young people with ALN through support planning;

- Embedding psychological approaches (Positive Behaviour Support) to supporting young people with learning disabilities to align with approaches for adults with learning disabilities (Starting Well Partnership):
  - Development of supported living schemes for adults with learning disabilities in Cardiff;
  - Enhanced monitoring of accommodation provisions;
  - Active review of individuals who step up / step down;
  - Increased support planning to enable people to access community activities within their locality;
  - Increased health care support staff to support access to health services;
  - Targeted technology enabled care, improving skills of people with learning disabilities to increase independence and reduce isolation;
  - Co-producing promotion of the Health Profile and enabling the voice of the citizen.

The end of the Integrated Care Fund, combined with the introduction of the new Regional Integration Fund has allowed us to undertake a thorough overhaul of all previous service delivery investment against the joint commissioning strategy and the six national care models. This has resulted in a developing programme where the outcomes of those initial workstreams have been re-aligned to form a foundation for the next phase in service development for adults with learning disabilities and their families and carers.

Over the next 5 years, the Learning Disability programme will deliver against the 8 areas of the strategy as set out below:

i. **Health and Feeling Good** - People have told us that they want to be able to socialise with their friends and have fun. They have also told us they want a range of support from befriending and peer support through to support with meeting complex health care needs.

ii. **Information – Accessible and easy to understand** - People have said they want to know what services are available and that they want to be involved in making choices about the opportunities available to them. They can only do this if information is easy to access and available to them in a format they can understand.

iii. **Choice and Control – Consultation and Inclusion** - People have told us they want to be listened to, communicated with, kept informed, have real choices and be involved in decisions about their care and support. People have told us that at times when they need help to make decisions, they would like an advocate to be available and not have to wait.

iv. **The Right Support at the Right Time** - The need to have information, advice and, if necessary, assistance at the time it is required to prevent the need for more support later on. Carers have said that, at times of crisis, they require immediate access to support as well as access to regular respite opportunities.

v. **Work, Volunteering & Day Opportunities** - People have told us they want a variety of different opportunities available to them and to have choice and flexibility. Families and carers have told us that having a building base where people with a learning disability can go during the day is important for some people; particularly those with high levels of health and care needs. People have told us that it is difficult to know where to look for available opportunities. People have commented on how positive volunteering has been for their confidence and independence and how they would like more opportunities to volunteer in a range of different areas. In addition, people have said they want more assistance in getting 'work ready' and more opportunities for paid employment.

vi. **The Transition from Child to Adult Services** - People have told us that the transition from children to adult services in health, social care and education is not working. People feel fearful and scared about the future and they don't feel supported by services. Where transition from children to adult services has worked well, we don't appear to be sharing this good practice to ensure this happens consistently. People feel that discussions about their future should start earlier in schools and youth clubs and that they should be fully involved in these.

vii. **Having my own home** - People have told us that they want to be supported to live as independently as possible and to be able to live near friends and family.

viii. **Collaboration and Co-Production** - People have said professionals need to work together and that all professionals need to work collaboratively with the people they support. Professionals need to take a strengths-based approach, using people's personal knowledge of what they can do and the strengths they have in order to achieve their own goals.

This Strategy provides us with a clear set of aspirations that enable us to continue to deliver against our strategy in supporting people with learning disabilities. Over the next few months, the LDP will seek to agree a prioritised delivery plan for our Learning Disabilities Strategy, informed by a more detailed review of the existing projects to ensure that their scope and delivery models are aligned effectively with this forward plan as outlined in the Emerging Map attached as Appendix A. This will form the basis of proposals for use of RIF Escalation funding and / or other funding streams as they become available

A schematic demonstrating the links between this programme and the respective models of care outlined within the RIF guidance is provided as Annex A. Further explanatory detail showing the links between the Learning Disabilities programme and the national models is provided in section 1 of this document.

Programme - Business case

Aims and Objectives

The Learning Disabilities Programme will seek to embed existing projects via delivery of 3 programmes of work for people with learning disabilities underpinned by the Joint Commissioning Strategy and under the following programme headings.

- Fit for my future (Transition from child to adult services)
- Right Support – Right Time
- Having my Own Home (Accommodation Solutions)

These programmes have an emphasis on a locality, community first, person-centred model of support that keeps the voice of people with learning disabilities at the centre.

Over the next few months, the Learning Disabilities Programme will seek to agree a prioritised delivery plan for our Learning Disabilities Strategy, informed by a more detailed review of the existing projects to ensure that their scope and delivery models are aligned effectively. This will form the basis of proposals for use of RIF Escalation funding and / or other funding streams as they become available.

As with our Joint Commissioning Strategy, our delivery programme will be underpinned by the key enabler of collaboration and co-production, working with service users and colleagues across health, social care, education and the third sector to achieve better outcomes for people.

Listening to people with a learning disability is at the heart of our programme and the services delivered across the region. We will continue to listen through our established Learning Disability Partnership Group, which supports stakeholder engagement and the voice of citizens, and will be chaired by a person with lived experience. Through these activities we will develop approaches that enable people with a learning disability to be involved with commissioning activities, and in making decisions which shape services.

We will continue to ensure that people with a learning disability, their families, and carers, are fully involved in developing their care, treatment or support plans, and they are regularly reviewed in line with good practice. Ongoing analysis of outcomes delivered and long-term goals in development of individual plans will enable a more effective approach to strategic planning across the region.

The programme is set out into 3 projects to take forward the following:

- **Fit for my future –** This project focusses on improving services that support a seamless transition into adulthood. Through strengthening the local offer of services at point of transition, young people can be enabled to remain within their locality and region through an improved range of services which can meet complex needs locally without the need to move out of area or access specialist college placements. Young people will be supported to access further education in line with their choice and preferences. Specialist complex needs day provision will be enhanced for young people coming through transition. Support planning services will provide increased support for young people reaching adulthood (Starting Well Partnership) and be available in adult services to continue to provide people with increased support to access opportunities and activities within their locality. This project will also maintain additional capacity to assess and plan for those young people preparing for transition to effectively plan for their move into adult services.

- **Right Support – Right Time -** focussed on ensuring services are equipped to respond to need with the right level of support, at the time when it is needed. This will include a support planning service across the lifespan for people with learning disabilities, in addition to support at transition. The project will continue to build upon closer working with Primary Care services to ensure that people with a learning disability have their health and wellbeing needs effectively monitored and supported. This will improve the uptake and quality of the annual health checks and health related screening offered to people with a learning disability by their GP. We also seek to expand the Learning Disability Liaison Nurse capacity at the University Hospital of Wales. This will ensure that planned discharge is taking place at the right time, with the right people involved building better links with Community Providers, the specialist Community Health Teams, and the LD specialised Nurse team based within Primary care, where appropriate. The project involves continued development of the complex needs day opportunities across the region, enabling people to access support within their locality. Through this project we will continue to deliver technology enabled care to increase independence and work with partner agencies to further develop the use of assistive technology. We will continue to undertake timely reviews of care and support which enable step up/step down to the right support at the right time as individual needs change and deliver this alongside case management teams. This project will develop the Adult Placement Scheme, providing short breaks to people with learning disabilities and their carers and explore the development of emergency short breaks provision.

    - **Having my Own Home –** This project focusses on improving accommodation solutions that supports people with learning disabilities to live independently as close to family and friends as possible, and within their locality. This project also includes the Adult Placement Scheme, providing shared lives options and reduces the need for residential placements that may be outside of a person's local community and expanding this offer across the Cardiff and Vale region. The project will focus on the development of community step-down facilities to enable move-on for people in NHS and independent hospital beds. We will work in partnership to develop accommodation and support that will enable people who are living out of county or in long term hospital beds to return to their own communities, where appropriate. This will also include supporting people with complex needs to be able to remain within their communities to support people to stay within their locality. We will develop further core and cluster accommodation solutions to increase choice, and continue to develop and deliver assistive technology-based accommodation (Smart Houses)

The programme will ensure we work at a more strategic level to understand and mitigate the barriers that people have told us are in place preventing levels of independence, thereby reducing the need for specialist services later on.

We will continue to work with Swansea Bay University Health Board to ensure the modernisation programme is working effectively to deliver more strategically coordinated community-based solutions. We will use our Joint Commissioning Strategy for Adults with Learning Disabilities 2019-2024 workstream groups to gain a better understanding of the reasons behind delayed transfers of care from the Assessment and Treatment Unit and inpatient provision, so we can explore the development of local stepdown solutions.

The focus on voice and choice of the individual will enable access to a range of wellbeing orientated activities, drawing on opportunities provided by the National Exercise Referral scheme, Third Sector, and other leisure, sport, and culture opportunities.

The links between the Learning Disabilities programme and associated national Models of care are articulated clearly within section 1 of this document and also in Annex A.

Baseline Position

The Cardiff and Vale population needs assessment references the population needs and assets in place for people with learning disabilities within the children and young people and the learning disability section

A refresh of the Cardiff and Vale PNA conducted in 2021/22 has highlighted these additional areas of focus:

- Continue to improve uptake of annual health checks and screening;
- Continue to promote the "community first" approach when planning placements and accommodation;
- Identify and mitigate against inequities amongst people with learning disability;
- Build on existing provision to provide opportunities for work and activities;
- Continue to base services on co-production.

Reflections on the impact of COVID-19 are captured within the refreshed PNA. This has had a particular impact on the well-being people with learning disabilities and their families and carers through the closure of face to face services, disruption to established routines and the shift to online support, which people and families reported as particular challenges caused by lockdowns. Also noted are the existing challenges of waiting lists, national staff shortages and COVID-19, and the impact these have had on the direct delivery of support for people with a learning disability.

Schools across the region are projecting a population increase, in particular within additional learning needs and the growth in numbers of children and young people with ALN requiring a placement within a specialist provision. A focus on transition support and the development of local college placements will ensure the region is able to meet these additional needs.

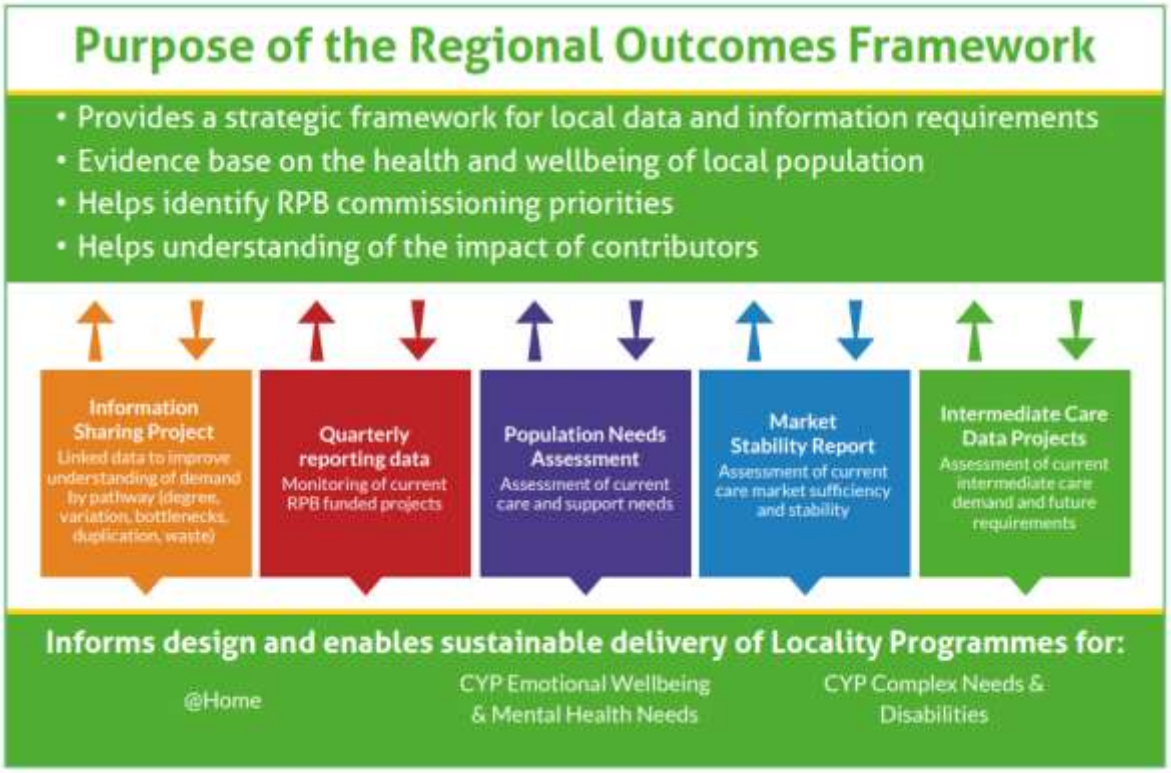
Cardiff and the Vale of Glamorgan are working with the continued challenge of limited specialist placements and availability to meet complex needs and the ongoing reliance on out of area placements. Projects that support people to access a range of meaningful opportunities in their local communities and increase the local offer available to people expands the range of opportunities for people available to support people across the region.

Benefits Realisation:

Cardiff and Vale Regional Partnership Board has a Regional Outcomes Framework (ROF) to which all our outcomes regionally align and that also articulate what we want to achieve for the whole population which includes people with learning disabilities and their families/carers. Those outcomes are:

- Reduced wasted system resource
- Increased time for people to live their lives
- Increased living well in their own home and community
- Improved environment that enables people's choices
- Better start for children and young people
- Decreased avoidable harm or mortality
- People get a safe response when in urgent need
- More empowered workforce.

The ROF has been developed over a period of years and is currently being used to chart progress against these outcomes for adults only. Over the next year, it is the intention to introduce data charting outcomes for other priority population groups including people with learning disabilities.



At an operational level, the region has positive experience of utilising Results Based Accountability to measure key performance outcomes for individual projects. This methodology will be utilised in the formation and delivery of all projects across the RIF programme portfolio. Qualitative information will be gathered via our Engagement Delivery Framework outlined within the Strategic Plan.

Plans for sustainability:

This programme is a key priority for the Regional Partnership Board which has already previously approved its Learning Disability Strategy. Partners have already demonstrated their commitment to the Learning Disabilities programme through the provision of match resources to support its work in 2022-23 as outlined in the project briefs below. The region has initiated work to develop a Memorandum of Understanding, completion of which will set a clear commitment to working collaboratively across the partnership to support the RIF aims and objectives. We are working with the Health Board Director of Finance and Local Authority Section 151 Officers to develop our roadmap for the ongoing development of sustainable funding streams over the remaining 4 years and how we work with Welsh Government to taper the match funding of resource requirements.

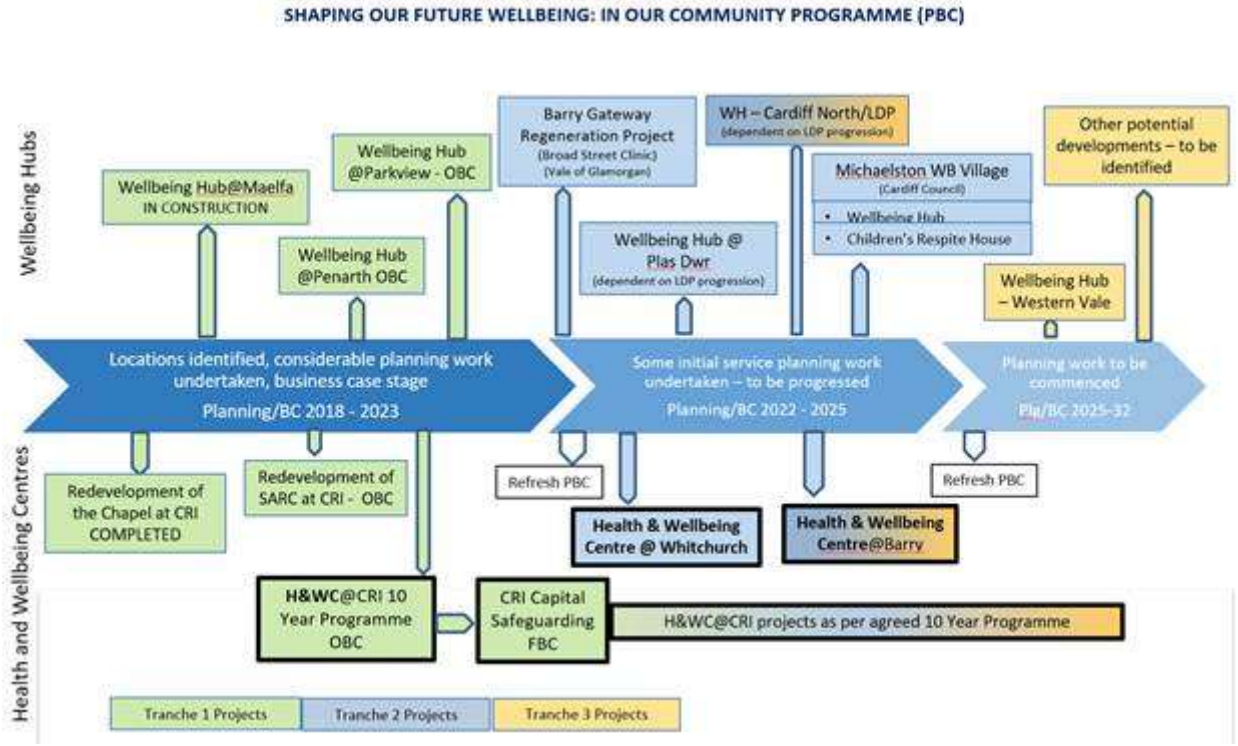
Our programmes will bring together the legacyI CF / Transformation Fund projects, triangulating them with core funded services that align to our programmes and accelerated services to deliver our programme aspirations and contribute to the development of the six national care models. By taking this approach we will be able to use the RIF to transform our core services.

Programme - Key enablers

Select which of the key enablers will maximise the delivery of the programme, using the free text box to describe how this will be achieved.

Key Enablers	Select
Integrated planning and commissioning	
The Learning Disabilities programme enables partners to work together to take forward jointly agreed priorities for this population through a centrally provided management structure which works alongside operational teams to design, support and deliver new ways of working. This ongoing commitment to integrated planning will be informed by the findings of the region-wide Population Needs Assessment and the Market Stability Report which are under development currently. The Learning Disabilities programme is also contributing to a region-wide exercise which will identify shared capital development priorities in preparation for emerging capital funding provision in 2022 onwards. We will work with the Cardiff and Vale Regional Commissioning Board to ensure there is an equitable approach to integrated planning and commissioning across projects The region is committed to developing opportunities for integrated commissioning. In relation to the Learning Disabilities programme, this is particularly relevant for the following projects: • Development of smart houses across the region and the potential for growth in this area	✓
Technology enabled care	
In relation to the Learning Disabilities programme, this is particularly relevant for the following projects: • Technological Solutions Project. - Development of technology solutions that enables individuals to live within their own homes with increased independence - Smart houses developed to upskill individuals to live with greater independence	✓

Digital infrastructure is fundamental to the delivery of all programmes within the RIF programme portfolio. Specific investment in this area will be sought via the Digital Care Region Improvement Programme to take forward a prioritised delivery plan.	
Promoting the social value sector	✓
The social value sector plays a key role with representatives from organisations on its Partnership board and programme delivery arrangements. Promoting the social value sector is particularly relevant in the following projects: • Lived Experience and Engagement (Focus will change each year based on priorities) - Working with third sector organisations and partners to deliver and promote services for adults with learning disabilities. - Enabling citizens to shape our priorities through our Learning Disability Partnership Group (chairing role and progression of opportunities) • Technological Solutions - Working with third sector organisation to enhance independence through the use of technology for adults with learning disability The Learning Disabilities programme is committed to supporting that 20% of the overall RIF is utilised to promote social value.	
Integrated community hubs	✓
It is intended that development of integrated community hubs will be led by the @Home programme utilising capital funding to complete feasibility plans by early 2023. It is anticipated that all priority groups within the RIF programme portfolio will be able to make use of these hubs upon their completion. The Health Board's *Shaping our Future Wellbeing: In our Community* (SOFW:IOC) programme business case has been developed with partners and was endorsed by Welsh Government (2019) and the subsequent capital business cases and WG investment seeks to support the development and reconfiguration of community infrastructure to create a network of Locality Health and Wellbeing Centres (H&WCs) and smaller Cluster focused Wellbeing Hubs (WHs) across Cardiff and Vale that support the above objective. The overall vision is summarised in the diagram below with the work driven through both the @Home programme and the SOFW:IOC delivery board	



Planning work commissioned in the last quarter of 2021/22 with the use of ICF Capital funding will inform the development of the proposals for the Barry Health and Wellbeing Centre/Hospital, the new H&WBC for the North Cardiff Locality and the opportunities created through the development of Michaelston Wellbeing Village which may have a particular focus on services for children and young people. There is a very pressing need to develop the plans for primary and community services in North Cardiff because of the speed at which housing developments are progressing in the area.

Workforce development and integration	
Workforce and organisational development is fundamental to the delivery of all programmes within the RIF programme portfolio. Specific investment in a Workforce and OD specialist will be included within the Partnership Support plans as part of our acceleration proposal.	✓

Programme - Priority population groups

Select both the primary and secondary beneficiaries of the programme by priority population group, using the free text box to describe the particular impacts this will have. Please also indicate if the beneficiaries are supported using DAP funding.

Priority population groups	Primary	Secondary	DAP
Older people including people with dementia		✓	
To provide a system-wide approach to supporting people living with dementia including individuals that have a learning disability.			
Children and young people with complex needs	✓	✓	

Young people with complex needs transitioning in to adult services through an integrated partnership approach to transition			
People with learning disabilities and neurodevelopmental conditions including autism*	✓		
To provide a system-wide approach to supporting people who may have multiple conditions with learning disability as a primary need.			
Unpaid carers*	✓	✓	
To provide a system-wide approach to learning disability which also supports the unpaid carer and families of those living with learning disabilities through information, advice and direct services that enable short breaks			
People with emotional and mental health wellbeing needs		✓	
To provide a system-wide approach to learning disability which supports those who may have emotional and mental health wellbeing needs			

Other beneficiaries

If there are other stakeholders benefiting from the programme, please provide this detail below.

Total programme cost and match funding projection

Total cost of Programme	Welsh Government contribution	Partner match monetary	Partner match resource	% support for unpaid carers	% for social value sector delivery
£1.215m	£1.013m	0	£0.202m	35%	0.09%

Programme resource and management details

Provide a summary of the planned resource and roles required to deliver this specific programme. These roles are 100% funded via the RIF and will accounted for within the allocated fund.

Posts / type of roles	Estimated FTE	Costs
Programme Management	2.0	£0.105m

Project plans

Title of project to support model of care (programme)
Fit for my Future (Transition from Child to Adult)
Models of care the project will contribute towards
Community based care – Prevention and community coordination Community based care – complex care closer to home
Project Summary
This project focusses on prevention and early approaches to supporting people with learning disabilities as they reach adulthood and has an interface with the Children with Complex Needs and Disabilities programme within the Starting Well Partnership. This project builds on the successful implementation of 'Planning for my Future' a regional transition protocol that outlines planning processes for all young people with ALN. This project focusses on young people transitioning into adult hood where learning disability is the main area of need, and where additional statutory support may be required for these young people to transition successfully. This project complements an existing workforce and has achieved early planning for young people through the recruitment of social work and support staff. This has reduced the delay in decision making for young people in planning for their future and increased the choice of services available to young adults with complex learning disabilities. Since 2018 over 200 additional people have been supported via a transition social worker to receive an early assessment to identify routes into adult services and plan for ongoing service provision to meet ongoing need. Within this project, additional services have been expanded to support young people with learning disabilities to access day opportunities through the provision of skilled support staff, working in school settings and in the community. This project has enabled young people with complex learning disabilities to stay within their education provision and move successfully into an adult provision seamlessly, alongside strengthening the local offer and reducing the need for out of area provisions, or better planning to understand need to support return. Across these projects, over 38 young adults have also been supported to remain with their family carers through enhanced local provision in 21/22. This project seeks to embed 'Planning for my future' for people with an identified learning disability through the continuation of transition social workers working across Child and Adult Services and expansion of the day opportunities services to support more young people to access local provisions that follow seamlessly on from school.

We are also seeking to embed and further develop our recent work with the local further education college that strengthens the opportunities for young people with learning disabilities to access a local college course. Whilst this is within a pilot phase at present, having started on a very small scale in September 2021, we anticipate that through a partnership approach across education and adult services we will be able to support more young people with complex learning disabilities to be able to access local college placements with support. This will enable people to remain close to home, within families and communities and access further education along with their peers. In addition, this approach will enable services to continue to ensure that services are 'fit for the future' of young adults with learning disabilities through local information and planning forums.

This project enables delivery of the Cardiff and Vale Learning Disability Strategy, within the following areas;

- Transition from Child to Adult
- Work, Volunteering and Day Opportunities
- Choice and Control
- Accessible Information
- Right Support - Right Time

Priority population group
People with learning disabilities, neurodiverse and neurodevelopmental conditions including autism
Key enablers
All five enablers will support delivery in this area
New or existing investment
This is a combination of new and existing investment
Estimated total cost
£0.368m

Start date	**Describe Phases**
01.04.2022 All embedding elements have already commenced	Embedding projects will build on existing delivery

Title of project to support model of care (programme)
Right Support, Right Time
Models of care the project will contribute towards
Community based care – Prevention and community coordination Community based care – complex care closer to home Promoting good emotional health and well-being
Project Summary
This project focusses on ensuring people with learning disabilities have access to the right support at the right time, in the right place and from the right person and will build upon the overall aspiration of the RPB to deliver locality-based care wherever possible across our region. We want people with learning disabilities to have equal access to services and support, and to be able to access this within their local communities and neighbourhoods. This project has focussed on a number of areas to improve the experiences and outcomes for people. Review and assessment – Additional social workers have provided timely access to assessment and review to ensure that people have access to the right level of support at the right time. This can include ensuring people are connected to local resources where possible, but also ensuring increased levels of support are made available at the times when these are needed such as hospital admission and discharge. Social workers have provided further assessments to those individuals living outside of area, to be able to identify the right support locally in assessing whether individuals can relocate back to the region. COVID 19 has had a significant impact on the changing needs of the learning disability population and throughout this time period over 1200 individuals were contacted and reviewed to ensure they had access to the right levels of care and support. We have strengthened our short breaks and placement schemes across the Vale of Glamorgan, to ensure that parents and carers have access to the breaks they need. This project also enables people with learning disabilities to live with other families/placement schemes which reduces the need for out of area homes and supports people to live within their communities with friends and neighbours. 50 new people have accessed this project since 2018 and we have been able to move from a residential model of short breaks provision to a community focused shared lives approach. We have begun to test the benefits of technology enabled care within peoples' homes. COVID 19 had a significant positive impact on the delivery of this project, with the need to expedite the provision of equipment to all people to reduce the impact of isolation and increase resilience of those who may need technology to support them in daily tasks. The feedback received from this project has been overwhelming, with individuals with lived experience being connected to each other and wider networks of individuals across the country. Our collaborative approach across the partnership with the 3rd sector has reached more individuals who have demonstrated positive outcomes through the use of technology within their own homes. Stories from this project can be viewed here following this weblink to demonstrate the outcomes achieved to date https://www.youtube.com/watch?v=YDZslgBET8E During the short space of time that the pilot has been running (since 2021) 39 people have benefited from additional technology to support them with daily living and maintain independence. COVID has impacted on delivery methodology (due to social distancing and PPE requirements) and it would be anticipated that as restrictions ease that this project scope can be increased to reach more individuals and continue the collaborative work between local authorities and the third sector expertise Reducing health inequalities – additional health care assistants have been supporting individuals with learning disabilities to access health checks and vaccinations, bringing additional capacity to the specialist learning disability teams. This project has been complemented through Improving Lives, with an additional Learning Disability Liaison Nurse at the University Hospital of Wales. They have been able to ensure that planned discharge is taking place, there are better links with Community Providers, the specialist Community Health Teams, and the LD specialised Nurse team based within Primary care where appropriate. This project will move to be delivered by Cardiff and the Vale UHB and Community Interest Company.

Priority population group
People with learning disabilities, neurodiverse and neurodevelopmental conditions including autism Unpaid carers
Key enablers
All five enablers will support delivery in this area
New or existing investment
This is a combination of new and existing investment
Estimated total cost
£0.495m

Start date	Describe Phases
01.04.2022 All embedding elements have already commenced	Embedding projects will build on existing delivery

Title of project to support model of care (programme)
Having my own Home
Models of care the project will contribute towards
Community based care – complex care closer to home Accommodation based solutions Home from hospital
Project Summary
This project supports people with learning disabilities to access accommodation that is close to home. This has supported a number of individuals to be able to return home to the region following extending out of area placements or following attendance at residential college. Utilising additional ICF Capital resource, this project has also supported 3 young adults in Cardiff with learning disabilities to access shared accommodation locally with wrap around support. This accommodation prevented the further need for hospital-based assessments or specialist private provider placements and enabled all residents to remain living close to their families. The project has also improved local opportunities for accommodation and supported people to move into local supported accommodation rather than leaving the area. The project has also increased and improved monitoring of local accommodation working to ensure high quality local options are available. Both Cardiff and the Vale of Glamorgan have developed 'Smart Homes' (Bridgewater Road/Castle Avenue). The Vale of Glamorgan 'Smart House' provides accommodation for up to 4 people with learning disabilities to live within their own home through the use of technology and direct support. This project will enable individuals to be supported within a home environment and be assessed for a period of up to two years that supports move on to local opportunities, enabling throughput of individuals who will benefit from this approach, and further homes developed with technology to support people with learning disabilities to live close to home. This project seeks to embed these arrangements and further strengthen the ability to provide accommodation solutions to people with learning disabilities across the spectrum of need. This will require further evaluation and development work to be able to predict and plan for future accommodations in addition to the wrap around support that individuals may need to access when supported to live within their local area. A number of individuals that would benefit from this project currently live outside of area and will require intensive and long-term approaches to meeting their immediate needs, with careful planning and transition support to move, if this assessed as needed.
Priority population group
People with learning disabilities, neurodiverse and neurodevelopmental conditions including autism Unpaid carers
Key enablers
All five enablers will support delivery in this area
New or existing investment
This is an existing investment
Estimated total cost
£0.150m
Start date **Describe Phases**

01.04.2022 All embedding elements have already commenced	Embedding projects will build on existing delivery

Regional investment model

Select the funding element which the project will be set against. Repeat the table and rationale below for each project.

Title of project to support model of care (programme)	
Learning Disability Programme	
Funding elements	**Select**
Element 1 - Acceleration funding year 1	✓
Element 1 - Acceleration funding year 2	
Element 2 - Embedding fund year 1	✓
Element 2 - Embedding fund year 2	
Element 2 - Embedding fund year 3	
Element 3 - Legacy integrated pooled fund	
Element 4 – National priorities (Dementia and Memory Assessment Services/ Diagnostic Support)	

Provide the rationale for the element selected.

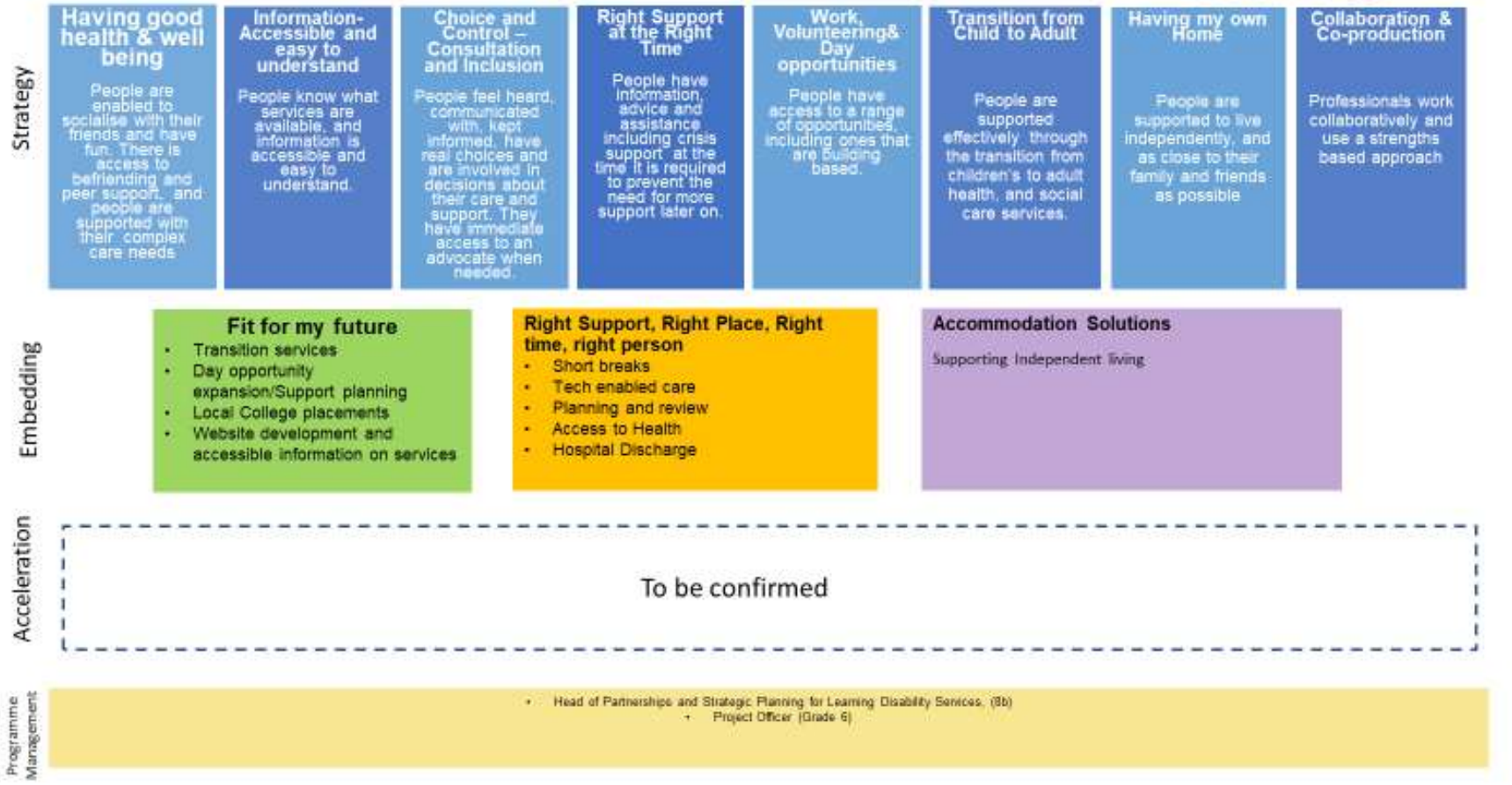
Embedding Acceleration to follow

Delivery partners

Title of project to support model of care (programme)				
Learning Disability Programme				
Delivery Partners	**Welsh Government contribution**	**Partner match monetary**	**Partner match resource**	**Total funding required**
Region	1.118	0	0.335	1.453

Appendix a Learning Disabilities Emerging Map

BWRDD PARTNERIAETH RHANBARTHOL CAERDYDD A'R FRO
CARDIFF & VALE REGIONAL PARTNERSHIP BOARD



BWRDD PARTNERIAETH RHANBARTHOL CAERDYDD A'R FRO
CARDIFF & VALE REGIONAL PARTNERSHIP BOARD

Health & Social Care Regional Integration Fund

@home programme

HENEIDDIO'N DDA AGEING WELL

Llywodraeth Cymru
Welsh Government

National Models of Care – Strategic Vision

The primary purpose of the Health and Social Care Regional Investment Fund is to build on the learning and development undertaken by the Integrated Care Fund and the Transformation Fund and to establish and embed six new National Models of Integrated Care by 2027.

The summary below describes how our local programmes and projects within this document will collectively deliver the associated National Models of Care and wider commitments of A Healthier Wales. Please refer to Annex A for supporting narrative.

Community-based care – Prevention and community coordination

The region endorses Welsh Government's commitment to community-based care with the following outcomes:

1) People's well-being needs are improved through accessing co-ordinated community-based solutions.
2) Local prevention and early intervention solutions support people to avoid escalation and crisis interventions.

In line with these aspirations, the @Home Programme aims to deliver the following commitment for 'older people including people with dementia' in Cardiff and the Vale of Glamorgan:

> *"To establish integrated, locality-based, health & care services focused on meeting and improving the health and wellbeing of the local population, based on the ambitions of A Healthier Wales"*

The programme will develop the following areas which will support the new model of care:

- Cluster-based integrated, multi-agency teams
- Consistent intermediate care model
- Alliance approach development in the Vale (cross-cutting enabler)
- Barry hospital/Health and Wellbeing Centre and North Cardiff Health and Wellbeing Centre feasibility and delivery
- Single route into all community services
- Coordinated hospital discharge services

Community-based care – complex care closer to home

Cardiff and Vale RPB support Welsh Government's commitment to community-based care by providing complex care close to home so that:

1) People are more involved in deciding where they live while receiving care and support
2) Complex care and support packages are better at meeting the needs of people and delivered at home or close to home

In line with these aspirations, the @Home Programme aims to deliver the following commitment for 'older people including people with dementia' in Cardiff and the Vale of Glamorgan:

> *"To establish integrated, locality-based, health & care services focused on meeting and improving the health and wellbeing of the local population, based on the ambitions of A Healthier Wales"*

The programme will develop the following areas which will support the new model of care:

- Cluster-based integrated, multi-agency teams
- Consistent intermediate care model
- Alliance approach development in the Vale (cross-cutting enabler)
- Barry hospital/Health and Wellbeing Centre and North Cardiff Health and Wellbeing Centre feasibility and delivery
- Single route into all community services
- Coordinated hospital discharge services

Promoting good emotional health and wellbeing

Our region is keen to ensure that:

1) People are better supported to take control over their own lives and well-being
2) People have improved skills, knowledge and confidence to be independent in recognising their own well-being needs

In line with these aspirations, the @Home Programme aims to deliver the following commitment for 'older people including people with dementia' in Cardiff and the Vale of Glamorgan:

> *"To establish integrated, locality-based, health & care services focused on meeting and improving the health and wellbeing of the local population, based on the ambitions of A Healthier Wales"*

The programme will develop the following areas which will support the new model of care:

- Cluster-based integrated, multi-agency teams
- Consistent intermediate care model
- Alliance approach development in the Vale (cross-cutting enabler)
- Barry hospital/Health and Wellbeing Centre and North Cardiff Health and Wellbeing Centre feasibility and delivery
- Single route into all community services
- Coordinated hospital discharge services

Preventing children entering care and supporting children to remain with their families

The scope of the @Home Programme does not include attainment of outcomes relating to Preventing children entering care and supporting children to remain with their families. However, the programme may choose to develop this aspiration in subsequent years as work progresses and in collaboration with the Starting Well Partnership.

Home from hospital

Our region is committed to ensuring that:

1) People go home from hospital in a timelier manner with the necessary support in place at discharge
2) People have a better understanding of the discharge process and are more involved in pre and post discharge planning

In line with these aspirations, the @Home Programme aims to deliver the following commitment for 'older people including people with dementia' in Cardiff and the Vale of Glamorgan:

> *"To establish integrated, locality-based, health & care services focused on meeting and improving the health and wellbeing of the local population, based on the ambitions of A Healthier Wales"*

The programme will develop the following areas which will support the new model of care:

- Cluster-based integrated, multi-agency teams
- Consistent intermediate care model
- Alliance approach development in the Vale (cross-cutting enabler)
- Barry hospital/Health and Wellbeing Centre and North Cardiff Health and Wellbeing Centre feasibility and delivery
- Single route into all community services
- Coordinated hospital discharge services

Accommodation based solutions

Cardiff and the Vale region want to ensure that:

1) People are more involved in the design of accommodation to meet their needs
2) People have more choice about where they live and with whom

In line with these aspirations, the @Home Programme aims to deliver the following commitment for 'older people including people with dementia' in Cardiff and the Vale of Glamorgan:

> *"To establish integrated, locality-based, health & care services focused on meeting and improving the health and wellbeing of the local population, based on the ambitions of A Healthier Wales"*

The programme will develop the following areas which will support the new model of care:

- Cluster-based integrated, multi-agency teams
- Consistent intermediate care model
- Alliance approach development in the Vale (cross-cutting enabler)
- Barry hospital/Health and Wellbeing Centre and North Cardiff Health and Wellbeing Centre feasibility and delivery
- Single route into all community services
- Coordinated hospital discharge services

In addition, the programme will contribute to a region-wide exercise to identify shared capital development priorities in preparation for emerging capital funding provision in 2022 onwards.

Programme title

If an element of the programme is moving from ICF/TF funding into the RIF, also include the previous programme title, if different.

Cardiff and Vale of Glamorgan @Home programme

Priority Models of Care for the programme

Priority model of care	Select	DAP*
Community-based care – Prevention and community coordination	✓	
Community-based care – complex care closer to home	✓	
Promoting good emotional health and wellbeing	✓	
Preventing children entering care and supporting children to remain with their families		
Home from hospital	✓	
Accommodation based solutions	✓	

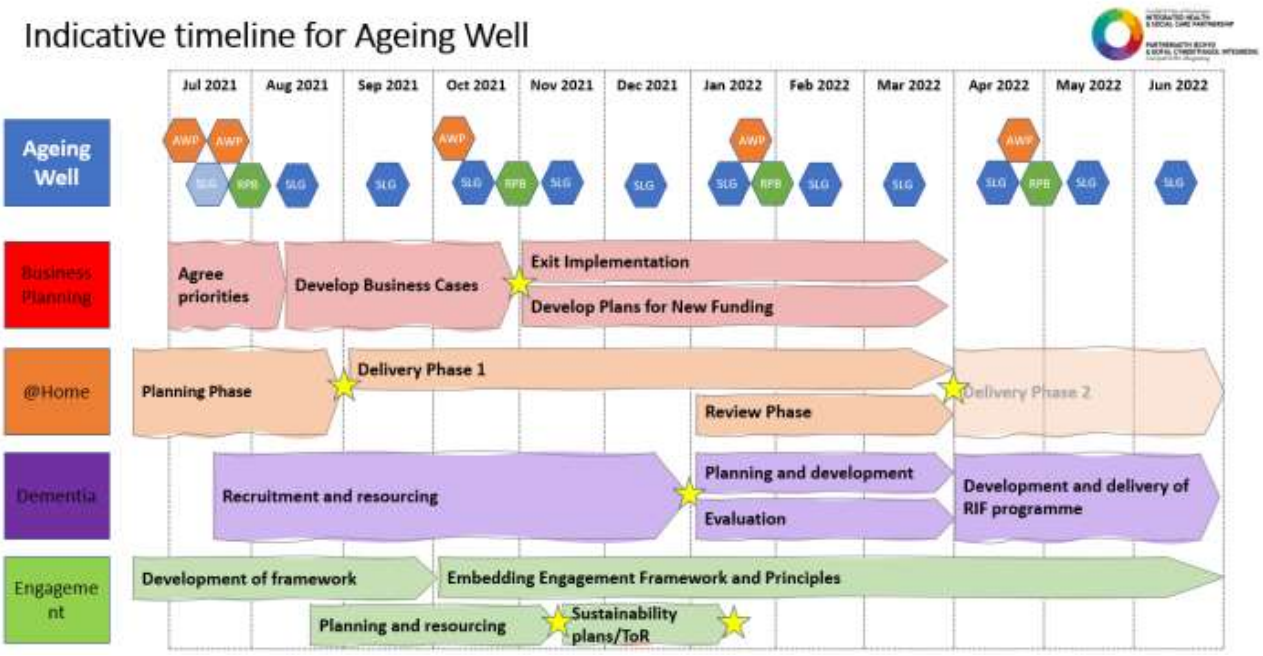
* the Cardiff and Vale Dementia programme Investment Proposal lists the use of all DAP funding with the exception of one project which sits in our carers strategy programme

Programme - Executive summary

Previously, the Regional Partnership Board has established a number of key service innovations utilising the Integrated Care Fund (ICF) and Transformation Funding with a view to improving the lives of 'older people including people with dementia' specifically:

- Schemes which develop single access points to community services
- A number of projects to develop specific areas of intermediate care and D2RA including a number of accommodation-based solutions
- A pilot project to support cluster development as an integrated, multi-disciplinary network
- Development of hospital-based teams who support discharge through accessing community support where required.

In the last year, the RPB undertook a comprehensive review of its governance arrangements to ensure we are in a position to drive change effectively across the region. This resulted in the introduction of the Ageing Well Partnership (AWP), one of three new programme delivery partnerships which will enable the RPB to give particular focus to improving outcomes for people at different stages in their lives. This partnership has now developed a clear set of aspirations to support 'older people including people with dementia' as outlined in its Delivery Plan summary below:



The Cardiff and Vale @Home Programme is one of the vehicles for the region's AWP to deliver those aspirations.

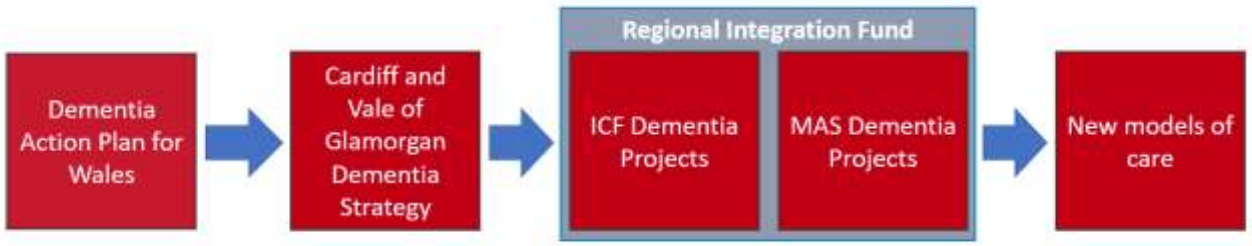
The demise of the ICF and Transformation Funds, combined with the introduction of the new Regional Investment Fund has allowed us to undertake a thorough overhaul of all previous service delivery investment against these newly agreed aspirations. This has resulted in a new programme where the outcomes of those initial workstreams have been re-aligned to form a foundation for the next phase in innovative service development for 'older people including people with dementia'. Over the next 5 years, the @Home programme will deliver:

- Cluster-based integrated, multi-agency teams
- Consistent intermediate care model
- Alliance approach development in the Vale (cross-cutting enabler)
- Barry hospital/Health and Wellbeing Centre and North Cardiff Health and Wellbeing Centre feasibility and delivery
- Single route into all community services
- Coordinated hospital discharge services

A schematic demonstrating the links between this programme and the respective models of care outlined within the RIF guidance is provided as Annex A. Further explanatory detail showing the links between the @Home programme and the national models is provided in section 1 of this document.

Dementia Action Plan (DAP) summary

The Cardiff and Vale Dementia Programme is the delivery vehicle for the region's Dementia Action Plan (DAP).



An external evaluation is currently being undertaken to:

- Understand how well the region has progressed towards achieving DAP priorities so far;
- Capture a baseline assessment of where the current DAP aligns with the newly launched All Wales Dementia Care Pathway of Standards and to identify any gaps which must now be taken into account;
- Identify areas in Dementia care which need further support or development as a result of the COVID-19 pandemic;
- Compare the DAP with the emerging findings of the region's Population Needs Assessment, again with a view to ensuring that key priorities are included within the revised DAP.

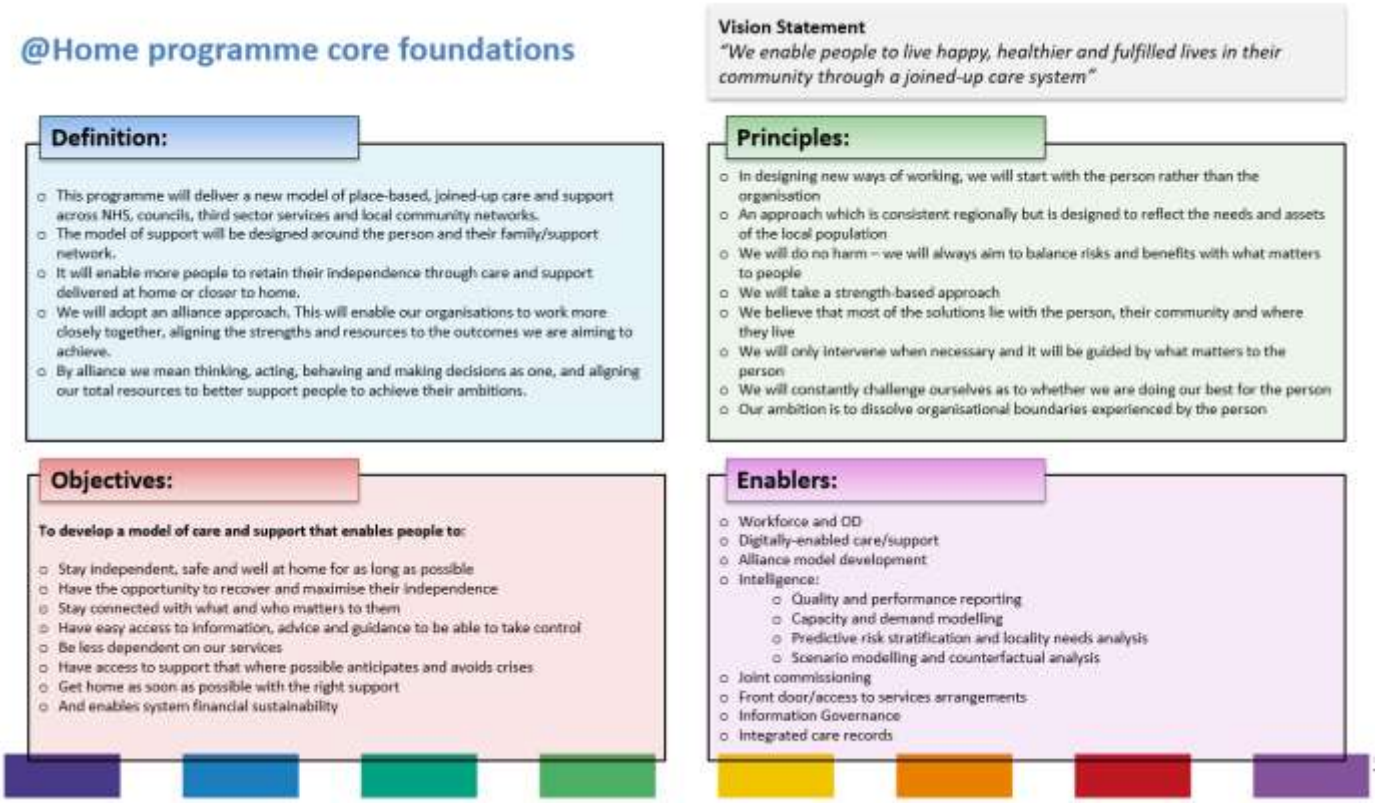
The outcome of this evaluation will help the region to inform priorities for recurrent funding from October 2022 and beyond. The resulting Dementia Programme will ensure that recurrent funding is aligned to meet the needs of people living with Dementia and their carers across the region through a delivery plan that dovetails with the wider RIF and anticipated capital programmes as appropriate.

Programme - Business case

Aims and Objectives:

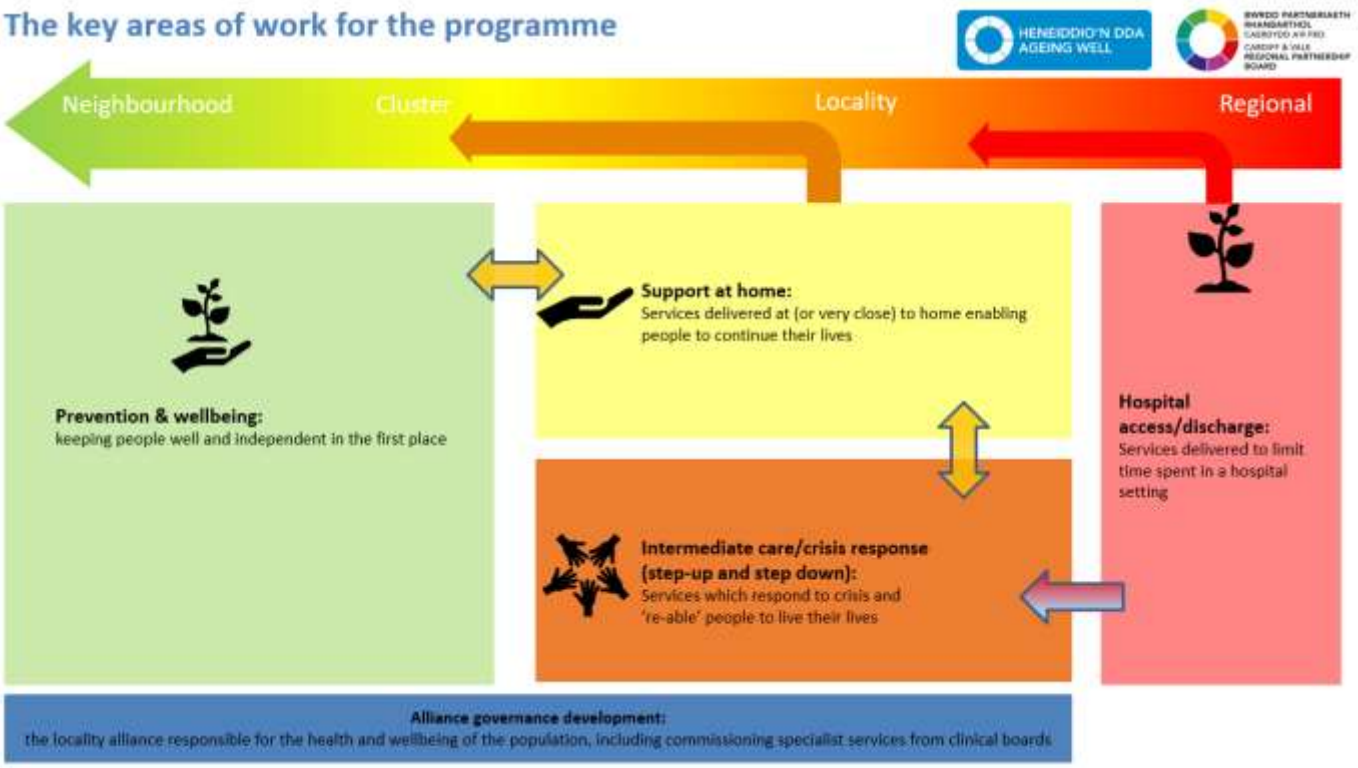
A Healthier Wales gives a clear mandate for regions to develop integrated locality-based working to enable people to live well for longer in their own homes and communities. This programme, although focussed on older people, is the delivery vehicle for this vision in the region.

This programme has been developed with the support of partners and through ICF and Transformation Funds, and has matured to a point where we can articulate the vision, definition, principles and objectives, as well as some of the key enablers. These core foundations set out the ambition of what the programme aims to deliver over the next 5 years:



By having a clearly defined set of core principles we are engaging partners in a joint vision for developing a new system of delivery for health and social care services.

The diagram below illustrates how we want to shift the focus for delivery of services away from the acute settings to a neighbourhood level which will ensure the person is able to stay healthy and well in their own home for as long as possible.



Utilising this approach, we have identified six areas for development which will build on the work which has previously been achieved through ICF and Transformation funding. The projects we have agreed to take forward are as follows:

- Access – single route into all community services
- Intermediate care – a responsive locality-based reablement service
- Accelerated cluster development – community-based integrated, multi-agency networks
- Health and wellbeing centres – delivering integrated services at a locality level
- Hospital to home – coordinated hospital discharge services
- Vale alliance – a new governance approach to delivering integrated services

A demonstration of how previous projects will now be embedded within the foundation of the new programme plan is provided below:

@Home Programme Map 22-23

Project	Access	Intermediate Care	Accelerated Clusters	Health & Well being Centres	Vale Alliance	Hospital to Home
Embedding	OP1 Independent Living Service OP2 Vale Single Point of Access	OP3 Cardiff CRT & Bridging OP5: Vale CRT & Bridging OP6 Vale Residential D2A OP7 Cardiff Nursing D2A OP14 Cardiff Residential reablement OP8 Accommodation Solutions OP15 Vale Dom care T5 Get me home plus	TF1 Accelerated cluster development TF2: Seamless social prescribing	Capital: Feasibility work		T4 Get Me Home OP9 Integrated Discharge Service
Accelerating		Intermediate Care Crisis Response Right sized provision of other IC home based, reablement and bed based intermediate care OD training and development	Roll out to further 4 clusters OP13 Loneliness and Isolation OP15 Vale Dom Care	Ongoing feasibility and business planning	Legal and OD costs to be defined.	Development of the 'discharge hub'

Links between the @Home programme and associated national Models of care are articulated clearly within section 1 of this document and also in Annex A.

Baseline Position:

Our latest Population Needs Assessment (due for publication in 2022) contains a chapter on older people which outlines a number of priority areas which the @Home programme aims to address, specifically:

- Recognise the diversity of the "older people" group and provide services to meet the needs of such a diverse group, including transport options
- Continue to embed the Cardiff and Vale Rehabilitation Model
- Further develop existing collaborations to provide high quality end of life care
- Integrate care and support services to enable older people to live independently and well at home for as long as possible, for example, through the @home programme
- Promote the use of Dewis Cymru to increase awareness of available support services
- Support new building developments to meet the needs of an ageing population, and increase the provision of a variety of accommodation options to enable older people to make informed choices on where and how they live
- Implement the Housing Adaptations Strategic Framework; and ensure existing properties are appropriate, safe, and support older people's independence
- Apply urban design standards and accessibility criteria when redesigning existing infrastructure, for example, increasing the time for people to cross the road at a light-controlled pedestrian crossing (106)
- Promote the Royal College of General Practitioners 'Tackling loneliness. A community action plan for Wales' amongst health care providers and partners to raise awareness of loneliness, and advise how lonely patients can be identified and supported (106

This programme also builds on our priorities highlighted through our area plan, specifically:

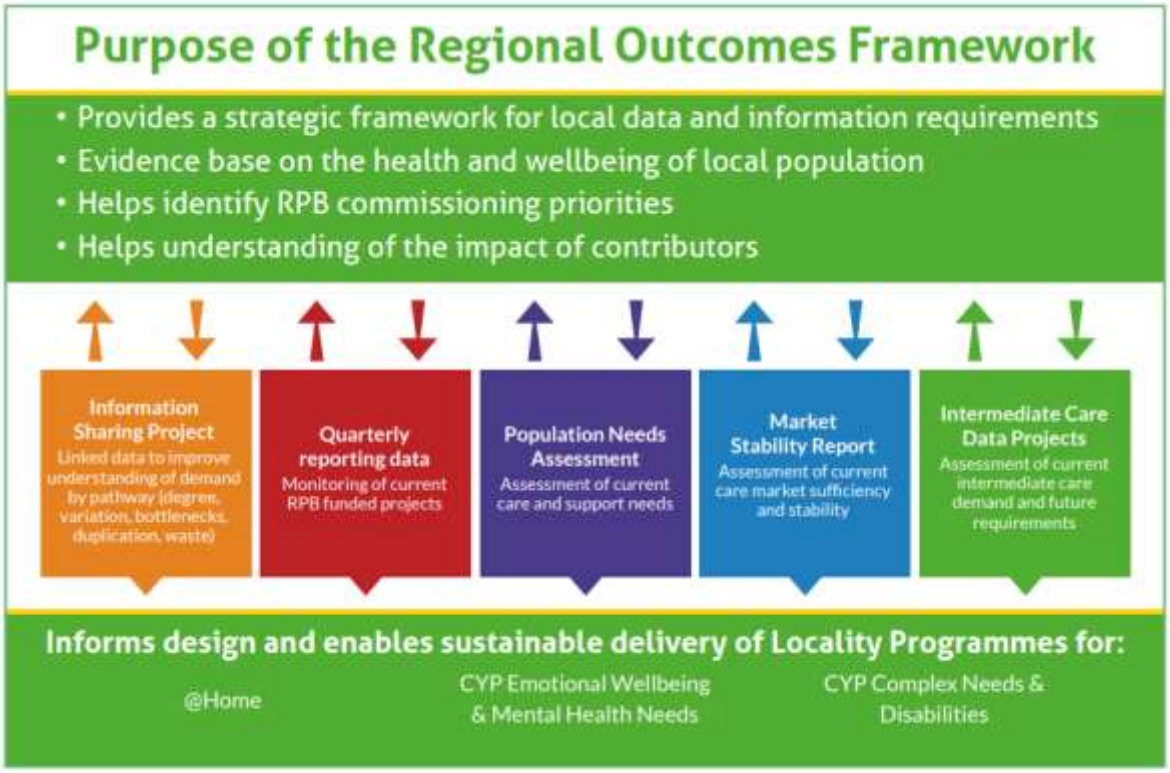
- OP1.1: Building on the First Point of Contact and Single Point of Access services, further develop digital services along with easily accessible telephone, online and face-to-face access points for the region, for both professionals and the public.
- OP1.2: Develop resilient communities with local services, infrastructure and strong community networks to meet local needs where older people live.
- OP1.3: Develop and provide a range of future accommodation options to meet demand and enable people to remain at home for as long as possible.
- OP1.4: Develop improved assessment, diagnosis and care planning practices which are built upon genuine collaboration with older people and their carers and families, so that their plans reflect what is important to them and achieves the outcomes they seek
- OP1.5: Develop Cardiff and Vale of Glamorgan as a dementia friendly region

Benefits Realisation:

Cardiff and Vale Regional Partnership Board has a Regional Outcomes Framework (ROF) to which all our outcomes regionally align and that also articulate what we want to achieve for the whole population which includes 'older people including those with dementia'. Those outcomes are:

- Reduced wasted system resource
- Increased time for people to live their lives
- Increased living well in their own home and community
- Improved environment that enables people's choices
- Decreased avoidable harm or mortality
- People get a safe response when in urgent need
- More empowered workforce.

The ROF has been developed over a period of years and is currently being used to chart progress against these outcomes for older people only. Over the next year, it is the intention to introduce data charting outcomes for other priority population groups.



At an operational level, the region has positive experience of utilising Results Based Accountability to measure key performance outcomes for individual projects. This methodology will be utilised in the formation and delivery of all projects across the RIF programme portfolio. Qualitative information will be gathered via our Engagement Delivery Framework outlined within the Strategic Plan.

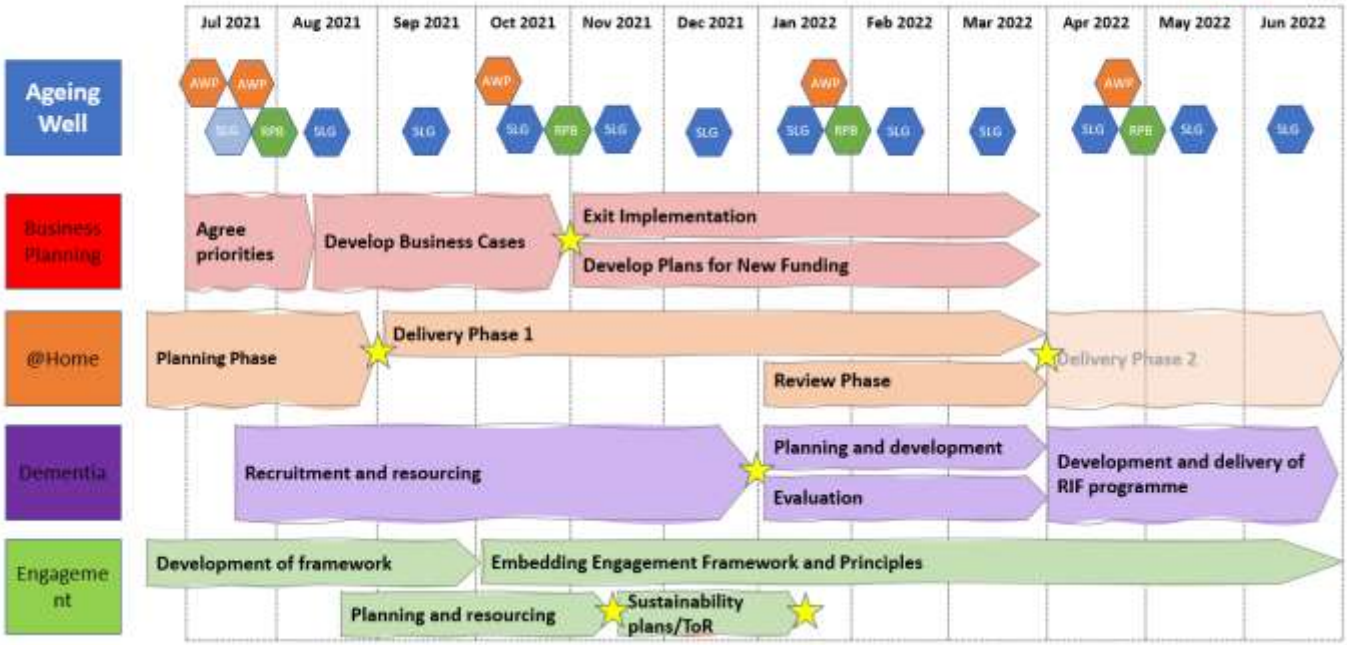
Additionally, each of our projects is focussed on delivering capability which will improve people's lives and contribute to the following key quantifiable metrics which will indicate whether benefits are being realised:

- Reduction in non-elective admissions
- Reduction in outpatient attendances
- Reduction in admissions to long-term residential care
- Increase in resolution of issue at first contact
- Reduction in the number of domiciliary care packages
- Reduction of re-entry/re-admission into system
- Reduce waiting times to assessment and packages of care

Plans for sustainability:

This programme is a key priority for the Regional Partnership Board's Ageing Well Partnership which has already agreed the following overall delivery plan. Partners have already demonstrated their commitment to the @Home programme through the provision of match funding to support its work in 2022-23 as outlined in the project briefs below. The region has initiated work to develop a Memorandum of Understanding, completion of which will set a clear commitment and roadmap for the ongoing development of sustainable funding streams over the remaining 4 years.

Indicative timeline for Ageing Well



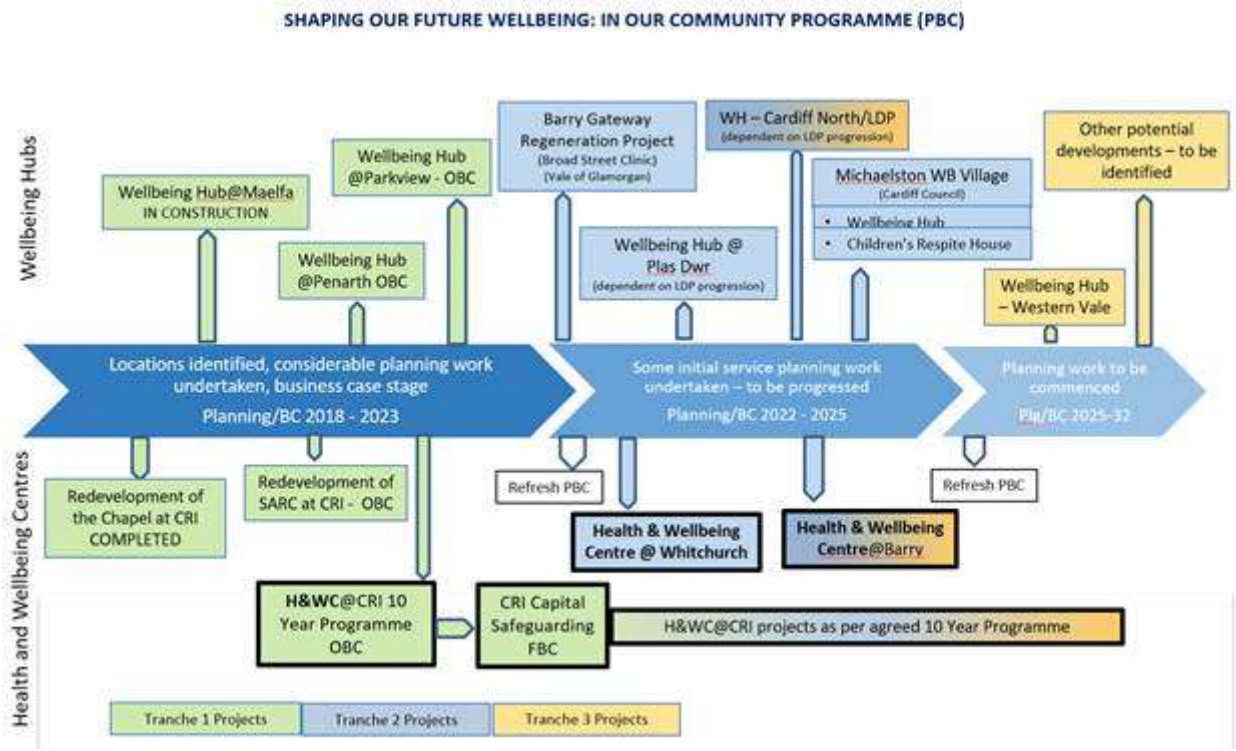
Programme - Key enablers

Key Enablers	Select
Integrated planning and commissioning The @Home programme enables partners to work together to take forward jointly agreed priorities for this population through a centrally provided management structure which works alongside operational teams to design, support and deliver new ways of working. This ongoing commitment to integrated planning will be informed by the findings of the region-wide Population Needs Assessment and the Market Stability Report which are under development currently. The @Home programme is also contributing to a region-wide exercise which will identify shared capital development priorities in preparation for emerging capital funding provision in 2022 onwards. The region is committed to developing opportunities for integrated commissioning. In relation to the @Home programme, this is particularly relevant for the following projects: • Accelerated cluster development – ensuring community assets, particularly the 3rd sector, are empowered to support local citizens • Intermediate care – ensuring the right level of support is available at the right time to enable people to stay well at home and avoid crises • Health and wellbeing centres – utilising capital assets at a locality level to support citizens in an integrated way • Hospital to hope – ensuring the right level of support is available at the right time to enable people to stay well at home and avoid crises • Access – ensuring the right level of support is available at the right time to enable people to stay well at home and avoid crises	✓
Technology enabled care The @Home programme revolves around developing seamless care which avoids duplication and improves safety and outcomes through having a shared record of the citizen which is available across systems and organizations.	✓
Promoting the social value sector The social value sector plays a key role with representatives from C3SC, GVS, Care and Repair, Platfform organisations on its programme board and project groups. Promoting the social value sector is particularly relevant in the following projects: • Accelerated cluster development – ensuring community assets, particularly the 3rd sector, are empowered to support local citizens • Intermediate care – ensuring the right level of support is available at the right time to enable people to stay well at home and avoid crises • Health and wellbeing centres – utilising capital assets at a locality level to support citizens in an integrated way The @Home programme is committed to ensuring that 20% of its overall funding is utilised to promote social value. It's current contribution within the embedding fund will be further expanded where possible through the use of acceleration funding.	✓

Integrated community hubs

The development of integrated community hubs will be led by the @Home programme utilising capital funding to complete feasibility plans by early 2023. All priority groups within the RIF programme portfolio will be able to make use of these hubs upon their completion.

The Health Board's *Shaping our Future Wellbeing: In our Community* (SOFW:IOC) programme business case has been developed with partners and was endorsed by Welsh Government (2019) and the subsequent capital business cases and WG investment seeks to support the development and reconfiguration of community infrastructure to create a network of Locality Health and Wellbeing Centres (H&WCs) and smaller cluster-based Wellbeing Hubs (WHs) across Cardiff and Vale that support the above objective. The overall vision is summarised in the diagram below with the work driven through both the @Home programme and the SOFW:IOC delivery board



Planning work commissioned in the last quarter of 2021/22 with the use of ICF capital funding will inform the development of the proposals for the Barry Health and Wellbeing Centre/hospital, the new H&WBC for the North Cardiff locality and the opportunities created through the development of Michaelson Wellbeing Village which may have a particular focus on services for children and young people. There is a very pressing need to develop the plans for primary and community services in North Cardiff because of the speed at which housing developments are progressing in the area.

✓

Workforce development and integration

Workforce and organisational development is fundamental to the delivery of all programmes within the RIF programme portfolio. Specific investment in a Workforce and OD specialist will be included within the Partnership Support plans as part of our acceleration proposal.

✓

Programme - Priority population groups

Priority population groups	Primary	Secondary	DAP
Older people including people with dementia	✓		
To establish integrated, locality-based, health & care services focused on meeting and improving the health and wellbeing of the local population, based on the ambitions of A Healthier Wales. The programme is focussed on the needs of *older people*, however it is hoped that the developments will be felt across population groups.			
Children and young people with complex needs		✓	
The initial scope of the programme is to develop those services for older people, however by taking a system-wide approach it is hoped that access and services will be improved for the whole population including *children and young people with complex needs*.			

People with learning disabilities and neurodevelopmental conditions including autism*		✓	
The initial scope of the programme is to develop those services for older people, however by taking a system-wide approach it is hoped that access and services will be improved for the whole population including *people with learning disabilities and neurodevelopmental conditions including autism.*			
Unpaid carers*		✓	
The initial scope of the programme is to develop those services for older people, however by taking a system-wide approach it is hoped that access and services will be improved for the whole population including *unpaid carers.*			
People with emotional and mental health wellbeing needs		✓	
The initial scope of the programme is to develop those services for older people, however by taking a system-wide approach it is hoped that access and services will be improved for the whole population including *people with emotional and mental health wellbeing needs.*			

Other beneficiaries

If there are other stakeholders benefiting from the programme, please provide this detail below.

Total programme cost and match funding projection

Provide a breakdown of the total programme cost, Welsh Government contribution, partner monetary and resource match including costs attributed to support unpaid carers and / or social value sector delivery. You can find more information on match funding in the guidance notes.

EMBEDDING:

Total cost of Programme	Welsh Government contribution	Partner match monetary	Partner match resource	% support for unpaid carers	% for social value sector delivery
£7.335m	£5.135m	£0	£2.200m	3%	7%

ACCELERATING:

Total cost of Programme	Welsh Government contribution	Partner match monetary	Partner match resource	% support for unpaid carers	% for social value sector delivery
£tbc	£tbc	£tbc	£tbc	£tbc	£tbc

Programme resource and management details

Provide a summary of the planned resource and roles required to deliver this specific programme. These roles are 100% funded via the RIF and will accounted for within the allocated fund.

Posts / type of roles	Estimated FTE	Costs
Project management costs for delivery, performance monitoring, coms, change and development.	8.5wte	£0.384m

Project plans

In this section, outline each project that will contribute towards the successful delivery of the associated National Models of Care. For the purposes of the investment proposal you will need to provide:

- Information on all sections within the table below.
- Repeat the table for each project being put forward.
- Indicate if the project will be delivered using DAP funding in the summary.
- For Dementia project, outline which strand the project relates to DAP or Memory Assessment Services/Diagnostic Support in the summary.

Title of project to support model of care (programme)
Access
Models of care the project will contribute towards
Community-based care – prevention and community coordination; community-based care – complex care closer to home; promoting good emotional health and wellbeing; home from hospital
Project Summary
Over a number of years, access to community services has become fractured due to the nature of services developing within statutory organisations with little coordination across organisations delivering community support. This includes Community Resource Teams in each of the local authorities and the health board, as well as services developed through nursing and the ambulance trust, along with a number of third sector services aimed at supporting people at home. Accessing these services can be unclear for the citizen when they are most likely in need of support. Regionally, separate approaches to try to streamline this process have been made in Cardiff and also the Vale of Glamorgan with the support of the ICF and Transformation funding, specifically: • First point of contact (Cardiff) – this service developed access to the Cardiff Independent Living Services, which provided a 'what matters?' assessment and hosted a range of preventative interventions, both from within the Council and third sector. • Single point of access (Vale of Glamorgan) – this service developed an MDT approach to support individuals needs with access to a range of services, particularly with assessing for the need of community support and dom care. • GP triage (Eastern Vale Cluster) – this service looked at the viability of a centralised call-centre for accessing GP services and signposting alternative local services. This pilot ended due to the viability of doing this on a large scale and the implementation of other health board services during the pandemic. However, the learning from this work has been retained and feeds into the whole Access project. The @Home programme aims to build on this work by continuing the development of centralised, coordinated and seamless access to community services. Over the next 2 years, Cardiff and the Vale of Glamorgan will focus on developing internal processes which support integrated working in their access services, before developing a regional approach. This regional approach across the statutory organisations will ensure the best outcome for citizens by allowing access to a range of services and supporting individuals to make informed decisions based on what matters to them. This will also aid to reduce wasted system resource by aiming to reduce contacts and assessments as well as getting the person to the right service when they need it.
Priority population group
Older people including people with dementia
Key enablers
Technology and digital solutions; promoting the social value sector; integrated community hubs; workforce development and integration
New or existing investment
Existing
Estimated total cost
Embedding: £1.734m Accelerating: tbc

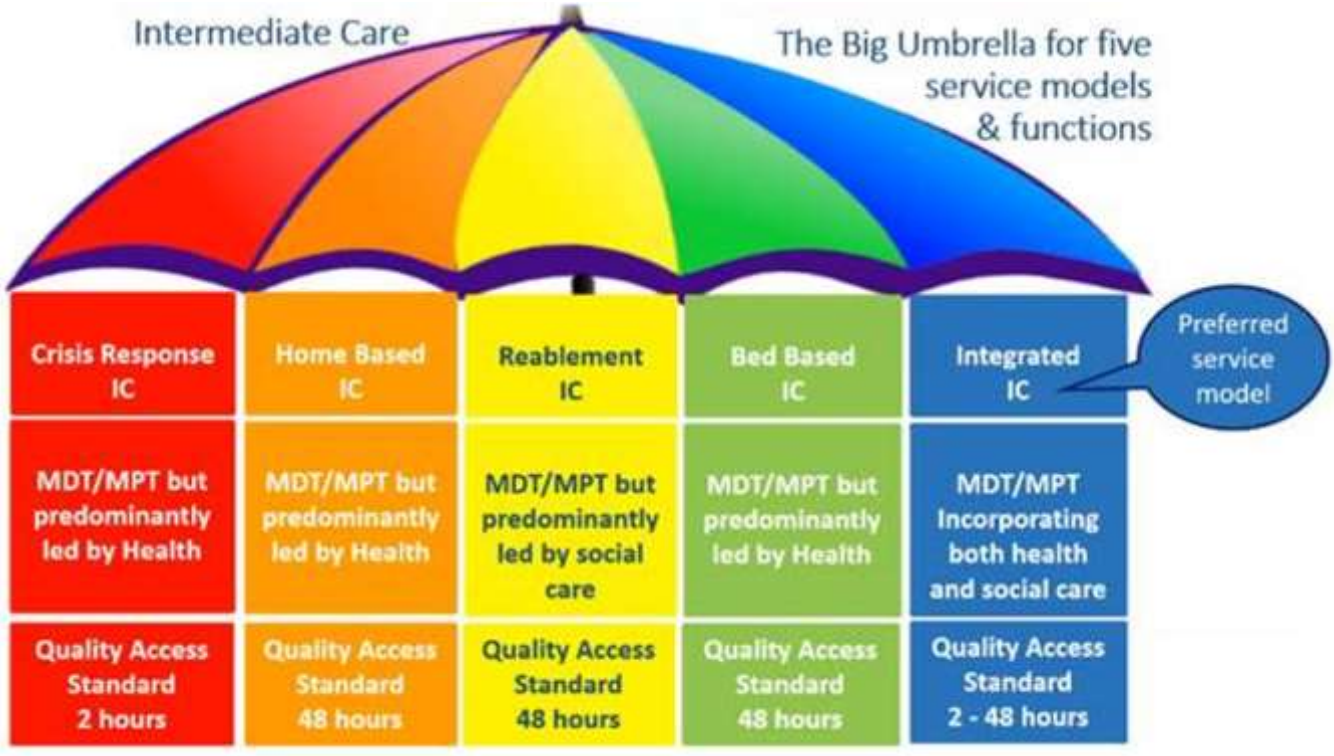
Start date	
2022-23 – phase 1	-commencement of RIF and service planning and implementation for Cardiff and Vale of Glamorgan
2023-24 – phase 2	-development of a region-wide vision and approach to access (including ties with UHB services) with implementation through the year
2024 onward	-review of the access work with work to embed the region-wide approach and to further develop

Title of project to support model of care (programme)
Intermediate Care
Models of care the project will contribute towards
Community-based care – prevention and community coordination; community-based care – complex care closer to home; home from hospital; accommodation based solutions
Project Summary

The approach to delivering intermediate care in the region has mainly focussed on the community resource teams in both Local Authorities and the Health Board. Through the use of ICF and Transformation funding, there have been a number of projects with the aim of developing specific areas of intermediate care with a focussed approach, these have been namely:

- CRT and bridging services – aimed at providing medium-term support for those who require a longer reablement process or time to ensure appropriate long-term care is provided
- Residential discharge to assess/reablement – aimed at providing short term support in a care home environment
- Accommodation solutions – providing temporary step-down accommodation for people whose homes are not suitable for their reablement or require minor adaptations before returning home
- Get me home plus – providing a higher level of care, often for medium-term stretches to allow for an earlier discharge as an appropriate level of long-term support is arranged

The ambition of the intermediate care project is to form a regional approach which brings together the various elements of intermediate care to allow for a broader scope in the development of the service as a whole. The project will aim to align services to the national strategy and pathways outlined below:



Over the next year the project aims to:

- Develop a regional approach which aligns services to the approach illustrated above

- Utilise the local modelling capability to understand the capacity and demand for services to allow a 'rightsizing' approach
- Develop an integrated 24/7 crisis response service which utilises best practice and learning from regions across Wales.

It is hoped that by looking to develop the intermediate care service as a whole, this will improve outcomes for citizens by providing the correct level of support when and where they need it, this will enable people's choices and also reduce pressure on acute health and long-term residential services.

Priority population group	
Older people including people with dementia	
Key enablers	
Integrated planning and commissioning; technology and digital solutions; promoting the social value sector; workforce development and integration	
New or existing investment	
Existing and new	
Estimated total cost	
Embedding: £3.368m Accelerating: tbc	
Start date	
2022-24 – phase 1 2024 onward – phase 2	-development of a regional vision and implementation of a crisis response service -ongoing development of a 24/7 service and a rightsized IC service across the region

Title of project to support model of care (programme)

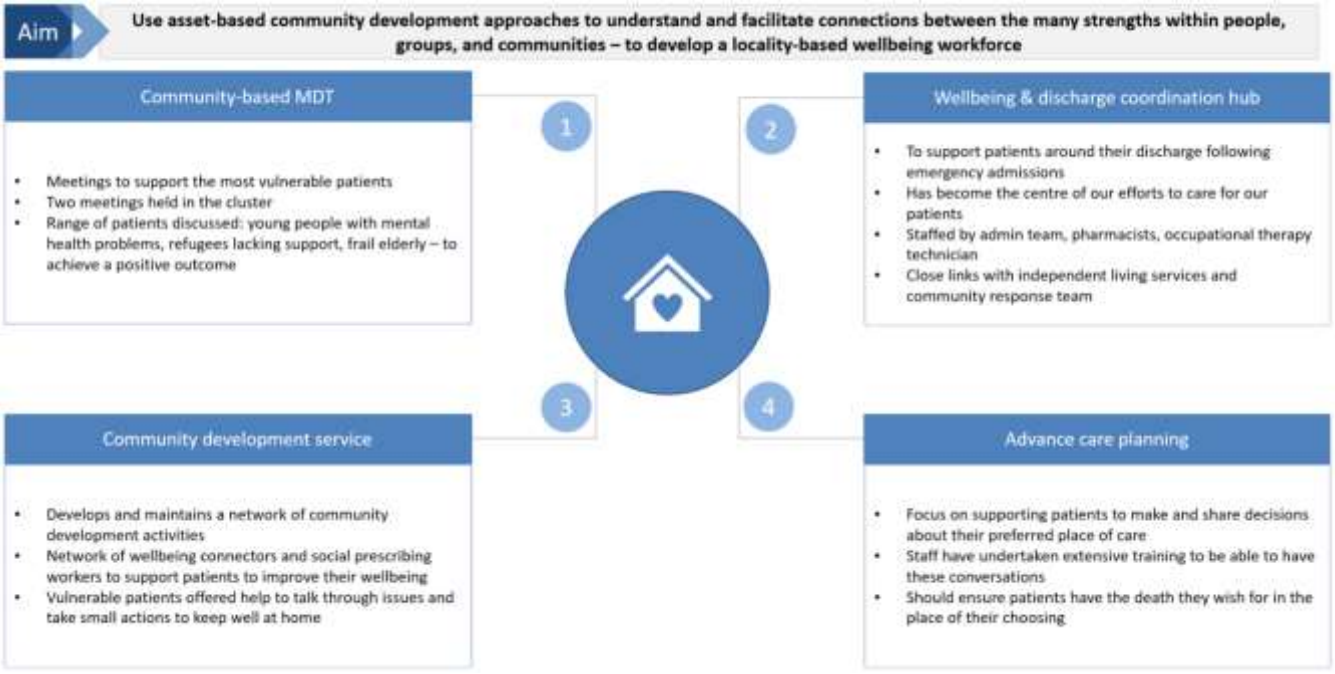
Accelerated Cluster Development

Models of care the project will contribute towards

Community-based care – prevention and community coordination; community-based care – complex care closer to home; promoting good emotional health and wellbeing; home from hospital

Project Summary

The development of clusters within primary care has created networks of GP practices who can pool a number of resources to help support citizens in their area. Utilising Transformation funding, the Cardiff South West cluster has been able to pilot developing the cluster to be an integrated network which utilises the range of services which are available within the community including local authority and third sector services. The below slide outlines the components of the model developed in Cardiff South West:



This work has been able to evidence the impact it has made, particularly on unplanned admissions and also presentations at A&E by citizens in the cluster area. This obviously has a significant impact on the acute demand and also on repeat appointments within the cluster, all of which provide better outcomes for the person.

Over the next 2 years, Cardiff and Vale want to begin a rapid rollout of this model, which also aligns to the national programme for primary care, in its ambitions for accelerated cluster development. Each cluster will develop its approach to implementing the different aspects of the model.

With the implementation over the next 5 years the outcomes as outlined above will be tracked to show the impact of this work on the local population and in-particular on acute services.

Priority population group

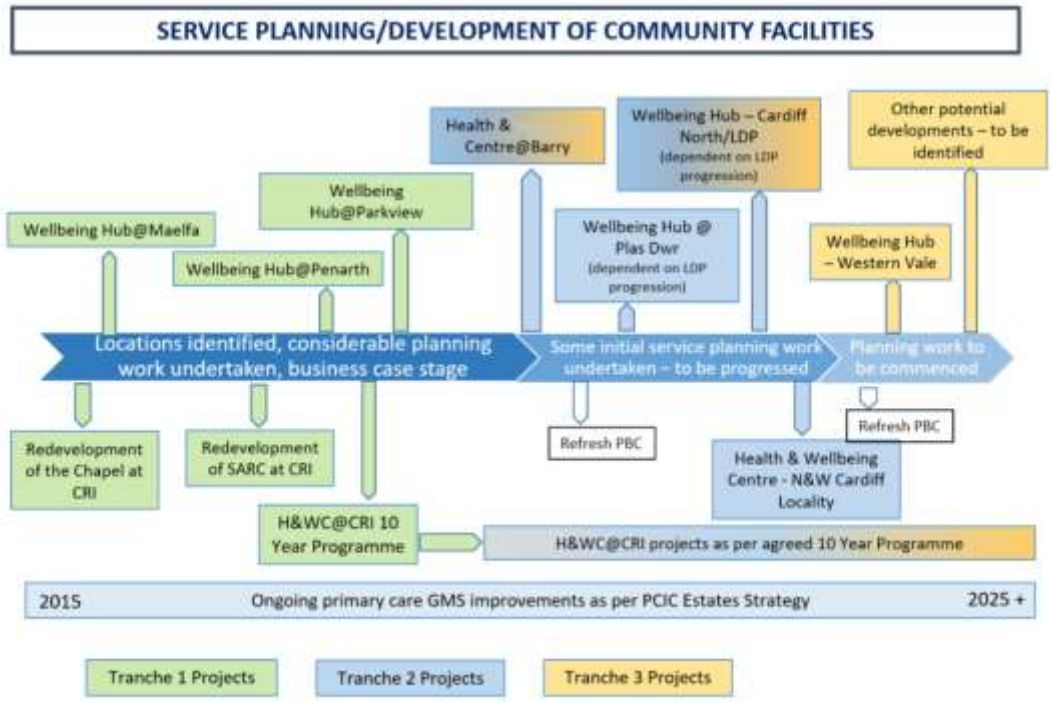
Older people including people with dementia

Key enablers

Integrated planning and commissioning; technology and digital solutions; promoting the social value sector; integrated community hubs; workforce development and integration	
New or existing investment	
Existing and new	
Estimated total cost	
Embedding: £1.042 Accelerating: tbc	
Start date	
2022-23 – phase 1 2023-24 – phase 2 2024 onward – phase 3	-embedding of SW cluster and continued development of Cardiff North and Cardiff East clusters. Along with the planning and implementation of 4 further clusters (sites tbc). -planning and implementation of final 2 clusters -review and evaluation of implementation with continued development of new cluster models

Title of project to support model of care (programme)
Health and Wellbeing Centres
Models of care the project will contribute towards
Community-based care – prevention and community coordination; community-based care – complex care closer to home; promoting good emotional health and wellbeing; home from hospital; accommodation based solutions
Project Summary

Since 2015 the Health Board has been developing its strategy for developing Health and Wellbeing Centres and Wellbeing Hubs with the ambition of creating integrated models of deliver which support the local population. The plan for development of these centres is outlined below and includes a forward view of the sites to be developed:



With the support of ICF Capital funding, the Health Board has been able to engage with partners to begin to develop initial service scopes for the main Health and Wellbeing Centres in each locality. This has involved engaging with stakeholders to understand the needs of the local population as well as articulating the intended use of these key assets.

By engaging in this work our partners have supported the development of a joint approach to what can be delivered from the Health and Wellbeing Centres. In line with the national strategy, we shall look to continue this engagement to develop service scopes which will inform the outline and full business cases for funding. Once a clear strategy and scope is agreed, all partners can begin to align services to these locality assets which will support locality-based integrated MDT working.

As the Health and Wellbeing Centres develop it is hoped that these will include accommodation-based solution for intermediate care, diagnostic and support for assessment and outpatient appointments, access to Local Authority and Third sector services, as well as hosting a number of community resources such as libraries and cafes.

Priority population group	
Older people including people with dementia	
Key enablers	
Integrated planning and commissioning; technology and digital solutions; promoting the social value sector; integrated community hubs; workforce development and integration	
New or existing investment	
Existing and new	
Estimated total cost	
Embedding: 0 Accelerating: tbc	
Start date	
2022-23 – phase 1 2023 onward – phase 2	-development of a shared service scope which promotes and supports integrated working -development and submission of business cases and onto build

Title of project to support model of care (programme)	
Hospital to Home	
Models of care the project will contribute towards	
Community-based care – prevention and community coordination; community-based care – complex care closer to home; promoting good emotional health and wellbeing; **home from hospital;** accommodation based solutions	
Project Summary	
Hospital discharge is integral to the system and so utilising ICF and Transformation funds we have developed services which aim to support citizens on discharge. The projects developed locally are: • Get me home – a local authority team based in the hospital who provide the link between the wards and Cardiff's Independent Living Service to provide a range of options to support a person on discharge • Integrated discharge service – a range of hospital-based roles which span nursing, social services and third sector and support discharge These projects have highlighted the need for focussed discharge support, moreover, this has been particularly important throughout the COVID-19 pandemic which has seen an increase in the complexity of patients requiring support on discharge. Whilst length of stay in hospital has increased due to the complexity of patients, this would have potentially been worse without this link between the community services, social services and the hospital. The hospital discharge teams have been able to develop relationships and trust with the ward staff which in-turn improves the support for the patient by having a coordinated discharge which brings together a person-centred approach focussed on what is best for the person. This means patients can be discharged quicker with the correct level of support required and a follow-up plan coordinated between health and local authorities. Over the next 2 years, the current projects will continue to embed and develop their services throughout the hospital, ensuring support for patients allows for a quicker discharge home. We shall also develop a 'discharge hub' which will specifically coordinate the step-down access into services. Ongoing monitoring of length of stay and accessing the correct levels of support on discharge will allow us to understand the time and resource saved for the patient.	
Priority population group	
Older people including people with dementia	
Key enablers	
Integrated planning and commissioning; workforce development and integration; technology and digital solutions; promoting the social value sector	
New or existing investment	
Existing and New	
Estimated total cost	
Embedding: £1.191 Accelerating: tbc	
Start date	
2022-23 – phase 1 2023 onward – phase 2	-embedding of the current projects with further development and alignment to the discharge hub -ongoing development of the discharge hub with integrated systems and regional approach to supporting discharge

Title of project to support model of care (programme)	
Vale Alliance	
Models of care the project will contribute towards	
All models of care will be supported by this work, with the initial exception of *supporting families to stay together safely and therapeutic support for care experienced children,* however the scope of this project hopes to develop to include children's services	
Project Summary	
The Vale of Glamorgan Council services and Health Board Services are currently separate in terms of their staffing, culture and organisational arrangement, as well as being separate legal entities. Whilst progress have been made to integrate the teams through the development of leadership posts which span both organisations, the work of the community services and other statutory duties have continued to be allocated on a separate basis. Coordination and colocation of these services can support a certain amount of integration through cooperation, however, there is still a degree of duplication and wasted resource. The Vale Alliance is an ambitious plan to create a single entity accountable to the Vale of Glamorgan Council and to the Cardiff and Vale University Health Board for meeting and improving the health and wellbeing needs of the population of the Vale of Glamorgan. *By alliance we mean thinking, acting, behaving and making decisions as one, and aligning our total assets and resources to better support people to achieve their ambitions.* This development is supported by the Social Services and Wellbeing (Wales) Act and will cover a number of core services initially. It is hoped that an alliance approach will enable the Health Board and Vale of Glamorgan Council to work more closely together, aligning the strengths and resources to improve outcomes for citizens. Over the next year the Vale Alliance will fully scope and plan for the legal and organisational development aspects of forming the alliance. This will then begin to be tested by forming a shadow alliance before the final establishment of the formal Vale Alliance in the next 2 years.	
Priority population group	
Older people including people with dementia	
Key enablers	
Integrated planning and commissioning; workforce development and integration; technology and digital solutions; promoting the social value sector	
New or existing investment	
New	
Estimated total cost	
Embedding: 0 Accelerating: tbc	
Start date	
2022-23 – phase 1 2023-24 – phase 2	-development and implementation of a shadow alliance -implementation of the formal Vale Alliance and ongoing developments for scope of services

Regional investment model

Select the funding element which the project will be set against. Repeat the table and rationale below for each project.

Title of project to support model of care (programme)	
Cardiff and Vale of Glamorgan @Home programme	
Funding elements	**Select**
Element 1 - Acceleration funding year 1	✓tbc
Element 1 - Acceleration funding year 2	
Element 2 - Embedding fund year 1	✓
Element 2 - Embedding fund year 2	
Element 2 - Embedding fund year 3	
Element 3 - Legacy integrated pooled fund	
Element 4 – National priorities (Dementia and Memory Assessment Services/ Diagnostic Support)	

Provide the rationale for the element selected.

The schemes described in this proposal include alignment of the embedding work to our future accelerating work. Final figures for the acceleration of the projects within this programme will be confirmed in the final submission.

Delivery partners

Details of local LHBs, local authorities, third sector and other providers that will support in the delivery of the projects are outlined below along with the relevant match contribution. This can be evidenced by either monetary or resource match. Repeat the table below for the number of projects being put forward.

RPBs will be expected to invest a **minimum of 20%** of their RIF allocation in delivery through social value sector organisations. RPBs should be connecting closely with their social value forums to ensure the wider sector can be engaged in the planning, design and delivery of these Models of Care. The information provided below will help aggregate the social value sector involvement at programme level.

Title of project to support model of care (programme)				
@Home				
Delivery Partners	**Welsh Government contribution**	**Partner match monetary**	**Partner match resource**	**Total funding required**
Region	£5.135m	tbc	£2.200	£7.335

BWRDD PARTNERIAETH RHANBARTHOL CAERDYDD A'R FRO
CARDIFF & VALE REGIONAL PARTNERSHIP BOARD

Health & Social Care Regional Integration Fund

Dementia Programme

HENEIDDIO'N DDA AGEING WELL

Llywodraeth Cymru
Welsh Government

National Models of Care – Strategic Vision

The primary purpose of the Health and Social Care Regional Investment Fund is to build on the learning and development undertaken by the Integrated Care Fund and the Transformation Fund and to establish and embed six new National Models of Integrated Care by 2027.

The summary below describes how our local programmes and projects within this document will collectively deliver the associated National Models of Care and wider commitments of A Healthier Wales. Please refer to Annex A for supporting narrative.

Community-based care – Prevention and community coordination

The region endorses Welsh Government's commitment to community-based care with the following outcomes:

1) People's well-being needs are improved through accessing co-ordinated community-based solutions.
2) Local prevention and early intervention solutions support people to avoid escalation and crisis interventions.

In line with these aspirations, the Dementia Programme aims to deliver the following commitment for 'older people including people with dementia' in Cardiff and the Vale of Glamorgan:

> *"By 2028 the population of Cardiff and the Vale of Glamorgan will be dementia aware and will reduce their risk of dementia.*
> *People with dementia will have equitable and timely access to a diagnosis; they will have person-centred care delivered locally with kindness. Carers will feel supported and empowered."*

The programme aims to deliver this through the following areas which support the new model of care:

- Developing a carer friendly region, which understands, can recognise and support people living with dementia in the community
- Memory assessment services which are equitable and accessible and provide seamless access to follow-up support

Community-based care – complex care closer to home

Cardiff and Vale RPB support Welsh Government's commitment to community-based care by providing complex care close to home so that:

1) People are more involved in deciding where they live while receiving care and support
2) Complex care and support packages are better at meeting the needs of people and delivered at home or close to home

In line with these aspirations, the Dementia Programme aims to deliver the following commitment for 'older people including people with dementia' in Cardiff and the Vale of Glamorgan:

> *"By 2028 the population of Cardiff and the Vale of Glamorgan will be dementia aware and will reduce their risk of dementia.*
> *People with dementia will have equitable and timely access to a diagnosis; they will have person-centred care delivered locally with kindness. Carers will feel supported and empowered."*

The programme aims to deliver this through the following areas which support the new model of care:

- Multidisciplinary community-based teams which can support people living with dementia at home or close to home
- Training which enables fantastic care through delivery of the suitable skill level and a person-centred approach to Dementia Care Mapping

Promoting good emotional health and wellbeing

Our region is keen to ensure that:

1) People are better supported to take control over their own lives and well-being
2) People have improved skills, knowledge and confidence to be independent in recognising their own well-being needs

In line with these aspirations, the Dementia Programme aims to deliver the following commitment for 'older people including people with dementia' in Cardiff and the Vale of Glamorgan:

> *"By 2028 the population of Cardiff and the Vale of Glamorgan will be dementia aware and will reduce their risk of dementia.*
> *People with dementia will have equitable and timely access to a diagnosis; they will have person-centred care delivered locally with kindness. Carers will feel supported and empowered."*

The programme aims to deliver this through the following areas which support the new model of care:

- Developing a carer friendly region, which understands, can recognise and support people living with dementia in the community
- Memory assessment services which are equitable and accessible and provide seamless access to follow-up support

Preventing children entering care and supporting children to remain with their families

The scope of the Dementia Programme does not include attainment of outcomes relating to Preventing children entering care and supporting children to remain with their families.

Home from hospital

Our region is committed to ensuring that:

1) People go home from hospital in a more timely manner with the necessary support in place at discharge
2) People have a better understanding of the discharge process and are more involved in pre and post discharge planning

In line with these aspirations, the Dementia Programme aims to deliver the following commitment for 'older people including people with dementia' in Cardiff and the Vale of Glamorgan:

> *"By 2028 the population of Cardiff and the Vale of Glamorgan will be dementia aware and will reduce their risk of dementia.*
> *People with dementia will have equitable and timely access to a diagnosis; they will have person-centred care delivered locally with kindness. Carers will feel supported and empowered."*

The programme aims to deliver this through the following areas which support the new model of care:

- Specialist teams which support people living with dementia and their families through hospital admission to discharge, including the transition back home
- Multidisciplinary community-based teams which can support people living with dementia at home or close to home
- Training which enables fantastic care through delivery of the suitable skill level and a person-centred approach to Dementia Care Mapping

Accommodation based solutions

Cardiff and the Vale region want to ensure that:

1) People are more involved in the design of accommodation to meet their needs
2) People have more choice about where they live and with whom

The scope of the Dementia Programme does not currently include attainment of outcomes relating to accommodation-based solutions. However, the programme may choose to develop this aspiration in subsequent years and will contribute to a region-wide exercise to identify shared capital development priorities in preparation for emerging capital funding provision in 2022 onwards.

Over the past 2 years the region has worked with care homes to improve environments for people living with dementia. The development of any future accommodation-based programmes of work will be inclusive to people with a wide range of needs incl dementia.

Programme title

If an element of the programme is moving from ICF/TF funding into the RIF, also include the previous programme title, if different.

Cardiff and Vale of Glamorgan Dementia Care Programme

Priority Models of Care for the programme

Priority model of care	Select	DAP
Community-based care – Prevention and community coordination	✓	✓
Community-based care – complex care closer to home	✓	✓
Promoting good emotional health and wellbeing	✓	✓
Preventing children entering care and supporting children to remain with their families		
Home from hospital	✓	✓
Accommodation based solutions		

Programme - Executive summary

The Cardiff and Vale Dementia Programme is the delivery vehicle for the region's Dementia Action Plan (DAP). A number of projects have already been established utilising the Integrated Care Fund with the aim of taking forward key priorities, specifically:

- GP diagnosis and support – to provide more timely and accessible assessments in GP settings
- Team around the individual (TATI) – to coordinate and provide wraparound community support
- Dementia care training – to develop a skilled and informed workforce
- Dementia friendly region – to develop awareness and support within communities
- Mental health matters – a hospital-based support project for cognitive impaired (ICF OP)

More recently, the Memory Assessment Fund facilitated the region to enhance its investment in these projects and also to widen the scope to include some further priorities such as:

- Dedicated speech and language therapy and palliative care nurse to support the TATI
- Additional third sector support through Marie Curie and Cardiff and Vale Action for Mental Health to further develop the dementia friendly region project
- Memory link workers based in hospital wards to provide dedicated in-hospital support and guidance to patients living with dementia and their families
- Carers information and support service aimed at the unpaid carers and families of people living with dementia

A schematic demonstrating the links between these projects and the respective models of care outlined within the RIF guidance is provided as Appendix A.

As we approach the mid-point of our local Dementia strategy, and given the recurrent nature in which these funds are now provided, it has been agreed to undertake an externally-led evaluation to:

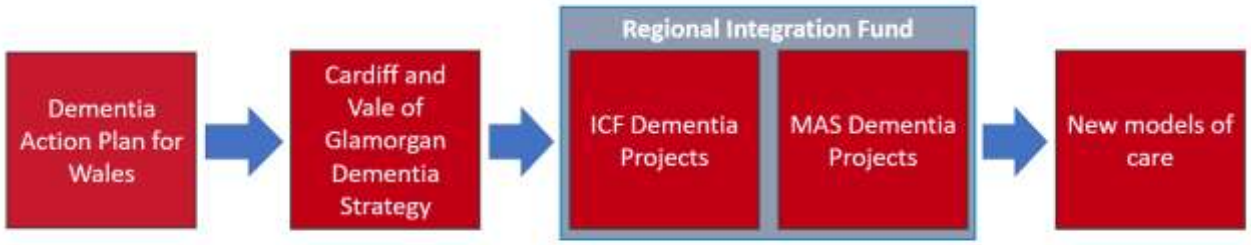
- Understand how well the region has progressed towards achieving DAP priorities so far;
- Capture a baseline assessment of where the current DAP aligns with the newly launched All Wales Dementia Care Pathway of Standards and to identify any gaps which must now be considered;
- Identify areas in Dementia care which need further support or development as a result of the COVID-19 pandemic;
- Compare the DAP with the emerging findings of the region's Population Needs Assessment, again with a view to ensuring that key priorities are included within the revised DAP.

The outcome of this evaluation will help the region to inform priorities for recurrent funding from October 2022 and beyond. The resulting Dementia Programme will ensure that recurrent funding is aligned to meet the needs of people with Dementia and their carers across the region through a delivery plan that dovetails with the wider Ageing Well agenda in the region such as the @Home Programme. Whilst the new shape of the programme is yet to be determined we would like to ensure that the social model outlined in *A Healthier Wales* is embedded in the core principles.

It is proposed to carry forward the existing programme of projects until September 2022 at which point the newly revised Dementia Programme will be launched following appropriate consideration and approval by the Cardiff and Vale Regional Partnership Board and Welsh Government.

Dementia Action Plan (DAP) summary

The Cardiff and Vale Dementia Programme is the delivery vehicle for the region's Dementia Action Plan (DAP).



An external evaluation is currently being undertaken to:

- Understand how well the region has progressed towards achieving DAP priorities so far;
- Capture a baseline assessment of where the current DAP aligns with the newly launched All Wales Dementia Care Pathway of Standards and to identify any gaps which must now be taken into account;
- Identify areas in Dementia care which need further support or development as a result of the COVID-19 pandemic;
- Compare the DAP with the emerging findings of the region's Population Needs Assessment, again with a view to ensuring that key priorities are included within the revised DAP.

The outcome of this evaluation will help the region to inform priorities for recurrent funding from October 2022 and beyond. The resulting Dementia Programme will ensure that recurrent funding is aligned to meet the needs of people living with Dementia and their carers across the region through a delivery plan that dovetails with the wider Ageing Well agenda in the region such as the @Home Programme.

Programme - Business case

Aims and Objectives:

The Cardiff and Vale population needs assessment references the dementia needs assessment in the chapter on adult mental health and cognitive impairment. Updated estimates from 2020 suggest there were 5,773 people over 65 living with dementia[1]; however, there were only 3,370 people on the general practice dementia register[2] suggesting that over 40% of people with dementia are potentially undiagnosed. Further evidence for the rationale for developing this programme comes from the dementia needs assessment, completed in February 2017, and from the Cardiff and Vale Dementia Strategy 2018-2028 launched in May 2018. The strategy's vision states:

"By 2028 the population of Cardiff and the Vale of Glamorgan will be dementia aware and will reduce their risk of dementia. People with dementia will have equitable and timely access to a diagnosis; they will have person-centred care delivered locally with kindness. Carers will feel supported and empowered."

There are eight strategic objectives within the Cardiff and Vale of Glamorgan Dementia Strategy:

1. Dementia is everyone's business
2. The risk of dementia will be reduced and there will be a timely diagnosis
3. Access to services will be equitable
4. Services will be fully coordinated
5. Services will be delivered with kindness and compassion
6. Support will be centred on Primary Care
7. Carers will be cared for
8. Crises will be avoided

The Cardiff and Vale Area Plan, Me, My Home, My Community there is a section dedicated to older people, including people with dementia. This project forms part of the response to OP1.4.

This will be achieved through the following projects focussed on specific areas of dementia care:

1. GP diagnosis, care and support – focussed on improving access to assessments to reduce waiting times and provide timely diagnosis and immediate support if required
2. Dementia friendly region – focussed on raising community awareness and support of dementia as well as improving social value
3. Team around the individual – focussed on ensuring the correct level of seamless wraparound support is available at home or as close to home as possible
4. Home from hospital – focussed on the support people receive in acute hospital settings and ensuring that people are able to be discharged swiftly and safely back home with the correct level of support

These key areas will be supported through 2 further enabler projects:

1. Dementia care training – focussed on improving knowledge and skills across all areas or the care system
2. Evaluation – focussed on ensuring we achieve outcomes which improve people's lives

[1] **Stats Wales.** Quality Assurance and Improvement Framework (QAIF) disease registers by local health board, cluster and GP practice. *Stats Wales.* [Online] 24 June 2021. [Cited: 25 October 2021.] https://statswales.gov.wales/Catalogue/Health-and-Social-Care/NHS-Primary-and-Community-Activity/GMS-Contract/qualityassuranceandimprovementframeworkqaifdiseaseregisters-by-localhealthboard-cluster-gppractice.

[2] **Social Care Wales.** Social Care Wales Population Projections Platform. [Online] 08 03 2021. [Cited: 20 10 2021.] http://www.daffodilcymru.org.uk/.

A demonstration of how previous projects will now be embedded within the foundation of the new programme plan is provided below:

Dementia Map 22-23

Project	Assessment and Diagnosis	Dementia Friendly Region	Team around the individual	Home from Hospital	Dementia Care Training
National Priority	DEM1 GP Diagnostics and Support	DEM4 Dementia Friendly Communities - Marie Curie MAS2b Dementia Friendly Communities - Marie Curie DEM4 Dementia Friendly Communities - CAVAMH	DEM2 TATI MAS4 SALT MAS8 Palliative Care Nurse	OP16 Mental Health Matters MAS5 Memory Link Workers	DEM3 Dementia Care Training

Links between the Dementia programme and associated national Models of care are articulated clearly within section 1 of this document and also in Annex A.

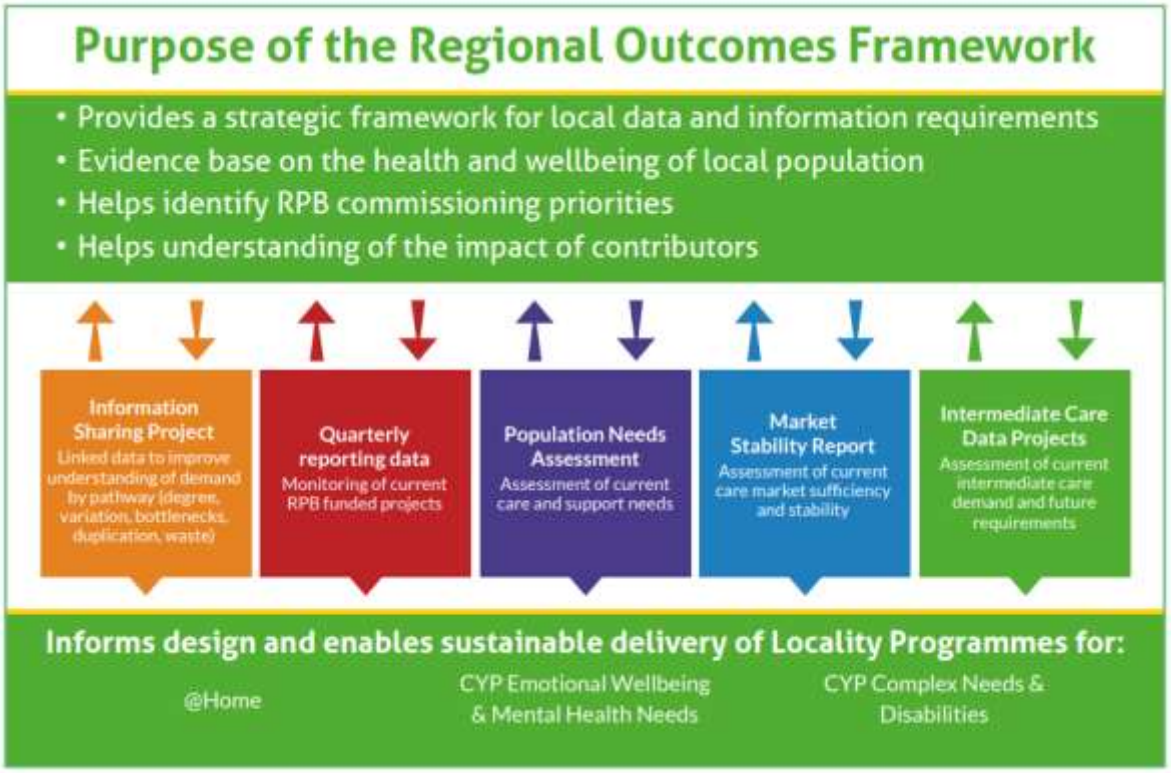
Unpaid carers of those living with dementia should also benefit from this work and support, but are explicitly addressed in the separate Cardiff and Vale programme for Unpaid Carers.

Benefits Realisation:

Cardiff and Vale Regional Partnership Board has a Regional Outcomes Framework (ROF) to which all our outcomes regionally align and that also articulate what we want to achieve for the whole population which includes 'older people including those with dementia'. Those outcomes are:

- Reduced wasted system resource
- Increased time for people to live their lives
- Increased living well in their own home and community
- Improved environment that enables people's choices
- Decreased avoidable harm or mortality
- People get a safe response when in urgent need
- More empowered workforce.

The ROF has been developed over a period of years and is currently being used to chart progress against these outcomes for older people only. Over the next year, it is the intention to introduce data charting outcomes for other priority population groups.



At an operational level, the region has positive experience of utilising Results Based Accountability to measure key performance outcomes for individual projects. This methodology will be utilised in the formation and delivery of all projects across the RIF programme portfolio. Qualitative information will be gathered via our Engagement Delivery Framework outlined within the Strategic Plan.

Additionally, each of our projects is focussed on delivering capability which will improve people's lives and contribute to the following key quantifiable metrics which will indicate whether benefits are being realised:

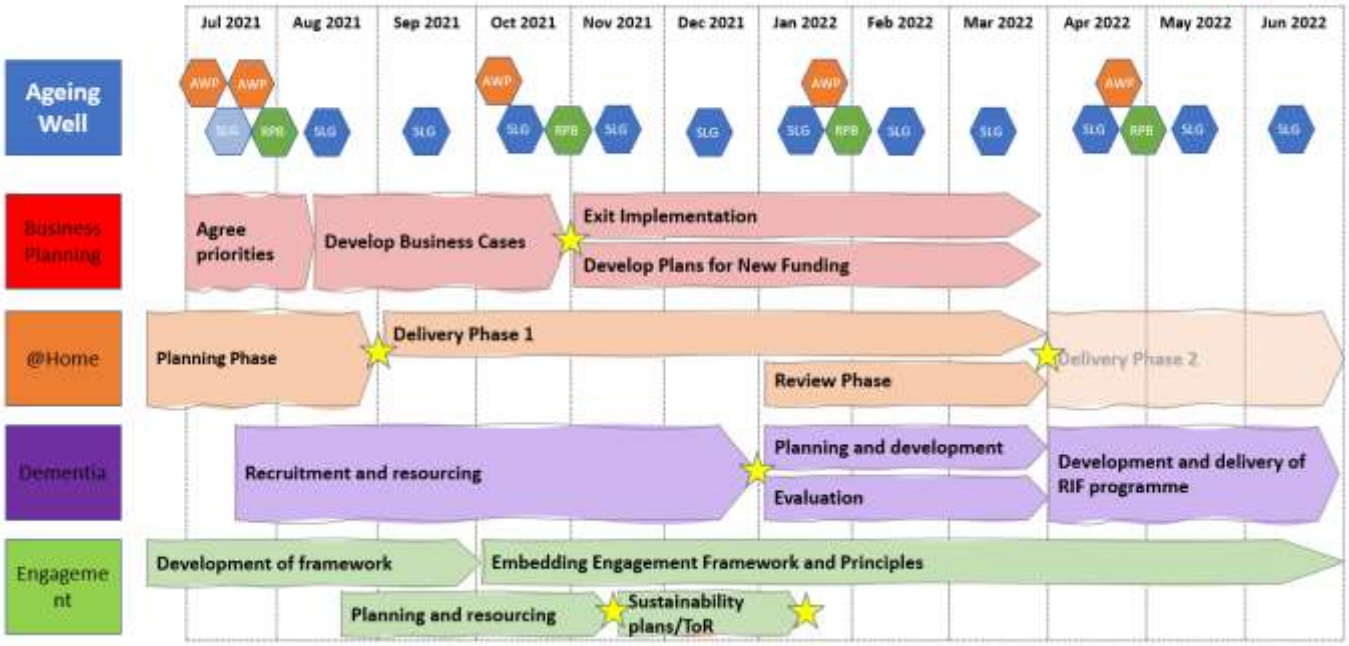
- Reducing wait times for assessment to 28 days (national guidelines)
- Reducing the number of people with dementia in residential care homes
- Reducing the number of unplanned admissions into care for people with dementia

Plans for sustainability:

Current schemes will be continued through 2022-23 as an in-depth evaluation is completed and a regional programme of work developed and co-produced. This programme of work will aim to build on the current progress, take on board recommendations of the evaluation, the views of people living with dementia through meaningful engagement and develop a longer-term response to COVID-19 and the impacts of the pandemic for people with dementia.

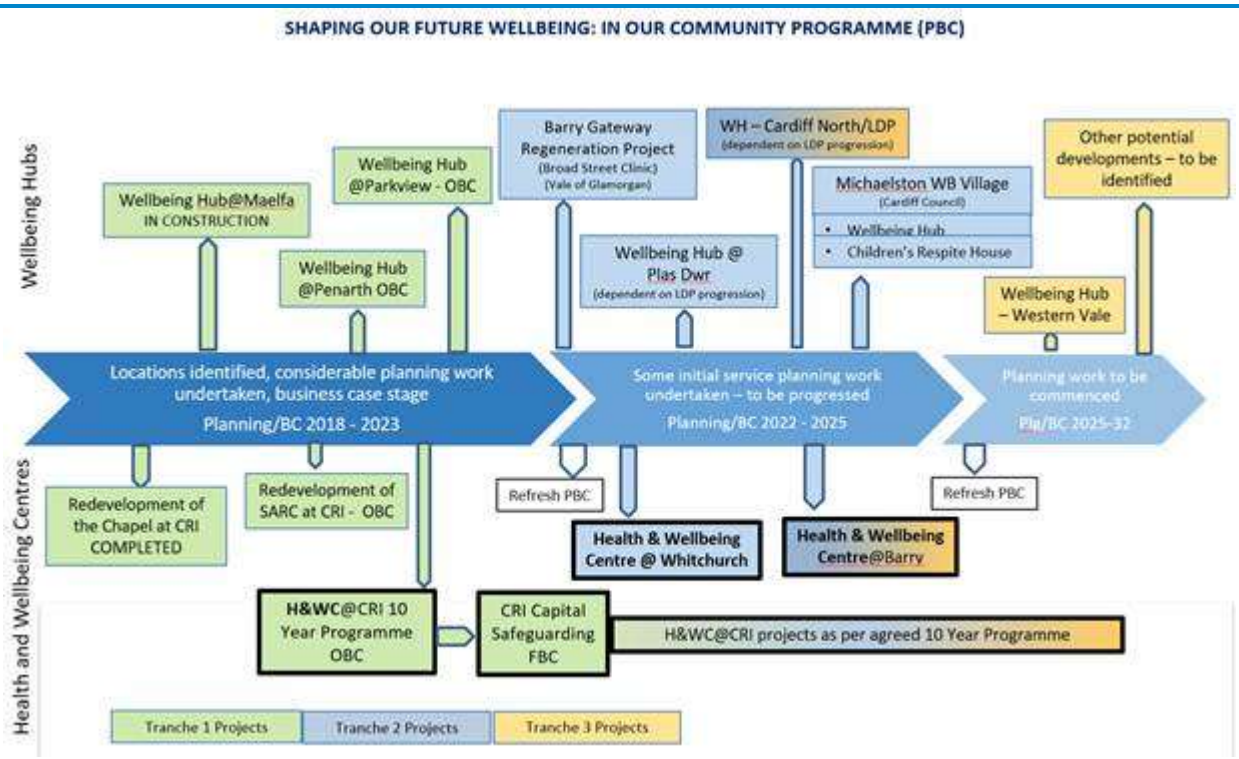
This programme is a key priority for the Regional Partnership Board's Ageing Well Partnership which has already agreed the following overall delivery plan (below). The region has initiated work to develop a Memorandum of Understanding, completion of which will set a clear commitment and roadmap for the ongoing development of sustainable funding streams over the remaining 4 years.

Indicative timeline for Ageing Well



Programme - Key enablers

Key Enablers	Select
Integrated planning and commissioning	
Of services which are integral to people living with dementia, including; community-based preventative services, long-term home care, residential and nursing homes, respite provision, third sector support services.	✓
Technology enabled care	
To enable shared care-records as well as advances in technology to help support people to live well and independent at home for as long as possible.	✓
Promoting the social value sector	
Improving access to support and services which improve people's lives and help people to stay well and connected to their community, along with those services which provide advice and guidance to support people to navigate the health and care system.	✓
Integrated community hubs	
The development of integrated community hubs will be led by the @Home programme utilising capital funding to complete feasibility plans by early 2023. All priority groups within the RIF programme portfolio will be able to make use of these hubs upon their completion. The Health Board's *Shaping our Future Wellbeing: In our Community* (SOFW:IOC) programme business case has been developed with partners and was endorsed by Welsh Government (2019) and the subsequent capital business cases and WG investment seeks to support the development and reconfiguration of community infrastructure to create a network of Locality Health and Wellbeing Centres (H&WCs) and smaller Cluster focused Wellbeing Hubs (WHs) across Cardiff and Vale that support the above objective. The overall vision is summarised in the diagram below with the work driven through both the @Home programme and the SOFW:IOC delivery board	✓



Planning work commissioned in the last quarter of 2021/22 with the use of ICF Capital funding will inform the development of the proposals for the Barry Health and Wellbeing Centre/Hospital, the new H&WBC for the North Cardiff Locality and the opportunities created through the development of Michaelson Wellbeing Village which may have a particular focus on services for children and young people. There is a very pressing need to develop the plans for primary and community services in North Cardiff because of the speed at which housing developments are progressing in the area.

Workforce development and integration	
To provide an integrated workforce who are knowledgeable and have the relevant skills to support people living with dementia at whatever point they come into contact with them. Specific investment in a Workforce and OD specialist will be included within the Partnership Support plans as part of our acceleration proposal.	✓

Programme - Priority population groups

Priority population groups	Primary	Secondary	DAP
Older people including people with dementia	✓		✓
To provide a system-wide approach to supporting people living with dementia, including prevention and community awareness.			
Children and young people with complex needs			
People with learning disabilities and neurodevelopmental conditions including autism*		✓	✓
To provide a system-wide approach to dementia care which supports those who may have multiple conditions including learning disabilities and neurodevelopmental conditions.			
Unpaid carers*		✓	✓
To provide a system-wide approach to dementia care which also supports the unpaid carer and families of those living with dementia through community awareness, training support and advice. Also see separate Carers Programme.			
People with emotional and mental health wellbeing needs		✓	✓
To provide a system-wide approach to dementia care which supports those who may have emotional and mental health wellbeing needs through development of mechanisms for people to be able to access support.			

Other beneficiaries

If there are other stakeholders benefiting from the programme, please provide this detail below.

People with Young Onset Dementia are also included.

Total programme cost and match funding projection

Provide a breakdown of the total programme cost, Welsh Government contribution, partner monetary and resource match including costs attributed to support unpaid carers and / or social value sector delivery. You can find more information on match funding in the guidance notes.

Total cost of Programme	Welsh Government contribution	Partner match monetary	Partner match resource	% support for unpaid carers	% for social value sector delivery
£1.5m	£1.5m	£0	£0	£0.071m (5%)*	£0.230m (15%)

*An additional project not included here supports unpaid carers for people living with dementia and is included in the unpaid carers programme

Programme resource and management details

Provide a summary of the planned resource and roles required to deliver this specific programme. These roles are 100% funded via the RIF and will accounted for within the allocated fund.

Posts / type of roles	Estimated FTE	Costs
Ageing Well Programme Management and Delivery	1.0	£0.110m
Clinical Lead/Consultant	0.2	£0.025m

Project plans

Title of project to support model of care (programme)
GP Diagnosis, Care and Support
Models of care the project will contribute towards
Place based care – prevention and community coordination
Project Summary
Previously, the model for memory assessment and diagnosis happened via consultant-lead specialist mental health outpatient and acute settings. This often meant long waiting times for assessment, longer distances for many to travel, assessments away from familiar settings, and a disconnect with local community services and third sector support. The knock-on effect of which means that carers can become over-burdened, avoidable complications can develop and the support network breaks down leading to unnecessary referrals to hospital-based services or to residential care. Cardiff and Vale UHB began trialling specialist-supported, GP-led memory clinics in 2016-18 to see if they could help to meet the growing demand for skilled assessment, diagnosis and care of dementia, so allowing specialist services to focus on the most complex and challenging cases, whilst also providing back-up to primary care and most efficient use of community support services. The pilot study, designed with input from people with dementia and carers, successfully developed an effective approach to timely diagnosis and subsequent care that was associated with high levels of patient and carer satisfaction, was locality-based, and resulted in waiting times for first assessment falling from a high of 29 weeks to a low of 3 weeks. Following the successful pilot, through ICF funding, we have continued extending the specialist-supported, GP-led clinics since 2018 to train a further group of GPs to aim to provide fortnightly clinics in each of the three clusters in the three localities. At full capacity this would provide about 1000 additional patient appointments each year and, assuming 2/3 attendees are new patients, about another 650 new patients can be seen. Increased demand and expectations for timely dementia diagnosis and effective post-diagnostic care and support has placed existing Memory Assessment Services under mounting pressure, particularly in the context of COVID19 restrictions. Referral numbers are rising and outstrip capacity. This situation is likely to continue given the predicted growth in numbers with dementia and greater awareness of the benefits of earlier diagnosis. However, we plan to continue this project with the aim of stabilising the waiting list and prevent a worsening trajectory with a current waiting list time of 16 weeks. Eventually we hope to ensure a first appointment can be offered within 28 days and a working diagnosis within 12 weeks of referral for all patients, in keeping with performance expected by the Dementia Action Plan for Wales. The project will continue to collaborate closely with the team around the individual, social care and the third sector as individual needs dictate. The outcomes of this project will be scrutinised as part of an interim evaluation in order to ascertain areas for potential improvement and development. This project is delivered using DAP funding and directly relates to delivery of the DAP and Memory Assessment Services/Diagnostic Support.
Priority population group
Older people including those with dementia

Key enablers	
Workforce Development and Integration	
New or existing investment	
Existing investment	
Estimated total cost	
£0.100m	
Start date	**Estimated completion date**
1st April 2022 as continuation of existing project pending evaluation outcome.	End March 2022: Completion of external evaluation. End April 2022: Established a newly formed Dementia Programme Board End May 2022: RPB Decision on future scope, objectives and funding – or appropriate exit strategy and funding re-alignment if appropriate End June 2022: presentation to Welsh Government for approval End September 2022: Implementation of revised programme.

Title of project to support model of care (programme)
Dementia Friendly Region
Models of care the project will contribute towards
Place based care – prevention and community coordination
Project Summary
Prior to implementing the Cardiff and Cale of Glamorgan Dementia Friendly Region project, community understanding and awareness of dementia was limited. This meant that people living with dementia did not feel supported in their local community and therefore not able to maximise their independence, often becoming isolated from day-to-day activities such as going to the shops or getting a haircut. In 2018, Cardiff and the Vale of Glamorgan Dementia Strategy confirmed the regions commitment to make dementia 'everybody's business'. Utilising the model and training developed by the Alzheimers Society, including; developing Dementia Champions who are given training and information on how to recognise and support people living with dementia who live in their community. This scheme also developed Dementia Friendly Businesses, where organisations can pledge to become dementia friendly through awareness training and adaptations to provide a welcoming and supportive environment for people living with dementia. Cardiff and Vale commissioned Third Sector partners Marie Curie to promote and deliver this work across the region. This project is delivered through Dementia Friendly Communities Coordinator(s) who; support a database of dementia friendly businesses and a relevant and up-to-date website for stakeholders; work in conjunction with the third sector to ensure that a grant funding element is available for innovative projects which contribute to the Dementia Friendly Region work. Social value is further promoted through the use of a grant fund to assist third sector organisations to become more dementia friendly and to create innovative solutions for projects to create wider understanding in the general population of challenges faced by people with dementia and their carers. At its core, this project creates wider understanding in the general population of challenges faced by people with dementia and their carers. This means that people with dementia will be able to be supported in the community for longer because the wider population will be more understanding of their needs; and furthermore people with dementia will be diagnosed sooner, therefore getting the help and support that they need. The outcomes of this project will be scrutinised as part of an interim evaluation in order to ascertain areas for potential improvement and development. This project will be delivered using DAP and MAS funding and directly relates to delivery of the DAP.
Priority population group
Older people including those with dementia
Key enablers
Workforce Development and Integration
New or existing investment
Existing investment
Estimated total cost
£81k

Start date	Start date
1st April 2022 as continuation of existing project pending evaluation outcome.	End March 2022: Completion of external evaluation. End April 2022: Established a newly formed Dementia Programme Board End May 2022: RPB Decision on future scope, objectives and funding – or appropriate exit strategy and funding re-alignment if appropriate End June 2022: presentation to Welsh Government for approval End September 2022: Implementation of revised programme.

Title of project to support model of care (programme)
Team around the individual (TATI)
Models of care the project will contribute towards
Place based care - complex care closer to home
Project Summary
Prior to the implementation of this project, community services were delivered separately to those from Health, this caused a disparity in the care being provided across the region by different local authorities and also duplicated effort where Health Board teams were not coordinated in delivering the care and support for people living with dementia and their community resource colleagues. Often people would not feel supported and in-turn this put pressure on emergency care as well as residential care – where people could be supported at home for longer with the correct support. The dementia 'team around the individual' is a critical Welsh Government initiative outlined in the National Dementia Action Plan for Wales. It is a 'wraparound' service for people with dementia and their carers, with a single point of contact. This model has been piloted locally since 2018, and links closely with the GP-led diagnosis clinics. Upon diagnosis, people with dementia (and their carers) are assigned a Memory Link Worker, who provides advice and signposts people from diagnosis to end of life care. They are supported by a team of people with different professional backgrounds, in order to tailor-make the care for people living with dementia so that they can live independently and at home for as long as possible. The Memory Link Worker can liaise with therapy-related specialists in dementia care situated in the community resource teams (e.g. Physiotherapists, Dietitians, Speech and Language Therapists, and Occupational Therapists), as well as Medical, Nursing and Psychology specialists situated in the Memory Assessment Service. Overall, this forms a complete wraparound service, alongside Social Care and the third sector as required. Regular MDTs ensure that communication between staff within the 'team around the individual' is optimal. Overall, this forms a complete wraparound service, alongside Social Care and the third sector as required. This means that people living with dementia are supported in a seamless or 'integrated' way by a team of people with different professional backgrounds, in order to tailor-make the care for people living with dementia so that they can live independently and at home for as long as possible. The project will be enhanced with learning from experts in the dementia care field, and undergo continuous development into the future, as treatments and support options evolve. This project will be delivered using DAP and MAS funding and directly relates to delivery of the DAP.
Priority population group
Older people including those with dementia
Key enablers
Workforce Development and Integration
New or existing investment
Existing investment
Estimated total cost
£742k

Start date	Estimated completion date
1st April 2022 as continuation of existing project pending evaluation outcome.	End March 2022: Completion of external evaluation. End April 2022: Established a newly formed Dementia Programme Board End May 2022: RPB Decision on future scope, objectives and funding – or appropriate exit strategy and funding re-alignment if appropriate End June 2022: presentation to Welsh Government for approval End September 2022: Implementation of revised programme.

Title of project to support model of care (programme)
Dementia home from hospital
Models of care the project will contribute towards
Home from Hospital
Project Summary
Work undertaken locally in Cardiff and Vale has identified that patients living with dementia or cognitive impairment occupy between 28 and 36% of all adult inpatient beds and in those over the age of sixty-five 45.8% of patients are living with dementia. This review also identified that patients living with dementia experienced an increased length of stay versus those without a diagnosis of dementia, on average by between twenty and twenty-eight days. They also experienced an increased risk of institutionalisation on discharge, an increased risk of delirium development, in-patient falls, requirement for 1:1 supervision, antipsychotic administration and in-patient mortality (Shute et al, Cardiff and Vale Health Board. Reference available). As such, attention is required on strategies to improve experience & outcomes of patients living with dementia admitted to secondary care. Since 2018, we have worked with our third sector partners Mental Health Matters to provide direct inpatient support each week enabling a regular point of contact, appropriate emotional support and cognitive stimulation, as well as timely referral and signposting to additional services. MHMW aim to provide meaningful activities and some basic care to promote dignity and respect that enhances the nursing care for patients with cognitive impairment. The support workers employed by MHMW develop a person-centred relationship with the patients and offer activities that are tailored to the patient's individual needs. This is achieved by a mixture of one to one befriending and group activities that focus on stimulating the mind and encourage movement of the body. This service will also have additional capacity to provide some support to people on discharge to ensure they have access to the support they need and to aid with the transition back home after an inpatient stay. In addition to this third sector inpatient support, since September 2021 we have also added the support of three ward-based memory link workers within general medical wards and a surgical ward to help enhance communication between community-based and hospital teams. These specialist posts are able to support families in contacting family members living with dementia in hospital as well as facilitate visits where able, support and contribute to early facilitated discharge, education of ward staff about dementia friendly initiatives and individualised care planning as well as liaison with liaison psychiatry teams. The potential impact of this coordinated support means that within both regional hospitals (University Hospital Wales and University Hospital Llandough) we can develop centres of excellence for dementia care in hospital which can then be used to model care across the wider health board. Where people living with dementia, their families and the clinical ward staff can feel supported, improve recovery time and facilitate faster discharges home. The project will be enhanced with learning from experts in the dementia care field, and undergo continuous development into the future, as treatments and support options evolve. This project will be delivered using DAP and MAS funding and directly relates to delivery of the DAP.
Priority population group
Older people including those with dementia
Key enablers
Workforce Development and Integration

New or existing investment	
Existing investment	
Estimated total cost	
£0.227m	
Start date	**Estimated completion date**
1st April 2022 as continuation of existing project pending evaluation outcome.	End March 2022: Completion of external evaluation. End April 2022: Established a newly formed Dementia Programme Board End May 2022: RPB Decision on future scope, objectives and funding – or appropriate exit strategy and funding re-alignment if appropriate End June 2022: presentation to Welsh Government for approval End September 2022: Implementation of revised programme.

Title of project to support model of care (programme)
Dementia Care Training
Models of care the project will contribute towards
Place based care – prevention and community coordination
Project Summary
Prior to Cardiff and Vale developing a dedicated dementia care training team, the training and support available in the region to all partners was not coordinated or consistent and therefore the care provided for people living with dementia was not standard and the understanding within Health and Social Care services was often limited. During 2017, Welsh Government launched their guidance for Dementia Training, called 'Good Work – Dementia Learning and Development Framework'. 'Good Work' is the mandated guide for competencies associated with dementia training, according to the National Action Plan for Wales. Within 'Good Work' there are three defined levels within the framework: informed, skilled and influencers. The levels depict the competencies required to meet each level. A Dementia Learning and Development Team was launched in 2018, and they have been very active in mapping where the 'Good Work' competencies can be achieved through training (via a training needs analysis), and delivered a variety of courses within health, social care and for unpaid carers and the third sector at both an "informed" and "skilled" level. In addition to this structured skills level approach which aims to ensure everyone has a similar level of skills and understanding, Cardiff and Vale have employed Dementia Care Mappers. Dementia Care Mapping™ was developed by Bradford University and is an established approach to achieving and embedding person-centred care for people with dementia, recognised by the National Institute for Health and Clinical Excellence. This person-centred approach employs specially trained facilitators to 'map' people with dementia in a variety of settings to include: care homes, district general hospitals and mental health inpatient units. The mappers then help to promote the care of individuals by tailoring the training and understanding of those who care for people living with dementia to the individual needs of that person. The use of these two approaches in a coordinated way means that those who care for people with dementia feel supported and confident in their understanding and skills, therefore, those living with dementia receive the very best care and support. By including support across partners, including for unpaid carers in developing knowledge and skills required to support the person with dementia, therefore avoiding crises and potential admissions to hospital or residential care. The project will be enhanced with learning from experts in the dementia care field, and undergo continuous development into the future, as treatments and support options evolve. This project will be delivered using DAP and MAS funding and directly relates to delivery of the DAP.
Priority population group
Older people including those with dementia
Key enablers
Workforce Development and Integration
New or existing investment
Existing investment

Estimated total cost	
£0.198m	
Start date	**Estimated completion date**
1st April 2022 as continuation of existing project pending evaluation outcome.	End March 2022: Completion of external evaluation. End April 2022: Established a newly formed Dementia Programme Board End May 2022: RPB Decision on future scope, objectives and funding – or appropriate exit strategy and funding re-alignment if appropriate End June 2022: presentation to Welsh Government for approval End September 2022: Implementation of revised programme.

Regional investment model

Select the funding element which the project will be set against. Repeat the table and rationale below for each project.

Title of project to support model of care (programme)	
Cardiff and Vale of Glamorgan Dementia Programme	
Funding elements	**Select**
Element 1 - Acceleration funding year 1	
Element 1 - Acceleration funding year 2	
Element 2 - Embedding fund year 1	
Element 2 - Embedding fund year 2	
Element 2 - Embedding fund year 3	
Element 3 - Legacy integrated pooled fund	
Element 4 – National priorities (Dementia and Memory Assessment Services/ Diagnostic Support)	✓

Provide the rationale for the element selected.

The dementia programme is the key delivery vehicle for the dementia action plan, to develop integrated models of care for people living with dementia.

Delivery partners

Details of local LHBs, local authorities, third sector and other providers that will support in the delivery of the projects are outlined below along with the relevant match contribution. This can be evidenced by either monetary or resource match. Repeat the table below for the number of projects being put forward.

RPBs will be expected to invest a **minimum of 20%** of their RIF allocation in delivery through social value sector organisations. RPBs should be connecting closely with their social value forums to ensure the wider sector can be engaged in the planning, design and delivery of these Models of Care. The information provided below will help aggregate the social value sector involvement at programme level.

Title of project to support model of care (programme)				
Cardiff and Vale of Glamorgan Dementia Programme				
Delivery Partners	**Welsh Government contribution**	**Partner match monetary**	**Partner match resource**	**Total funding required**
CAVUHB	£0.879m			£1.500m
Cardiff Council	£0.165m			
VoG Council	£0.088m			
CRISP	£0.014m			
Marie Curie	£0.081m			
Mental Health Matters	£0.135m			
Leadership	£0.138m			

Appendix A

A schematic demonstrating the links between these projects and the respective models of care outlined within the RIF guidance: