BWRDD PARTNERIAETH RHANBARTHOL
CAERDYDD A'R FRO

CARDIFF & VALE
REGIONAL PARTNERSHIP BOARD

Annual Report
2022 – 2023

This document is available in Welsh / Mae'r ddogfen hon ar gael yn Gymraeg

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The Cardiff and Vale RPB Team would like to take this opportunity to recognise Amanda Phillips whose hard work and dedication was an inspiration to us all. She has made an immeasurable, positive difference to people's lives and will be greatly missed.

Opening remarks

I am delighted to present the 2022-23 Annual Report which is my first as the current Chair of Cardiff and Vale Regional Partnership Board. Together, we continue to work together to improve our service and enable people in Cardiff and the Vale of Glamorgan live the best lives they can.

Our Starting Well, Living Well and Ageing Well Partnerships involve partners from health, care and non-statutory sectors as well as citizen and carer representatives.

This report highlights just some of the work that the Regional Partnership Board has delivered to improve the lives of people living in Cardiff and the Vale of Glamorgan. I would like to thank everyone involved in our work for their commitment to working together to deliver seamless services that focus on the needs of local communities. In particular, I want to acknowledge the work of our third sector partners who have helped to alleviate pressures and provided valuable insights into different, new and innovative ways of working. They have demonstrated an invaluable ability to work across organisational boundaries.

This year has seen the preparation of our new Joint Area Plan, a 5 year long commitment to delivering key service developments for a wide variety of citizens throughout the region. Supported by our capital and revenue funding streams as well as the wider work of all our partners, this Joint Area Plan is informed by the findings of our Population Needs Assessment, Market Stability Report and a review of all our workstreams. It also reflects the organisational priorities of the partners and provides a response to national policy and guidance. The result is a plan that focuses upon key objectives where, by working together we can deliver a greater impact for our citizens.

The success of our Joint Area Plan will depend in large part upon the ongoing development of key enablers to partnership working which we have supported in 2022-23: ensuring effective information sharing, exploiting digital innovation and building our workforce. Working with our local Public Service Boards and emerging Pan Cluster Planning Groups, all our efforts are aligned and focused upon our commitment to delivering clear and demonstrable outcomes for our citizens.

I am also pleased to share the range of innovative engagement work we have undertaken using our shared framework. We have ensured that people know that their voice matters and underpins our work.

On behalf of my RPB colleagues, I would like to thank everyone who has supported the RPB's work over the last year. Together we are able to deliver outcomes that far outweigh what we can do alone.

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Cllr Eddie Williams

Chair, Cardiff and Vale Regional Partnership Board

Cabinet Member, Social Services and Health, Vale of Glamorgan Council

Part 1: Overview of Cardiff and Vale Regional Partnership Board

Who are we?

Our Regional Partnership Board (RPB) includes representatives from Cardiff Council, Vale of Glamorgan Council, Cardiff and Vale University Health Board, Welsh Ambulance Service NHS Trust, housing, Third & Independent sectors and carer representatives.

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.

The RPB includes the following partners:

Public sector

Cardiff Council
Vale of Glamorgan Council
Cardiff and Vale University Health Board
Welsh Ambulance Services NHS Trust

Local third sector

Cardiff Third Sector Council
Glamorgan Voluntary Services

National third sector

Llamau – Children and Young People
Platfform – Older people

Representatives for people with needs for care and support

YMCA Cardiff
Care Forum Wales
Unpaid Carers Representatives

Partnership Governance

As a partnership, we work together to support people when they need it at every stage in their lives. 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.

Our delivery programmes are based on achieving better outcomes for people in each life stage.

Strategic direction as a partnership and interpretation of national policy.

Partnership governance

Public Service Boards

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

Statutory Partners Governance; duties, plans and decision-making

Create conditions for programmes to deliver. Interprets and operationalises RPB direction.

Provides assurance to the RPB (and PSBs as relevant) in the delivery of RPB priorities.

STRATEGIC LEADERSHIP GROUP

- Vale Pan Cluster Planning Group (name t.b.c)
- Cardiff Integrated Delivery Partnership (Pan Cluster Planning Group)

Life stage themes

- DECHRAU'N DDA STARTING WELL
- BYW'N DDA LIVING WELL
- HENEIDDIO'N DDA AGEING WELL
- STRATEGIC ENABLERS PORTFOLIO

Delivery and enabler programmes

- emPOWER *(children and young people's emotional wellbeing and mental health)*
- Complex health and disabilities
- Early Years Pathfinder
- Learning Disabilities
- Unpaid carers
- Neuro-divergence
- Mental Health
- Physical disabilities
- Sensory impairment
- VAWDASW reports to the Community Safety Partnership
- @Home
- Dementia
- Digital Care Region
- Capital programme
- Joint Commissioning
- Workforce and OD
- Regional Innovation Coordination (RIC) Hub

Providing up to date information about health and wellbeing in Cardiff and Vale of Glamorgan

The Cardiff and Vale RPB has developed the Regional Information Sharing Site (RISS) so partners can easily share data. The data from individual partners is brought together in the Regional Outcome Framework (ROF) to clearly demonstrate how we are achieving agreed outcomes that improve the lives of people living in Cardiff and Vale.

This means that partners can easily access source and outcome focussed information which helps to shine a light on what is happening across our region. Any organisation with an interest in improving health and wellbeing in Cardiff and the Vale of Glamorgan can also use the ROF data and related viewers to inform their own priorities and use of resources.

Click here for more information on how data is informing our work.

Population Needs Assessment

The Social Services and Well-being (Wales) Act 2014 introduced a duty on local authorities and Local Health Boards to prepare and publish an assessment of the care and support needs of the population, including carers who need support.

To undertake the assessment, we used existing data, assessments and reports and ran focus groups to update the information and more fully understand people's experiences in Cardiff and the Vale of Glamorgan. In addition, a public survey was available for people to complete and promoted by our partners and on social media. Covid-19 restrictions limited our face-to-face engagement.

We used these findings to deepen our understanding of the key challenges our population faces and what services and support they find useful. As well as identifying specific challenges for demographic groups, certain cross cutting priorities can be identified, including:

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: ensuring that people are involved in planning their care, and that we work to reach out to all people from across our diverse 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

Click here to find out more about our Population Needs Assessment.

Market Stability Report

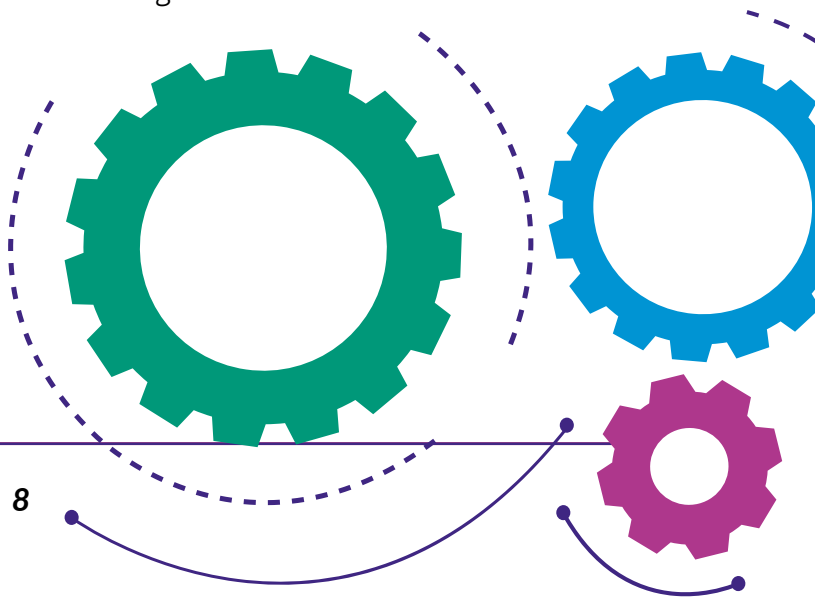
We assessed whether there will be sufficient services in the future to meet the demand we identified in the Population Needs Assessment. We published our Market Stability Report that highlights the challenges we face and what needs to be done to address them. We found we need to:

1. Address workforce capacity and skills shortages by focussing on recruiting new staff and training for our current workforce
2. Ensure the fees we pay to providers are fair and reflect increasing costs
3. Develop in-house services to lower market risk where it makes sense in terms of social value, we will develop these as in-house services and/or work in partnership with local "not for profit" organisations
4. Modernise our approaches to commissioning and contracting including coproducing our commissioning strategy with providers
5. Re-establish and strengthen quality assurance processes
6. Shape the market to close gaps in non-regulated services including. prevention and early intervention services
7. Maximise choice and control by increasing take-up and deploying Direct Payments appropriately

Click here to read the Market Stability Report.

Joint Area Plan

Throughout 2022-23 we have been preparing our new Area Plan for the next 5 years. Supported by our capital and revenue funding streams as well as the wider work of all our partners, this Area Plan is embedded upon the findings of our Population Needs Assessment, Market Stability Report and a review of all our workstreams. The RPB operates in the context of the strategies, plans and day-to-day work of all our partners. We add value when we bring partners together to address issues or deliver change which no one organisation can address alone.



Starting Well Partnership

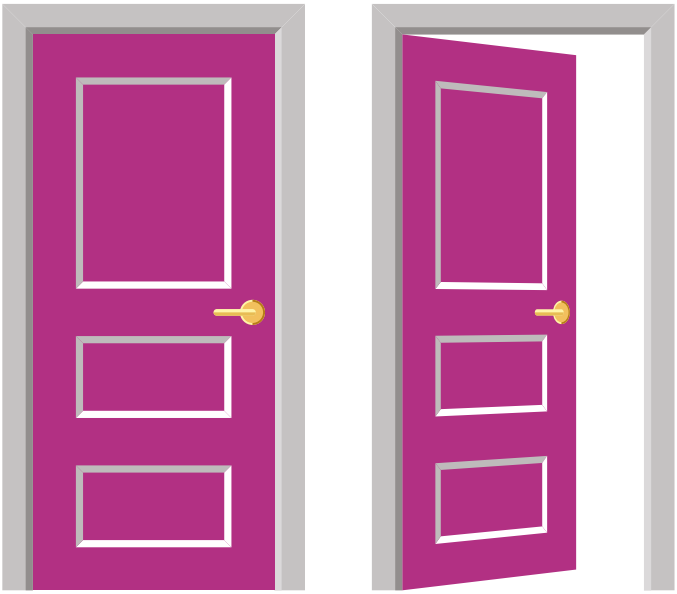
We want every baby, child and young person in Cardiff and Vale to have the opportunity to thrive. Our work covers three key areas:

emPOWER: Emotional health and wellbeing

Children with complex needs and disabilities

Early Years Pathfinder

We want to ensure that all babies, children, young people and their parents and carers can access the right help at the right time in the right place and experience a No Wrong Door when they reach out to services.



emPOWER

During 2022-23 we worked with the UHB's Youth Board and children and young people supported by third sector partners to coproduce "emPOWER" as the name of our programme for emotional mental health priorities. The emPOWER programme is a partnership commitment across Cardiff and the Vale of Glamorgan to develop services and systems that work together to deliver better outcomes and experiences for babies, children and young people.

The key priorities of the programme are:

- Provide earlier intervention and preventative services
- Make it easier for children, young people and families to access the right support at the right time without the need for repeating their stories or for new referrals
- Enable earlier multi-agency discussions where this is beneficial for the individual
- Decrease the demand on very specialist services
- Embed the NEST/ NYTH Framework across our systems and ways of working

In May 2022, the Emotional Wellbeing and Mental Health Services Single Point of Access (SPOA) and local authority Early Help teams began a No Wrong Door multi-agency pilot. Children who would benefit from a multiagency approach to support were triaged by the Single Point of Access Team and shared with the relevant Early Help lead to enable an informed discussion to take place about the best part of the system to meet their needs.

The discussions have increased understanding and knowledge of the services provided within local authority Early Help teams and Health. This has also, enabled children and families to be directed to the right support at the right time and has enabled earlier interventions and reduced the demand for the Specialist Mental Health Assessments unless it is clear the child's needs require this approach.

Film: Vale of Glamorgan: Families First Advice Line

Both Early Help Teams are confident in using the Thinking Together Conversation model to enable their teams to "hold on" to a child's support unless an onwards referral is necessary. Where escalation to a Part 1 Assessment was required, the Early Help Teams as well as SPOA are confident that the system works effectively with the Practitioner conducting the assessment.

The No Wrong Door project has enabled access to the appropriate support, with support for practitioners to "hold on" and if necessary, access more specialist support without the need to go through "another door". It is a good practice example of how NEST is becoming embedded in Cardiff and Vale.

In addition, early data shows that the majority of the referrals to date have not required a "specialist intervention at medical end of spectrum" and that working in this way can support people to avoid escalation to specialist or crisis interventions.

The UHB's emotional health and wellbeing website was coproduced with young people and empowers children, parents and professionals to access information independently that might assist with wellbeing needs and offers tools and guides that can support for a those who are awaiting assessment while they wait. Further development of the website is planned for 23/24 to strengthen content and provide additional signposting and support.

Click here to visit the website.

Click here to find out more about the support we are offering to children, young people and families who are neurodivergent: Community Connections.

Click here for more information about how we are supporting babies, children, young people and families who are neurodivergent.

Case Study: Ayla's Story: No Wrong Door in action

Ayla is a 10-year-old girl who visited her GP with anxiety, sleep difficulties and reported behavioural issues. The GP requested a Part 1 Mental Health Assessment from the Emotional Wellbeing Mental Health Service's Single Point of Access (SPOA) and identified that there was a need for parental support. The referral did not mention any previous or current support that had been accessed or other referrals in progress.

The referral was triaged by SPOA and was identified that a No Wrong Door multi-agency discussion would be useful. During the discussion, the local authority's Early Help representative advised that Ayla had been referred to the Family Gateway at the same time as a referral was submitted to SPOA by the GP. Early Help also confirmed that the family had accessed Flying Start when Ayla was a baby. In addition, there had been some confusion when the Family Gateway had completed their wellbeing assessment as mum had advised that she was already "open to CAMHs".

The team agreed that the best parts of the system to support Ayla at this time was a service Barnardo's provided around behaviour and also CEREBRA for sleep health. There was also the option of step up or practitioner support through a Thinking Together Conversation with the Emotional Health and Wellbeing Practitioner within the Early Help team.

Prior to the No Wrong Door process, this referral would have been declined for a Part 1 Mental Health Assessment and Ayla and her parents would have had to go back to their GP to ask for a referral to other support options. The No Wrong Door process enabled access to the right support at the right time, and, if necessary, access more specialist support without the need to go through "another door".

Early Positive Approaches to Support

Early Positive Approaches to Support delivers groups to parents of children under the age of five, who may have additional learning needs, to support them in developing resilience and wellbeing skills that empower them to promote positive development for their children.

Evaluation has shown that parent carers gained more confidence in understanding their children and their needs and have also improved their own wellbeing which subsequently has improved their relationships with their children. Some of the participants have gone on to train as Early Positive Approaches to Support facilitators.

"Since attending Early Positive Approaches to Support we have seen such an improvement in family life. Our son is far more regulated and we are also so much calmer when we do experience difficulties, as we know what to do, and how best to meet his needs. I really believe in the ethos of Early Positive Approaches to Support as it gives us, as parents / caregivers the knowledge and skills required to meet our child's needs. In meeting their individual needs our family life has improved no end. Following undertaking the Early Positive Approaches to Support course as an attendee, and seeing the benefits of it, I later trained to become an Early Positive Approaches to Support facilitator myself as I really wanted to help others by continuing to be part of Early Positive Approaches to Support."

"The success of Early Positive Approaches to Support is fantastic. I had a fantastic meeting with the parent carer facilitator pioneers yesterday. Their passion and enthusiasm are phenomenal. It is such a great project to be part of, and as you know I'm very passionate about it... What makes us all care so much is the impact we can see it is having. It truly is making a difference to parent / carers in so many ways."

Dr Emma Johnson, Clinical Psychologist - Early Positive Approaches to Support

emPOWER in numbers

66% of parents felt better able to support their child's mental health needs.

92% of parents reported an improvement in their own wellbeing.

79 prevented from becoming Children Looked After by ARC.

No Wrong Door means if a child , young person or family seeks help through one pathway but another one may suit their situation better, we will make sure they are able to access this with no extra effort.

ARC (Adolescent Resource Centre) is a regional service for children and young people on the edge of care. It provides support to children and young people and their families to prevent crisis/placement breakdown and keeps families together.

Children with complex needs and disabilities

We have focussed on improving the access and experience of babies, children and young people with complex needs and their families, including beginning to coproduce a strategy that sets out partnership principles and priorities.

Projects are being delivered that improve outcomes for CYP with complex health and disability needs. So far, the programme of support has benefited more 850 babies, children, young people and young adults with disabilities across the life span of ICF.

Complex health and disabilities

Blended diet for children with enteral feeds

The number of children being tube fed in Cardiff has doubled in the last 4 years. RIF funding has enabled additional hours to be allocated so that children can receive a blended diet in school settings in addition to at home.

This dietetics programme provides an enhanced dietetic service to children with complex needs attending Ty Gwyn or Ysgol y Deri Schools, including support through transition. It involves working with a multi-disciplinary team to implement blended diets in school and Community Settings.

Currently, over 150 children receive an enhanced service and 25 children are fed blended diets via tube. This service ensures they are fed safely and get a nutritious diet.

Child & Adolescent Learning Disability Service (CALDS)

CALDS are a multi-disciplinary health team who work with Health, Education, Social Care and the third sector to support children and young people with a Learning Disability. They support families of school aged children with a Learning Disability who have emotional, behavioural or developmental needs who have not responded to other interventions.

They have directly and indirectly supported over 50 children and young people with LD and their families. They also support professionals working with children and young people, particularly around sleep support, toileting support, behaviour support and access to health care.

CALDS GADPG
Child and Adolescent Learning Disability Service
Gwasanaeth Anableddau Dysgu Plant a'r Glasoed

The service has helped us to address the gaps in specialist knowledge and approaches that are required for all children and young people with LD through training staff and students in a range of settings. Through access to this, children and young people will receive the right support at the right time, from the right service with other service areas supported to develop knowledge and skills in supporting this group of children.

Case study: Jane's experience of CALDS

Jane is 16 years old and has a diagnosis of ASD, Learning Disability and Tourette's Syndrome. She has a history of 'shutting down' with anxiety when overloaded, resulting in non-attendance at school for long periods of time.

CALDS Psychology worked with her school around implementing environmental changes in the classroom. The plans and proactive changes in the classroom had a positive impact on her and her schooling.

Jane was referred to a CALDS LD Nurse for access to health care as her complex health diagnosis required GP and hospital appointments. They worked with the family for several months around health needs and coproduced a Health Profile and a pain management plan with Mum, that could be used in school and during after school support. This included making sure health appointments did not disrupt Jane's usual routine and so she was able to access the health care appointment without distress or anxiety and antipsychotic medication was not required. Jane now has a coproduced Health Profile and pain management plan which considers her best interests and least restrictive practice.

Her mum thanked the LD Nurse for liaising with health services as she felt the reasonable adjustments made a big difference in her daughter accessing healthcare. Her Mum said that she felt 'listened to' and now reaches out to LD Nurse. Previously she had been guarded in trusting professionals.

Early Years Pathfinder

The Early Years Pathfinder is a transformation programme that pilots innovative ways of working in the early years (0-7), with the aim of developing better outcomes for children with Additional learning needs and their families.

Following scoping work in previous years, work is developing in four workstream areas:

Neurodiversion - tests opportunities to support children and families within communities whilst they are on the diagnostic pathway

Peri-natal Mental Health – expands the skillset within the perinatal workforce to meet need and respond to emerging areas (such as support for fathers within the perinatal period)

Child Care Workforce - working with Early Years childcare settings to understand training needs and develop resources so they feel upskilled and confident to meet the needs of children with Additional Learning Needs

Looked After Children in Education – developing pathways and processes for children who are looked after and require additional support and planning to ensure a successful transition into education

During 22-23 we undertook scoping for all of the workstreams to inform detailed business cases to Welsh Government outlining planned delivery to March 2025.

We were able to collate a baseline of training that was delivered to the early years' childcare workforce during 22-23 and an understanding of their levels of confidence in working with children with additional needs:

50 members of the workforce were upskilled in the Vale of Glamorgan, across 28 settings

8% of early years childcare providers in Cardiff stated: we have made excellent progress in this area

60% of early years childcare providers in Cardiff stated: we are making progress, but still have work to do

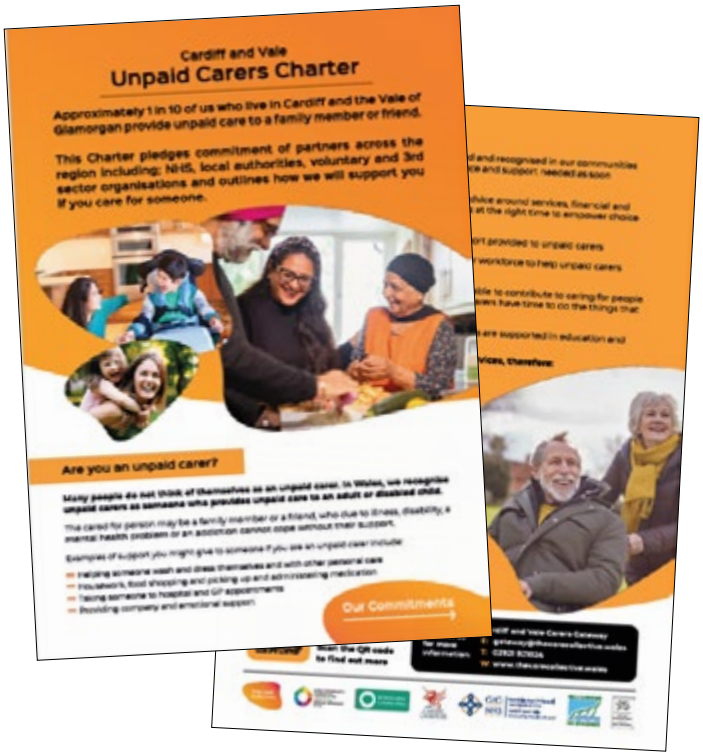
This has provided valuable insight into priority areas for action in 23-24.

Living Well Partnership

Our Living Well Partnership supports a wide range of partnership activities that support people to live well, including:

- **Unpaid carers**
- **People with physical disabilities**
- **People with learning disabilities**
- **Neurodiverse people**
- **People with poor mental health or emotional support needs**
- **People with sensory impairment.**

This year, we have particularly focussed on neurodiversity, supporting unpaid carers to access support, increasing the voice of people with learning disabilities in our work and implementing the Autism Code of Practice.



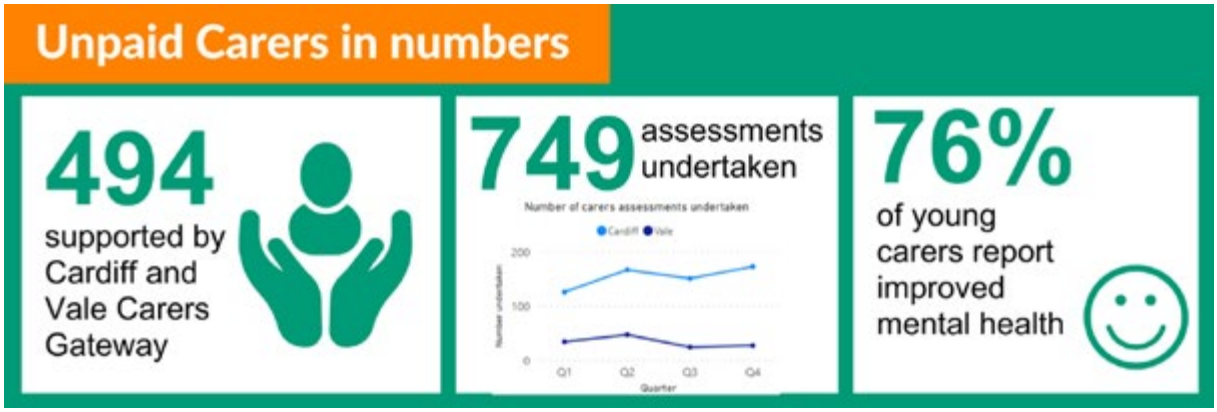
Unpaid Carers Programme Overview

Our work to support unpaid carers covers a range of services, through a number of different individual projects:

- **Carers Gateway** – a single point of information and advice for unpaid carers, provided by the Care Collective
- **Young Carers** – providing support and activities for young carers, provided by the YMCA
- **Young Carers in School** – supporting schools to understand and be able to support young carers, provided by the Care Collective
- **Carer Friendly/Hospital support** – supporting hospital settings to become carer friendly and also ensuring the discharge support is available when the person they care for is in hospital

This work is also underpinned by the **Cardiff and Vale Unpaid Carers Charter** which was formally launched on 24th March 2023. This sets out the commitments of all partners in the region in ensuring unpaid carers are recognised and supported for their vital contribution.

The RPB worked with C3SC to fund short breaks for carers during 2022-23. This funding will be expanded during 2023-24 to fund a wider range of activities to help carers do the things that matter most to them.



Programme Learning

The development of the regional Unpaid Carers Charter has had a positive impact on the understanding and support for unpaid carers, with partners inputting and getting behind the work of unpaid carers. This has been particularly evident in the work of Cardiff Council who have set up Care'diff as a newsletter and support meetings for unpaid carers.

The formal launch of the Charter took place on 24th March 2023 with CEO of the Health Board, Councillors from Cardiff and Vale of Glamorgan for Health and Social Care, Interim CEO of the Care Collective and also our two unpaid carer representatives on the Regional Partnership Board. The event was well attended and gave a chance for networking across organisations and services as well as having a panel Q and A where members pledged their support to the Charter.

As a result of feedback from unpaid carers that they were unaware of support we invested in advertising the Carers Gateway. We estimate over 10,000 people engaged with our advertising and this has meant more people have been able to access the Carers Gateway.

Cardiff and Vale Unpaid Carers Charter Launch

Case study: Noah's Story: Cardiff & Vale Carers Gateway – Carers Wellbeing

Background

Noah is a 79-year-old carer whose 74-year-old wife has Alzheimer's Disease. The couple live in the Vale of Glamorgan and previously had no support with care needs.

Amongst other symptoms, Noah's wife hallucinates and has a constant need to be in his presence. Her condition is very demanding, especially for Noah who is now 79. He said he was finding it difficult to be patient and the constant care demands were making him very stressed.

Film: Cardiff and Vale Carers Gateway

A Wellbeing Assessment was completed with Noah by a Carers Wellbeing Worker from the Carers Gateway and was forwarded to Adult Services in the Vale of Glamorgan Council.

They have been able to support him through:

- **A place for Noah's wife to attend a Day Centre at Rondell House, Barry twice weekly.**
- **Assistance for his wife to shower and dress**
- **Occasional overnight care support worker so Noah can visit friends and family overnight**

This has allowed Noah to continue caring for his wife and allowed him to also have time to himself.

"We are the Representatives for Unpaid Carers on the RPB and have been involved in a range of work, from designing and launching the Unpaid Carers Charter to working on the Joint Area Plan. The RPB has been very receptive to our thoughts and opinions, for example, the Unpaid Carers Board has taken one of our ideas forward in their plan for 2023-24. We feel we have set strong foundations in place to improve the support offered to unpaid carers in our region."

Bobbie-Jo Haarhoff and Mike O'Brien
RPB Representatives for Unpaid Carers

People with Learning Disabilities

Our work with partners covers a range of services for people with learning disabilities through several different projects:

Fit for my Future: These projects are supporting young people who transition into adult services at the age of 18 to ensure the right support is in place for a young person's future. They include Transition Social Workers and Day opportunities services

Right Support/Right Time: These projects make sure that services respond to the needs of people with learning disability at the time when they need support. They include review social workers, support planners, health care support workers and Adult Placement Scheme for short breaks

Having my own Home: This project supports people to access the right accommodation to meet their needs, alongside the development of adult placement schemes.

The Cardiff and Vale of Glamorgan Learning Disability Partnership (LDP) is made up of people with learning disabilities and services who support people with learning disabilities. This partnership is key to coproducing the partnership priorities for people with learning disabilities and their families and carers across the region. The LDP has come together to write a plan that is coproduced with people with lived experience for delivery of services over the next year.

The work of the LDP is guided by the Joint Commissioning Strategy for Adults with Learning Disabilities 2019-2024, which was co-produced with citizens. It outlines the key priorities for people with learning disabilities across the region, and areas of development required to improve outcomes for people. We delivered 3 workshops in 2022/23 for people with lived experience and practitioners to come together to review the strategy and write the plan for delivery. We are planning more workshops with people with learning disabilities in 23/24 to monitor the delivery of the plan and check progress.

"I have limited verbal communication skills, although I can clearly communicate when I would like to be alone and some very basic needs, like when I would like a drink/snack."

"I vocalise loudly and 'bang' the side of my wheelchair repetitively when I am not happy. I understand clear and simple communication and respond well to a 'now' and 'then' approach to help me structure my day...I attend Vale of Glamorgan Learning Disability Day Services and staff have taken time to get to know me. I have gradually built up my attention span whilst participating in new activities with my staff allowing me to work at my own pace, giving me space and responding quickly to my requests. I like using the 'Touch Therapy' room to relax and spend time out of my...My carer says that because I'm busy during the day, I'm sleeping better at night and support staff are noticing that I'm using more words to communicate my needs".

"RIF funding has enabled us to innovate and develop new services to meet local need in response to local request. For example, we have been able to build a highly successful transition day service for young people with the most complex needs. This makes a huge difference to young people and their families, enabling them to remain living at home in their communities. They are able to plan what a good adult life looks like while in school and we can see individuals making significant progress when they leave."

Emma Mulinder - Operational Manager Cardiff Learning Disability Services

Case Study: Employing people with lived experience

Much of the knowledge about problems and challenges that people with learning disability face comes from people who have shared their lived experience. With this in mind, Cardiff and Vale UHB recruited two people with a learning disability into the Community Learning Disability teams in Cardiff and the Vale of Glamorgan to provide their expertise and guidance. The RPB worked with the Regional Innovation Co-ordination (RIC) Hub to showcase Stacey and Joanna's story. Following this work, Stacey and Joanna met with the Director of Operations for Primary Care and Intermediate Care to discuss the impact lived experience roles can have in our health and social care system. This secured further funding and produced an appetite for more lived experience roles in the service.

Click here to watch a short film about the impact this has had on the service.

"Stacey and Joanna's Story highlights how the Regional Partnership Board can utilise the valuable knowledge and experience of people with lived experience in our work"

Cath Doman, Director of Integrated Health and Social Care at Cardiff and Vale UHB

Read more about employing people with lived experience.

Learning Disabilities: Towards Independence

The 'Towards Independence' project uses multi agency working to provide a regional local further education opportunity for individuals with Profound and Multiple Learning disabilities and behaviours that challenge.

A course was developed for young people with complex needs at Cardiff and the Vale College, called 'Towards Independence'. The course is open to people with Profound and Multiple Learning disabilities and behaviours that challenge.

People on the course are highly supported in college, working alongside a team of specialist support staff, both in and out of the classroom. Learners participate in a variety of projects specifically designed to facilitate opportunities for skill development in a range of areas. These projects provide meaningful learning experiences, encourage self-advocacy, and promote independence.

The local offer enables individuals with complex needs to progress their life skills alongside their peers in their local college and communities where they can remain living in their family home.

Case Study

Matthew has a Profound Multiple Learning Disability. In his last year of school his family were torn between wanting Matthew to access further education and both his and their desire for him to remain local. While the family felt college would be a good experience for Matthew, they planned to opt for day services as there was not a college course that could meet Matthew's needs. The family were delighted when the new course was developed; Matthew could continue in further education and remain living at home. Matthew has been attending Cardiff and Vale College with support of day service staff, has settled into the course and is enjoying being on the college campus with his peers.

Learning Disabilities: Having My Own Home – Supported Independent Living

Supported independent living aims to provide a model of individualised strengths based and co-produced supported accommodation services, which promotes and maintains independence and inclusion. This commits to the principle that all people with learning disabilities, regardless of the level or type of disability, are able to make choices about how to live their lives given the right support.

Case Study: Jason's Story

Jason has a diagnosis of Mild Learning Disability (LD) and Autism Spectrum Disorder (ASD) and was living successfully at home with his family prior to the pandemic. Jason lost a lot of his meaningful occupation and routines during this time, which led to a decline in his mental health requiring him to be detained under the Mental Health (MH) act. The initial MH assessment did not pick up on his LD or ASD and he was detained on a general psychiatric ward.

In hospital Jason settled very quickly on the ward and was identified for discharge. It was agreed for Jason to be discharged to our emergency accommodation service (EAS) while a suitable permanent accommodation was sought. On arriving at EAS, he became extremely distressed very quickly, demonstrating elevated challenging behaviour and placing others at risk. He was conveyed back to psychiatric hospital.

The failed discharge highlighted the complexity of Jason's needs and, in particular, the complexity of his autism. Jason was transferred to a learning disability psychiatric unit where work was undertaken to understand his autism and behavioural support related needs.

A very considered move ensued, with the provider Behavioural Support lead working very closely with the hospital, Multi-Disciplinary Team (MDT) and support team to execute a very careful transition.

Jason settled immediately in his new home. He joined several activities and social groups within the first week. His relationship with his new co-tenant was a much better relationship than expected. Jason and his family were very happy with the move. He has made new friends and has been able to resume the independent life he lived prior to his MH decline, and he no longer needs interventions or additional support.

Jason is keen to tell others about his move and his life in supported living. He really is living a great life and wants everyone to know about it.

Supporting people with learning disabilities in numbers

77 supported by Fit for my Future

40 person-centred reviews

2 people with lived experience employed

Neurodivergence and Autism Code of Practice

The 'Delivery of Autism Services Code of Practice' was published by the Welsh Government in September 2021. This aimed to provide clarity about the legal rights of autistic adults and children and what people should expect from health boards, local authorities and NHS trusts and Regional Partnership Boards.

The RPB has worked together to:

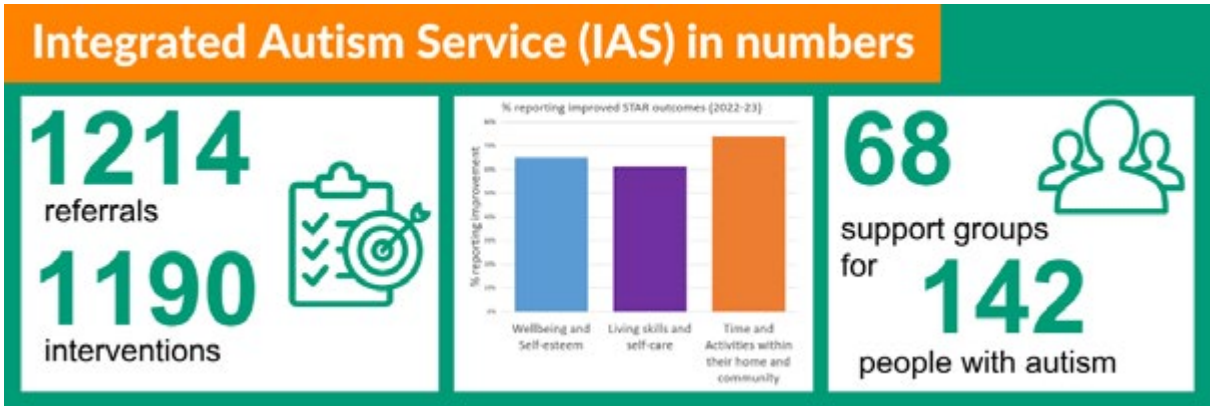
- Maintain oversight and monitor the implementation of the Autism code of practice duties with stakeholders
- Champion Autism within our RPB, via Keith Ingram, Autism Lead Officer
- Develop an outcomes focused outlook to elements of reporting by making links to Cardiff and Vale's Regional Outcomes Framework and Welsh Government's Models of Care
- Promote Autism Awareness and encouraged health and care staff to undertake multiple training modules to gives the knowledge people need to effectively provide support to autistic people
- Consider engagement focus going forward, including short term plans to increase awareness about services and support, and long-term ambition to increase our understanding of barriers that people face linked to diagnosis and our understanding of attitudes towards autism in different communities

The Cardiff and Vale Integrated Autism Service (IAS) celebrated five years of supporting autistic adults and their carers in our region in 2022. They offer diagnostic and support services and work with mainstream services to increase their skills and knowledge in working with autistic people.

Staff and people who had used the service reflected on their time with the IAS.

Click here to see their comments, for instance:

"It was uncomplicated, especially with the self-referral. The wait is shorter than in some areas of the UK. The correspondence was straight forward and very helpful. And today wasn't scary."



Triage Assessment Clinic

A long-term ambition for IAS is for the triage assessment to reduce wait times for diagnostic assessment. A pilot triage clinic started in September 2022, which invited everyone whose referrals were accepted by the service for diagnostic assessment.

The clinics were run by two experienced clinicians who assessed whether the person who was referred could be autistic and therefore, should be put forward for further assessment.

The triage clinic offered more timely access to an initial assessment, and aimed to reduce the number of people who required a full assessment in order to reduce waiting times. Initial evidence has been positive and this process should reduce the demand on the service in the long-term, while also providing an opportunity to share informed recommendations for people, whether they qualified for a full assessment or not.

Responding to the Welsh Government Neurodivergence Programme

The Welsh Government recognised the pressure that ND services were under, which intensified as a result of the pandemic. They reviewed the demand for their services and their capacity to meet people's needs.

Funding in 2022-23 has enabled us to hold additional waiting list clinics, provide additional resources and plans for expanding ND services across children, young people and adults through:

Improved environmental adjustments to support access to clinics for Children and Young People with neurodiversity and additional waiting list clinics to support a reduction in waiting times for assessment.

The development of an emotional health and wellbeing website to support people with wellbeing needs whilst awaiting assessment. Further work to our website is planned for 23/24 to strengthen this content and provide signposting and support for neurodiverse children and young people.

Case Study: Kara's experience of Transitions Neurodivergence Services

Kara has an attachment disorder and was evicted from her accommodation due to her behaviour. She worked with Transitions Neurodivergence Services and has now found a new home:

"I got this flat along with support from staff and I know there are always people here to help. I gave the flat a chance, it was hard at first. I let people support me, whereas in previous placements I was pushing people away. I do that less now. Moving into my own flat made me realise I can be mature, to look at the barriers.... The lessons I've learnt are don't push people away, let them help you. If you have troubles, go and speak to someone. Don't keep it inside and let it explode then bad things happen as a result.

I want a life, I will be 21 soon. I will be going back to college and doing childcare. This is what I always wanted to do when I was younger. That and a social worker... but I don't want to do that anymore! LOL."

Click here for more information on the plans around our Children and Young People Neurodiversity services.

Ageing Well Partnership

Ageing Well supports older people, including people living with dementia, through two key programmes:

- **@Home**
- **Dementia**

@Home

The RPB has brought together a number of projects under the RIF that work together so people can access the support they need, when and where they need it. Key achievements over the past year include:

- Developing our access points into services through Cardiff's First Point of Contact and Vale's Wellbeing Matters services, this includes a successful implantation of an Integrated Care Hub across our hospital sites.
- Rollout of a multidisciplinary approach to cluster development which means that our GPs are working more closely with local authority and third sector services to ensure people are provided with the right services to support their needs.
- Delivery of our integrated Wellbeing Hub at Maelfa to support people through more joined up services in a community setting.

[@Home Overview: Bringing support closer to home]

@Home in numbers

80,228
referrals handled by the community access

4,764
referrals dealt with by the hospital discharge hub

6,613
people accessing our Intermediate Care services

These projects form the @Home Programme.

Over the next five to ten years, the programme will deliver a new model of joined-up care and support to help people live independently for as long as possible, receiving care in, or as close to, their home and community as possible.

In addition, the @Home Programme will deliver further improvements to people's experience of using health and social care services. These will include:

- New health and care facilities in the heart of communities across the region, reducing the need to travel to hospital;
- Information, advice and guidance that is easy to access and means so people can take control of their care;
- Services to help people stay well;
- Support to help avoid hospital admission and get people home from hospital as soon as possible so they have more time at home doing the things that are important to them.

Taken together, the @Home Programme represents an ambitious new offer for health and social care to people who live in Cardiff and the Vale of Glamorgan. Although it will take time for all these changes to take place, we are committed to improving everyone's experience of using health and social care services.

Listen to people involved with @Home speak about what the programme has achieved.

Case Study: Lucy's Experience of Intermediate Care – Community Resource Team (CRT)

Lucy had been confined to her bed for several years due to mobility issues and had been told by her GP that there was nothing further they could do to improve her physical condition. She was admitted to hospital for another condition and referred to CRT.

Lucy wanted to be able to get out of bed and down her stairs, as well as doing some light exercises. She discussed this with Alyssa, a Physiotherapist, who was determined to help her reach her goals. Lucy and Alyssa worked together and exceeded Lucy's aims much more quickly than expected.

After being immobile for several years Lucy can now go downstairs and outside to a bench in the garden. She goes downstairs on a stairlift every day for breakfast and lunch, and sits outside for a cup of tea. She sees her neighbours who she had not seen for years and eats meals with her husband. She describes her experience with Alyssa and the CRT as "life changing" and said the service had done more than she had ever expected.

Lucy said Alyssa delivered care with kindness, vigilance, determination and knowledge and she has transformed her quality of life.

Loneliness and isolation report

C3SC were funded to report on where the RPB should focus to help tackle social isolation and loneliness, particularly amongst older people. They wrote a briefing highlighting the adverse effects of feeling isolated and describing a number of services across Cardiff and the Vale that have been found to help reduce the problem.

This interim report has been our starting point, looking at what is currently available to our communities and how organisations can work together to build on opportunities to increase people's wellbeing and social inclusion.

Click here to read the full report.

Dementia

The dementia programme is the delivery vehicle for Cardiff and Vale's Dementia Strategy and is focussed on the following priorities:

1. People understand what increases their risk of getting dementia and how to prevent it
2. Our communities are compassionate towards people with dementia
3. People are quickly assessed and diagnosed closer to home in GP led clinics, rather than in hospitals
4. Care and support are available in the community and provided by specially trained teams during assessment process through to diagnosis
5. Our hospitals are dementia friendly environments.

This work is supported by a dedicated Learning and Development team to ensure our teams have the right skills to support our citizens.

We are now halfway through the Cardiff and Vale of Glamorgan's Dementia Strategy, a ten-year plan which links with national strategies including the National Dementia Action Plan and the All-Wales Dementia Care Pathway of Standards. Over the past year we have:

- Trained over 650 people to support people with dementia
- Held 28 Awareness Sessions in the community to help people understand more about dementia
- Had commitments from over 100 businesses to take dementia friendly action
- Memory Link Workers have supported 2,000 people to help them get support more easily
- Our commissioned partners Mental Health Matters (MHM) supported 9000+people with activities during their stay in hospital.

Looking ahead, we will focus on:

- Speaking with as many people as possible including those affected by Dementia to decide what we should focus on next.
- Find out and share all the great work that is already happening.
- Evaluate the difference that our work is having on peoples' lives building on from proactive and collaborative reviews undertaken by Cardiff Council including forming a community of practice for our care home providers. ·
- Continue to build on the work that has been done so far to deliver high-quality, consistent, and person-centred dementia care for the people of Cardiff and the Vale of Glamorgan.
- Train more dementia Care Mappers across all partners Health, social care and third sector to evidence progress and inform change.

Listen to the Dementia Learning & Development Team speaking about their proudest moments.

Case study: Liz's experience of the Vale Wellbeing Matters Service showing how services work together

Liz slipped in the kitchen when she was trying to take gas and electric metre readings and banged her head on the cupboard. She managed to crawl into the living room and pressed a telecare alarm to get help as she was unable to get off the floor.

A St John's falls responder attended to help get Liz up and carried out some observations. They ensured Liz was comfortable and left her with her partner, but gave advice in the event of any deterioration.

St John's called for a wellbeing check six days after their visit. Liz said she was feeling sick following the fall, and that bruising had come up and was spreading down her neck. Liz also told them that she is a carer for her partner who has dementia.

She was advised to speak to her GP, and she made an appointment for the following day. After the appointment, the team called back to check that she was feeling better. The District Nursing Team visited Liz to run some observations on her to ensure she did not need any further treatment. The Well Being Matters Service also referred Liz the third sector for support with care and advice regarding help with her partner.

Capital

Our capital funding builds and transforms spaces to maximise their use to our communities. It invests in the long-term aim of ensuring support is delivered as close to home as possible and is available when people need it. Our investments this year have focussed on some of our most vulnerable communities, as well as keeping people well and living lives that are as independent and enjoyable as possible.

In 2022-23 we secured £7.8 million pounds of Housing with Care funding on delivering projects under three key objectives:

Objective 1 - increase the existing stock of housing with care

We invested in creating 44 easy access apartments with lounge, communal spaces, roof terrace in Addison House, Older Persons Community Living Scheme.

Objective 2 - increase the stock of intermediate and short-medium term care settings

This included:

- Meridian House Family Supported Living - 9, 2 and 3 bed family apartments with onsite support
- Children's Services Accommodation Portfolio - 5 accommodation schemes to support the accommodation strategy
- Merthyr Dyfan – accommodation for adults with learning disabilities

Objective 3 - Provide a small, fixed element of discretionary funding which meets the needs of Housing with Care

This supported people to live in their own homes and do the things that matter to them through providing funding for:

- Care & Repair Cardiff & Vale
- Third sector led capital grants scheme (GVS & C3SC)
- Tech enabled care (Cardiff Council)
- Assistive Living Tech (Cardiff Council)
- Assistive Living Tech & tech enabled care (Vale of Glamorgan Council)
- Disabled Facilities Grants

The Third Sector Capital Fund helped a wide range of organisations to provide support and promote social inclusion. This funded the following:

Organisation	Investment
Motion Control Dance	Sensory and tactile equipment for dance classes
Gibbonsdown Community Group	Community Café set up equipment
Headway	Building adaptations and equipment
Moss Rose Cottage	Furnishing and decorating accommodation for family/ carer facility
Sporting Memories Foundation	Equipment for four sporting memories clubs
Action for Children	Equipment & toys for Ty Robin
YCSA	Warm space items and boiler replacement
Cathays & Central Youth and Community Project	Creation of accessible toilets
Wales Council for Deaf People	Equipment for the deaf community to support individuals at home
Vision 21	New equipment and upgrades to sustain services
ACE -Action for Caerau & Ely	Sensory packs to support 50 families in the community
ValePlus	Design support for plans to add an additional classroom
Age Connects	Purchasing volunteer management software system and IT equipment

These short films highlight just three examples of the positive impact that our capital funding programme is having in our communities:

Moss Rose Cottage received funding for a range of equipment to help get them set up, for example, tables, chairs, a snooker table, arts supplies, printers and cooking equipment.

Women Connect First received funding for computers and equipment to help their members stay in touch and do activities during the pandemic. They are still used to this day.

Motion Control Dance received funding for a computer that has allowed them to stay in touch with people and promote their classes.

Health and Social Care Integration and Rebalancing Capital Fund (IRCF)

Capital funding under the pathfinder IRCF programme was secured for the Rhiwbina Community Wellbeing Hub.

Strategic Enablers

Underpinning our work are the enablers of joint working, such as joined up care records, our workforce, innovation technology-enabled care, how we use our buildings to enable community-based support.

Regional Innovation Co-ordination (RIC) Hub

Cardiff and Vale RIC Hub sits within the Dragon's Heart Institute in Cardiff and Vale University Health Board. It's aim is to co-ordinate and prioritise research, innovation and improvement (RII) activity that support priorities set out by the Regional Partnership Board RPB. The Hub is part of a Wales wide network that aims to provide a collaborative innovation ecosystem by working together with academia and industry. It aligns with the Welsh Government's strategic aims set out in A Healthier Wales and bases all work on four key design principles - Higher Value, Evidence Driven, Scalable and Transformative.

This year, the Hub has engaged extensively with the RPB's three programmes, Starting Well, Living Well and Ageing Well, to ensure enhanced co-ordination of innovation, celebrate, import and export good practice and avoid duplication. This year's work focussed on:

- Social and Green Prescribing
- The Future of Innovation and Smart Technology
- Lived Experience.

Click here to read the RIC Hub's Annual Report.

Developing a stable and sustainable care market

The Regional Commissioning Board directs a program of work, on behalf of the Regional Partnership Board, to ensure the partnership bodies work effectively together to:

1. Ensure that information is shared and used effectively to improve the delivery of services, care and support, using technology and common systems to underpin this;
2. Ensure that services and resources are used in the most effective and efficient way to improve outcomes for people in their region;
3. Promote the establishment of pooled arrangements where appropriate;
4. Prepare flash reports for the Regional Partnership Board and Strategic Leadership Group on the extent to which the board's objectives have been achieved
5. Consider regional contracting and fee setting

During 2022-23, the Regional Commissioning Board:

Market Stability Report: Developed the Market Stability Report and agreed actions required by commissioners in the related delivery plan

Market Sufficiency: Agreed the data sets needed to bring alignment for Regional Commissioning Board Dashboard to monitor ongoing market sufficiency within the system

Market Stability: Developed a Regional Escalating Concerns Policy and decision risk matrix that providers and commissioners are now using as part of their quality management processes

Alignment of Provider communications: Set up a regional micro website pages for Regional Commissioning so Regional Escalating Concerns resources and Regional Common Contracts and Service specification for residential care and other useful resources can easily be updated and accessed

Cost of Care delivery evidencing: Worked together to create a cost of care calculator tool using the 'Let's Agree to Agree' set of principles for Residential care-based services and domiciliary care-based services.

Workforce

Integrated Recruitment Advertising Campaign

The Intermediate Care Board found there was a shared challenge in recruiting suitably qualified community-based staff to support hospital discharge, avoid admissions and provide a range of care in the community.

Positions that they were struggling to recruit to included:

- Nurses
- Health Care Assistants
- Dietitians
- Carers
- Speech and Language Therapists
- Occupational Therapists

We undertook a Strengths, Challenges, Opportunities, Threats (SCOT) analysis to inform the service specification for the advertising campaign. We found that there was a shared desire to:

- Raise awareness of available roles and developments
- Increase applications to community roles
- Create a positive image of caring roles
- Share public and current staff voices
- Promote living and working in our region

This enabled us to have a shared position that focussed on the rewards of working in the community teams in Cardiff and Vale of Glamorgan and meant we were able to create a campaign called 'Join our Caring Community'.

Following the procurement process, we appointed 'Hello Staring' to help us develop assets and purchase advertising.

Due to the timing at the end of the financial year there were only three roles available on launch, so we focussed on the time limited elements for phase 1. This included advertising on the sides of 32 buses and a billboard we offered free of charge in Cardiff city centre (Westgate Street) during Six Nations.

We have created a shared web page for potential applicants that links to available roles and the normal application process.

So far, we have received 92 visits with a 6.5% engagement rate.

Phase 2 of our advertising campaign will commence once more roles are available. Once the number of roles available increase we will launch phase 2 which will include:

- Meta (Facebook, Instagram and the Meta Network)
- LinkedIn
- Guardian Jobs (for specific roles)
- Wales Online - editorial and advertisement
- TV Hub and All Four

We are recording the impact on applications as we progress through the campaign so in addition to increasing applications, we will also have monitoring data to inform any future advertising.

Click here for more information about the 'Join our caring community' advertising campaign.

Creating a shared Digital Care Record

In order to test the ability of the National Data Resource and Local Data Repository link records across incumbent systems the region undertook a proof-of-concept project that connected Cardiff Council Social Services and Health Board Children Looked After services, using the Welsh Government-supported Local Data Repository tooling. This tooling provides the means by which incumbent e-care record, locked away within any of our c.150 regional care or health 'systems', may gain agility, to present 'where its required', 'to whom its required', and 'when its required' anywhere in the region.

As a learning Health and Care system, we have both learnt lessons from the inside of this project but have also matured our understanding that to deliver the aspirations of an integrated health and care region, technical tooling alone is insufficient.

Taking learning from Somerset, Wirral, Humber, and a range of Health and Care digital initiatives (LHCREs) across the UK, it is clear that an underpinning of integrated care, is integrated e-records, and that this requires co-ordinated digital eco-system change, at a regional level, and across the pillars of tools, rules, behaviours and people.

We have set up a Digital Care Record Steering Group to help progress and expand this work.

Business Intelligence and Outcome Reporting

We have worked as a partnership to effectively share information and demonstrate how we are achieving our outcomes. During 2022-23 we developed:

Regional Integration Fund RIF project and programme reporting – improved understanding of the RIF programme's performance and the difference it has made through the refinement and further development of project and programme level.

Regional Information Sharing Site (RISS) - greater insight into people's experiences with health and social care through the development of a 'beta' version of the RISS with Lightfoot Solutions Ltd.

An early example of how the RISS is informing our work is the identification of a "high risk cohort" as a result of joining some key health and social care data from Cardiff Council, Cardiff and Vale University Health Board and Welsh Ambulance Service Trust. It has provided new intelligence into those needing to access emergency hospital care, the length of time they spent in hospital and their outcomes following care.

Regional Outcomes Framework (ROF) - Further refining using the new capability gained from the RISS, including adding new and improved ways to track and evidence outcomes at an individual and system level.

Further Faster / Hospital @ Home – New data-driven insights derived from the RISS to inform planning and decision-making to help prevent unnecessary hospital attendances and admissions.

Partnership "hospital discharge / Six Goals" data – Improved understanding of people's experience when ready for discharge from hospital. This was achieved following an in-depth review of existing data collection and reporting.

emPower – Improved understanding of how best to evidence the impact of the programme with Attain consultancy by mapping and drawing existing data and intelligence across the CAVRPB.

Part 3: Communication, Engagement and Social Value

During 2022-23 we utilised the building blocks we put in place around communications and engagement in the previous year, including our new brand guidelines, engagement framework and participation site. Here we highlight the practical application of this work and the difference this has made across the partnership.

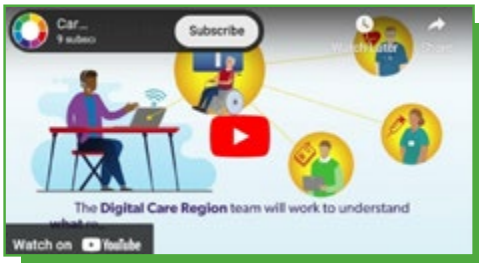
Communications: Impact and partnership

At the heart of all our communications is a focus on how we are working together to improve the outcomes for people in our region.

The films in the Capital section are an example of this. They demonstrate how the RPB and GVS worked together to provide small grants to invest in capital. Rather than focus on the items that were purchased, we wanted to highlight the positive and ongoing difference they have made to people.

Accessible information and storytelling

Our approach is to provide simple and clear information, especially where the information we are trying to do communicate is complex. These films show two ways we have done this.



Digital Care Region

Currently, portions of a citizen's health or social care record are scattered across more than 150 different electronic record systems maintained by Cardiff and Vale University Health Board, Cardiff Council, Vale of Glamorgan Council and the third sector. Our aim is to work in partnership to allow care records to be readily and suitably available to the right care professionals, at the right time, through means which they define. This will mean that health and social care staff can view a more holistic care record in regard to every person they see, leading to the provision of better-informed care.

Regional Outcomes Framework

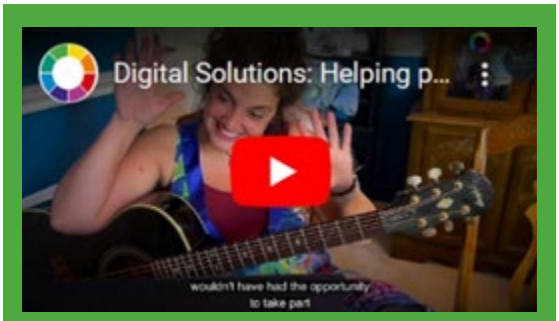
Here we use the story of Mary to show how Cardiff and Vale Regional Partnership Board are building a database to share information and shine a light on what is happening across our region.

The film explains how the database can be used to inform decisions, point where to explore further and monitor the impact of work.

Supporting our partners

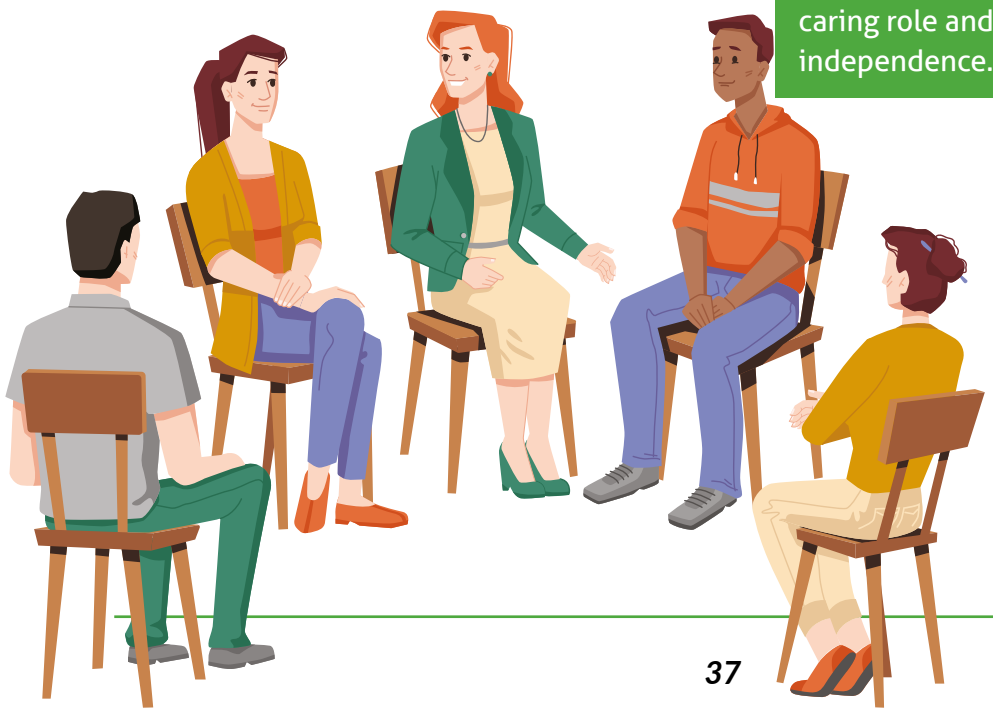
We have supported our partners in communicating the key messages they have identified. These films focus on work that partners identified as needing to be highlighted, but also emphasise partnership working and the impact they have had:

Early Help and the Families First Advice Line can talk to people in Vale of Glamorgan about all aspects of life and offer information, advice and support on topics such as family life, behaviour, school attendance and parental support. They work in partnership with the Police and Health.



Digital Solutions provides simple and accessible technology that is designed to improve quality of life for people living across Cardiff and Vale of Glamorgan local authorities.

The Cardiff and Vale Carers Gateway provides information and support to unpaid carers. They improve the quality of life for carers and the cared-for in our locality and help carers to make the most of their life alongside their caring role and to maintain their independence.



Case Study: Promoting the Cardiff and Vale Carers Gateway

We have also been piloting investing in advertising and design alongside some of our key work. As a result of feedback on the Unpaid Carers Charter, we also promoted the Carers Gateway though:

Capital FM – Cardiff and Vale of Glamorgan

Individual people reached: **128,038** people heard the adverts over 4 times on average. Approximately **574,000** listens in total.

Bro Radio

The Vale's premier community station reaches over **20,000 people** every week with its programming. Our adverts ran for four weeks.

Spotify

36,612 individuals were reached with the campaign, each hearing the adverts 1.45 times on average. **107 people clicked** on the ads.

Pharmacy Bags

30,000 bags distributed to 30 pharmacies across Cardiff and the Vale

Meta

The first campaign reached slightly higher numbers but had a lower click-through rate (CTR). This is likely because the first campaign was learning who the right audience was, once it had done so it applied this learning to the second burst where fewer people were reached but, as the CTR demonstrates, these people were the right people so more of them clicked through.

Burst One – December-January:

Reach: 38,824
Impressions: 130,129
Clicks: 1,473
Clicks to unique reach rate: 3.80% (very strong as the benchmark is 0.9%)

Burst Two – February:

Reach: 20,680
Impressions: 61,933
Clicks: 962
Clicks to unique reach rate: 4.65%

Engagement

We continued to develop our Engagement Community of Practice. This is a platform where practitioners carrying out engagement work in Cardiff and the Vale can easily share resources. It was co-designed by practitioners (supported by C3SC & ProMo-Cymru) with the aim to establish a common, joined up approach to engagement that will increase the range of voices heard. It was built in a response to engaging with citizens and practitioners across the region.

We also meet as a group and this year have benefitted from the expert advice and knowledge of Nick Duffin from the Consultation Institute. We used this to create an engagement template to support legally compliant engagement.

My Voice Matters

We have focussed on engaging with people across Cardiff and Vale, including investing in a Participation Site that can be used by our partners to support their engagement. It has enabled the RPB and our partners to set up a number of public and private groups, including:

Area Plan engagement – **dementia** and **children and young people**

Joint publicity for recruitment campaign

Social prescribing

Cardiff and Vale University Health Board Strategy Refresh

Communications and engagement preferences

Since the launch in November 2022, we have had nearly 3,000 visits and 526 people have engaged on the site.

We commissioned Hijinx to create a film with people with learning difficulties about their experiences of health care. Participants created their animated portraits in a workshop led by Jon Ratigan and Emma Prentice. You can hear what rights are most important to them in this short film. A longer, protected version was shared with people involved in health and care in key meetings.

We commissioned Age Cymru to find out how older people in our region want to find out about and get involved in our work. We learnt:

- The best ways to communicate are word of mouth, GP notice boards and other community settings, via third sector, local papers/radio;
- The best ways to engage is face to face in local groups in the community and via trusted intermediaries;
- Social media is not used regularly by many participants and is not a trusted source of information;
- People find some health and care information hard to understand;
- There is a lack of awareness about RPB, but people are keen to learn more.

Click here to read the full report.

We asked people about ageing well in our region. Their responses were recorded in this film.

Feedback: "This is fantastic, a true reflection of the current situation without it being too glum, just realistic. I am so glad we could be a part of this, it is so important for these voices to be heard. Well done, a vital piece of work for all of us."

Social Value

Social value helps help drive a series of outcomes that support a range of priorities, including tackling inequity, delivering health and wellbeing outcomes that people want, rebalancing care. The Social Value Action Plan focuses on actively involving people, and challenging top down approaches or any presumption that any part of the system has a monopoly of knowledge on what might work and what will really be effective.

Over the last 3 years revisions to our Governance Structure have provided us with an opportunity to build upon this initial work and reflect upon the best way of ensuring that social value is placed at the core of everything we do.

Social value plays a critical role when planning and commissioning services and requires commissioners of public services to actively consider the best means of securing wider social, economic and environmental benefits alongside better value for money by involving a range of services. This results in decision makers continually developing their understanding of what different diverse communities might want and exploring what's possible when developing responses by involving different partners.

About the Social Value Forum

We worked together to establish a Regional Outcomes Framework which outlines a range of shared priorities where, by working together, we aim to deliver significant improvements for individuals and their communities.

Our joint wish to achieve greater social value lies at the heart of this framework which aims to enable people to live the best lives they can in their homes and communities.

We are working to ensure that ways to measure our effectiveness in enhancing social value are embedded within each of the underpinning shared priorities.

The RPB is beginning to 'bake in' social value into all its programmes of work, recognising that supporting people and places to thrive is at the heart of the RPB's overarching outcome, enabling people to 'live the best lives they can in the homes and communities.'

We published our **Social Value Triennial Report** setting out some of our key progress and highlights of our investment in social value.

Looking Ahead

In 2023-24, we publish our Joint Area Plan, setting out where partners will come together to improve the health and wellbeing of the local population. The strategic direction set out in this plan will relate to the joint activities we are committing to as a partnership, building on a long history of collaboration.

Our shared outcomes include:

Making a Difference – Our Commitments for 2028

We will:

- Work together to keep our 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 disabilities** 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.

We will also be accelerating our work at cluster level to address the needs of a wider group of people who are at risk of deterioration.

Both these workstreams work in close collaboration with the 6 Goals programme.

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.

Neurodiversity 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.

As part of our response to the Welsh Government's Further Faster initiative, we will be accelerating our work to develop a community based, step up crisis response service for people over the age of 65 to reduce the number of attendances / admissions to hospital.

Strategic Enablers

The development of new models of care cannot be achieved in isolation of a number of significant enablers; in particular how we support and co-produce with our staff across the partnership, new care models and ways of working that lead to better health and wellbeing outcomes for the population.

The following set out the main strategic enabler themes which have programmes of work directly connected to the delivery of the commitments set out in the Joint Area Plan and the successful operation of the RPB.

Workforce: new ways of working, organisational and cultural development, securing capacity and capability to deliver new models of care

Communication, engagement and co-production: involving stakeholder in plans and delivery; sharing and celebrating its impact

Regional Innovation Co-ordination Hub: co-ordinating innovation by supporting new approaches, bringing people together to solve issues and connecting the RPB to the wider innovation network

Digital Care Region: shared care records, information governance, information sharing and technology-enabled care

Strategic capital programme: health and wellbeing hubs; rebalancing care; enabling co-location;

Commissioning: securing and stabilising the market to improve outcomes for people

Good governance: ensuring effective and responsible management of the RPB's functions to deliver its objectives

RPB Funding Stream	Description	Allocation £'000
Regional Integration Fund	Dementia	1,500
	Infrastructure	750
	Integrated autism	367
	Starting Well	5,858
	Living Well	3,563
	Ageing Well	7,363
Welsh Community Care Information System (WCCIS)		190
Regional, Innovation and Improvement Coordination (RIIC) Hub		250
Neurodiversity		187
TOTAL		**20,018**

22/23 review: Housing with Care Funding

Objective 1- increase the existing stock of housing with care				
Scheme	**Lead Organisation**	**Total project cost**	**Total HCF Approved (all yrs)**	**HCF Spent 22 23**
Addison House Older Persons Community Living Scheme	Cardiff Council	£8,687,713	£4,283,114	£4,283,114
Objective 2-increase the stock of intermediate and short-medium term care settings				
Meridian House Family Supported Living	Cardiff Council	£3,153,680	£2,420,680	£796,500
Children's Services Accommodation Portfolio	Cardiff Council	£1,225,000	£1,225,000	£1,225,000
Merthyr Dyfan - accommodation for adults with learning disabilities	First Choice Housing Association for Vale of Glamorgan Council	£772,250	£502,000	£347,402
Total		**£5,180,930**	**£4,147,680**	**£2,368,902**
Objective 3-Provides a small, fixed element of discretionary funding (max 10% of regional allocation) to support Objectives 1 and 2				
Care & Repair Cardiff & Vale	Care & Repair			£275,000
Third sector led capital grants scheme	GVS & C3SC			£100,000
Tech enabled care	Cardiff Council			£70,000
Assistive Living Tech	Cardiff Council			£175,000
Assistive Living Tech & tech enabled care	Vale of Glamorgan Council			£141,336.50
Disabled Facilities Grant	Cardiff Council			£391,113.50
Total				**£1,152,450**

22/23 review: Health and Social Care Integration and Rebalancing Capital Fund (IRC)

3 yr capital programme-2022-2025, guidance issued in late 2022.

Split into 2 priorities: All Wales allocation (competitive bidding), £50m in 22/23, £60m in 23/24, £70m in 24/25.

Priority 1 - Development of integrated health and social care hubs and centres

Priority 2 - Rebalancing the residential care market

1 capital scheme funded in 2022/23 under the pathfinder IRCF programme- Rhiwbina Community Wellbeing Hub £400,000.

IRCF Revenue Funding Secured- Feasibility work on 3 IRCF Hub schemes + revenue resources.

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CARDIFF & VALE
REGIONAL PARTNERSHIP BOARD