Partneriaeth Ranbarthol Gorllewin Morgannwg | West Glamorgan Regional Partnership

WEST GLAMORGAN REGIONAL PARTNERSHIP

Area Plan and Action Plan Priorities for 2025-2026

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Region: West Glamorgan Regional Partnership

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Vision and Aims of the Partnership

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West Glamorgan developed a co-produced set of vision and aims at its inception that the region continues to follow:

- We will drive transformational improvements in wellbeing, health and care for the populations we serve through better practice, better services, better technologies and better use of resources.
- We will change the way that we work with citizens away from paternalistic care to shared responsibility and co-production.
- We will secure the delivery of seamless care which will meet the outcomes that matter to the people we serve and support through integration, earlier intervention and prevention
- We will manage our common resources collaboratively and pool resources wherever we can.
- We will have a single and simple governance structure covering Public Service Boards, the Regional Partnership Board and sub-structures for the region.
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The Regional Programme exists to:

- Drive continuous improvement in wellbeing, health and care in partnership.
- Work in co-production with partners from the third sector, voluntary sector, private sector, statutory sector and our citizens to secure more seamless care in communities.
- Cross service boundaries to develop better, more seamless care.
- Promote a healthier region through asset-based communities.
- Make sure our agencies put people at the heart of wellbeing, health and care transformation, integration and prevention.
- Help to make sure that people live healthier and happier lives
- Deliver the Regional Transformational Strategy and Plan
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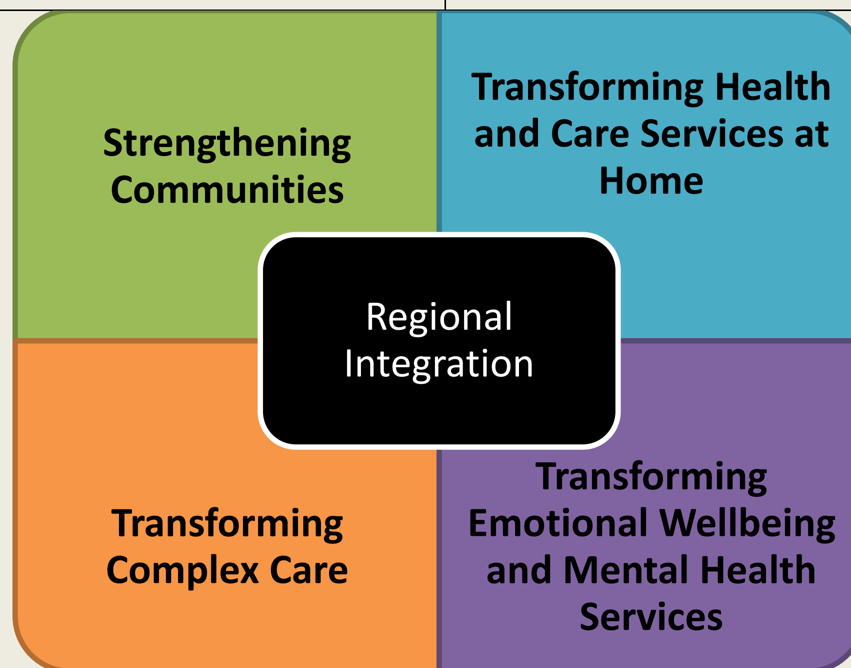

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Programme	Area Plan Priority	Models of Care Supported	Programme Lead
Communities and Older People	• Transforming Health and Care Services at Home • Strengthening Communities	• Place Based Care – Prevention and Community Co-ordination • Place Based Care – Complex Care Closer to Home • Home from Hospital	Dave Howes and Craige Wilson

Overview of the Programme

Our Communities and Older People programme has an ambition to transform health and social care with innovative, financially sustainable models. We have a vision where every community member and older adult thrives in safety, health, and prosperity. We will achieve this though partnering with community & older people, third sector and statutory partners, working hand-in-hand with the communities to design services that truly meet their needs. Part of our efforts involve creating a Prevention and Early Intervention Model designed to help individuals remain in their communities longer, without needing statutory services.

At the other end of the spectrum, we support individuals in being safely and promptly discharged from statutory services with the support of the community. Together, we will build a brighter, healthier future for all

Workstream	Brief Description of Workstream	Progress to Date
Regional Performance and Finance of Section 33 Intermediate Care / Integrated Community Care System	The workstream oversees the financial performance and service delivery for Section 33 services, by reviewing budgets, actuals, and key metrics like referrals, discharges, and reablement outcomes. The group also evaluates the full scope of funding sources—Core, Regional Integration Fund, 6 Goals Funding, Further Faster, and Allied Health Professional Funding—to ensure resources are used effectively	The programme has strengthened its financial and performance reporting arrangements, with updated financial mapping presented to the Communities and Older People Programme Board in December. Development of the regional performance dashboard is progressing well, with an initial version demonstrated at the December board meeting. The dashboard will support improved transparency, enabling partners to monitor key indicators such as referrals, discharges, length of stay, reablement outcomes, and readmission trends to inform strategic decisions and service redesign. There are gaps in the performance data which is being actively worked through and actioned across the partnership. An initial workshop bringing together both finance and performance colleagues was held on Friday 13th February. Partners from across the system attended to discuss the financial pressures currently being faced, the existing funding gap, and to identify what support the partnership could provide to help mitigate these risks and shape a way forward. The findings are now being written up, and further workshops are planned throughout March and April to consider the processes and changes required to develop a sustainable system. There is a clear interdependency with the D2RA workstream, so we are working to bring the two areas together and

		create joint workshops covering the key elements of work—finance, performance, process, demand, capacity, and workforce.
Monitoring and Oversight Joint Equipment Store	This workstream monitors the performance and the financial aspects of the Joint community equipment stores (CES)	Options to address the funding gap have been presented to partners; however, the gap remains a significant challenge. Financial issues are now being taken forward collaboratively through the Finance and Performance Workstream.
Pathways of Care Delays Action Plan and Implementation	This workstream will be responsible for: • Develop and manage the Care Delay Action Plan. • Hold service/site leads accountable for timely completion and identification of new actions. • Address challenges impacting execution. • Monitor KPIs to assess effectiveness. • Facilitate cross-site collaboration for alignment and problem-solving. • Manage risks with proactive solutions. • Review timelines, milestones, and deliverables to reduce delays.	Strengthened POCD Arrangements - West Glamorgan strengthened POCD performance through consistent daily huddles, weekly validation and weekly executive reporting, supported by a reset of weekly POCD meetings to secure stronger operational input and clearer weekly grip. Although the Winter Sprints have now concluded, they delivered significant impact by tightening daily controls, improving data quality, strengthening escalation routes, increasing clinical and operational presence, and exposing underlying issues such as referral gaps and unsafe discharge routes. Insights gained from daily reviews and Sprint activity also highlighted growing patient complexity, higher clinical risk and increased pressure on community and assessment services. While the Sprint structures have ended, West Glam continues to maintain system oversight and improvement through twice-weekly operational meetings as part of BAU, ensuring ongoing focus on performance, escalation and delay reduction. Updated POCD SOPs and guidance - Revised D2RA guidance and refreshed SOPs—including IDH and coding processes—were developed and are being taken forward to Programme Board for agreement, strengthening consistency across partners. Improved coding governance and referral accuracy - Inconsistencies between Signal and IDH were addressed by enforcing immediate COP referrals and preventing premature P3 coding, reducing 24–48 hour delays linked to incomplete referrals. Regional POCD Action Plan progressed - The updated Action Plan was completed and submitted to ROAG, setting out clear deliverables. This is of course an interdependency on the other workstreams across the programme. Reablement performance improved - Reablement delays have improved, contributing to shorter delays for some cohorts.

D2RA Processes	The project aims to: • Improve patient flow. • Minimise a person's stay in the hospital once they are well enough to be discharged. • Address the lack of a clear, simple process for enabling timely, safe transfer or supported discharge from hospital . • Develop and improve the trusted assessor model with a training programme to expand the trusted assessor resource. • Consider the demand for services broken down by pathway and explore 7-day working across the system to prevent delays in discharge. • Meet target flow and length of stay measures. • Revise supporting policies and procedures	Progress has slowed due to winter pressures, but key activities within the refreshed regional action plan continue. A joint finance and performance workshop on 13 February brought partners together to review financial challenges and identify support needed to address system risks, with further workshops planned across March and April. Given the interdependencies between the D2RA, Pathways of Care Delays, and Finance and Performance workstreams, work is underway to align these areas and deliver joint sessions covering finance, performance, process, demand, capacity and workforce. Process-mapping will be completed through these workshops to support region-wide standardisation of pathways and the development of the Integrated Discharge Hub, including finalising the SOP, streamlining triage and embedding real-time decision-making. These sessions will also inform the wider sustainability work, drawing on the Community Services Review, internal audit findings and demand-and-capacity recommendations. Deloitte continues to lead the demand and capacity analysis for Pathways 1–3, with outputs—particularly the completed Pathway 2 work—feeding directly into the remodelling of the D2RA model. A structured programme of multi-day workshops will run through March to May, with a draft model due for Executive consideration at the end of April. In parallel, the regional Trusted Assessor model continues to be strengthened and expanded. Trusted Assessors are already embedded within several pathways, with further development underway. Work remains focused on standardising criteria, improving consistency and extending coverage into care homes, aligned with the regional aim of improving the speed and equity of discharge decisions.
Communities and Older People Aging Well Strategy: “Stronger for Longer”	The aim of this strategy is to unlock the potential of the communities within the West Glamorgan region to support this cohort of individuals to gain knowledge of what is available to them to help them to maintain a level of wellbeing and independence wherever they live. This strategy will help steer the work of the Communities and Older People Programme and help focus the work on the most urgent priorities	Agreement / endorsement of the “Stronger for Longer” strategy vision and themes, providing a shared regional framework for prevention, ageing well, and community-based support. This will now enter into a phase of approval though local management arrangements once it has been endorsed by the Regional Partnership Board – the document will be shared at management board following the RPB.

Unscheduled Care Board	The UEC board is focused on creating a clear workstream group with defined aims and objectives, aligning with strategic priorities, and providing updates on the UEC work through presentations and reports. The board also addresses funding and performance monitoring issues related to urgent and emergency care. The UEC board updates the C&OP board to keep everyone informed about ongoing work and prevent duplicated efforts or resources.	Ambulance & ED Flow: Earlier gains (summer–autumn) moderated in winter, but key flow metrics are improving. Time to triage and total time in ED have both reduced following recent PDSA testing. Admissions have fallen, although attendances remain high. Frailty & SDEC: Frailty front-door service operational and expanding. SDEC model embedded with improved streaming and earlier decision-making. Discharge & Flow Pathways: SAFER/R2G reviews completed with actions underway. Integrated Discharge Hub strengthened; care-home clinical conversation now embedded. Community Response: Community falls response enhanced with equipment rollout. Aider service progressed and operational. High-Intensity Users: Additional capacity in place, early evidence of reduced repeat attendance. Impact of PDSA Testing (MGH): Reduction in ED time for most patients, including an 18.6% decrease in total time spent. 30% improvement in time to triage. Earlier senior review and improved discharge timeliness.

Programme	Area Plan Priority	Models of Care Supported	Programme Lead
Carers Partnership Board	Strengthening Communities	• Community Based Care – Prevention and Community Coordination (MC1) • Community Based Care – Complex Care Closer to Home (MC2) • Promoting Good Health and Wellbeing (MC3) • Home from Hospital (MC5)	Gaynor Richards

Overview of the Programme

The Regional Carers Programme one of six population boards sitting within the West Glamorgan Region. The Programme oversees the implementation of the Regional Carers Strategy which was coproduced with unpaid carers across the region and launched in April 2023.

The vision of the Carers Strategy represents the future we aspire to, where we recognise the contribution of unpaid carers to our society. The Strategy aspires to build upon previous successes and make changes where needed to transform services, enabling unpaid carers across the region to have fulfilling lives based on what matters to them. We plan to do this by actively identifying unpaid carers, to listen, respect, and properly support unpaid carers to not just continue their caring role but to enable them to have fulfilling lives.

We are refreshing the current Strategy for post April 2026, to refocus efforts across the region and ensure we are meeting the needs of unpaid carers.

Workstream	**Brief Description of Workstream**	**Progress to Date**
Access to Services	Learning from feedback from the 24/25 Short Breaks Grant Scheme, continue to review and further transform the current respite/ short breaks provision across the region, Undertake research to understand the respite provision on offer across the country and compare this to the regional offer.	A regional discussion at the SAB1 Board agreed the need to understand respite provision across the region, with scope for a regional piece of work. A Task & Finish group will be scheduled, and this will feed into the refreshed Strategy workplan post-March 2026.
	Develop guidance for employers across the region to raise awareness of the needs of unpaid carers in the workplace and offer practical solutions for how they can support them.	The Health Board has developed a workplan to raise awareness of unpaid carers within its workforce. Both Councils are continuing to develop resources and raise awareness of the needs of employed unpaid carers.
	Review, promote and improve the access to services for carers (MC3) in Primary Care settings such as Pharmacies, Opticians and Allied Health Professions	All pharmacy resource packs have been delivered. The Upper Valleys pilot has commenced following the Pharmacy Collaborative meeting on 25.09.25. For optometry, Llwchwr Cluster has been selected to pilot the Framework, with four optometrists participating. Further rollout is under consideration but dependent on resources.

Information, Advice, Assistance & Awareness including Comms & Engagement	Ensure accurate and high-quality information, advice and assistance (IAA) (MC1) by developing an unpaid carers handbook. The handbook will compliment similar resources which are on offer via national organisations and will be offered to unpaid carers (in the 1st instance) when they become unpaid carers for the first time, usually in a hospital setting).	**Hospital IAA (Reaching Carers in Hospital Settings)**: Posters and leaflets have been designed and are being printed before pilots begin in selected wards in Morriston and Neath Port Talbot Hospitals. **Handbook / FAQ Development**: Unpaid carers confirmed the need for comprehensive, centralised IAA in both physical and digital formats. This will form the core of the new handbook/FAQ resource. **Strategy Refresh**: Engagement on the vision and priorities took place at the regional event. Further engagement planned through to March 2026.
	Raise awareness of the essential role of carers across the region, including the challenges and issues facing carers today (MC3).	Annual Carers Event (18 Sept 2025): Held at Swansea.com Stadium with 151 attendees (52 unpaid carers). Feedback informed the refreshed strategy, particularly around the need for more browsing time and potential satellite events in community settings.
	Young Carers: Raise awareness of young carers and support the development of tailored strategies, ensuring access to IAA and age-appropriate support.	**Hospital IAA for Young Carers**: Digital leaflets and posters reviewed by young carers; will be distributed across 5 pilot wards (Singleton & NPT). Pilot delayed **Young Carers Event (6 November 2025)**: Focusing on school support, respite, and Carers ID cards. Information gathered will inform future actions. **Transport Challenges**: Young carers have highlighted barriers to accessing services; a paper on complexities and proposed solutions will be developed and fed back via governance. **Carers Assessment**: Review of young carers assessment pathways has begun but requires further clarification, including transitions referrals.
Future Funding for Unpaid Carers	Develop a revised approach to the current funding (commissioning model) which will be developed in line with lessons learned from the EWMH Programme: New Commissioning Workstream lessons learned.	This work is paused temporarily to allow full learning from the EWMH Programme before proceeding.

Programme	Area Plan Priority	Models of Care Supported	Programme Lead
Dementia	• Transforming Mental Health Services	• Community Based Care - Prevention and Community Coordination • Promoting good emotional health and wellbeing • Complex Care Closer to Home	Stephen Jones

Overview of the Programme

The vision for the Dementia programme is that people with dementia and their carers can access the services and support when, where and how they need it across health, social care and voluntary services. The focus of the programme is the implementation of the 20 All-Wales Dementia Standards. The All-Wales Dementia Care Pathway and Standards were published in 2021 following extensive engagement with 1800 individuals living with dementia, unpaid carers, voluntary organisations and health care professionals across Wales.

The work has been led by Improvement Cymru as part of the Dementia Care Programme and directed by the requirements of the Dementia Action Plan for Wales, overseen by the Welsh Government Dementia Oversight Implementation and Impact Group (DOIIG)

The pathway includes 20 standards that represent what people believe will make a positive difference to dementia care in Wales. The standards sit within four themes: Accessible, Responsive, Journey, Partnership & Relationships.

Workstream	Brief Description of Workstream	Progress update
Regional Strategy, Community and Connectors	• Review the feedback from the two pilot areas of the local listening campaigns carried out in 24/25. • Carry out engagement for a regional strategy that will inform the priorities for people with dementia and their carers • Produce resources on brain health and modifiable risk factors for circulation • Development of a network of organisations that support people with a Dementia diagnosis to be involved in future coproduction opportunities • Continue to pilot the role of Dementia Connector across the region to support people to make the connections into services that help with their health and wellbeing. • Continue to build links with community groups that can support individuals with a dementia diagnosis	• Additional copies of the Brain Health Booklet printed and distributed across the region. • Easy-read version of the booklet in development; plans for multi-language versions and QR code circulation to partner comms teams. • Virtual Network established with 30 organisations signed up. • National Showcase Event (initially scheduled for 12 February) postponed to April due to organiser issues. • Welsh Government consultation on the next Dementia Action Plan due for circulation before Christmas. • Regional Strategy engagement questionnaire ready for release; planning underway for regional engagement event. • SAB1 advised that Listening Campaigns are no longer yielding new insights; focus now shifting to understanding needs and implementing actions that improve experiences. • Short-term dementia grant scheme launched—ring-fenced for existing RIF-funded third sector dementia projects. Scheme focuses on providing basic training to carers/family members of PLWD in

	• Facilitate a lesson learnt exercise on the Dementia Connector pilot (March 2026)	Morriston OPAU to improve confidence and help expedite discharge. Pilot runs until 31 March 2026; applications close 8 December 2025.
Memory Assessment	• Develop a Memory Assessment Pathway and Standard Operating Procedure for all staff to follow • Work with teams to ensure people with Learning Disabilities have access to the Memory Assessment Service. • Implement a process to ensure individuals that have received a diagnosis is referred to a Dementia Connector immediately	• SAB1 approved £45,000 unallocated funding to undertake a regional review of the Memory Assessment Service; work underway to commission an external agency to revise pathway and SOP. • Swansea University collaborating with the Dementia Hwb on demand modelling for a dedicated regional MCI clinic. • Clinics involved in piloting the national Memory Assessment Toolkit. • Area 4 completed quality improvement work on post-diagnostic support, now being scaled regionally. • Ongoing response to requirements of the National Dementia Audit.
Hospital Charter	The charter will be publicised in each hospital across the region demonstrating how the health board have promoted a person-centred, rights-based approach.	• Charter roll-out progressing across Morriston, Singleton and Neath Port Talbot hospitals, including identification of ward champions. • Environmental improvements underway based on King's Fund dementia-friendly audits. • Flexible visiting times and meal choice options implemented; Welsh language documentation and bilingual staff badges in use. • Routine use of Dementia Care Mapping (DCM) continues, including expansion into acute care and care homes. • VR and AI technologies being explored with Swansea College to enhance patient experience. • Monthly dementia audits and six-monthly training audits piloted; self-assessment tool for charter compliance in development.

Programme	Area Plan Priority	Models of Care Supported	Programme Lead
Wellbeing and Learning Disability	Transforming Complex Care	• Community based care –prevention and community coordination (MC1) • Community based care – Complex Care closer to home (MC2) • Promoting good emotional health and wellbeing (MC3) • Home from Hospital (Home First) (MC5) • Accommodation Based Solutions (MC6)	Amy Hawkins

Overview of the Programme

The Wellbeing and Learning Disability Programme is one of six population boards sitting within the West Glamorgan Region and is underpinned by its recently launched five-year regional co-produced Learning Disability Strategy. The West Glamorgan Regional Partnership Board ratified the strategy on the 12th of December 2023. The Strategy is broader than RIF, with RIF enabling system change alongside supporting changes in core service delivery.

Vision Statement "In the West Glamorgan Region, people with a learning disability have the right support to make their own choices to achieve a happy, healthy life that is meaningful to them. They have opportunities to learn, work and actively contribute to their communities"

The Wellbeing and Learning Disability Programme aspires to build upon previous successes and make changes where needed to transform services, enabling people with learning disabilities to have fulfilling lives based on what matters to them. We plan to continually learn from those with learning disabilities throughout the lifetime of the strategy.

Workstream	Brief Description of Workstream	Progress Update - 22nd August – 3rd October
Transport	• Workshop coproduced held in 2024 to review what transport issues people with learning disabilities are impacted by across the region and what can be done to make transport better	• No update – work has now completed and workstream is closed
Getting the Right Care and Support	• Review the easy read information available to help people with a Learning Disability access to health and social care services • Continuation of people with a Learning Disability being fully involved in developing their care and support plans, as required under the SSWB (Act) 2014 • Work with people with learning disabilities on what support they want to receive at a community-based level, including how and when it should be provided	The Integrated Working plan-on-a-page was approved at the July Board meeting, and the work is now aligned with the Regional Commissioning Board's Pooled Funds programme. The next steps involve continuing the development of an integrated approach in partnership with the Health Board, Swansea, and Neath Port Talbot. The Easy Read Task & Finish Group held its first meeting on 2 October. The group is not yet quorate, and Health Board and NPT partners have been identified and are currently being engaged before the next meeting takes place. The group, chaired by Neil Williams, who brings lived experience, is focusing on improving accessibility and inclusion, as well as understanding the barriers faced by people with learning

	• Increase the number of people with a Learning Disability received an annual health check	disabilities and by professionals when using Easy Read materials. The next steps are to secure full partner attendance and begin mapping current Easy Read usage and identifying gaps. Further Easy Read meetings delivered in the period to progress the key outputs.
My Community	• The scope includes developing an approach to help support people who use social care support to work with others around them to maximise their wellbeing and to build capacity in the communities in which they live, helping them to be more health, social, confident, skills and valued. • It will reduce paid care as people living within supported living provision will be accessing resources and participating within their local community, rather than being passive recipients of paid care • Methodology used will be recorded to enable other supported living providers to implement the approach within their organisations	The **Supported Living and Community Capacity** work is progressing well. A working group made up of third-sector providers and Swansea officers is continuing to shape the scope of the programme, with all activity being driven by the experiences and priorities of people who use services. Three Swansea locality networks—Killay, West Cross, and Fairwood—continue to meet monthly, with 57 residents identifying their priority activities and outcomes. The **Direct Payment Cooperative, Friends United Together**, continues to receive support to manage its own support arrangements, maintaining its user-led approach and strengthening autonomy for members. In **Better Together NPT**, the main event planned for 2024 has been completed, and the team is now organising a series of Wellbeing Taster Days. These are designed to broaden participation and increase the range of community activities available to people. Next steps include finalising the methodology for wider roll-out to additional supported living providers and continuing the user-led design of community-based options.
Making my own decisions and having my say	• Ensure people with learning disabilities and their families have a meaningful voice in decisions that affect them. • Ensure involvement in the Wellbeing and Learning Disability Board by making them accessible • Development of a network of organisations that support people with Learning Disabilities to ensure future coproduction opportunities are available to access	Three **Regional Integration Fund (RIF)** projects, starting from July 2025, are now mobilising under the priority area. These include *Supporting the Delivery of Wellbeing Outcomes through Community-Based Options* in Swansea, *Community Pathways to Independence* in Neath Port Talbot, and *NEXT STEPS – From Day Services to Early Help, Prevention & Community Engagement* also in Swansea. All three projects are now aligning with the established My Community activity. Joint planning is underway to strengthen regional delivery, enhance collaboration, and maximise impact through shared learning and consistent community-based models.

		Next steps include establishing regular cross-project alignment sessions and ensuring that people with lived experience are actively involved in shaping project direction. Work will also continue to improve the accessibility of the Wellbeing and Learning Disability Board for people with learning disabilities.

Programme	Area Plan Priority	Models of Care Supported	Programme Lead
Emotional Wellbeing and Mental Health	Transforming Mental Health Services	• Community Based Care – Prevention & Community Coordination (MC1) • Promoting Good Emotional Health & Wellbeing (MC3) • Accommodation Based Solutions (MC6)	Karen Stapleton

Overview of the Programme

The Regional Emotional Wellbeing & Mental Health Programme oversees the implementation of the Regional Emotional & Mental Wellbeing Strategy which was endorsed in April 2023.

Vision Statement

To have vibrant, diverse, and individually focussed services which promote emotional and mental wellbeing, are delivered and commissioned in a dynamic and integrated way, adopting innovative models and promoting the strengths of communities to improve the lives of those in the region.

The Aims are:

- To focus and promote emotional and mental wellbeing (rather than illness)
- To enable communities to generate solutions for themselves, work from their strengths supported within a dynamic multiagency environment.
- To truly join up commissioning and provision of services to support service design around the individual not the organisation.
- To work to a common set of values and service model principles which permeate everything we do and the way that we do it.
- To underpin this with a good understanding of the need supported by granular data/information.
- To develop and deliver services which are supported by the evidence and ensure that there is a strong underpinning emphasis on research and development within the Region to add to the evidence base.

Workstream	Brief Description of Workstream	Progress to Date
Joining it Up: **Therapeutic Services Review**	This workstream focuses on strengthening prevention and early support for people with mental health needs by developing a new joint commissioning model for voluntary sector services, planned for implementation in April 2027. It aims to coproduce outcomes with people with lived experience, co-design a commissioning approach with the voluntary sector, and ensure services align with what matters to individuals. Alongside this, the workstream is exploring how psychological therapies across the NHS and third sector can be better integrated by mapping current provision, identifying gaps and duplication, and building shared understanding of pathways, governance and clinical risk. This exploratory work will inform future commissioning,	Following a pause in commissioning work during the summer, the workstream has refocused activity on evidence gathering and integration opportunities. Mapping of psychological therapy provision across NHS, third sector and cluster-based services has been completed, identifying areas of overlap, unmet need and potential for greater cohesion. Thematic analysis of information gathered from statutory and third sector partners has also been carried out to highlight key risks and opportunities for integration. A significant strand of work is underway to analyse the 3,500-person NHS psychological therapies waiting list, examining geographical and demographic patterns to understand pressure points and where community-based support could complement NHS capacity. Plans are in

	improve access, reduce waiting times and support earlier intervention through a more joined-up system.	place to provide feedback to stakeholders and begin co-producing efficiencies in the current system, including the development of new service specifications with people with lived experience and partners across sectors.
Cementing it Together: Improving Access to Services (including Comms & Engagement)	This workstream is focused on building multi-agency pathways that ensure adults and children receive timely and appropriate support at the first point of contact, aligned with the No Wrong Door model and First Contact, Right Response principles. For children and young people, upcoming work includes mapping referral pathways, establishing governance and information-sharing processes, and co-designing multi-agency panels in Swansea and Neath Port Talbot.	The SortedSupported website is widely used across the region and provides a comprehensive digital hub for adult mental health and wellbeing information. Plans are underway to expand the website to include dedicated content for unpaid carers and people with learning disabilities. The No Wrong Door model for children and young people is progressing, with a project coordinator now recruited and due to support delivery from spring 2027. The publication of the all-Wales Mental Health Strategy and the SBUHB review of mental health services will influence and reshape the adult access-to-services delivery plan, with adult pathway redesign to be negotiated through the mental health transformation programme.
Filling in the Gaps; Community Psychology	To develop and embed an evidence-based, community-led Community Psychology model across West Glamorgan that strengthens early intervention, enhances wellbeing, and reduces reliance on statutory services through psychologically informed practice.	The Community Psychology model continues to develop as a core element of the regional emotional wellbeing strategy, with an emphasis on joined-up, preventative community-based support. The business case for the City Cluster has been completed and approved at EMWB and was further approved at SAB2. Recruitment to the Community Psychologist post is underway. The Community Psychology Strategic Plan is being finalised to ensure consistency, sustainability and clear direction for regional delivery. Evaluation work is progressing, with learning shared with partners to inform both development and future commissioning. Psychologically informed, community-led interventions continue to be co-produced and embedded across clusters, responding to local needs as they emerge.
Understanding Data and Evaluation	The workstream aims to build a robust, region-wide Data Framework that brings together population-level datasets, community insights, and lived-experience feedback to create an accurate and comprehensive picture of emotional wellbeing and mental health needs across West Glamorgan. This evidence base will support stronger strategic commissioning, service	Updates to the Lived Experience Engagement Report continue to ensure citizen voice remains central to planning and commissioning. Engagement is underway to establish a Data and Insight Steering Group, which will support PNA development and regional data alignment. Community Psychology insights are being gathered to inform the regional PNA as part of wider evaluation activity. An application to the SAIL Databank has been

	redesign, and development of the 2027 Population Needs Assessment. Work includes aligning data across partners through a new Data and Insight Steering Group, improving digital mapping, and exploring opportunities to link datasets via the SAIL Databank to reduce duplication and enhance shared understanding over time.	prepared, with meetings taking place to discuss access requirements and costs. Embedded PhD research supervised by the workstream lead is ongoing, contributing to evaluation of the Community Psychology model, informing service development and supporting the development of the Population Needs Assessment. A funding application for an additional PhD researcher has also been developed with Swansea University and partners.

Programme	Area Plan Priority	Models of Care Supported	Programme Lead
Children and Young People	Transform complex care	• MC1: Community Based Care – Prevention and Community Coordination • MC 3: Promoting good emotional health and well-being • MC 4: Supporting families to stay together safely, and therapeutic support for care experienced children • MC 6: Accommodation Based Solutions	Keri Warren

Overview of the Programme

Our vision as outlined in the Business Case from 2022 for this programme is that West Glamorgan will support children and young people to be safe, healthy and prosperous.

The Children and Young People [CYP] Programme covers the services and support for people who are under the age of 18 (supporting children and young people to 25 with Additional Learning Needs-ALN). This programme focuses on:

- Emotional wellbeing of children and young people including behavioural support.
- Children and young people who require specialist support from health and social care, such as children who are looked after or at risk of being looked after by the local authority and children and young people with complex needs such as mental health conditions, learning disabilities or illness.
- Supporting children and young people who receive services and support as they transition into adulthood, where they may receive a different type of service as an adult.

To achieve this, we will need to work closely with CYP, their carers, their families, local communities and other important stakeholders such as Education in order to hear the 'voice of the child' and understand their rights/needs and what matters to them, in order to co-produce services and support that will meet those needs.

An underlying principle of this work is to follow a 'whole systems approach' to change across health and social care services for children and young people (covering statutory and voluntary sectors).

Workstream	**Brief Description of Workstream**	**Progress to date:** September 2025
CYP Emotional Well Being and Mental health	Improve access to **Emotional Wellbeing and Mental Health support** for children and young people including behavioural support through the development of a multi-sector multi-disciplined single point of entry/access for CYP emotional health and wellbeing to implement a No Wrong Door approach.	**No Wrong Door:** Project manager due to commence post March 16th. Meeting of 'Delivery Group' held 4/2/2026 to ensure preparations by partner leads for onboarding in place.
	Implement Welsh Government NYTH/NEST framework NEST framework (mental health and wellbeing) | GOV.WALES .	Feedback to West Glam self assessment received from National lead-positive feedback on delivering whole system approach implementing the framework in practice across the

	Undertake a review of the tidy.minds website	region. This progress celebrated in the West Glam Journal. NEST/NYTH Gets National Attention in West Glam! - West Glamorgan Regional Partnership Presented at the national NYTH/NEST Community of Practice of how the region is supporting young carers as part of whole system support for emotional wellbeing and mental health. Examples of NEST in action requested for national resources. Ongoing – A joint Sorted Supported and tidyMinds steering group developing content.
Transition from Child to adult services (CYP Complex Care).	Further develop regional approach to Transition (from Child to adult services, CYP Complex Care) by implementing the Regional Principles and Standards developed 2024. Develop guidance for children, young people and professionals across the region to raise awareness of multi-agency transition process.	Workshop held 26/9/25 focused on barriers and solutions related to the transition of children and young people with complex needs from child to adult services. Conversations highlighted challenges in education, service coordination, communication, and governance, and proposed multi-agency collaboration and integrated planning as key approach to improve outcomes. Meeting held 10/2/26 with key leads to follow up from workshop on areas to prioritise, agreed that this work feeds into the wider 'Strengthening of Multi-Agency Panels and Pathways' and to include CYP with complex ALN who would require multi agency support.
CYP Accommodation	Develop and deliver new regional and local accommodation models for safe, secure accommodation and wrap around support for Children and Young People with complex needs, with a focus on prevention and early intervention. (MC 3, 6)	Meeting scheduled for March 6th to consider priority area for a joint regional response to accommodation for: • Learning Disability with behaviours that challenge • Acknowledged there is a need Joint regional response to accommodation (by all agencies within the RPB structures) in the community, specifically below the "Hillside" type provision. Digital story created showcasing the RIF funded Post Adoptive Children and Families project. Article to be included in the National RPB newsletter.
Children's Services Review	Focused on strengthening multi agency complex needs panels for CYP to ensure that they function effectively and efficiently. The review aims to tighten how these panels operate, this involves improving early communication, ensuring the right people are present at meetings, and having decision-makers or those who can quickly escalate decisions involved to avoid delays,	Meeting held 12/2/26 to review draft for Multi agency working-Regional Response to Children and Young People with Complex Needs. Highlighted confusion between Children Looked after and Children's Continuing Care processes. All partners are in review of the current draft regional 'Standard Operating Procedure for children looked after. Further face to face meeting to be scheduled shortly to finalise.

	especially in crisis situations. The goal is to strengthen governance and expedite decision-making processes to provide timely and appropriate care.	
CYP Participation and Engagement	'Working together to include the voices of Children and Young People across West Glamorgan Regional Programmes'**:** undertake engagement with children, young people, parents and carers on the priorities of Children and Young People Programme will ensure the voices of Children and Young People, Parents, Carers, Families, guardians and others are considered and heard (MC 3)	Engagement completed during Children's Mental Health week.
Prevention and early intervention	Review and improve models of care that wrap around families to keep families together. (MC4) Continue to identify and implement transformative prevention and early intervention services (MC1, 3, 4)	Promotion of RIF projects continue and ongoing workshops/networking and gathering evidence of implementation to inform practice.

Programme	Area Plan Priority	Models of Care Supported	Programme Lead
Neurodiverse Programme	Transform complex care	• Community Based Care – Prevention and Community Coordination (MC1) • Community Based Care – Complex Care Closer to Home (MC2) • Promoting Good Health and Wellbeing (MC3)	Julie Davies

Overview of the Programme

The Neurodiverse Programme (ND) has been established to ensure that people with neurodevelopmental disorders have access to the services and support they need to participate fully within their communities and live fulfilled lives regardless of an assessment or diagnosis.

Partners have agreed to develop a co-produced Neurodiverse Strategy which is focussed on the needs of people (including children and young people) with ND regardless of assessment.

The strategy development will take a needs-led, person centred approach to supporting individuals (including families) who are neurodiverse in our communities to live their best lives. This will include:

- a system shift towards building community resources.
- implementing an inclusive approach to neurodiversity.
- focus on a need led approach which is not based on an assessment or confirmed diagnosis.

Workstream	Brief Description of Workstream	Progress to Date
Neurodiverse	Implementation of Welsh Governments Autism Code of Practice	Full National report: Evaluation of the Code of Practice on the Delivery of Autism Services | GOV.WALES Awaiting further national steer on expansion to ND Code of Practice.
	Coproduce, develop a plan and implement a programme that Increases opportunities for neurodiverse individuals to be involved in their local community (MC3)	No Update
	Review and develop local groups that support social interaction for neurodiverse individuals	No Update
	Develop and enhance the availability of preventative services that would enable autistic people in their daily lives (MC1)	
	Codesign and develop a regional Neurodiverse Strategy with people with lived experience.	A joint meeting of the ND Board and Strategy Development group 20/1/26 discussed how to ‘Respond and Improve the System’, looking at the statements of lived experience

		feedback and consider what is 'within our gift' to guide strategic direction over the next 12 months. The ND Board will meet 26/2/26 to endorse interim priorities: • Clarify and Improve 'Diagnostic/Assessment' Pathways • Access to clear, accurate, transparent, quality assured information
	Establish ND Liaison Network to ensure the work of the region is co-produced (enabler) (MC3)	Not yet started.
	Refined information management to strategically support demand and capacity modelling (Enabling Digital Programme)	Routinely review at ND Board waiting lists for Children's ND Services, Integrated Autism Service and Adult ADHD.

Programme	Area Plan Priority	Models of Care Supported	Programme Lead
Regional Commissioning Programme	Transform complex care	All	Marie Davies

Overview of the Programme

The programme has been designed to develop a partnership-led approach to commissioning across MH/LD, older adults and children's services. The purpose of the programme is to:

- Improve outcomes for citizens with complex needs
- Develop consistent, region-wide commissioning processes
- Strengthen partnership working

All population cohorts receiving a commissioned package of care will be included in this work prioritised in 3 stages:

1. Mental Health/Learning Disabilities
2. Older Adults
3. Children and Young People

Workstream	Brief Description of Workstream	Progress to Date
Joint Working Workstream (MH/LD)	Development of a joint working protocol to support and enable joint working between partners (LA and Health) in learning disability and mental health teams. It will include: • Inter-agency dispute policy • Joint funding split • CHC (Continuing Healthcare) process for partners to follow • Joint funding arrangements and process • Regional brokerage and monitoring of packages of care • DST tracker monitored at a regional level	The workstream has been in place since November 2025 and has made steady progress. Initial activity has focused on developing a shared Continuing Healthcare (CHC) process to ensure all partners are operating consistently and in line with national guidance. The Board has endorsed a pilot of a Joint Funding Matrix (JFM). The JFM is intended for use in cases where joint funding is required following a Decision Support Tool (DST) outcome confirming no primary health need. It is not designed to replace the CHC assessment process and will not be used to review CHC eligibility. Instead, the tool will support partners to determine appropriate funding apportionment in agreed joint-funded cases. Preparatory work is currently underway to identify suitable pilot cases and to develop an operational guide to support practitioners in applying the JFM in practice.

Commissioning Specification & Accommodation Plan (MH/LD)	Define service models, capacity/demand and market approach to delivery of accommodation services for people with Learning Disabilities/complex needs and Mental Health. Priorities include: • Closer to home (repatriation) • Specialist MH/Dementia nursing provision • Expansion of shared lives • Cross boundary voids and matching • Expansion of shared lives project	The workstream has been operating since November 2025; however, the Board has not yet agreed its formal priorities. While several potential areas of focus have been identified as possible early 'quick wins', a collective decision on the definitive scope and direction of the workstream remains outstanding. These discussions will be progressed through upcoming Regional Commissioning Programme Board meetings, where agreement on priorities and next steps will be sought.
Market Stability Report	A Market Stability Report (MSR) in Wales is a strategic assessment of the social care market, required by the Social Services and Well-being (Wales) Act 2014. It evaluates whether the care and support market in a specific region can meet current and projected needs, assessing both the stability and sustainability of services like care homes and home care. These reports help local authorities and health boards plan and commission services by identifying gaps and risks, and they include an analysis of current supply, future demand, and potential issues. Reports are required every five years, the next report is due in 2027	Agreement has now been reached on a standardised template for use across all partners, alongside a shared set of data requirements and agreed quality metrics to ensure consistency in reporting and evaluation. In addition, a provider questionnaire has been developed to support more detailed insight and to strengthen future analysis. The first data-gathering exercise, covering the period from April to September, has been completed. This initial collection was undertaken to test the suitability and robustness of the proposed data sets, and the regional team is currently awaiting feedback from partners to inform any necessary refinements. Next steps remain dependent on further direction from the National Task & Finish Groups. Once this guidance is received, formal data collection is expected to commence in April 2026, enabling the region to move into a more structured and consistent reporting phase.