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CARDIFF & VALE REGIONAL PARTNERSHIP BOARD

HENEIDDIO'N DDA AGEING WELL

@Home programme: Q3 RIF Summary

Area Plan Commitment:
People will be able to age well at home with more opportunities for wellbeing and independence. Services will reflect the diversity of people as they age well.

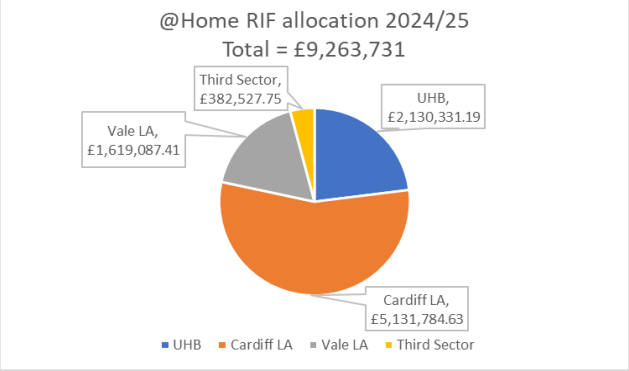
Overview of Programme:
The @Home programme aims to establish integrated, locality-based, health and care services focused on meeting and improving the health and wellbeing of the local population, based on the ambitions of A Healthier Wales. The key drivers for the programme include:
· Increase Healthy Days at Home
· Reduction in ambulance conveyances
· Reduction in emergency admissions and re-admissions to hospital
· Reduction in bed days/length of stay in hospital

Area plan delivery plan aims for 24-25:

- MDT meetings operational in all 9 clusters, or at locality level if needed
- Model agreed and rollout of Integrated Care Hubs completed
- Telehealth model defined and pilot implemented and evaluated
- Future Care Planning model and standard operating procedures designed and agreed
- Delivery of the Community Nursing specification as part of cluster/locality delivery model
- All 57 GP practices have access to social prescribing
- Place plans completed for all 9 clusters
- Role of Housing With Care Centres agreed including co-location of teams
- Capacity and demand analysis defined to determine workforce model for intermediate care
- Rollout of Safe@home including; GP and care home referrals
- A defined ECC integrated delivery model comprised of; CAV247, UTCs
- A joined-up integrated discharge model
- Defined blueprint which describes

Progress against Q3 Plan	Achieved?	Comment
TEC/Telecare pilot explored and costs outlined and agreed	✓	
Data analysis run to inform business case for ECC	✓	
Funding requirements for gaps established and business case for Enhanced Community Care drafted	x	Further refinement of model, benefits and costs to be finalised in Q4
Future Care Planning group established	✓	
Prototype Place Plan for SW Cluster drafted	x	Further engagement to be undertaken to finalise plan and agree governance

What's next for Q4	Comment
Enhanced Community Care Business case finalised and submitted to UHB governance	*On track*
Scope and project plan developed for Future Care Planning	*On track*
Place planning approach evaluated and rollout plan developed	*On track*



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@Home programme: Q3 RIF Summary

Performance Summary

Key metrics	Target OR baseline		Current performance*	Comment
Access—prevention: single point of access to step up and preventative community services				
Number of people contacting a single point of access	Baseline: 2022-23 total	96,370	69,404	On track
% of peoples needs met through information, advice and signposting	Baseline: 2022-23 average	64%	68%	
% of individuals who reported an improved quality of life following support from ILS	Baseline: 2023-24 total	98%	93%	
Access—Hospital to Home: community support in the hospital to support timely and effective discharge				
Number of people referred to the Integrated Discharge Hub	Baseline: 2022-23 total	4,690	2,456	Lower referrals from wards partly due to more appropriate referrals being made - further education and promotion also underway.
% of referrals triaged within 1 day	Baseline: 2022-23 average	49%	53%	
% of people moved on to their pathway within 72hr of triage	Baseline: 2022-23 average	64%	97%	
Intermediate Care—Crisis Response (Safe@Home) service which can support individuals to remain at home				
Number of patients admitted to Safe@Home	Baseline: 2023-24 Q4	79	791	On track
Number of avoided hospital admissions	Baseline: 2023-24 Q4	56	626	
Average response time from Acceptance to Face to Face (hours)	Baseline: 2023-24 Q4	24.77	14.60	
% of referrals that were kept at home and did not have an outcome of "admitted to hospital"	Baseline: 2023-24 Q4	71%	81%	
Intermediate Care—home-based and reablement to support both step up and step down reablement				
Number of people supported through home-based and reablement IC	Baseline: 2022-23 total	6,659	4,882	On track
% of people supported by CRT and VCRS who reported an improvement in their restriction following support	Baseline: 2022-23 total	95%	96%	
Number of people discharged from hospital to D2RA 72 hours domiciliary care	Baseline: 2022-23 Q3-Q4 total	105	305	
Intermediate Care—bedded reablement accommodation options for discharge to asses including step-down flats				
Number of people supported through step down bedded reablement (reablement beds, D2A, accommodation solutions flats)	Local target	134	70	Increase expected in final quarter - but activity below baseline with ongoing discussions for future plans for step-down bedded options
Number of assisted discharges through intervention by the Accommodation Solutions Teams	Baseline: 2022-23 total	105	155	
Number of bed days saved through the use of step down accommodation	Baseline: 2022-23 total	2,328	1,659	
MDT Cluster: clusters working with an innovative MDT approach including social prescribing and discharge follow-up				
Number of individuals receiving IAA, Early Help and Support and Targeted support	Baseline: 2022-23 total	8,211	22,739	On track
Number of clusters adopting an MDT model	Target	9	6	
% Patients who showed an improvement in SWEMWBS score following support from South West cluster MDT	Baseline: 2022-23 average	85%	86%	

**RAG rating: Red = Forecasted performance for entire year is 25% or greater away from baseline or target, Amber = Forecasted performance for entire year is between 5% - 25% away from baseline or target, Green = Forecasted performance for entire year is 5% or less away from baseline or target.*

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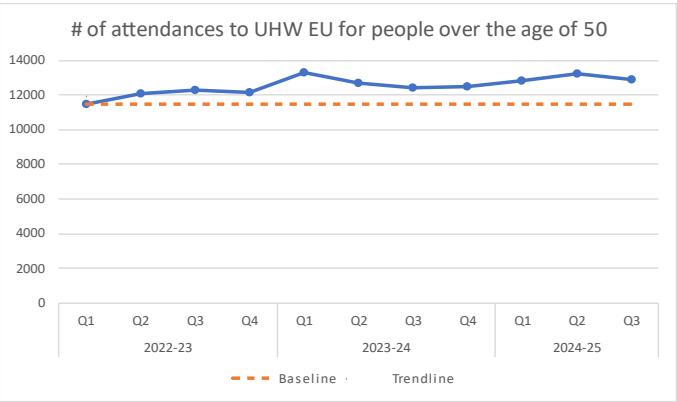
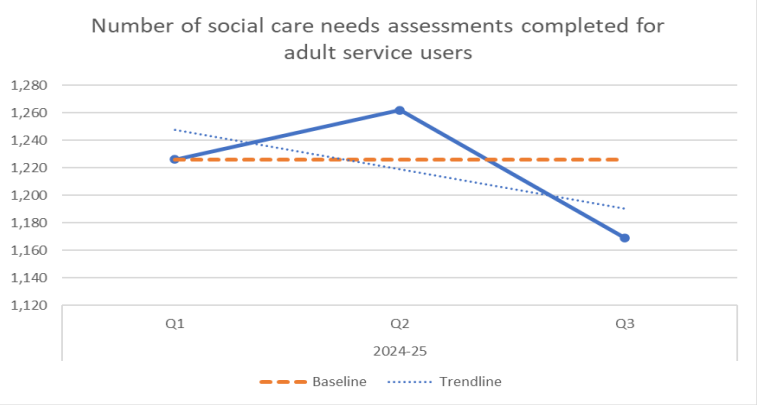
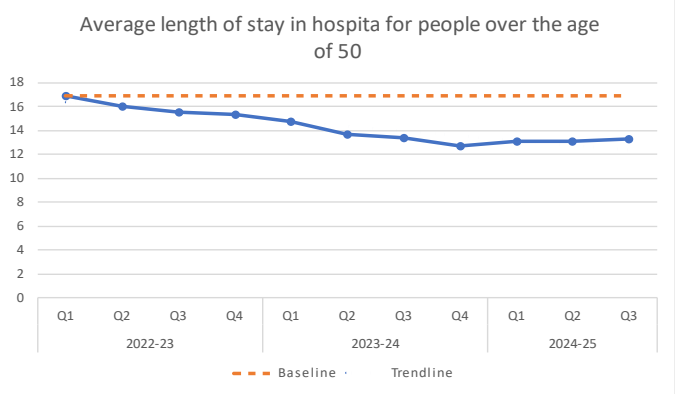
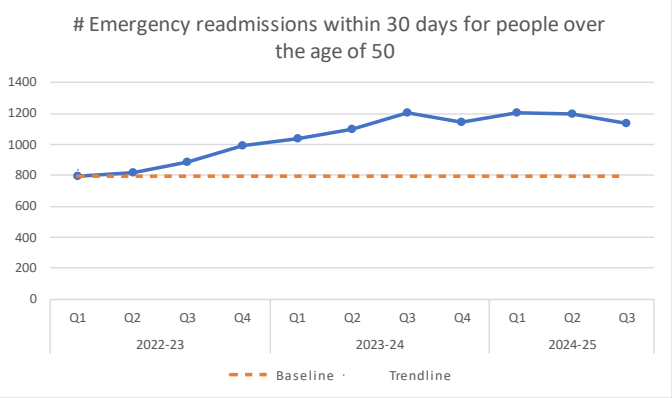
@Home programme: Q3 RIF Summary

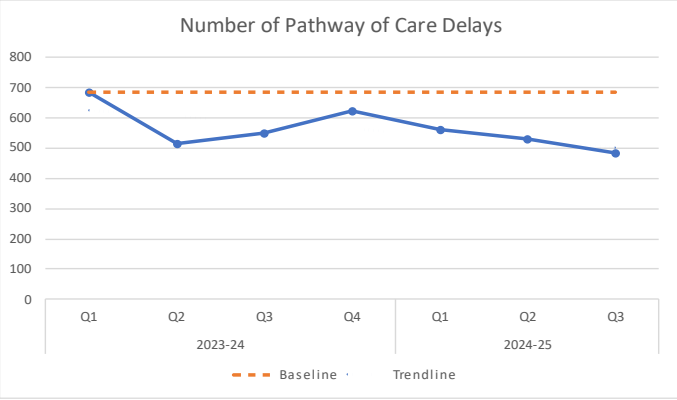
Programme drivers











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HENEIDDIO'N DDA AGEING WELL

Dementia programme: Q3 RIF Summary

Area Plan Commitment:
People with dementia will be supported to live well and do the things they need to and enjoy in their communities with timely access to diagnosis and person-centred care.

Overview of Programme:
We aim to raise awareness of dementia and its determinants whilst working to develop community-based services that enable equitable and timely access to diagnosis and person-centred care. Included in the scope of the programme are:
· Compassionate communities who are aware of their risk factors through a coordinated campaign of raising awareness and an increased number of 'dementia friendly' communities
· Community-based care and support through increasing advocacy in the design of person-centered care plans and service developments
· Clear community-based pathways for timely assessment and diagnosis
· The Dementia Friendly Hospital Charter
· A regional approach to dementia care learning and development
· Measuring and benchmarking progress with people affected by dementia
· Focused Communications, Engagement & Coproduction Plan to engage those affected by Dementia and those who are

Area plan delivery plan aims for 24-25:

- Launch and promote the dementia prevention resource
- Further develop the Dementia Friendly network
- Continue to widen engagement and coproduction
- Map services and develop pathways between services and organisations
- Ensure professionals, service users and unpaid carers are aware of existing services and access
- Continue delivery of GP led Memory assessment clinics
- Develop clear pathways for information, advice and support at the time of diagnosis
- Wider rollout of John's Campaign and self assessment tool (VIPS)
- Increase inpatient activities and links with wider ward teams
- Continue to use dementia care mapping for discharge and care
- Increase number of staff who are informed and skilled level training
- Develop a clear communication plan for the programme.
- Dementia Connector funding agreed

Progress against Q3 Plan	Achieved?	Comment
Build on people reported outcomes for hospital charter 24-25	Yes	Questionnaire shared with Mental Health Matters to start collecting in Q4.
Measuring accessibility and activity of community care and support pathways connected to memory team	Yes	PARIS report enhanced to capture direct activity for people living with dementia.
Start to measure the spread and reach of prevention resource	Yes	Initial measures defined and added to report card.
Develop a coproduction plan on dementia programme of work	Yes	On Track in DCN
Work with Bevan Commission to support work with WAST and EU to improve pathways and increase profile of the programme	Yes	On Track. Scoping and mapping exercise completed. Focus is on community engagement in Q4.
Develop links with the unpaid carers programme and support available for carers	Yes	In Progress. Unpaid carers representatives join in DCN to shape.

What's next for Q4	Comment
Initial discussions with pillar leads around the Area Plan Delivery Plan.	On track
Pilot Dementia Connectors for early signposting and support.	On track
Continue to pilot feedback questionnaire and gathering people reported outcomes.	On track
Continue to engage more Dementia friendly wards and John's Campaign initiatives.	On track
Coproduce an engagement event with all partners with mental health focus, including Dementia.	On track
Connect with social prescribing to improve waiting well outcomes.	On track

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Dementia programme: Q3 RIF Summary

Performance Summary

Key metrics	Target OR baseline		Current performance*	Comment
Dementia Friendly Businesses-improving community understanding and support for dementia through accessibility, awareness and training				
Number of organisations pledging to become Dementia Friendly	Baseline: 2022-23 total	90	175	
Number of people in the community recognise the challenges for people affected by dementia as a result of Dementia Friendly communities	Baseline: 2022-23 total	202	3,020	
Community care and support-providing intensive care and support to people living with dementia through CRT/VCRS, memory link workers and social work teams				
Number of direct and indirect contacts made by Memory Assessment Service Memory Link Workers (MLWs)	Baseline: 2022-23 total	5,516	6,021	No RAG for SW due to variability in demand couold be a positive step.
Number of Initial Reviews undertaken by social workers (from hospital to placement)	Baseline: 2022-23 Q3-Q4	69	53	
Number of people seen by CRT and VCRS that have had a memory team referral	Baseline: 2022-23 total	2,441	2,309	
Assessment and diagnosis—supporting timely diagnosis for people with dementia in the community through GP led clinics				
Number of GP led clinics held	Target	168	110	
Number of new people seen at GP led memory assessment clinics	Baseline: 2022-23 Q3-Q4	340	226	
% of people who had a diagnosis of dementia in a GP led memory assessment clinic that were diagnosed as Stage 1 dementia	Baseline: 2022-23 Q3-Q4	54%	62%	
Training and development-supporting training for paid and unpaid carers in skills for supporting people with dementia				
Number people trained to Good Work Informed level	Local target	1250		Data delay due to staff sickness/absence.
Number people trained to Good Work Skilled level				
Number people trained to Good Work Influencer level	*Measure under development*			
Engagement and activities in the hospital with inpatients to support delivery of the Dementia Friendly Hospital Charter				
Total number of people supported by Mental Health Matters	Target	7,400	6,175	The progress has reached Q4 Target.
Number of patients supported by inpatient Memory Link Worker in general surgery	Baseline: 2022-23 Q3-Q4	168	166	
Number of wards undertaking VIPS initiative	Target	Increase	12	

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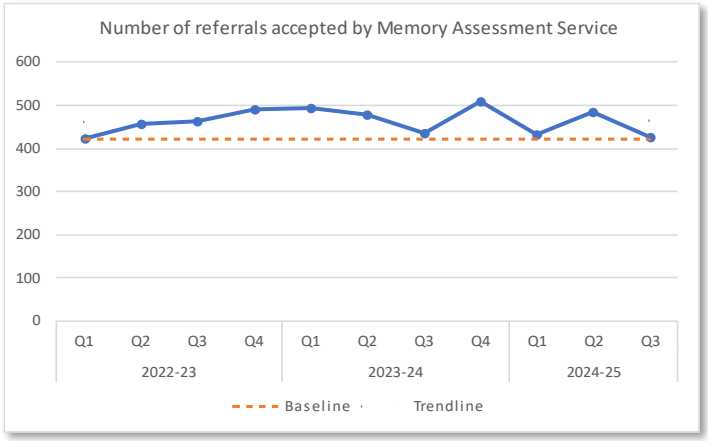
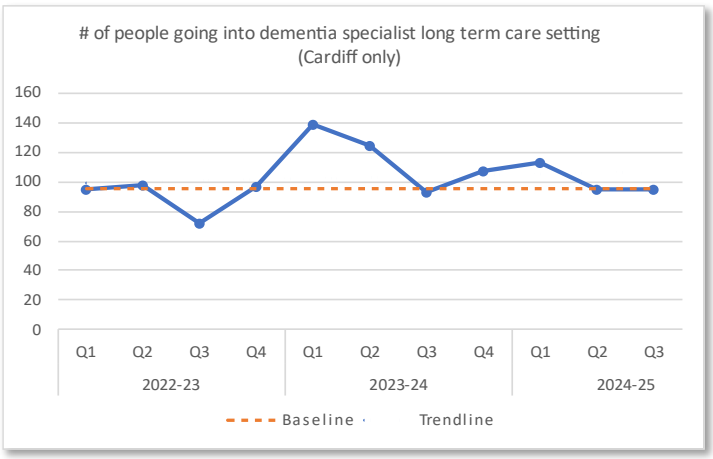
Dementia programme: Q3 RIF Summary

Programme drivers

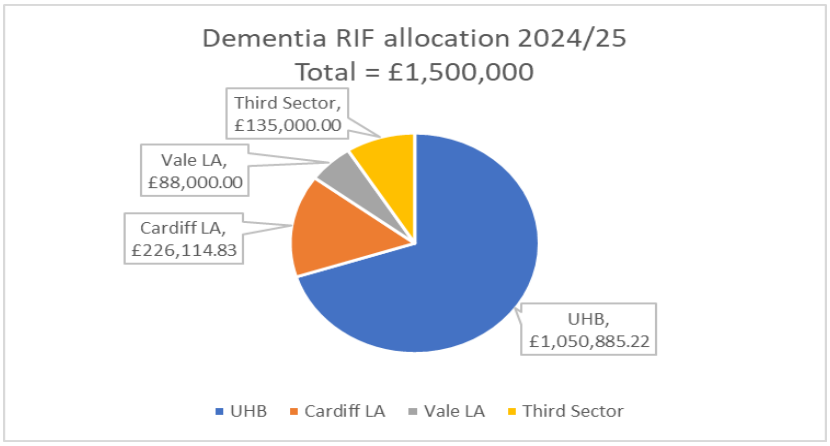




Several other programme drivers relating to inpatient activity have been identified as key areas of interest:

- Number of attendances to UHW emergency unit for people living with dementia aged 65+ years
- Number of hospital admissions for people living dementia that are planned care
- Average length of stay (from admission to discharge, excluding day cases) for people living with dementia

Work is currently underway with partners to understand the accuracy of inpatient data relating to people living with dementia. This work will continue into 2024/25.



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BYW'N DDA LIVING WELL

Learning Disabilities: Q3 RIF Summary

Area Plan Commitment:
People with learning disabilities will have the ability to live as independently as possible in their local community

Overview of Programme:
The Learning Disability Programme aims to develop integrated support services enabling people with learning disabilities to live as independently as possible in their local community. Projects included in the scope of the programme are:
· The right support at the right time
· Having my own home
· Fit for my future
The programme enables the 8 elements of the Regional Joint Commissioning Strategy for People with Learning Disabilities to be delivered at pace through the additional RIF resource.

Area plan delivery plan aims for 24-25:

- Develop a partnership action plan that responds to population need and partnership priorities, maximising quick wins in responding to need
- Co-produce and develop a partnership LD service specification, setting out the ambition for an integrated service offer which aligns the contributions from all partners.
- To understand the whole system service offer and support available from each partner, including access into advice, information, assistance and services
- Understand service demand and capacity to respond across all partners and assess the gaps and areas of duplication
- Understand the offer from universal services such as housing, third sector, primary care and secondary care
- To understand how many people with a learning disability live in Cardiff and Vale of Glamorgan who need health, care and support
- Deliver a CALDS service for 5 – 18 year olds
- Develop a liaison nursing service for

Progress against Q3 Plan	Achieved?	Comment
Extension of the Regional Joint Commissioning Strategy for 3 years (Q1 aim)	✓	Strategy extended and work currently being finalised to publish updated version.
Undertake analysis of existing data and findings	✓	Data development plan in progress and LDPB undertaking prioritisation of need.
Review SBUHB specification of services & arrange for sharing across partners	✓	Drafting and approval of specification ongoing.
Develop liaison pathway/protocol	✗	Childrens Liaison Nurse now in post.
Complete LA website delivery across Cardiff/Vale	✓	Ongoing - launch end of Q4.
Scope of third sector provision (see Regional Commissioning)	✓	Work underway and progressing
Development of partnership action plan that responds to strategy priorities.	✓	LDPB re-established and priorities in development.

What's next for Q4	Comment
Finalise and agree data requirements by establishing a task and finish group with relevant partners to review current data processes, improve individual and population data, and data sharing requirements	LD Improvement manager undertaken scoping of current data and priorities, LDPB to inform development of delivery plan with increased governance across programme.
Ensure governance and accountability of LDPB across programme of work, including oversight of spend and impact	By end Q4
Arrange workshop to identify agreed partnership priorities for 25/26	By April 2025
Review relevant action for LD capital estate across the region	By April 2025

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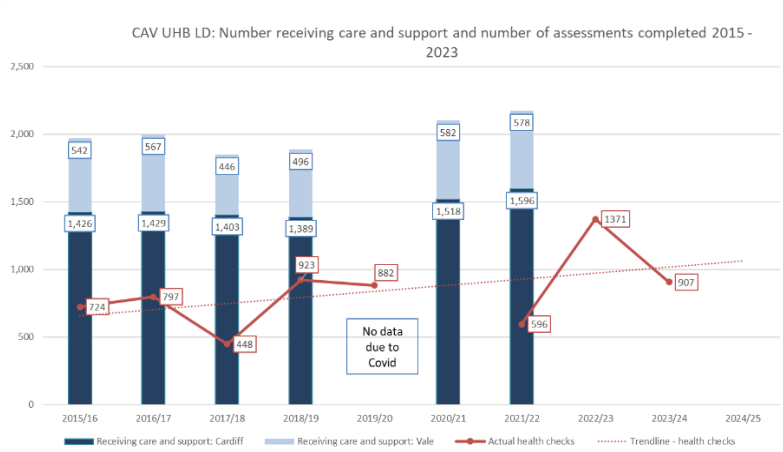
Learning Disabilities: Q3 RIF Summary

Performance Summary

Key metrics	Target OR baseline		Current performance	Comment
Fit for my future				
Number of people discussed at TRIG (LD)	Baseline: Q3-Q4 2023-24	56	36	
Number of people transitioning (ND)	Baseline: Total 2023-24	17	17	
Number of young people accessing day opportunities as part of their transition (18-25)	Baseline: Total 2023-24	19	20	
Right Support Right Time				
Number of care plan reviews for people with learning disabilities completed by Planning and Review team	Baseline: Q2-Q4 2023-24	244	176	Long term sickness has impacted on the number of individuals engaged with by HCSWs with lived experience.
Number of people with lived experience and health professionals spoken with by the two healthcare support workers with lived experience	Baseline: Total 2023-24	864	366	
Number of individuals accessing Shared Lives (previously APS) Vale	Baseline: Q2 2022-23	53	Data unavailable	
Having my own home				
Number of referrals in to supported living	Baseline: Total 2023-24	53	26	
Number of people in supported living placements in Cardiff	Baseline: Q4 2023-24	347	339	
Number waiting for suitable support living accommodation	Baseline: Q4 2023-24	76	113	

Programme drivers



- Trend line indicates a gradual increase in uptake of health check to pre-pandemic levels
- Target health check numbers to be at least that of local authority/health caseloads of people with a known LD
- Information has been requested from local authorities to understand care and support population need for 22/23 onwards
- Information has been requested from SBUHB to understand health population need from 23/24 onwards
- Information on number of health checks completed in 23/24 is anticipated in October 2024
- Information on number of invites for health checks has been requested for 23/24 onwards

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Unpaid Carers: Q3 RIF Summary

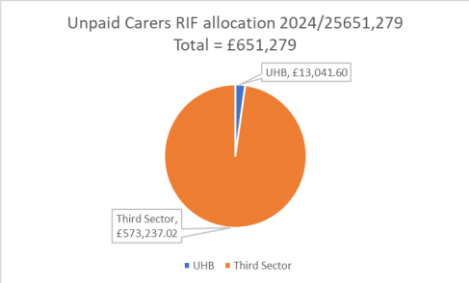
Area Plan Commitment:
Unpaid carers will be recognised for the vital contribution they make to the community and the people they care for and enabled to do the things they want to alongside caring.

Overview of Programme:
The unpaid carers programme aims to develop a regional approach to ensuring that unpaid carers are recognised and that every step is taken to ensure the region is an environment that supports the highest quality of life possible for unpaid carers and the people they care for. The key outcomes align to the Regional Unpaid Carers Charter:

1. Ensure unpaid carers are identified and recognised in our communities
2. Ensure the right information and advice is given to unpaid carers at the right time
3. Improve the quality of support provided to unpaid carers
4. Develop and improve the skills of our workforce to help unpaid carers achieve what matters to them
5. Make best use of the resources available to contribute to caring for people in our communities and make sure unpaid carers have time to do the things they enjoy
6. Work together to ensure unpaid carers are supported in education and work
7. Ask unpaid carers to tell us what you think
8. Listen to the voice of unpaid carers to inform the development of services and support

Area plan delivery plan aims for 24-25:

- Implement a new model to increase Carer Friendly organisations (with specific focus also on schools)
- Support the Unpaid Carers Assembly and wider engagement activities
- Implement and test a new model for the Carers Gateway
- Develop resources to signpost carers for mental health and wellbeing support
- Increase discharge support for unpaid carers through designated hospital-based support staff
- Develop a regional understanding of assessment pathways and processes
- Commission the 3rd sector to provide short breaks for unpaid carers (final year of the scheme)
- Implement a new model of young carers support in Cardiff
- Develop a regional approach to



Progress against Q3 plan	Achieved?	Comment
Regional approach to young carers support defined	✓	
Implementation of communications plan	×	Developments underway and awaiting rebranded Charter. To be completed in Q4
Recruitment to Carer discharge support post	×	Due for recruitment in Q4
Mental Health and Wellbeing task and finish group established	✓	
Carers Rights Day - Joint comms campaign	✓	
Mapping of current assessment pathways	×	Awaiting national work
Charter re-design to reflect new arrangements	×	Redesign underway - to be completed in Q4
Co-produce Unpaid Carers Assembly	✓	
Support a collaborative approach to short breaks	✓	

What's next for Q4	Comment
Define Delivery Plan 2025-26 priorities	On track
Develop the Mental health and wellbeing project plan	On track

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Unpaid Carers: Q3 RIF Summary

Performance Summary

Top 3 Objectives	Target OR baseline		Performance to date*	Comment
Carers Information Service —a single point of access for information and advice for unpaid carers				
Total number of new carers identified and supported	Baseline: 2022-23 total	416	544	On track
Total number of calls handled (inbound and outbound)	Baseline: 2022-23 total	1,902	3,052	
Total number of emails handled (inbound and outbound)	Baseline: 2022-23 Q2	801	1,379	
Young Carers—support for young carers in Cardiff				
Number of new young carers to receive a service	Baseline: 2022-23 total	192	38	Challenges in recruiting to the new posts as part of the transfer to Cardiff Council provision have impacted performance. Expected increase now full establishment in place.
Number of 1-1 sessions delivered	Baseline: 2022-23 total	241	127	
Number of Group Respite sessions delivered	Baseline: 2022-23 total	216	27	
Carer Friendly/Young Carers in Schools Project–development and training for schools to be more carer aware				
Number of staff attended training sessions	Baseline: 2023-24 total	80	144	Data collection issues with schools. Work underway to increase the no. of schools who provide data.
Average number of identified young carers in primary school per quarter	Baseline: Q1 2023-24	160	85	
Average number of identified young carers in secondary school per quarter	Baseline: Q1 2023-24	640	240	
% of staff with increased confidence to identify a young carer	Baseline: Q1 2023-24	100%	84%	
Short breaks — Grants to support unpaid carers accessing activities and/or vouchers.				
Number of 3rd sector organisations supported	Baseline: 2022-23 total	17	8	On track - reported 6-monthly
Number of unpaid carers supported	Baseline: 2022-23 total	2,047	1,334	
TBC: Wellbeing score				

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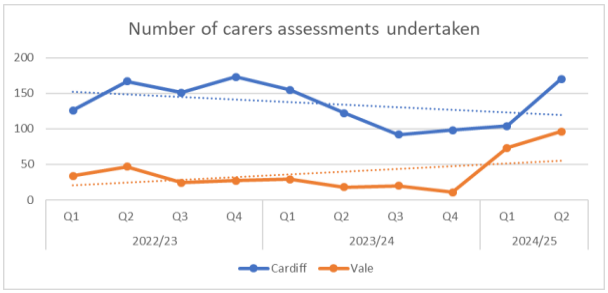
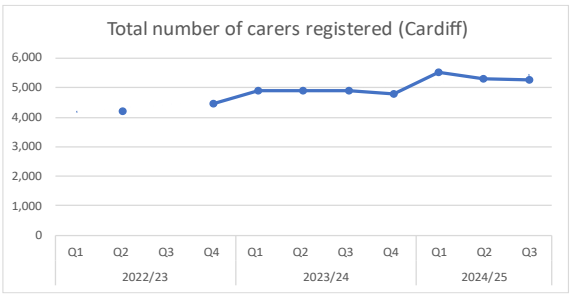
Programme drivers





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BYW'N DDA LIVING WELL

Neurodivergence Programme Summary Q3 (inc. RIF)

Area Plan Commitment:
Ensure people who are Neurodiverse receive the right support at the right time.

Overview of Programme:
- Strengthening support to ensure the right support is available at the right time
- Improving ADHD service provision
- Transitional arrangements which enable a seamless journey for young people into adult hood
- Meeting the new national guidance on neurodiversity requirements
- Improving timeliness and access to assessment and diagnosis
- Implementing the Code of Practice

Programme Aims
- Develop business proposal that outlines demand and capacity & sustainability options for delivery of the Integrated Autism Service
- Implement a Single Point of Access into Children's ND services that provides a response to referral & triage to the right part of the system based on presenting needs
- Pilot an ADHD pathway in one CMHT to test new ways of working
- Deliver an Information and Advice service from local authority front doors that support ND people based on presenting needs

Progress against Q3 Plan	Achieved?	Comment
Present to clinical board on demand and capacity & service requirements to meet needs	✓	Demand and capacity assessment for IAS completed. Business plan in development for ADHD, concerns highlighted via SBAR to HB, decision awaited.
Review multi agency arrangements in SPOA	✓	SPOA now fully embedded into service. A review of the outcomes of this work has begun and will be ongoing
Draft ND friendly City strategy – Cardiff	✓	Partnership priorities agreed to be included in strategy. Strategy currently in process of being written up
Submit proposal for additional NDIP funding to support BCYP on ND waiting list.	✓	

What's next for Q4	Comment
Improve access to support through creating ND friendly environments	Fully engaging in Cardiff strategy and spreading good practice across wider system partners.
Develop No Wrong Door proposal for ND	
Set up a ND Strategic Partnership Board to cover whole population and drive improvement across the region	By end Q4
Manage potential risk for end of ND budget	By end Q4. Addd seeking confirmation from WG
Deliver on agreed activity for additional NDIP funding	By end Q4
Ensure submission of regional response to Part 2 of the review of progress against Autism code of practice	Embed requirements of autism CoP into responsibilities of ND strategic board

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BYW'N DDA LIVING WELL

Neurodivergence Programme Summary Q3 (inc. RIF)

Performance Summary

Key metrics	Baselines		Current performance	Comment
Integrated Autism Service				
Number of people with Autism referred for advice/support	Baseline: Total 2023-24	1,568		IAS Q3 report expected 24.1.25.
Number of people with Autism received interventions	Baseline: Total 2023-24	1,258		
Number of people with Autism received a diagnostic assessment	Baseline: Total 2023-24	221		
Improved Wellbeing & Self-esteem STAR	Baseline: Total 2023-24	44%		
Number of weeks waiting to receive diagnostic assessment intervention for people with Autism (Average from acceptance)	Baseline: Total 2023-24	84		
Children's ND				
Number of CYP on waiting list (0-18)	Baseline: 2023-24 Q1	2,726	3,854	EPAtS sessions have been on pause due to delays in core funding confirmation.
Number of CYP referred	Baseline: Total 2023-24	3,059	1,957	
Number of initial appointment slots (capacity)	Baseline: 2023-24 Q3	105	164	
Number of families receiving support through community connectors	Baseline: Total 2023-24	153	506	
% of people with a better awareness of available support after their connection sessions	Baseline: 2023-24 Q3	92%	100%	
Number of families attending EPAtS groups	Baseline: 2023-24 Q1	17	0	
Cardiff Local Authority - ND Team & Transition				
Number of referrals for ND team	Baseline: Total 2023-24	88	16	
Number of referrals for transitioning	Baseline: Total 2023-24	19	13	
Number of individuals on active caseload	Baseline: Q4 2023-24	44	54	
Number of visits undertaken (ND Team)	Baseline: 2023-24	87	121	
Number of assessments/reviews completed (ND Team)	Baseline: Q3 & 4 2023-24	27	42	
Number of individuals on waiting list (ND team & transition)	Baseline: Q4 2023-24	36	37	

Programme drivers

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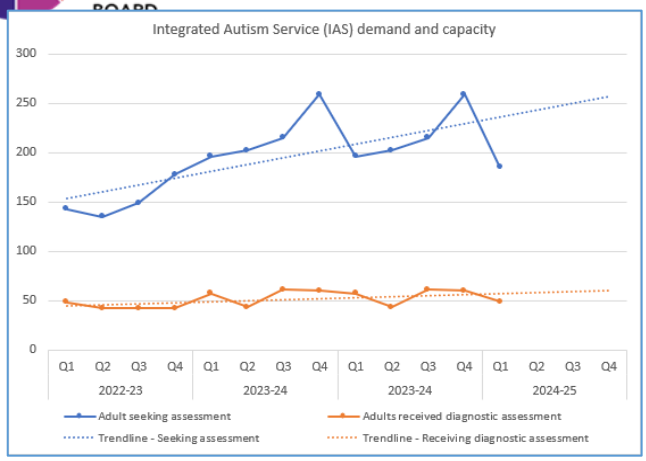

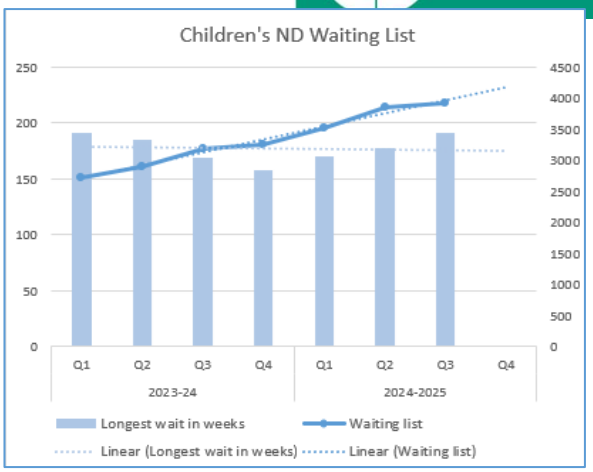

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DECHRAU'N DDA STARTING WELL

emPower and CHLD: Q3 RIF Summary

Area Plan Commitment:
emPower: Work together to keep our babies, children and young people healthy, well and safe from harm; and deliver a Nurturing, Empowering, Safe and Trusted (NEST) approach to emotional wellbeing and mental health.
Complex Health and Disability: Improve the support offer for babies, children and young people with complex needs.

Overview of Programme:
The emPOWER programme aims to deliver an integrated care model for infants, children, young people and their families with emotional well-being and mental health needs across health, education and social care. Complex Health and Disabilityprovide additional capacity through RIF funding to pilot and upscale areas of work to benefit babies, children and young people with needs related to complex health and disability.

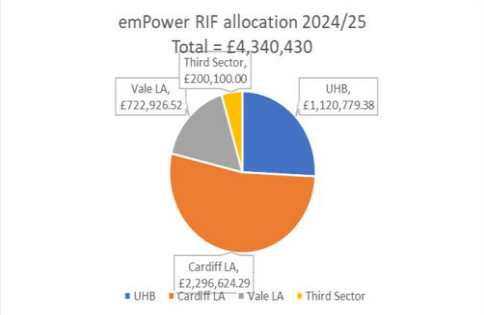
Area plan delivery plan aims for 24-25:

<u>emPower:</u>
Implementation of new pilot model of delivery for local authorities of the Goleudy model.

- Expansion of Multi-Agency No Wrong Door early intervention to include education services.
- Develop and pilot multi-agency No Wrong Door for young people with complexity of need.
- GP Signposting pilot with West Quay General Practice – Vale of Glamorgan.

<u>Complex Health and Disability:</u>

- Scope the development of a multi-agency No Wrong Door for children and young people with complex additional learning needs
- Review 2019 joint continuing care protocol & revise to meet current need
- Review the Regional Transition protocol & map against existing



Progress against Q3 plan	Achieved?	Comment
Sign off from leads of No Wrong Door complexity of need process	✗	Deferred pending outcome of SWP Leads group
Begin pilot of the new dashboard view for BCYP on the ND pathway	✓	Pilot started 5.11.24
Review regional continuing care protocol and Transition protocol	✗	Commitment paused pending outcome of SWP priorities
Pilot No Wrong Door complexity of need process	✗	Pending SWP priorities
Pilot inclusion of education into No Wrong Door (early intervention) to include Education	✓	Commitment in place; Education involved in SWP development.
Sign off revised data that demonstrate programme drivers & performance indicators	✓	Work progressing. Will extend into Q4 ready for Q1 25/26.

What's next for Q4	Comment
Present final strategy for sign off & launch	Delayed - refocus on setting up SW Board and agreed initial priorities for partnership working under the RPB umbrella
Review lessons learned West Quay signposting pilot	Ongoing
Sign off from leads of No Wrong Door complexity of need process	Ongoing
Take learning from emPOWER to inform development of a No Wrong Door/multi-agency process for babies, children and young people with learning disability.	Alignment across SW and LD to be implemented
Develop options that support ownership and sustainability for the Summary Care View	Review of pilot to be undertaken and decision re future delivery
Improve governance and accountability for SW programme through set up of SW Board and agreed cross sector priorities	To be supported by ongoing stakeholder work via 2 CVCs engagement with wider third sector

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emPower and CHLD: Q3 RIF Summary

Performance Summary

Key metrics	Target OR baseline		Performance to date*	Comment
No Wrong Door – babies, children, young people and their families are able to experience a No Wrong Door approach when they request emotional wellbeing support from our system.				
% of parents who feel appropriately supported by FFAL	Baseline:	100%	80%	
Number of Thinking Together Conversations (TTC)	Baseline:	224	181	
Number of EH practitioners reporting an increase in confidence to deal with EMHWB issues following TTC	Baseline:	45	33	
Number of direct interventions by In Reach team	Baseline:	665	375	
Number of professionals who received training by In Reach team	Baseline:	1,267	1,233	
Right Support, Right Time – babies, children and young people experience family-led early intervention and prevention that prevents placement breakdown and supports reunification where this is possible**.**				
Number of children who received support by Family Support	Target:	100	230	No RAG rating for reunification as this figure is representative of numbers of children looked after.
Number of families on the waiting list for Family Support	Baseline:	24	6	
Number of plans agreed following FGCs	Baseline:	136	98	
% CYP who are happier following FGC	Baseline:	85%	80%	
No. of CYP Supported through reunification (Cardiff and Vale)	Baseline: 2023-24 Q2	5,084	4,470	
# children maintained within family (Cardiff and Vale)	Baseline: 2023-24 Q2	3,769	3565	
Being looked after ends (Cardiff only)	Baseline:	208	179	
Children and young people with complex needs - community-based intensive and therapeutic support for CYP on the edge of care that helps to maintain CYP in families or stable placements**.**				
Number of Children Looked After prevented	Baseline:	31	24	
Number of families worked with by ARC	Baseline:	92	114	
Number of children to receive therapy from Enfys	Baseline:	33	11	
Goleudy - Intensive and theraputic support for children and young people admitted to hospital or at risk of placement breakdown				
Number of CYP closed	Baseline:	31	4	
Number of CYP in active support	Baseline: 2023-24 Q3	10	9	

Planning for my future - improving services that support a smooth transition for young people with complex disabilities and health needs into adult hood, including adult services.
Supporting CYP to receive the right support at the right time who present with neurodiversity

Number of requests for support (education)	Baseline: 2023-24 Q1+Q2	51	Data unavailable	
Number of young people discussed at TRIG (transition review interface group) meetings (Cardiff only)	Baseline:	55	44	
Number of young people allocated a transition social worker to aid their transition to adult services	Baseline:	46	31	
Integrated approaches				
Number CYP who receive an enhanced dietetic service through their special school (average)	Baseline:	156	166	EPAtS Sessions have been on pause due to delays in funding confirmation.
Longest wait on CALDS waiting list (weeks) (average)	Baseline:	43.3	59	
Number of families attending e-PAtS groups	Baseline:	75	0	
Number of families on waiting list for EPAtS	Baseline:	48	40	

**RAG rating: Red = Forecasted performance for entire year is 25% or greater away from baseline or target, Amber = Forecasted performance for entire year is between 5% - 25% away from baseline or target, Green = Forecasted performance for entire year is 5% or less away from baseline or target.*

Programme drivers

The following indicators have been identified as the 'programme drivers' and are used to determine current progress