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

Cardiff and Vale Regional Partnership Board

Joint Area Plan

2023-28

DRAFT Annual Delivery Plan 2025-26

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

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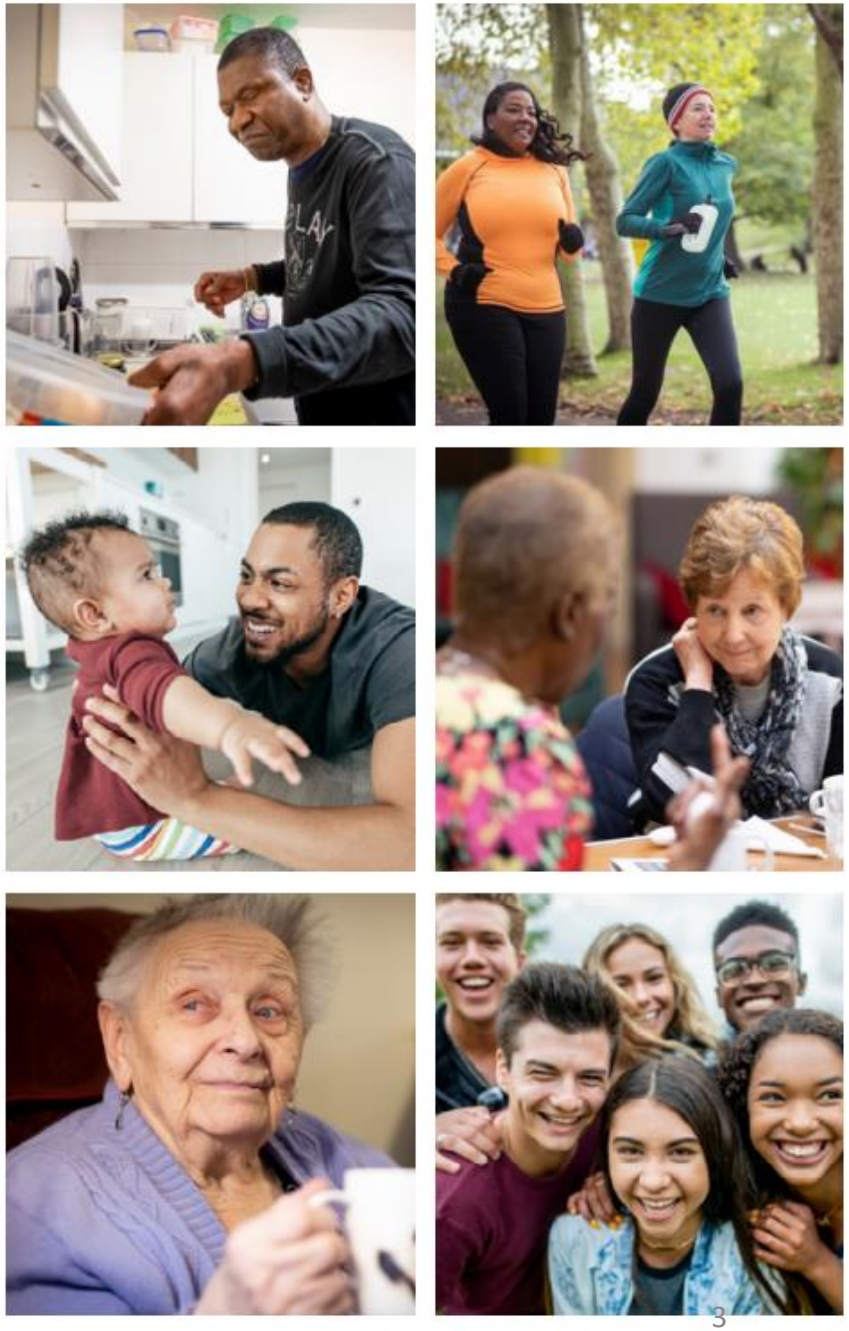
Introduction

The Cardiff and Vale RPB's Joint Area Plan sets out the partnership's plans to improve the health and wellbeing of the local population. This relates specifically to the joint activities we are committing to as a partnership, building on a long history of collaboration.

Every 5 years, we review our priorities and plans, in light of emerging innovation, policy, the refreshed Population Needs Analysis and Market Stability Report. We share these with as wide a range of people as possible to identify how, by working together, we can make the biggest difference for people in Cardiff and the Vale of Glamorgan. This companion document sets out what we commit to deliver as a partnership during 2025/26.

This Annual Delivery Plan builds upon what is already happening within our individual organisations, focusing on key areas where we need to work together to make real change happen. Fundamentally, it must:

- Support delivery of the commitments in the Joint Area Plan
- Be realistic and meaningful to those that deliver and receive services
- Be achievable this year
- Measurable
- Partnership-focused



Making a Difference – Our Commitments for 2028

- **We will:**
- Work together to keep babies, children and young people healthy, well and safe from harm.
- Deliver a Nurturing, Empowering, Safe and Trusted approach to emotional wellbeing and mental health.
- Improve the support offer for babies, children and young people with complex needs.

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.

With people with **physical and sensory impairments** we will find out more about their needs, experiences and priorities, developing and delivering changes that enable people to live as independently as possible.

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.

People with **Learning Disabilities** will have the ability to live as independently as possible in their local community.

We will support all people in our region to have the opportunity to live positive, independent lives without being affected by **violence and abuse.**

We will build a co-produced plan with stakeholders and people with **mental health needs** that enables people to do the things that matter most to them.

Neurodivergence services will have strengthened provision with a focus on providing the right support at the right time.

People with Dementia will be supported to live well and do the things they need to and enjoy in their communities.

Our commitments

The Regional Partnership Board aims to improve how health and care services are delivered for people in Cardiff and the Vale of Glamorgan. We bring together networks of professionals and service users from a range of organisations and interest groups to help us.

Our commitments are underpinned by our shared principles:

- **Prevention:** promoting early intervention that prolongs good health and well-being for all age groups whilst reducing reliance on long term service provision
- **Care closer to home:** providing care and support as close to people's homes as possible
- **Inclusion and diversity:** ensure that people are involved in planned their care, and that we work to reach out to all people from across all of our communities
- **Sustainability:** ensuring the long-term viability of our environment through carbon reduction is a fundamental necessity and we are committed to ensuring that our plans reflect this need
- **Social value:** ensuring that the things we do have the best possible impact on our well-being

Governance

Cardiff and Vale Regional Partnership Board (RPB) includes representatives from carers and service users, Cardiff Council, Vale of Glamorgan Council, Cardiff and Vale University Health Board, Welsh Ambulance Service NHS Trust, housing, third and independent sectors.

We work with our population, recognising its diversity, and colleagues from across our region to improve the health and wellbeing of everyone living in Cardiff and the Vale of Glamorgan. We share resources, skills and services to ensure people can access the right service, in the right place, at the right time so, you can do the things that matter most to you, at all times of life.

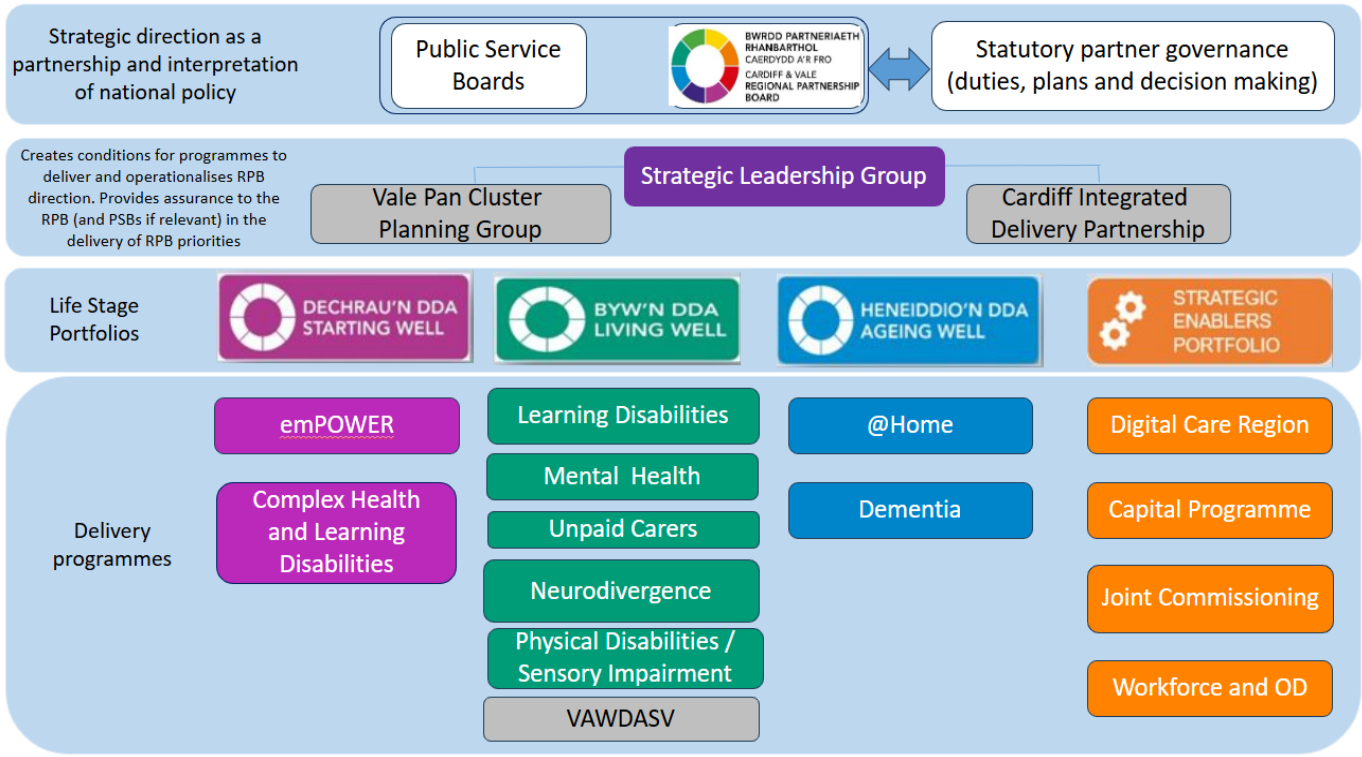
Our work is organised around three life-stage themes:

Starting Well: giving every child the best start in life

Living Well: supporting people to live well and do the things that matter to them

Ageing Well: enabling people to stay independent as they become older

All of these require partners to work together to achieve our commitments. Our delivery programmes are based on achieving better outcomes for people in each life stage.



Assurance

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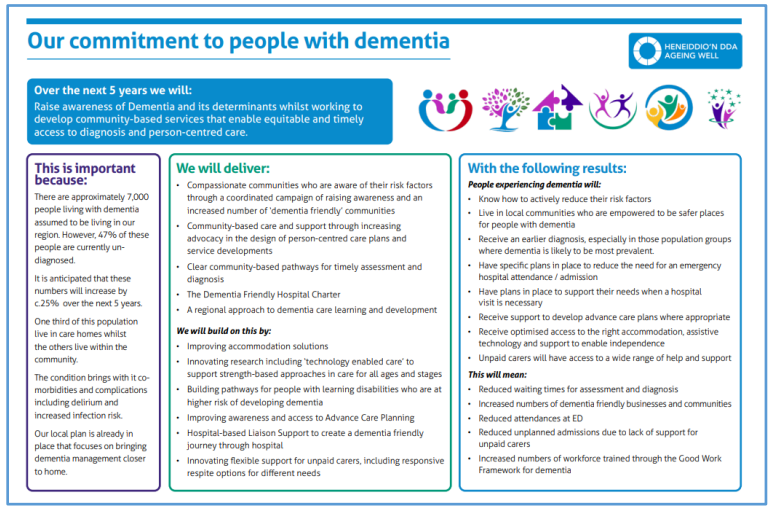
The following table outlines the local reporting structure that we use to track our progress and ensure that our partners receive timely information on our plans:

The RPB Team

Who is the report for?	What's involved?	Frequency
Individual partner organisations	▪ Annual reports to Local Authority Scrutiny Committees ▪ Quarterly reports to Cardiff and Vale UHB Finance and Performance Committee for information ▪ Any other requirement	As required
Programme Board (*Key stakeholders with a role in delivering the change we want to see*)	▪ Local dashboards for each programme ▪ Programme level financial forecast ▪ Welsh Government reports for relevant funding streams	Quarterly
	▪ Project level financial forecast	Monthly
Statutory Assessments	**Population Needs Assessment** – this year we plan to develop a new cyclical approach to Assessing our Population Needs in way that informs our shared planning in a more timely, regular way. **Market Stability Report** – this annual reporting cycle informs us of local care market pressures and developments and helps shape our priorities for the coming year	Annual cycle
Strategic Leadership Group (*Senior officers / Directors – the 'engine room' of the RPB*)	▪ Local dashboards for each programme ▪ High level financial forecast ▪ Welsh Government reports for relevant funding streams	Quarterly
Regional Partnership Board **Click here for our membership**	Deep dives into our programmes, considering its impact on the relevant Area Plan commitment. Service Users and operational colleagues have the opportunity of shaping their deep dive in any of the following ways: ▪ Exploring a problem – investigating an issue to mitigate impact. ▪ Exploring a situation – exploring a new demand or need for a particular priority area to understand how we might best respond. ▪ Exploring a new idea – exploring an idea for working differently, to think about how it might come to life along with the challenges of making it happen.	Annual
Welsh Government	Relevant funding stream reports	Quarterly
	Annual Report Area Plan Delivery Plan	Annual

Planning Cycle



Our commitment to people with dementia

HENEIDDIO'N DDA AGEING WELL

Over the next 5 years we will:
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.

This is important because:

There are approximately 7,000 people living with dementia assumed to be living in our region. However, 47% of these people are currently un-diagnosed.

It is anticipated that these numbers will increase by c.25% over the next 5 years.

One third of this population live in care homes whilst the others live within the community.

The condition brings with it co-morbidities and complications including delirium and increased infection risk.

Our local plan is already in place that focuses on bringing dementia management closer to home.

We will deliver:

- 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-centred 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

We will build on this by:

- Improving accommodation solutions
- Innovating research including 'technology enabled care' to support strength-based approaches in care for all ages and stages
- Building pathways for people with learning disabilities who are at higher risk of developing dementia
- Improving awareness and access to Advance Care Planning
- Hospital-based Liaison Support to create a dementia friendly journey through hospital
- Innovating flexible support for unpaid carers, including responsive respite options for different needs

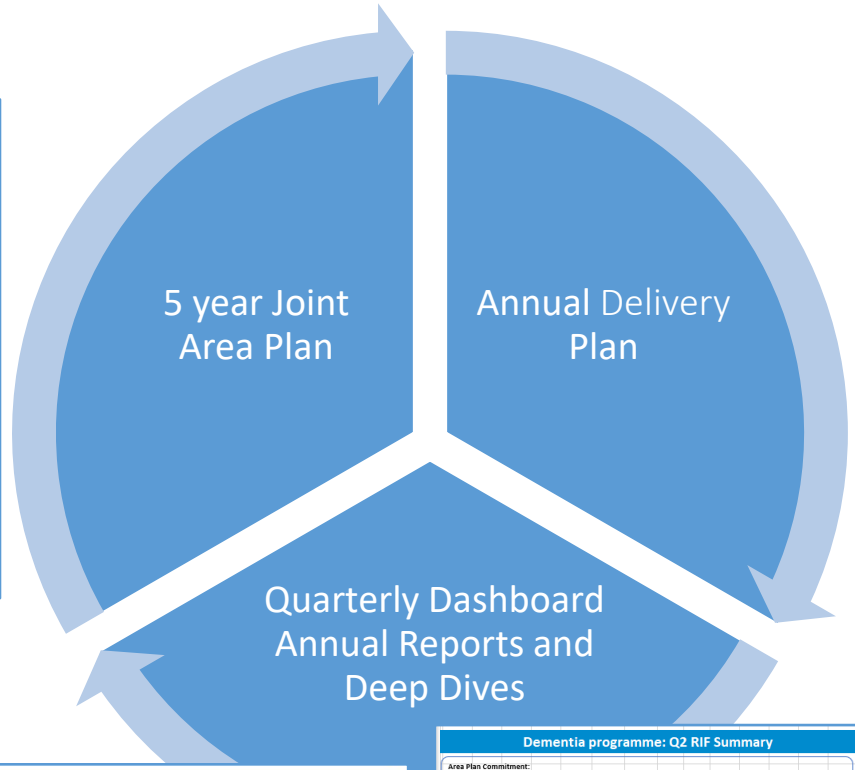
With the following results:

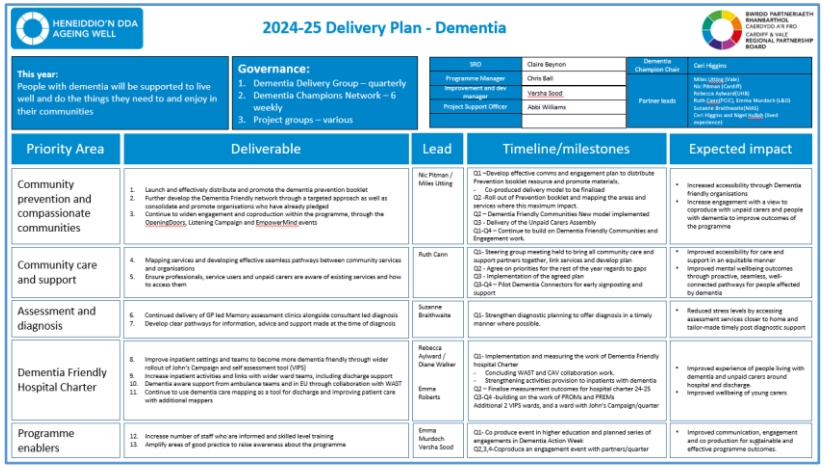
People experiencing dementia will:

- Know how to actively reduce their risk factors
- Live in local communities who are empowered to be safer places for people with dementia
- Receive an earlier diagnosis, especially in those population groups where dementia is likely to be most prevalent.
- Have specific plans in place to reduce the need for an emergency hospital attendance / admission
- Have plans in place to support their needs when a hospital visit is necessary
- Receive support to develop advance care plans where appropriate
- Receive optimised access to the right accommodation, assistive technology and support to enable independence
- Unpaid carers will have access to a wide range of help and support

This will mean:

- Reduced waiting times for assessment and diagnosis
- Increased numbers of dementia friendly businesses and communities
- Reduced attendances at ED
- Reduced unplanned admissions due to lack of support for unpaid carers
- Increased numbers of workforce trained through the Good Work Framework for dementia





HENEIDDIO'N DDA AGEING WELL

2024-25 Delivery Plan - Dementia

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This year:
People with dementia will be supported to live well and do the things they need to and enjoy in their communities

Governance:
1. Dementia Delivery Group – quarterly
2. Dementia Champions Network – 6 weekly
3. Project groups – various

SRO	Claire Beynon	Dementia Champion Chair	Carl Higgins
Programme Manager	Chris Ball	Partner leads	Miles Utting (Vale); Nic Pitman (Cardiff); Rebecca Aylward (UHB); Ruth Cann(PCC); Emma Murdoch (L&D); Suzanne Braithwaite(Mind); Carl Higgins and Nigel Hullah (lived experience)
Improvement and dev manager	Varsha Sood		
Project Support Officer	Abbi Williams		

Priority Area	Deliverable	Lead	Timeline/milestones	Expected impact
Community prevention and compassionate communities	1. Launch and effectively distribute and promote the dementia prevention booklet 2. Further develop the Dementia Friendly network through a targeted approach as well as consolidate and promote organisations who have already pledged 3. Continue to widen engagement and coproduction within the programme, through the OpeningDoors, Listening Campaign and EmpowerMind events	Nic Pitman / Miles Utting	Q1 –Develop effective comms and engagement plan to distribute Prevention booklet resource and promote materials. - Co-produced delivery model to be finalised Q2 -Roll out of Prevention booklet and mapping the areas and services where this maximum impact. Q2 – Dementia Friendly Communities New model implemented Q3 - Delivery of the Unpaid Carers Assembly Q1-Q4 – Continue to build on Dementia Friendly Communities and Engagement work.	• Increased accessibility through Dementia friendly organisations • Increase engagement with a view to coproduce with unpaid carers and people with dementia to improve outcomes of the programme
Community care and support	4. Mapping services and developing effective seamless pathways between community services and organisations 5. Ensure professionals, service users and unpaid carers are aware of existing services and how to access them	Ruth Cann	Q1- Steering group meeting held to bring all community care and support partners together, link services and develop plan Q2 - Agree on priorities for the rest of the year regards to gaps Q3 - Implementation of the agreed plan Q3-Q4 – Pilot Dementia Connectors for early signposting and support	• Improved accessibility for care and support in an equitable manner • Improved mental wellbeing outcomes through proactive, seamless, well-connected pathways for people affected by dementia
Assessment and diagnosis	6. Continued delivery of GP led Memory assessment clinics alongside consultant led diagnosis 7. Develop clear pathways for information, advice and support made at the time of diagnosis	Suzanne Braithwaite	Q1- Strengthen diagnostic planning to offer diagnosis in a timely manner where possible.	• Reduced stress levels by accessing assessment services closer to home and tailor-made timely post diagnostic support
Dementia Friendly Hospital Charter	8. Improve inpatient settings and teams to become more dementia friendly through wider rollout of John's Campaign and self assessment tool (VIPS) 9. Increase inpatient activities and links with wider ward teams, including discharge support 10. Dementia aware support from ambulance teams and in EU through collaboration with WAST 11. Continue to use dementia care mapping as a tool for discharge and improving patient care	Rebecca Aylward / Diana Walker Emma Roberts	Q1- Implementation and measuring the work of Dementia Friendly hospital Charter - Concluding WAST and CAV collaboration work. - Strengthening activities provision to inpatients with dementia Q2 – Finalise measurement outcomes for hospital charter 24-25 Q3-Q4 -building on the work of PROMs and PREMs Additional 2 VIPS wards, and a ward with John's Campaign/quarter	• Improved experience of people living with dementia and unpaid carers around hospital and discharge. • Improved wellbeing of young carers
Programme enablers	12. Increase number of staff who are informed and skilled level training 13. Amplify areas of good practice to raise awareness about the programme	Emma Murdoch Varsha Sood	Q1- Co produce event in higher education and planned series of engagements in Dementia Action Week Q2,3,4-Coproduce an engagement event with partners/quarter	• Improved communication, engagement and co production for sustainable and effective programme outcomes.

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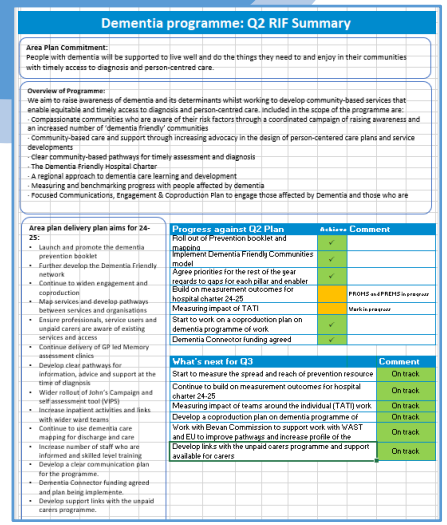
Annual Report
2023 - 2024

May 2024



Dementia programme: Q2 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 booklet
- 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 and plan being implemented.
- Develop support links with the unpaid carers programme.

Progress against Q2 Plan	Achieve	Comment
Roll out of Prevention booklet and mapping	✓	
Implement Dementia Friendly Communities model	✓	
Agree priorities for the rest of the year regards to gaps for each pillar and enabler	✓	
Build on measurement outcomes for hospital charter 24-25		PROMS and PREMS in progress
Measuring impact of TATI		Metrics progress
Start to work on a coproduction plan on dementia programme of work	✓	
Dementia Connector funding agreed	✓	

What's next for Q3	Comment
Start to measure the spread and reach of prevention resource	On track
Continue to build on measurement outcomes for hospital charter 24-25	On track
Measuring impact of teams around the individual (TATI) work	On track
Develop a coproduction plan on dementia programme of	On track
Work with Bevan Commission to support work with WAST and EU to improve pathways and increase profile of the	On track
Develop links with the unpaid carers programme and support available for carers	On track

Annual delivery plans 2025-26

DECHRAU'N DDA STARTING WELL

DRAFT 2025-26 Delivery Plan: Babies, Children and Young People

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This Year:

- We will implement programme governance.
- We will ensure wide regional engagement.
- We will work together to improve experiences for babies, children and young people.

Governance:

1. **Starting Well Leads Group**
2. **Relevant task and finish groups**
3. **Third sector stakeholder group**
4. **Cross referenced to strategic plans**

SRO	TBC
ASRO	TBC
Programme Manager	Anna Tee
Project Manager	
Project Support Officer	Colleen Eley

Partner leads	Cardiff Council – Deborah Driffield Vale of Glamorgan Council – Rachel Evans CAV UHB – Becci Ingram

Priority area	Deliverable	Lead		Timeline / milestones	Expected impact
Starting Well strategic programme board development	• SRO for programme agreed with individual leads for actions, governance and dates in diaries • Ensure full representation across stakeholders including primary care, third sector and appropriate mechanisms to ensure progress informed by the voice of lived experience.	TBC		Q1 SRO agreed and dates in diaries Q1 review of membership & processes Q2 First Starting Well strategic programme board Q2 Agree priorities for action	Functioning SW Board in place to provide oversight of regional activity to improve experiences for babies, children and young people. Reduced duplication of activity and better joined up activity
Regional Leadership Group request to address continued and growing cost pressures related to complex needs requiring specialist support	• Undertake a baseline assessment of existing partner data to inform current position • Development of action plans informed by baseline • Report on progress to Regional Leadership Group	TBC		Q1 set up subgroup to drive work Q2 complete baseline assessment and agree action plan Q3 report proposal for next steps to RLG	Thorough understanding of current position Opportunities identified to improve support for CYP with complex needs and reduced duplication and cost

Ensure joined up partnership activity focus on Early Years agenda	• Undertake a baseline assessment of services, resources and assets that support the First 1000 days
	• Agree actions required to address gaps associated with the First 1000 days:
	  ○ perinatal agenda
	  ○ regional approach to ACEs and trauma
	  ○ mental health for perinatal and CYP populations
	• Progress actions as outcome of Public Health Prioritising the Early Years event
		TBC		Q1 develop timetabled plan of activity required supported by relevant meeting structures and linkage to existing strategy
				Q1 Maximise on engagement at Early Years event to improve strategic engagement across region with SW Programme
					Range of regional activity in place that engages the right organisations and drives continuous improvement in areas of need

Strategic links with ND Programme to best meets needs of CYP and their families	• Embed recommendations from WG rapid design event • Identify additional improvements for specific population groups including youth homelessness	TBC		Q1 Receive recommendations from WG & plan/approve spend for 25/26 relating to BCYP	Improved support for neurodivergent CYP and their families that is doesn't rely on a clinical diagnosis Improved potential for improved lives over the longer term
Improved safeguarding for BCYP across health and social care	• Deliver a child safeguarding regional shared care record as identified by the Regional Safeguarding Board and the Digital Care Board	TBC		Q1 Agree project specification Q2 Deliver prototype	Shared record in place to enable improved access to information needed to support safeguarding processes
Improved support for CYP not engaged in mainstream services	• Review current partner processes to identify how to highlight children 'missing' from the system • Pilot the use of 'receiving an education' as a cross-cutting measure	TBC		Q2 Explore regional approach and form recommendations	Single regional agreed measure to support joint working Reduced risk of children missing to the system
Underpinning NYTH/NEST framework	• Identify NYTH/NEST leads across the region to drive improvement and oversight of improvements following self-assessment processes • Ensure submission of self assessments as required	TBC		Q1 Review feedback on last submission Q2 Identify leads Q3 Progress actions accordingly	Active ownership across region of NYTH/NEST framework Self assessment process that drives continual improvement
Strategic oversight of RIF funded interventions	• Undertake assessment of all interventions and agree process to understand impact, outcomes and return on investment to inform decision making on final 2 years of RIF	AT		Q1 – 4 Progress assessments and regularly report to SW Board	Improved understanding of interventions and impact Improved financial position going into 26/27

BYW'N DDA LIVING WELL

DRAFT 2025-26 Delivery Plan - People with Learning Disabilities

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This Year We Will:

- Drive forward improvement that focuses on improving lived experiences for people with a learning disability that can only be addressed through working together.

Governance:

1. Learning Disability Partnership Board
2. LD Implementation Group
3. LD partnership Group
4. Strategy Workstream Group

SRO	Jane Thomas
ASRO	
Programme Manager	Anna Tee
Project Manager	
Project Support Officer	

Partner leads	

Priority Area	Deliverable	Lead	Timeline / milestones	Expected impact
1. Understand the local population	1. Develop a comprehensive overview of available data, especially for those already known to services. Outline clear definitions, spectrum of need, and potential digital solutions for data management. 2. Conduct a population needs assessment for people with learning disabilities in the region, identifying unpaid carers as a key group.	LB (AG)	Q1 Set up data sub-group to oversee delivery of work Q1 Scope existing data sources including links to x57 GP Practices Q2 Complete necessary data assessments for data sharing Q2 PNA for people with LD Q3 Develop scope for digital solution, IG process ('opt in') Q3 Integrate data from other service offers, e.g. carers where possible. Q4 explore inclusion of people living independently	Agreed single regional definition & thresholds for children and adults Understanding of current data sources Understanding of population & levels of need Improved support for carers
2. Embed a co-produced approach centred on lived experiences	1. Co-produce a lived experience engagement network to ensure 'nothing about us without us'. 2. Third sector lead to enable voice to be heard 3. Include digital inclusion offer, building on systems including Insight app.	JB (AT)	Q1 Set up network sub-group to define scope with easy read plan and explore good practice Q2 Agree principles and ambitions for network and establish implementation plan Q3 Embed network across digital platforms Q4 Evaluate the network's impact, highlight successes and improvements, and ensure lived experiences are heard and impact across all levels	Established and engaged network with impact on regional work Common understanding of approach Improved lived experience voice driving programme
3. Develop a regional future care delivery model	1. Explore how to best support people through a single, joined-up service. 2. Embed a functioning Acute Liaison Nurse service for the region, developing a business case that adopts a population health approach. 3. Ensure internal governance secured in C&VUHB. 4. Agree on a service delivery model with SBUHB.	AW	Q1 Establish multiagency steering group, map service pathways and sustain ALN service Q2 Draft regional service model Q2 Formalise internal governance structure in UHB Q3 Begin phased implementation , finalise collaboration agreement with SBUHB Q4 Evaluate impact to secure long-term funding and publish results	Roadmap seamless, person-centred care pathway Fully embedded ALN service improved access, reduced admissions and better hospital experiences Clear governance and strategic oversight in CAVUHB Improved joint working with SBUHB
4. Enhance prevention through community-based services and promoting independence	1. Ensure consistent and systematic delivery of Annual Health Checks. 2. Improve day services to meet increasing demand. 3. Integrate prevention into workforce training. 4. Increase volunteer and employment opportunities. 5. Better understand needs and gaps in sex and relationships support. 6. Improve accommodation options, including supported living and shared lives.	LB (AG)	Q1 Develop project plans for 1-6 based on pilot project outputs where appropriate Q2 Establish working groups if needed to oversee projects and develop progress reporting arrangements (e.g. monitoring AHCs) Q3 Implement project plan actions to enhance prevention Q4 Evaluate impact across 1-6 expected impacts may include increased capacity in day services, education offer and regional shared lives scheme	Improved service delivery, independence, choice, social inclusion, skill building and planning for people More inclusive community spaces, reduced reliance on specialist settings and improved everyday experiences
5. Implement a Capital programme for improving/increasing learning disability buildings	1. Influence and support improved healthcare environments. 2. Increase and enhance supported living schemes. 3. Expand and improve day services environments. 4. Proactively explore opportunities to improve community and mainstream places to better support people with a LD.	RH (AW)	Q1 Assessment of all capital estate, identify gaps and engage stakeholders in setting priorities for improvement Q2 Review current RPB Strategic Capital Plan to ensure alignment with priorities for improvement in Q1 Q3 Ensure robust project briefing, governance and delivery routes for priority projects Q4 Prepare and submit business cases and funding bids for RPB Capital Funding to deliver priorities.	Better experience of care Reduced incidence of restrictive practice Higher number of people with tenancies Lower number of people in hospitals
6. Enhance transition for young people moving into adulthood	1. Assessment of current practice against WG guidance 2022 to inform programme 2. Improved transition processes for people with a learning disability	HW? (AT)	Q1 Scope data utilisation to improve transition process Q2 Set up regional transitional panel to agree on scope and parameters (e.g. age 14) Q3 Draft updated transitional protocols/processes Q4 Finalise and agree updated transitional protocols/processes with all partners	Better experiences of transition Improved access to support through joined up approach

BYW'N DDA LIVING WELL

DRAFT 2025-26 Delivery Plan Unpaid Carers

BWRDD PARTNERIAETH RHANBARTHOL CAERDYDD A'R FRO

This Year We Will:

• Identify and recognise unpaid carers of the vital contribution they make to the community and the people they care for, and in doing so enable unpaid carers to have a life alongside caring.

Governance:

1. Unpaid Carers Board – Bi-monthly
2. Project Groups - various

SRO	Nic Pitman
ASRO	Nicola Hale
Programme Manager	Chris Ball
Project Manager	
Project Support Officer	Abbi Williams

Unpaid Carers Rep	Mike O'Brien
Partner leads	Iain McMillan (Vale) Nic Pitman (Cardiff) Suzie Becquer-Moreno (UHB) Gareth Howells (TuVida) Andrew Templeton (YMCA) Duncan Innes(C3SC) Lani Tucker (GVS)

Priority Area	Deliverable	Lead	Timeline / milestones	Expected impact	Social Value
Carer Friendly	1. Increase awareness of unpaid carers within health and social care through new carer friendly training 2. Increase awareness of the Unpaid Carers Charter through comms campaign and co-produced evaluation 3. Co-produce the 3rd annual Unpaid Carers Assembly and develop wider engagement/coproduction	Lisa Howells Chris Ball Mike O'Brien	Q1 • Communication and engagement plan developed to promote the refreshed Charter and support mental well-being work • Website fully updated to promote and signpost unpaid carer services Q3 • Delivery of the Unpaid Carers Assembly • Begin coproduced evaluation of the Unpaid Carers Charter	• At least 200 staff trained to be carer aware • Increased engagement with carer charter pages of the RPB website (new measure) • At least 50 unpaid carers directly engaged with the programme	• 3rd sector commissioned provider for training • Coproduction of the Assembly
Information and Advice	1. Embed new models of Information and Advice for unpaid carers into business as usual, following 24-25 arrangements 2. Develop awareness campaigns for underrepresented communities 3. Develop local resource and online presence to signpost carers for mental health and wellbeing support 4. Increase discharge support for unpaid carers through designated hospital-based support staff	Claire Gilhooly/ Lisa Howells Nic Pitman Chris Ball Suzie Becquer-Moreno	Q1 • Recruitment to discharge support post Q2 • Implementation of communications plan • Draft MH resource developed for final engagement Q3 • Implement a framework on language inclusivity and how to promote services for underrepresented communities • Launch MH resource throughout the region	• Maintain increase to unpaid carers accessing Information and Advice • Increased engagement with wellbeing services for unpaid carers on Dewis • Unpaid carers receiving hospital and discharge support through UHL pilot (baseline to be developed)	• 3rd sector provider of IAA (Vale only) • Coproduction of mental wellbeing resources
Respite/Short Breaks	1. Commission the 3rd sector to provide short breaks for unpaid carers 2. Improve understanding and signposting of local opportunities for respite	Chris Ball	Q1 • Evaluation of current schemes/agreement on 2025-26 plan • Commissioning of grants provider	• At least 300 unpaid carers received a short break	• 3rd sector providers to deliver through grant scheme
Young Carers / in Schools Programme	1. Evaluate and develop the existing model of young carers support (including support and training for schools) 2. Exploring regional (AIDI) Young Carers ID cards 3. Co-produce the 2nd annual Young Carers Celebration event	Rachael Sims / Lisa Howells Nicola Hale Nicola Hale	Q1 • Evaluation of current scheme/agreement on 2025-26 plan • Ongoing development of monitoring and reporting with feed to unpaid carers board Q2 • Development of a regional plan around digital Young Carers ID card Q4 • Hold Young Carers Celebration event for Young Carers Action Day	• Increased engagement with wellbeing or mental health support for young carers (new measure) • More than 80% of staff within schools become more confident to identify young carers • Increased online presence and engagement for Young Carers and digital ID cards (subject to funding) • At least 150 Young Carers received a break, through celebration event.	• 3rd sector provider for YCiSP • Co-production of Young Carers Event
Partnership Collaboration	1. Improve links across other RPB programmes	Chris Ball	Q1 • Identify other programmes of work to connect with and develop mechanisms to link		

BYW'N DDA LIVING WELL

DRAFT 2025-26 Delivery Plan - Neurodivergence

BWRDD PARTNERIAETH RHANBARTHOL CAERDYDD A'R FRO

This Year We Will:

- Drive forward a regional approach to improvement that supports a needs led approach that can only be achieved through thinking differently and working together.

Governance:

1. Neurodivergence (ND) Regional Strategic Partnership Board
2. ND Delivery Group
3. Workstream Groups

SRO	Dan Crossland / Andy Jones
ASRO	
Programme Manager	Anna Tee
Project Manager	
Project Support Officer	

Partner leads	

Priority Area	Deliverable	Lead	Timeline / milestones	Expected impact
1. Regional overview of available information to outline current ND system	1. Produce a comprehensive overview of available data sources, outline clear definitions, spectrum of need, and potential digital solutions for data management. 2. Apply critical focus to identify opportunities to work differently.	TBC	Q1 Set up task group Q2 Defined scope of data/digital requirements Q4 Produce overview supported by recommendations for improvement	Improved understanding of situation across breadth of regional partners Identified improvement opportunities Effective use of available data
2. Embed a co-produced approach centred on lived experience	1. Create robust processes to ensure lived experience informs progress and direction of the ND programme, including strategic links with co-existing ND programmes of work across region to avoid duplication. 2. Improved understanding of unmet need and opportunities to work with wider networks /existing national structures e.g. universities	TBC	Q1 Scope existing processes, stakeholders and map to good practice Q2 Proposal for improved processes to ND Regional Board	Programme of work is informed and driven by a full range of lived experiences Engagement with programme of work is meaningful and adds value to everyone involved
3. Develop a regional future delivery model for support	1. Explore the benefits of organising and holding a regional workshop to explore a population wide model of support, that shifts the focus away from performance against waiting lists to meeting population need. Workshop to be informed by output and guidance anticipated from WG Rapid Design Event for children's ND services, that integrates social and medical models and involves universities schools, tertiary education, DWP, workplaces as well as the traditional statutory and third sector providers. 2. Ensure strategic link with relevant work across region including ND Friendly Cardiff, roll out of ALN Education review, etc.	TBC	Q1 Explore approaches in other regions across Wales and learn from best practice Q2 If decided as appropriate, hold regional workshop, ensuring clear aims, focused actions, exploration of systemic issues, etc.	Programme of work interrelates with wider strategic context, reduces duplication and maximises on partnership working Programme work is action focused and feels worthwhile to all stakeholders Improved join up between services delivering support across the region
5. Ensure oversight and improvement against Autism Code of Practice	1. Review feedback from WG review and identify actions required 2. Embed and action feedback from service users 3. Maintain oversight of CoP at Board in readiness for anticipated ND Code of Practice	TBC	Q2 Review feedback and develop action plan Q1-4 Agenda oversight as standard agenda item	Continued progress to better meet standards set out in Code of Practice Ultimately improve support for local population
6. Review the impact of NDIP/RIF-funded projects	1. Review each funded intervention to ensure robust data and monitoring, governance and understanding of difference made at the wider system level to inform clear cases of need to secure core funding and therefore sustained interventions.	TBC	Q1 – 4 Progress assessments and regularly report to ND Regional Board	Improved understanding of interventions and impact Improved financial position going into 26/27

DRAFT 2025-26 Reducing Violence Against Women, Domestic Abuse and Sexual Violence

BYW'N DDA LIVING WELL

BWRDD PARTNERIAETH RHANBARTHOL CAERDYDD A'R FRO

This Year We Will:

- Continue to undertake the activity identified in the regional VAWDASV strategy 2023 – 2028 Implementation Plan

Governance:

1. Regional VAWDASV Executive and related sub-groups
2. Regional MARAC Steering Group and Operational Group

SRO	Louise Bassett
ASRO	
Programme Manager	Natalie Southgate
Project Manager	
Project Support Officer	Regional Advisor – Leah Morgan

Partner leads	Mike Ingram, Deborah Gibbs (Vale) Sian Sanders, Sean Maidment (Cardiff) Linda Hughes-Jones (UHB) Estella Enos (Probation) Sharon Grant (SWP)

Priority Area	Deliverable	SRO	Timeline / milestones	Expected impact
PREVENT – continue to ensure the workforce is skilled to identify, refer and support victims and perpetrators	Implement the regional Training Plan and ensure ongoing workforce development	Regional Adviser	• Q1 – source and cost required training as per the Training Needs Analysis • Q2 – Arrange required training • Q3 – Review and refresh the Training Needs Analysis document • Q4 – Evaluate approach with partners	Staff who are trained and competent to recognise signs and symptoms of VAWDASV and are provided with the tools to Ask and Act, and where to signpost to specialist support
SUPPORT - Ensure that innovative, flexible and evidence-based services are available to meet the needs of victims experiencing any form of VAWDASV	Re-commission specialist VAWDASV services	Natalie Southgate (Cardiff) and Hedd Wyn John (Vale)	• Q1 - Collate all available data on needs, delivery issues / performance • Q2 - Hold consultation workshops with key partners to review data and findings • Q3 - Finalise commissioning documents and prepare for tendering exercise • Q4 - Work with all key stakeholders to ensure smooth transition to new service delivery	Specialist services will be commissioned to support women experiencing VAWDASV, women with complex needs and men experiencing DASV.
PREPARE - Improve strategic planning and commissioning of VAWDASV services through a more coordinated partnership approach across the region.	Develop and agree a regional dashboard of high-level data and outcomes	Regional Adviser	• Q1 – Agree key data needs • Q2 – Develop draft and seek support • Q3 – Arrange to prepare regularly • Q4 – Implement and continually review	Dashboard will aid the Regional Executive / other boards to review emerging trends and current responses to issues of VAWDASV.

BYW'N DDA LIVING WELL

DRAFT 2025-26 Delivery Plan Mental Health

BWRDD PARTNERIAETH RHANBARTHOL CAERDYDD A'R FRO

This Year We Will:

- Work with people with mental health needs and other stakeholders to find out more about their experiences and priorities, then develop and deliver services that support people to have good mental health.

Governance:

1. Joint Operational Group – quarterly
2. EmpowerMind events - tbc

SRO	Daniel Crossland
Programme Manager	Chris Ball
Improvement and Development Manager	Versha Sood
Project Support Officer	Abbi Williams

Unpaid Carers Rep	
Partner leads	

Priority Area	Deliverable	SRO	Timeline / milestones	Expected impact
Starting well: Babies, Children & Young people with MH needs (cross referenced with Starting well delivery plan)	1. A collaborative event between Regional Partnership Board and Prebirth pathways (with all partners) 2. Draft early years pathways delivery plan 3. Review currently pathways for early years specific to Mental health including early years trauma	Cath Wood	• Review and assess progress against First 1000 Days agenda • Explore opportunities across perinatal agenda • Utilise PH event in April 25 to prioritise partnership activity across Early Years • Prioritise a regional focus on adverse childhood experiences and trauma, identifying partnership opportunities for improvement • Review and revise priorities with a key focus on primary care capacity to support improving mental health across perinatal and CYP populations	• Other outcomes to be identified through partnership as part of outcome setting process.
Ageing well: Older adults with mental health needs.	1. Continue to further engage and facilitate co-production through annual EmpowerMind and ongoing coproduction forum (JOG) 2. Develop a plan and delivery structure to help achieve the key areas identified in the above events including; improving awareness, access and support offered in a person-centred way. 3. Develop and agree a partnership set of outcomes for older people with mental health needs.	Jo Wilson	• Q1 – follow up on themes from co-produced event (March 24 & 25) and finalise a delivery plan • Q2-Q4- Incorporate actions into workstreams (pillar work). Share the work with Dementia Champions Network and Dementia delivery group • Q2-Q4- Implement change through working groups in different programmes • Q4 – Further coproduce event in March 2026	• Engagement with at least 150 service users and stakeholders to inform service development. • Other outcomes to be identified through partnership as part of outcome setting process.
Other groups with mental health needs.	1. Support engagement and delivery of the local suicide and self-harm strategy 2. Develop a regional understanding of the services available and commissioned for low level mental health support (tier 0) 3. Develop links with the Neurodiversity and Learning Disability programmes to ensure alignment 4. Increase awareness of mental wellbeing services for unpaid carers		• Create a needs assessment of people living with co existing dementia and LD • Q2 - Develop mental wellbeing resource for unpaid carers	• Other outcomes to be identified through partnership as part of outcome setting process.

BYW'N DDA LIVING WELL

DRAFT 2025-26 Delivery Plan – Sensory Impairment

BWRDD PARTNERIAETH RHANBARTHOL CAERDYDD A'R FRO

This Year We Will:

- Undertake a baseline assessment of current need and existing service delivery to inform the initiation phase of a Sensory Impairment Programme in 2026-27

Governance:

1. Strategic Leadership
2. ND Delivery Group
3. Workstream Groups

SRO	TBC
ASRO	
Programme Manager	Meredith Gardiner
Project Manager	
Project Support Officer	

Partner leads

Priority Area	Deliverable	Lead	Timeline / milestones	Expected impact
1.Undertake a needs assessment for people with Sensory Impairment	1. Scoping exercise to define the shape and coverage of the needs assessment; 2. Identification of a Steering Group and appropriate SRO; 3. Engagement with service users and key stakeholders; 4. Inform links with Population Needs Assessment approach 5. Complete a Status Review outlining findings and recommendations for action.	TBC	Q1: Scoping exercise, Steering Group and SRO Q2 – 3: Engagement and links with PNA process. Q4: Produce overview supported by recommendations for improvement	Improved understanding of situation across breadth of regional partner to inform the initiation of a Sensory Impairment programme in 2026-27.

If you are interested in helping to inform the scoping exercise for this work, please note your name and email address below:

HENEIDDIO'N DDA AGEING WELL

DRAFT 2025-26 Delivery Plan - Dementia

BWRDD PARTNERIAETH RHANBARTHOL CAERDYDD A'R FRO

This Year:
People with dementia will be supported to live well and do the things they need to and enjoy in their communities

Governance:
1. Dementia Delivery Group – quarterly
2. Dementia Champions Network – 6 weekly
3. Project groups – various

SRO	Claire Beynon
Programme Manager	Chris Ball
Improvement and Development Manager	Versha Sood
Project Support Officer	Abbi Williams

Dementia Champion Chair	Ceri Higgins
Partner leads	Miles Utting (Vale) Nic Pitman (Cardiff) Rebecca Aylward(UHB) Ruth Cann(PCIC), Emma Murdoch (L&D) Suzanne Braithwaite(MAS) Ceri Higgins and Nigel Hullah (lived experience)

Priority Area	Deliverable	SRO	Timeline / milestones	Expected impact
Community prevention and compassionate communities	1. clear understanding of Unpaid Carer support and needs through engagement 2. Better links between services to improve Care Coordination and easy access to services and interventions 3. Increase awareness of dementia prevention through targeted actions to promote the prevention booklet 4. Maintain and increase the Dementia Friendly networks and forums including; Dementia Champions and Opening Doors	Nic Pitman Miles Utting	Q1 – Review the plan for dementia prevention resource rollout & its impact Q2 – Build on the work to measure impact of dementia friendly communities' work. Q1-Q4 – Continue to build on Dementia Friendly Communities and Engagement work.	• Unpaid Carers offered support at point of diagnosis (baseline to be established) • Increase from baseline 4,629 Dementia Friendly organisations • 4 more community engagement events to improve outcomes of the programme
Community care and support	1. Strengthen and expand awareness and access to Advocacy through scoping and mapping of local services 2. Access to services and Interventions – Engage with different community care and support teams to clarify and simplify pathways for accessing support	Ruth Cann	Q1 – Steering group meeting held to bring all community care and support partners together, link services and develop plan including Advocacy services Q1-4 – Continue the existing work of Care and support	• At least 2,200 people living with dementia supported including urgent/acute needs (based on 24-25 data) . • Increased number of people accessing advocacy services (baseline to be established)
Assessment and diagnosis	1. Access to Services and Interventions – Maintain waiting list times for diagnosis 2. Strengthen links with Community Services to support people to "Wait Well"	Suzanne Braithwaite	Q1 – Strengthen diagnostic planning to offer diagnosis in a timely manner where possible. Q2 – Develop plan for "wait well" initiatives through improved connection with community services including social prescribing	• Maximum 20 week waiting time for a diagnosis • People supported whilst waiting for diagnosis (baseline to be established)
Dementia Friendly Hospital Charter	1. Access – Evaluate impact on A&E pressures for people needing Enhanced Supervision (dementia, confusion and delirium) 2. Improve inpatient settings and teams to become more dementia friendly through wider rollout of John's Campaign and self assessment tool (VIPS) 3. Increase inpatient activities and links with wider ward teams, including discharge support 4. Continue to use dementia care mapping as a tool for discharge and improving patient care	Natasha Goswell	Q1- Implementation and measuring the work of Dementia Friendly hospital Charter Concluding WAST and CAV collaboration work. Strengthening activities provision to inpatients with dementia Q2 – Finalise measurement outcomes for hospital charter 24-25	• At least 7,000 people supported through inpatient activities and support • 12 additional wards / departments signed-up to Dementia Friendly Hospital Charter
Programme enablers	1. Increase number of staff who are informed and skilled level training (simple language initiative) 2. Collaboratively develop a sustainable training model across all partners	Emma Murdoch Sioned Owen	Q1 – Coproduce event in higher education and planned series of engagements in Dementia Action Week	• At least 750 staff trained to "Goodwork Framework"

HENEIDDIO'N DDA AGEING WELL

DRAFT 2025-26 Delivery Plan @Home: Delivery of an Integrated Community Care System

BWRDD PARTNERIAETH RHANBARTHOL CAERDYDD A'R FRO

North Star:
Accelerating the delivery of our place-based, integrated care model in 2024
Area Plan commitment:
Establish integrated, locality-based, health and care services focussed on meeting and improving the health and wellbeing of the local population.

Governance:
1. Quarterly leads meeting
2. 6-monthly summit
3. Strategic Leadership Group

Specific links developed with partner delivery programmes (ECC, 6 Goals, Vale Alliance, Ageing Well Cardiff)

SRO	
Programme Director	Cath Doman
Programme Manager	Chris Ball
Project Support Officer	Abbi Williams

Clinical Leads	Rachel Lee, Katja Empson, Chris Bryant, Ben Roper, Karen Pardy
Finance Lead	Chris Markall
Partner Leads	**Cardiff:** Carolyne Palmer, Lisa Wood **Vale:** Jason Bennett **UHB:** Geraldine Johnstone, Diane Walker, Rhys Davies, Neil Morgan **3rd Sector:** Duncan Innes, Lani Tucker

Priority Area	Deliverable	Lead	Timeline / milestones	Expected impact
Enablers	1. Establish an Integrated Community Care System summit for partners to contribute and develop the ICCS model 2. Deliver a place plan for Cardiff South West cluster along with evaluation proposal for wider role out of approach 3. Continue scoping and input of digital to support data sharing, following VCRS with Future Care Planning and Discharge solutions 4. Develop community engagement through the programme, utilising place planning and future care planning opportunities	Chris Ball Cath Doman Tim Evans Chris Ball	Q1 -Deliver the place plan for Cardiff South West -Agree scope for a shared care viewer for discharge Q2 -Deliver the first ICCS summit -Deliver evaluation and proposal for wider adoption of place planning approach	
Connected communities	1. Further embed our community access services Independent Living Services and Wellbeing Matters building on 80,000 contacts in 24-25 2. Establish cluster leadership teams and at least maintain current provision of MDT meetings and community connectors 3. At least maintain capacity of Urgent Primary Care Centres at 700 appointments per year and look to development of urgent treatment centre model 4. At least maintain community nursing capacity 50% weekend capacity and look at increasing weekend capacity in line with national ambitions 5. Completion of baseline Improving Cancer Journey scoping to inform recommendations and action plan in 26-27 6. Deliver a model for new Housing with Care centres to link with available support	Carolyne Palmer & Jason Bennett Karen Pardy Emma Lewis Anna Mogie Rachel Lee Jane Thomas	Q1 -Delivery of financial model to support ICCS development to shift capacity from acute to community -Engage with services on developing community provision, including relationships and community beds model Q2 -Support recruitment and wider rollout of ICCS elements -Engage with lived experience to input into the Improving Cancer Journey evaluation Q3 -Model for Housing with Care centres agreed -Discharge model developed to support winter pressures Q4 -Evaluation and planning for 2026-27 delivery	• Over 80,000 contacts supported with information, advice and assistance • 34,900 people supported through the MDT cluster model • 2,800 Emergency Unit attendances avoided • 2,400 emergency admissions avoided • 41,200 hospital bed days saved • Increase in people dying in their place of choice (baseline to be established)
Enhanced community care	1. At least maintain capacity of Safe@home and Physician Response Unit to support crisis response 2. Agree a new operating model of reablement for community beds 3. Further develop models across intermediate care and reablement services to reduce duplication	Rhys Davies Neil Morgan Carolyne, Rhys & Jason		
Reducing time in hospital	1. Model for discharge agreed including streamlining of processes and further development of Trusted Assessor principles to reduce days delayed from	Diane Walker		

BWRDD COMISIYNU RHANBARTHOL
REGIONAL COMMISSIONING BOARD

DRAFT 2025-26 Delivery Plan – Regional Commissioning

BWRDD PARTNERIAETH RHANBARTHOL
CAERDYDD A'R FRO

This Year We Will:
Work in partnership with organisations who are commissioned to deliver care and support to ensure high quality services of the best value are available to meet the needs of our regional population.

Governance:
1. Regional Commissioning Board – monthly
2. Project groups – various
3. Section 16 forum Cardiff – quarterly
   Section 16 forum Vale – quarterly

SRO	Iain McMillan
Programme Manager	
Improvement and Development Manager	Alison Law
Project Support Officer	

RCB Chair	Iain McMillan
Partner leads	Eve Williams (Vale), Natalie Eddins (Vale) Angela Bourge (Cardiff Adults), Denise Moriarty (Cardiff Adults) Nick Blake (Cardiff Children), Rob Hinds (Cardiff Children) Anna Mogie (PCIC) Dianne Walker (UHB), Chris Markall (UHB)

Priority Area	Deliverable	Lead	Timeline / milestones	Expected impact
Increasing Complex Dementia Services Sufficiency	• A regional definition for different levels of dementia care and specifications to deliver against these definitions for all care settings. • Undertake demand analysis for each level of dementia care based upon our population needs • Undertake analysis of the existing Market's ability to deliver to the new specifications		Q1- Develop definitions for levels of care Q2 – Engagement on definitions Q3 - Draft specifications aligned to new definitions Q3 – Demand analysis across commissioning partners Q4 – Provider and community consultation Q4 – Market analysis (aligned to MSR review)	• Options will be identified that will lead to the increase in complex dementia service sufficiency • Improved experiences of people living in all care settings. • Reduce delays in hospital discharge for those with complex care needs
Improving service quality and safeguarding	• Develop and implement: Equipment protocol annexe for residential settings. • Review and update Joint Common Contract for residential services. • Consultation response & regional implementation planning: National escalating concerns process • Develop a migrant worker's action plan, aligned to contract expectations of services delivered across the region in the employment of migrant workers.		Q1 - Scope best practice & review communication plan Q3 – Develop revised draft equipment protocol Q3 - Review and update EC process Q4 – Review and update Joint common contract Q4 - Deliver on the migrant worker action plan	• Improved experience of people living in care settings • Improved wellbeing of workforce • Reduced delays in transfer of care while equipment is sourced for care settings. • Increased consistency in services provided. • A reduction in people who are harmed due to the joint approaches to managing concerns.
Managing the Cost of Care	• Activity by all partners to understand the costs providers face when delivering a package of care to inform fee setting (Children and Adults) • Joint and local market engagement • Explore the use of a cost calculator to assess high-cost placements • Annual report on partnership spend against residential, nursing and placements • Update on Eliminate plans 25/26		Q1-Q4- Market engagement Q2 – Pooled Budget report Q3 – Cost of Care exercises & Eliminate plan update Q4 – Fee setting	• Improved knowledge of partner spend • Fees set at a sustainable, affordable level. • Reductions in profit for a small number of providers.
Development of services through Section 16 organisations	• Report on the business model of existing suppliers of care and support services, identifying areas of opportunity for Section 16 organisations • Development of a shared partnership response to the report findings.		Q2- Data gathering / Report drafting Q3,4-Coproduce proposal through the Section 16 forums	• Improved choice and range of expertise for our population • Third sector providers report improved collaboration with partners.

RHAGLEN GYFALAF
CAPITAL PROGRAMME

DRAFT 2025-26 Capital Programme

BWRDD PARTNERIAETH RHANBARTHOL
CAERDYDD A'R FRO

This Year:
Commitment – Ensure that the Strategic Capital Plan provides the framework for the effective delivery of capital funding streams.

Governance:
Partnership Capital Delivery Board, Senior Leadership Group, Regional Partnership Board

SRO	Cath Doman
Capital Planning Lead	Rebecca Hooper
Programme Manager	Jim Wilcox
Project Manager	Vacant

Partner leads	Vale of Glamorgan LA (Lance Carver) Cardiff LA (Sarah McGill) C&V UHB (Ash O'Callaghan) C3SC (Anna Ros-Woudstra)

Priority Area	Deliverable	Lead	Timeline / milestones	Expected impact
Integration and Rebalancing Capital Fund	1. Monitor the development of the FBC for the Wellbeing Hub @ Ely Parkview. 2. Following acquisition funding in 24/25, secure funding for the refurbishment of specialist CLA accommodation. 3. Support applications for schemes across the region.	Rob Wilkinson Jen Horton Jim Wilcox Anna Ros-Woudstra	Q1 – VoG application for complex needs day provision. Q2 – Regional application for JES ILWC / CLA Construction. Q3 – Ely Parkview FBC completion and construction start.	• Finalisation of FBC and commencement of construction for Ely Parkview. • Commencement of refurbishment for CLA accommodation. • Submission of applications for new scheme.
Housing with Care Fund	1. Objective 3 Programme annual reports and application appraisal for 2025/26. 2. Development of application process for Welsh Government panels. 3. Review of children's accommodation strategy, alignment with Starting Well.	Lani Tucker Jen Horton Jim Wilcox	Q1 – Technical scrutiny of adults LD, complex women's, and children's accommodation schemes. Objective 3 programme allocation. Alignment with Living Well. Q2 – Penarth Extra Care on-site progression, alignment with Ageing Well. Q3 – VoG CLA and UASC construction.	• Analysis of Objective 3 programme once annual reports submitted against deliverables in 2025/26. • Completion of multi-year projects in 25/26.
Place Based Planning	1. Review of the South-West Cluster pilot. 2. Production of a finalised South-West Cluster Plan. 3. Commencement of place-based plans for Cardiff East and Cardiff South. 4. Identification of a pilot cluster for the Vale.	Chris Ball Jim Wilcox	Q1 – Task & Finish Group to finalise scope for PBP. Q2 – Production of SW Cluster Plan Q3 – Commencement of Cardiff East, Cardiff South, and Vale Clusters.	• Cardiff South-West Cluster Plan • Drafts for the next clusters identified.
Capital Pipeline	1. New governance structure to include Partnership Capital Delivery Board for the region. 2. Updated pipeline plans from all partners.	Rebecca Hooper Jim Wilcox	Q1 – updated pipelines submitted to Welsh Government following approval by SLG in March. Q2 – updated positions after establishment of Partnership Capital Delivery Board. Q3 – pipeline review with partner capital leads.	• 6 monthly review of pipelines to be undertaken. • Report on pipeline progression.

DRAFT 2025-26 Workforce

BWRDD PARTNERIAETH RHANBARTHOL CAERDYDD A'R FRO

This Year:
Implement delivery of the Charter's 5 commitments

Governance:
Regional Workforce (Social Care) Partnership Board (RWPB)

SRO	Lance Carver
Programme lead	Steve Davies
Programme Support	Abbi Williams

Partner leads	Cardiff Council: Angela Bourge UHB: Liane Morse

Deliverable	Timeline / milestones	Expected impact
1. Attraction of new care workers	- Work with Social Care Wales to raise awareness of the "WeCare Wales" campaign. - Developing strong links with schools and colleges in our region to promote social care as a positive career choice.	• Enhanced recruitment and retention • Increased workforce competency
2. Strengthening recruitment processes	- Promote Social Care as a career choice for individuals who wish to get back to work. - Support individuals who are interested in a career in social care to become "work ready" by providing mandatory training and safe recruitment checks to ease the burden on employers.	Ability to recruit 'work ready' applicants for care work: fit to practice and fully aware of the role responsibilities.
3 Personalisation of the social care workforce	- Ensuring that the Social Care Wales Workforce Development Programme Grant is appropriately utilised to support the registration and qualification requirements of our social care workforce. - Undertaking an annual training needs analysis to inform training in line with Continuing Professional Development requirements of our workforce. - Delivering good quality, easily accessible learning and development. - Working with providers and Social Care Wales to enable Migrant Care Workers to access the appropriate learning and development opportunities and support for registration and qualification.	Care Workers and Managers in our region are competent, confident and appropriately qualified, delivering excellent services to the residents of Cardiff and the Vale of Glamorgan.
4 Supporting retention and career development	- Actively supporting implementation of the Welsh Government Real Living Wage across the region. - Hosting an annual celebratory event that raises the profile of Care Workers across the region. - Providing regular Forums to enable Social Care Managers to come together to learn and share best practice. - Organising regular support and feedback sessions for overseas care workers to address their concerns, recognise their contributions, and enhance their job satisfaction.	Higher staff retention rates together with an increase in the number of career development opportunities.
5. Promoting Wellbeing of the workforce.	- Active promotion of the Social Care Wales Canopi programme. - Linking the workforce to Care Worker health and wellbeing resources from Social Care Wales. - Championing the role of supervision in line with regulatory requirements. - Creating a cultural integration programme to help Migrant Care Workers adjust to their new environment and feel more connected to their community. - Provide learning and development opportunities and awareness raising for Providers and Contract Monitoring Officers regarding issues related to modern day slavery to protect vulnerable workers.	Active promotion of wellbeing within the workforce, ensuring timely access to support that is tailored to meet the demands of the job.

2025-26 Digital Care Region

This Year:
The Regional Summary Care Viewer will continue to unlock health and care information and deliver a shared record that is available in the right place, at the right time and to the right staff. The programme will also deliver Future Care Plans from Primary Care to NHS

Governance:
1. Regional Digital Board

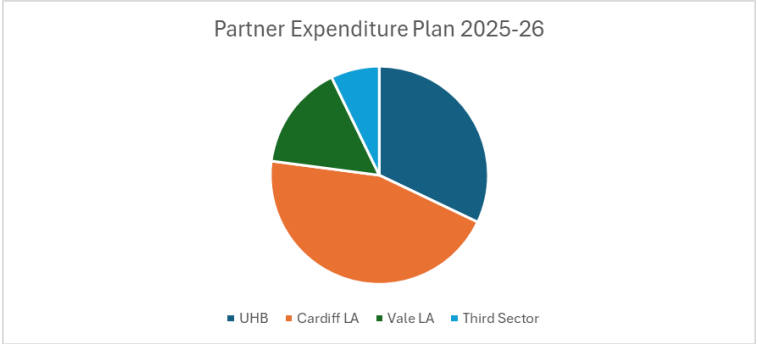
SRO	Cath Doman
Programme Manager	Tim Evans
Project Support	
Anything Else	Regional Digital Board

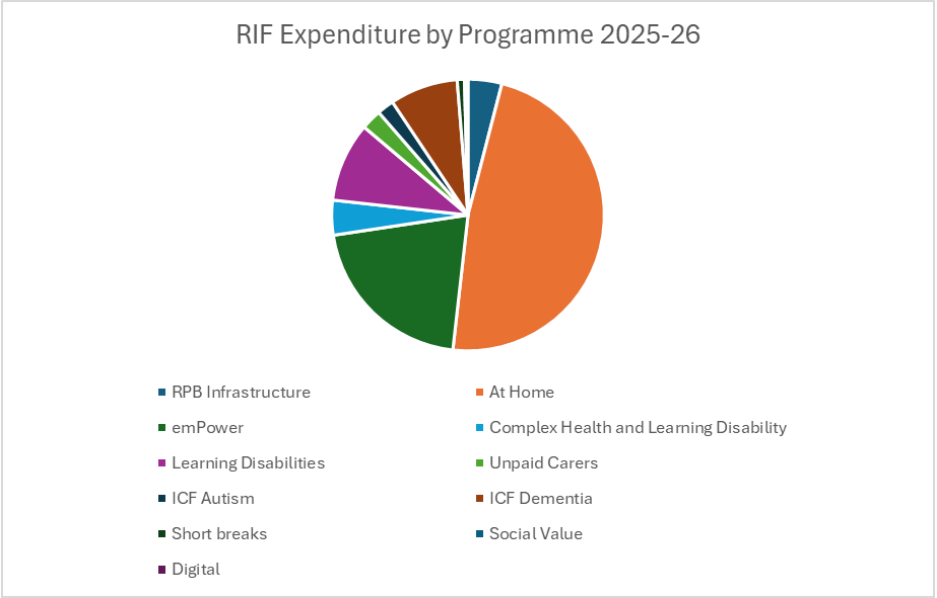
Partner leads	(Vale) Iain McMillan, Nikki Johns (Cardiff Council) Isabel Bignall, Gareth Newell. (UHB) Mark Cahalane, Angela Parratt, Dr Mark Wardle (UHB CCIO) Dr Karen Pardy (DCR CIO) (WASNHST) Leanne Smith

Priority Area	Deliverable	Priority	Lead	Timeline / milestones	Expected impact
Summary Care Viewer (ScV)	Further develop the Summary Care Viewer application to support the sharing of urgent care / child protection data between LA's and uHB ED's. Deploy the Summary Care Viewer to support the Cardiff Resource Team to sharing LA and UHB data. Design an Integrated discharge shared view.	Link back to Area Plan	Tim Evans Chris Ball Anna Tee	Q1 Deliver Child Safeguarding regional shared care view. Q1 Deliver Summary Care Viewer to Cardiff Community Resource Team (CRT) Q2 Add GP / Primary Care data to Summary Care Viewer (dependency upon agreement of Surgeries) Q3 Provide access to SCV to all regional GP practices and WAST Q3/Q4 Develop integrated discharge shared care record?	Summary Care Viewer will improve integration of health and care services, enabling faster, safer sharing of data. It will deliver time and cost savings, reduce duplication, support better clinical decisions and improve outcomes for patient, service user and staff.
AWS Cloud Regional Single Sign On IG Framework	To deliver an organisationally agnostic, modernised and scalable hosting for ScV, enables staff operating in their home organisation to access shared record without having to separately login to another network/system.	Link back to Area Plan	Tim Evans	Q1/Q2 Agree IG joint controller arrangements. Cloud host the summary care viewer application and open access to regional partners Q3 Add In-Context launch capabilities Q4 Extend access to new partners to support additional use cases	AWS Cloud hosting will strengthen the resilience, scalability, and performance of the SCV. Single sign-on will streamline access, improve usability, and reduce clinical risk by minimising login barriers and ensuring fairer, safer and faster information sharing.
Future Care Planning	Enable GP created Future Care Plans to be available to WAST crews at the point of care	Link back to Area Plan	Sioned Owen Tim Evans Chris Ball	Q1 Establish Project Governance, develop/test digital solution. Information Governance approvals Q2 Deploy solution to pilot services Q3 Initial benefits evaluation Q4 Extend to all GP practices in CAV region	Making Future Care Plans available at the point of care should support services to reflect a patients wishes, reducing unnecessary conveyances to hospital , enabling people to die in their preferred place, and deliver cost savings
Digital and Business Intelligence development	Undertake an options appraisal to inform regional commissioning of an integrated BI system or wider functional and informatics solution, assessing feasibility and strategic fit, and proceed with the agreed approach.	Link back to Area Plan	Cath Doman Sioned Owen	Q1: Develop options appraisal for regional BI system or functional and informatics solution. Q2: Present options appraisal to the Regional Digital Board for decision. Q3 onwards: Implement and develop the agreed approach based on the selected option.	Enhanced functionality and integration, supporting services in delivering safer, more efficient care through improved data accessibility and decision-making.
DHCW Connecting Care Integrated Care Record	To co-produce with DHCW and other regions an agreed approach and design for a regional / national shared record.	Link back to Area Plan	Tim Evans Mark Cahalane	Q1: Work with DHCW to define programme scope / governance and funding for CAV region. Q2 to Q4: Support delivery of integrated care	Enable deeper integration of health and care systems, improving information sharing and supporting more coordinated care.

Financial Allocations for 2025-26

Forecast 25/26 – Partner Expenditure Plan		Programme Expenditure 2025/26 £					
RIF Programme	Allocation £	UHB	Cardiff LA	Vale LA	Third Sector	Total	Variance*
RPB Infrastructure	750,000	754,541	20,000	20,000	0	794,541	44,541
At Home	9,263,731	2,220,334	5,131,785	1,686,006	415,610	9,453,734	190,003
emPower	4,125,354	1,120,780	2,181,549	622,926	200,100	4,125,355	1
Complex Health and Learning Disability	820,328	487,079	174,938	158,310	0	820,328	0
Learning Disabilities	1,774,484	176,851	1,022,548	530,771	140,000	1,870,170	95,686
Unpaid Carers	479,042	13,042	143,750	0	322,250	479,042	0
ICF Autism	397,728	397,728	0	0	0	397,728	0
ICF Dementia	1,600,000	1,144,539	232,461	88,000	135,000	1,600,000	0
Short breaks	172,237	0	0	0	172,237	172,237	0
Social Value	45,000	0	0	0	45,000	45,000	0
Digital	35,000	35,000	0	0	0	35,000	0
Total	19,462,904	6,349,894	8,907,030	3,106,013	1,430,197	19,793,135	330,231
Forecast 25/26 - Partner Expenditure Plan		Programme Expenditure 2025/26 £					
Other Programmes	Allocation £	UHB	Cardiff LA	Vale LA	Third Sector	Total	Variance
Neurodiversity	TBC	TBC	TBC				





**Variances have been approved by SLG subject to strict management processes for management to in year allocations.*

Forward Plan

RPB Meeting Agenda	June 2025	September 2025	November 2025	Jan 2026	March 2026	May 2026
Deep Dive	Diabetes	Mental Health and Neurodiversity	First 1,000 Days	Digital Care Region	Integrated Community Care System	Annual Delivery Plan 2026-27
Annual Status Reports	Starting Well Overview of rising and changing demand	@Home Regional Commissioning Board	Unpaid Carers Workforce	VAWDASV Sensory Impairment	Dementia Learning Disabilities	
Assurance	Population Needs Assessment	Q2 reports		Q3 reports	Population Needs Assessment	Q4 reports