Older People

Regional Priority / Outcome as identified in the Population Needs Assessment:

- **To support older people to live, or return following a period of hospitalisation, to their own homes and communities through early intervention, integrated care models and a whole system approach.**
- **To improve emotional well-being for older people by reducing loneliness and social isolation through earlier intervention and building community resilience.**
- **To mitigate the long-term impact of Covid-19 pandemic through, especially reducing waiting lists and times to access support, appointments, and medical procedures.**

HOW WILL WE MEASURE SUCCESS? Our Population level indicators.

		
Increase early intervention support and inclusion opportunities, to reduce loneliness and isolation	**Reduce Delayed Transfers of Care through improved integrated working.**	**Increase wellbeing through access to the right support at the right time to reduce crisis referrals.**

The regional Gwent Adult Strategic Partnership will develop, co-ordinate and monitor delivery of this plan on behalf of the Regional Partnership Board. A market position summary was undertaken as part of the Population Needs Assessment and actions below have been agreed

1. Increase early intervention support and inclusion opportunities, to reduce loneliness and isolation.
2. Reduce Delayed Transfers of Care, through improved integrated working.
3. Increase wellbeing through access to the right support at the right time to reduce crisis referrals.

(WHAT we are doing) **Action**	**(WHO)** **Partner Agencies**	**(HOW)** **will we deliver**	**(WHEN)** **Timescales/ Milestones**	**Progress Measures** ***How much and how well have we delivered?*** ***What is the difference made?***
Ensure that the Home First ethos is always reinforced, if a person requires hospital admission	Gwent Adult Strategic Partnership	• Preventative Measures (Clinical Futures Level 3 and 4) e.g., home first, Care Closer to Home. • Integrate Frailty into community services. • Define and agree what Discharge to Recover then Assess Medel (Wales) (D2RA) means for Gwent. • Support Winter Planning arrangements.	Monthly	• Home First measures to be included, setting out clearly how many people supported, how well service delivered, and the difference made.
Oversee regional delivery of Frailty Service, in helping to address the needs of the ageing population by providing preventative support and early intervention	Gwent Adult Strategic Partnership	• Frailty Service leads from each LA area to report as standing item setting out progress. • The Gwent Adult Strategic Partnership are developing an integrated 'place-based' approach to supporting people by reconfiguring existing services to strengthen community resources. • Redesign of Older People's Pathway.	Monthly	• Individual Frailty measures set out in service specification. • Relevant measures to be included, setting out clearly, how many people supported, how well service was delivered and difference made. • Regular reporting to GASP.

Maximise the use of Assistive Technology	• Gwent Adult Strategic Partnership • HHSC Partnership • Dementia Board	• Continue to support the roll out of assistive technology across health and social care and identify good practice (in relation to Dementia 'magic tables' • Explore regional opportunities to develop Telecare services		• Improved independence. • Improved emotional and/or physical wellbeing.
Covid Recovery planning	• Gwent Adult Strategic Partnership	• Ensuring learning is shared about public service systems to support future planning. • Ensuring individuals and professionals are aware of the Long COVID pathways • Monitor care home outbreaks.	Monthly	• Shared learning and increased planning.
Integrated Wellbeing Network (IWN) Development to support older people including those at risk of loneliness and isolation	Integrates Service Partnership Boards	• Assess and identify good practice in Community connector roles. • Ensure accurate information and advice available through	Quarterly updates	• Increase number of engagements and community interactions as part of age friendly communities. • Designed measures to be included setting out

		effective IAA, Dewis, public awareness campaigns. • Support and build community resilience and grow social networks, tapping into sources of support in the community. • Review health and wellbeing hubs and identify effective hub coordination. • Explore volunteering solutions and links to schools to promote Age Friendly Communities. • Promote and extend regional Ffrind I Mi volunteering scheme.		clearly how many people supported, how well the service was delivered, and the difference made.
Oversee and monitor delivery of Regional Integrated Funding delivery models of care and capital spend	Gwent Adult Strategic Partnership	• The Partnership will oversee and review progress of all RIF funded projects through a standing item update at each meeting. • A complete list of related projects will be shared with members to determine the schedule of meeting/presentations • Projects will use a standard PowerPoint presentation setting out objectives, progress,	Standing item, each meeting	• Support delivery of national Models of Care and monitor effectiveness of projects.

		barriers, and next steps, in delivering against the Area Plan • Following the presentation, the Chair with partners will update a risk register for the Chair to update Leadership group and share a partnership report card. • The Chair will include an overview of RIF delivery as part of annual presentation to RPB.		
Review other local, regional and national plans to identify areas of collaboration and alignment of resources.	ISPB NCN LAs ABUHB PSB	Review and identify areas of collaboration • ABUHB IMTP • ISPB, NCN • Local Authority Corporate Improvement Plans • PSB regional Wellbeing Plan and delivery Marmot principles Identify how work contributes and deliver National Outcome Framework	Quarterly	Maximise resources Single work programmes Identify opportunities for joint commissioning