Llywodraeth Cymru
Welsh Government

Towards an Integrated Community Care System

A joint position statement for the Housing with Care Fund, the Integration and Rebalancing Capital Fund and the Regional Integration Fund

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Foreword

As Ministerial colleagues we are pleased and proud to present this position statement which illustrates the collaborative, whole system approach being taken to investing in, and transforming our health and care system in Wales.

Totalling over a quarter of a billion pounds annually, the strategic investment of the Housing with Care Fund (HCF), the Integration and Rebalancing Capital Fund (IRCF) and the Health and Social Care Regional Integration Fund (RIF) is enabling good progress towards realising our ambition for an Integrated Community Care System (ICCS) for Wales.

While this position statement specifically focuses on these three major funds, we recognise that there are other programmes of work that are also helping us to realise our ambition including the Urgent and Emergency Care Six Goals programme, the Strategic Primary Care Programmes and the Social Prescribing Framework, whose contributions will be integral to establishing and delivering the ICCS.

The fundamental principles underpinning the ICCS are a preventative approach to population health and wellbeing and delivery of seamless health and care support, at or as close to home as possible when needed. Its aim is to help people and communities maintain and manage their own health and wellbeing, and achieve what matters to them, living as independently as possible in the community.

The alignment of the Housing with Care Fund, the Integration and Rebalancing Capital Fund and the Health and Social Care Regional Integration Fund, is crucial to its development, ensuring we can invest in both health and care services and estates to offer effective care and support in the community.

Collectively we would like to recognise and thank the seven Regional Partnership Boards (RPBs) across Wales, and their delivery partners, who are playing a key role in leading the transformation required to realise our ambition of an ICCS for Wales. The RPBs are overseeing the investment of the funding described in this position statement and are playing a fundamental role in helping us to learn what works for people and communities, in turn helping us to shape and design the six national models of integrated care that are part of our ICCS.

However, we also recognise that working in partnership and adopting new and different ways of working can often be challenging, especially in the current financial climate. In a time when our health and care system is significantly challenged by increasing demand and complexity of care needed, we must work even closer together as partners, maximising resources and expertise to deliver better health and wellbeing outcomes for our population, right from pre-birth through to older age.

Looking ahead to the next year of the fund we will be working closely with RPBs and our statutory delivery partners to ensure local and regional good practice is shared, scaled and transferred across Wales to help us build a more consistent community care offer for our population.

Our aim is that the people of Wales, wherever they live, can be assured of equitable access to an effective and seamless community care service experience.

We also recognise the need to ensure we are doing the very best we can to support our dedicated front-line workers by simplifying and joining up processes and procedures across organisational boundaries, helping them to work better together and supporting people in the community more holistically.

Collectively we acknowledge strong progress to date set out in this position statement, but we are also clear that we are entering a new phase where additional focus and effort will be needed to push further on both partnership working and integrated service delivery to transform our system and realise the ambition of an Integrated Community Care System for Wales.

Jeremy Miles MS
Cabinet Secretary for Health and Social Care

Jayne Bryant MS
Cabinet Secretary for Housing and Local Government

Dawn Bowden MS
Minister for Children and Social Care

Sarah Murphy MS
Minister for Mental Health and Wellbeing

Creating an Integrated Community Care System for Wales (ICCS)

Contextually, *'A Healthier Wales'*; the Welsh Government's long-term plan for health and social care, sets out a vision for a whole system approach to delivering health and care services for the people of Wales. It sought to increase value by aligning funding streams more closely around shared objectives; to assist people to stay well at home and prevent the need for admission to hospital, or to return home quickly if they have required a hospital stay.

A key focus was to look to develop new models of delivery for the priority population groups[1] set out in the Social Services and Well-being Act.

Over the first two years of the funds covered in this statement, essential learning and development has led us to the position of being able to articulate our 'blueprint' for an Integrated Community Care System for Wales (see Figure 1). This blueprint shows how the ICCS is designed to help people achieve **'what matters'** to them and aims to build a joined up seamless care and support offer for people that will enable them to:

- Achieve good health and wellbeing.
- Prevent escalation of need.
- Live well at home as independently as possible.
- Access joined up care and support services closer to home.
- Avoid unnecessary admission into hospital.
- Return home from hospital safely and swiftly if they require secondary care.

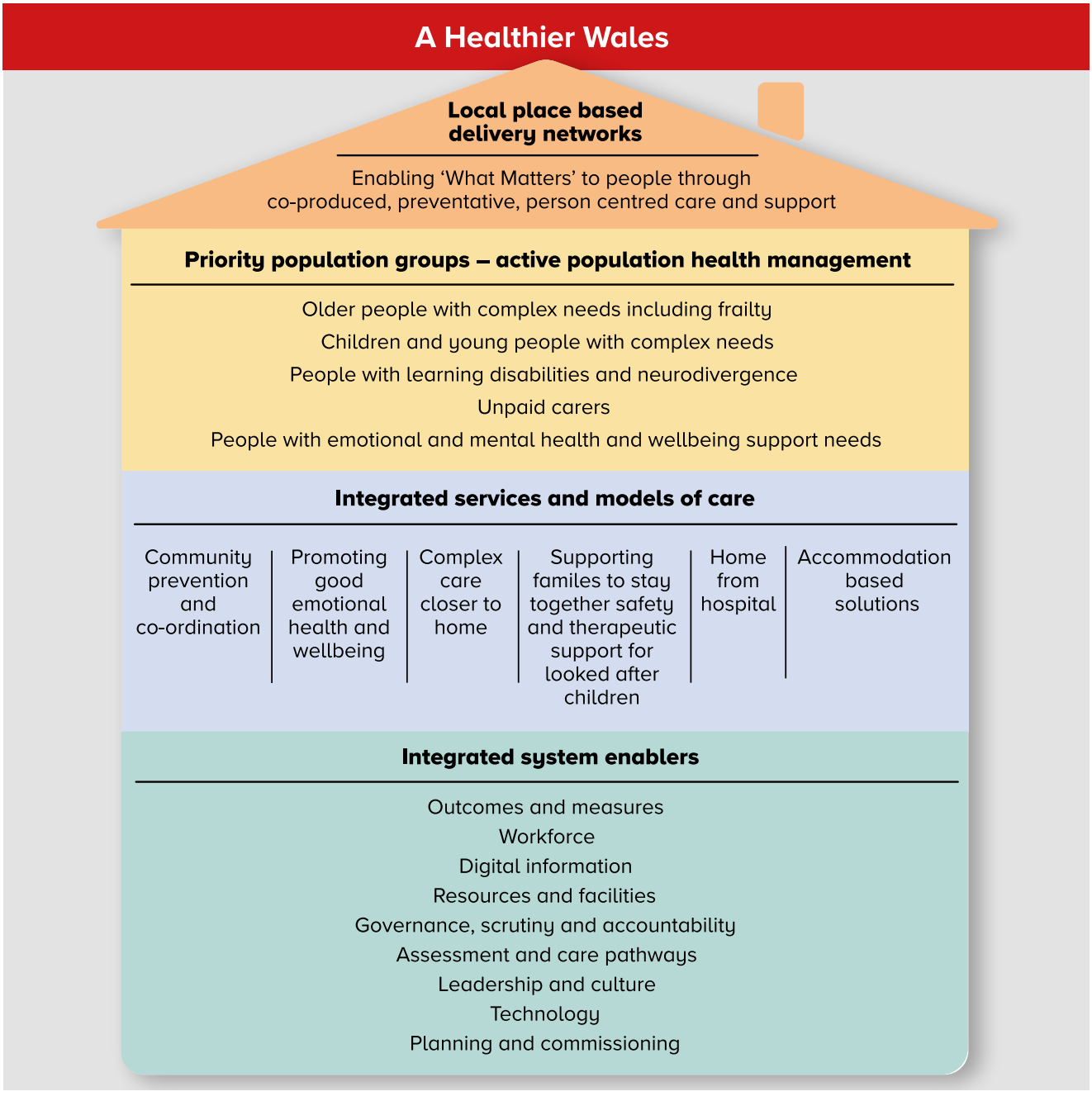
The blueprint describes a whole system approach to providing seamless health and care services outside of hospital and identifies the key enablers (see green section of the blueprint) that need to be developed to support effective, seamless and integrated systems including:

- Shared outcomes and measurement frameworks.
- A skilled and enabled workforce to work across organisational boundaries.
- Robust, reliable and shared digital information.
- Clear governance, scrutiny and accountability arrangements to support integrated service delivery.
- Joined up assessment and care pathways.
- Shared resources and facilities, including pooled budgets.

1 Older people, including people with dementia, children and young people with complex needs, people with learning disabilities and neurodevelopmental conditions, unpaid carers, people with emotional and mental health well-being needs.

- Effective leadership and organisational culture to support collaborative and integrated working. Making best use of technology to support self-care-and helping people to live well at home.
- Joined up planning and commissioning of health and care services.

Figure 1: Emerging Integrated Community Care System Blueprint for Wales



The initial phase of implementation will focus on building a system that is attuned to the specific needs of older people with complex needs and frailty, although ongoing work will also reflect the needs of other priority population groups (see yellow section of the blueprint).

A Welsh Government cross-sector Leadership Group has been established to oversee the more detailed design and implementation of the ICCS 'blueprint'.

Importantly, it will seek to align investment and delivery from across a wide range of existing programmes and initiatives, including the three integration funds (HCF, IRCF and RIF), the Urgent and Emergency Care Six Goals Programme, and the Strategic Primary Care Programme.

Alignment of these funds and programmes provides an opportunity to review and consolidate a complex and dynamic policy and programme landscape.

Regional Partnership Boards and Pan Cluster Planning Groups will have a key role to play in helping to shape the continual development of the ICCS and in ensuring that delivery is responsive to local needs and conditions.

It is crucial that all partners continue to develop and strengthen regional and local partnership arrangements to maximise their impact and effectiveness.

The recently revised Part 9 Statutory Guidance on Partnership Working, which will come into force at the end of 2024, will more clearly articulate the focus on building an Integrated Community Care System and the relationship between the RPBs, and Pan Cluster Planning Groups in achieving this.

Background to the three funding programmes

With a combined annual value of over £276m, the RIF, IRCF and HCF are making a significant investment to support the development and delivery of local and regional integrated community care services. Through these programmes a range of both revenue and capital funding is being targeted towards the development of six national models of integrated care that will provide seamless health and social care for people in communities across Wales.

Housing with Care Fund (2022 – 2025)

The Housing with Care Fund – £60.5 million in 2024-25 – is aimed at enabling the provision of supported housing and accommodation for vulnerable people in society with care and support needs.

The primary objective of the HCF capital grant is to provide financial support to continue developing and / or purchasing properties for people with care and support needs to live independently in their communities.

The fund also includes capital investment to support the development of children's residential care facilities.

The fund has three key objectives which are:

- **Objective 1:** long term tenured housing with care, such as extra care and supported living for adults with a learning disability.
- **Objective 2:** short and medium-term settings, such as step up / step down, rehabilitation settings in the community, transitional accommodation for young people leaving care, and residential care for children with complex needs.
- **Objective 3:** minor projects that meet the HCF aims.

To date 104 schemes have been funded totally, a spend of £72m.

Integration and Rebalancing Capital Fund (2022 – 2027)

The Integrated Health and Social Care Hubs (IHSCH) Programme was established to deliver the Programme for Government (PfG) commitments to 'invest in a new generation of integrated health and social care centres across Wales' and 'Develop more than 50 local community hubs to co-locate front-line health and social care and other services.'

The programme includes a £70m a year capital funding programme delivered via the Health and Social Care Integration and Rebalancing Capital Fund (IRCF) established to directly support the PfG commitments.

The Fund has three key priorities which are:

a) a coherent approach to planning the co-location and integration of health and social care services within the community

b) the rebalancing of adult residential care provision by increasing delivery from within the not-for-profit sector

c) supporting the elimination of profit from the provision of children's residential care.

To date, 25 projects have been approved for IRCF capital funding totalling just over £92m.

Regional Integration Fund (2022 – 2027)

The Health and Social Care Regional Integration Fund (RIF) is a 5-year fund making £146.2 million available annually to support delivery of a programme of change from April 2022 to March 2027.

The RIF builds on the learning and progress made under the previous Integrated Care Fund (ICF) and Transformation Fund (TF) and will seek to create sustainable system change through the development of six national integrated models of care.

Key features and values of the fund include:

- A strong focus on prevention and early intervention.
- Developing and embedding national models of integrated care.
- Actively sharing learning across Wales through Communities of Practice.
- Sustainable long-term resourcing to embed and mainstream new models of care.
- Creation of long-term pooled fund arrangements.
- Consistent investment in regional planning and partnership infrastructure.

Investment through the Regional Integration Fund has already begun to identify and embed some of the key components / services within each model of care.

Housing with Care Fund (HCF) Overview and Spotlights

Housing with Care Fund (HCF)[i]

The primary objective of the Housing with Care Fund (HCF) is to increase the stock of housing to meet the needs of people with care and support needs.

The HCF is a preventative programme, building on the previous Integrated Care Fund (ICF) capital programme and underpins the Programme for Government Commitment (PfG) to 'support innovative housing to meet care needs.'

The programme contributes to the commitment to 'fund regional residential services for children with complex needs ensuring their needs are met as close to home as possible and in Wales wherever practicable' and also contributes to the PfG commitment under the same theme to 'Eliminate private profit from the care of children looked after'.

Finally, in producing new homes, HCF programme activity also contributes to delivering the PfG commitment to deliver 20,000 new low carbon homes for social rent during the 2021-2026 Senedd term.

The purpose of the HCF is to support independent living in the community for people with care and support needs, and to provide intermediate care settings in the community so that people who need care, support and rehabilitation can return to living independently or maintain their existing independence.

As well as larger strategic projects, HCF capital investment is also being used to provide specialised equipment such as assisted technology and aids and adaptations for people's homes. These are all critical in reducing unnecessary hospital admissions, inappropriate admissions to residential care, and delayed transfers of care.

Priorities for Investment

The three-year HCF programme budget has been in place since 2022-23 with £60.5m available per annum. A further year of indicative funding for 2025-26 is also expected. Priority Groups include:

- older people, including people with dementia
- children and young people with complex needs
- people with learning disabilities, neuro-diverse and neurodevelopmental conditions
- unpaid carers
- people with emotional health and mental well-being needs.

HCF delivers three types of accommodation:

- **Objective 1:**
  Long term tenured housing with care, such as extra care and supported living for adults with a learning disability. These schemes may be funded entirely from HCF or through a blend of HCF funding and Social Housing Grant.

- **Objective 2:**
  Short and medium-term settings, such as step up / step down, rehabilitation settings in the community, transitional accommodation for young people leaving care, and residential care for children with complex needs.
- **Objective 3:**
  Minor projects that meet the HCF aims. RPBs are responsible for determining how to allocate the discretionary funding for minor projects in their region.

Progress to Date

Tables 1 and 2 provide an overview of spend by client group and project type for the HCF programme over the past two financial years[2], and demonstrate an increase in spend as the programme has bedded in. Underspend over the past two financial years has largely been attributed to the lead times involved between a project's conception and commencement of works on the ground, and various resourcing issues experienced by regional teams and delivery partners. HCF has provided a level of programme resource funding at a regional level, which several regions are utilising. This has helped with the delivery of projects and will continue to do so during 2024-25.

Table 1: First Priority Group

Investment by First Priority Group	2022/23		2023/24	
	Projects	£	Projects	£
Children and Young people with complex needs	20	£7,250,611	35	£12,212,522
Older people including people with dementia	5	£5,469,028	6	£9,243,013
People with emotional health and mental well-being needs	3	£1,548,756	4	£1,769,416
People with learning disabilities, neurodiverse and neurodevelopmental conditions	15	£7,243,322	22	£6,762,555
Unpaid carers	0	0	1	£48,000
Other	0	0	2	£1,884,756
Objective 3	-	£8,547,356	-	£8,594,760
Total	**43**	**£30,059,073**	**70**	£40,515,022

2 Projects which benefit from HCF may do so over multiple years. Some projects funded in 2022–2023 and 2023–2024 may also receive additional funding in other financial years.

Table 2: Project Type

Investment per Project Type	2022/23		2023/24	
	Projects	£	Projects	£
Extra care	2	£5,090,208	4	£8,234,627
Children's Home	4	£1,443,030	3	£1,284,247
Children's Residential	17	£7,011,478	27	£10,833,925
Intermediate care	1	£87,000	2	£360,184
Other	5	£653,631	3	£896,853
Supported Living	14	£7,244,370	31	£10,310,425
Objective 3	-	£8,547,356	-	£8,594,760
Total	**43**	**£30,059,073**	**70**	£40, 515 021

Joined up working

Alongside HCF, the Integration and Rebalancing Capital Fund (IRCF) programme supports the development of community hubs and rebalancing of the residential care sector. The two funds are complementary and are supported by Regional Integration Fund (RIF) revenue funding to support new models of preventative care.

Together the two capital funds and the revenue fund represent a significant increase in funding to accelerate the move towards independent living and care closer to home, as set out in A Healthier Wales.

Looking forward

Since its inception, the annual commitments made through the HCF programme have increased, with an anticipation that the pipeline of schemes for the current financial year will lead to the most successful year yet.

The HCF team will continue to engage with the Regional Partnership Boards and partners to facilitate the delivery of accommodation-based solutions to meet the needs of the population of Wales.

The funding will continue to be invested in housing designed to ensure people with care and support needs can continue to live independently in a home which meets their needs whilst allowing them to maintain their independence.

CASE STUDY

Region: **Gwent**

Project: **Severn View Park Care Home – Crick Road**

The home is an Innovative care home that specialises in dementia care (long-term and short-term care) and rehabilitation.

The home's design is based on four households with the aim to reflect as closely as possible a domestic homelike feel.

There are four residences, each housing eight residents, and a care delivery model that is based on household relationships.

The residences are centred around a village hall, with surrounding gardens and allotments.

£5.6m of financial support has been provided by the Welsh Government, through ICF and the Housing with Care Fund. The project opened its doors in July 2024.

CASE STUDY

Region: **North Wales**

Project: **Bwthyn y Ddôl**

This is a partnership project between Conwy County Borough Council, Denbighshire County Council and Betsi Cadwaladr University Health Board (BCUHB).

Bwthyn y Ddol is a residential assessment and support centre for children with complex needs and their families.

The purpose-built facility will be a flagship sub-regional scheme. Located in Colwyn Bay it is a truly innovative approach to the care of children with complex needs.

The build includes a dedicated assessment unit, space for therapies and care, alongside accommodation for planned stays.

£4.8m of financial support has been provided by the Welsh Government's Integrated Care Fund (ICF) and Housing with Care Fund (HCF). The project is due to open its doors in Autumn 2024.

CASE STUDY

Region: **Cardiff & Vale**

Project: **Addison House**

Addison House Community Living Scheme offers tailored accommodation to support older adults to maintain their independence now and in the future.

Designed to be 'care ready', the scheme enables residents to receive personalised care in their own homes supported by a dedicated Community Living team who work closely with residents to ensure they feel comfortable, stronger, and more self-assured; and remain as independent as possible in their own homes.

Communal areas foster social engagement and access to health and wellbeing services, ensuring a holistic approach to care.

£4.3m of financial support has been provided by the Welsh Government's Housing Care Fund (HCF). The project opened its doors in January 2024.

Integrated Rebalancing Care Fund (IRCF) Overview and Spotlights

Integration and Rebalancing Capital Fund (IRCF)

The Integrated Health and Social Care Hubs (IHSCH) Programme was established to deliver the Programme for Government (PfG) commitments to *'Invest in a new generation of integrated health and social care centres across Wales'* and *'Develop more than 50 local community hubs to co-locate front-line health and social care and other services'*.

The IHSCH programme covers a wide range of activities including the development and implementation of a capital funding programme delivered via the Health and Social Care Integration and Rebalancing Capital Fund (IRCF) established to directly support the PfG commitments and has three priority programme areas:

1. a coherent approach to planning the co-location and integration of health and social care services within the community across Wales
2. the rebalancing of adult residential care provision by increasing delivery from within the not-for-profit sector
3. support the elimination of profit from the provision of children's residential care (incentives to support a change of business model in children's residential care towards a not-for-profit model).

Regional Partnership Boards have been identified as critical vehicles to lead the development of a joined-up approach to planning health, social care and housing capital investment to enable seamless service delivery closer to home; and manage use of the IRCF fund across Wales. Each RPB has developed a 10-year Strategic Capital Plan which also sets out a list of prioritised health and social care projects forecasting the necessity of IRCF investment over a short to medium-term time frame.

The three-year IRCF programme budget has been in place since 2022/23, and an additional two-years of capital funding has been ring-fenced to support the IRCF programme up to March 2027.

Alongside this Capital funding, Welsh Government has made specific revenue funds available for RPBs to aid programme delivery:

- Resource for RPBs to enable partners across sectors to work together to develop and implement a 10-year Integrated health and social care Strategic capital plan (£200,000 per RPB per annum for 3 years).
- Co-ordinate and facilitate the development of seamless, integrated delivery of services through health and social care hubs intended to support the change in systems, processes, cultures, and behaviours to ensure hubs are more than buildings containing co-located services (£500,000 per RPB per annum for 2 years and £250,000 in year 3).

Progress

At date of publication, 25 schemes across Wales have been awarded funding up to a total of £92 million through IRCF.

In terms of the 3 priority areas, 20 have a link to the integrated hubs with 5 schemes in terms of rebalancing the adult residential care provision. Although no schemes have been received under IRCF to support the elimination of profit from the provision of children's residential care, schemes have been funded through the Housing with Care Fund.

The IRCF process is based around the five-case business model with projects submitted subject to a multi staged application and approval process; the number of stages is determined by the scale and risks of the project. IRCF funding covers a mix of proposals from small scale refurbishments, bringing buildings back into use and larger scale new build health and social care hubs.

Defining Hubs

It is recognised that there are many 'hubs' in existence in Wales, with no two being the same. Some offer direct health and social care support services while others offer a wider range of wellbeing related support, but not health and social care specific.

All of these hub types are valuable and play a key part in our wider wellbeing eco-system. However, for the purposes of the IRCF, a definition was needed to clarify the types of Hubs eligible for investment. Through engagement with RPBs, the Community of Practice and Welsh Government officials, a definition of 'hub types' was created to articulate a spectrum of hubs ranging from A-E, as shown in the diagram below.

Over the course of the programme to date, there has been a wide range of applications received from large complex investments, requiring outline and full business cases (OBC / FBC) to smaller lower value schemes (both new build and refurbishment) based on a business justification case (BJC).

The integrated nature of the schemes approved highlight the reach of the schemes in terms of health, social care and well-being.

All schemes are based on being multi-agency developments with a lead organisation and are at varying stages of development with significant builds to date including 19 Hill Development, Newport, Croes Atti Residential Care Home in Flintshire and Carmarthen Hwb in West Wales. Schemes such as Rhiwbina Health and Wellbeing Hub and Amlwch Intergenerational Community Wellbeing Hub are already making a difference in terms of providing people with easy and seamless access to a wider range of health, social care and wellbeing services closer to their home.

The IRCF will continue to engage through the RPBs to facilitate cross-sector strategic planning in relation to capital investment, building on the 10-year integrated health and social care strategic capital plans collaborating with health, social care, housing, third sector, education and regeneration partners to develop integrated service delivery facilities and integrated accommodation-based solutions.

Integrated Health and Social Care Hubs

- It is recognised that there are a wide range of Hubs in operation across Wales and all play a valuable role in supporting peoples well-being.
- For a Hub to be eligible for IRCF the greatest part of It's service offer must be health and Social Care related. Type A hubs are important but outside the scope of IRCF.
- Hub types B to D indicate a graduated range of Integrated Community Health and Social Care Hubs which may be considered for funding through IRCF.
- Hub types are intended to be cumulative i.e. a Type D Health and Care Hub may include aspects of Type A to C Hubs.
- Type E Hubs could be stand alone population specific Hubs or could be part of a wider Hub network.
- The scale and range of services outlined here is not intended to be prescriptive or exhaustive, more illustrative. The exact make up will be dependent upon local design and identified need.

Type A
General Community Hub

Characteristics:
- A community facility offering a wider range of general community and well-being services e.g. debt advice book loan, exercise classes, housing advice, adult education, blue badge assessment.
- Some well-being services / support may be delivered from this site but not the main purpose of the facility.
- Statutory Health and Social Care Services not delivered.

E.g.
- A library, a Leisure Centre, Village Hall offering daytime activities, could be a County Voluntary Council giving general advice and support but not specific health and social care.

Type B
General Community Well-being Hub

Characteristics:
- Focus on general population well-being and health promotion
- Some limited statutory health and social care service delivery.
- Limited clinical capacity.
- Some scheduled / sessional health and care service delivery.
- General well-being support available including advice from wider support services such as housing.
- Bookable accommodation for Primary Care facilities and outreach primary care services / allied health professional teams.
- Connections to wider Accelerated Cluster Development.
- Periodic Multi-disciplinary services on site.

E.g. Offers:
- Health interventions
- Daytime Activities
- Housing, employment and anti-poverty services
- Communities of Care e.g. Dementia.

Type C
Health, Care and Well-being Hub

Characteristics:
- Focus on general population health and social care and ill-health prevention.
- Substantive GMS services available including adequate clinical capacity.
- Substantive statutory health and social care services available on site.
- May host periodic complimentary clinical staff and other multi-disciplinary services.
- Part of accelerated cluster delivery.

E.g.
- Integrated Centre offering LA and / or 3rd sector well-being services and health services such as leg clinic, mental health support and / or health professional.
- Outreach into communities or other connected Hubs.

Type D
Large Scale Integrated Health, Care and Well-being Hub

Characteristics:
- Larger facility with substantive community health and social care services.
- Multiple GP Practices.
- General to accelerated cluster delivery.
- Hub for primary health care and broad range of community care services across a wider catchment population.
- Location crucial to maximise access and opportunities to consolidate public sector estate.
- Diverse range of clinical, community and commercial Capacity.

E.g.
- Integrated centre offering primary health care, LA, other public sector and 3rd Sector well-being and advisory services, pharmacy and dentistry.

Type E
Population Specific Health and Well-being Hub

Characteristics:
- General health and well-being services with a focus on a specific population group (not open to the wider population).
- Primary and Community health and Social Care Services supporting a specific population group across wider geographical area.
- Wide range of fixed community and health resources on substantive and / or sessional basis.

E.g.
- Children's Centre.
- Dementia Centre.
- Substance Misuse Services.
- Learning disabilities support Hub.
- Outreach / in reach communities or other connected Hubs.

Integrated Operation and Service Delivery – All services delivered from the Hub should be interconnected and part of a holistic, seamless offer for people.

Management and Governance – Hubs should be managed and supported by a multi agency / sector arrangement and part of wider cluster planning arrangements.

Ownership – Hubs may be owned by any partner organisation from any sector.

Digital – All Hubs should be complimented by a digital offer to improve access to advice and support.

Community Engagement and Voice – Hubs should be shaped and informed by citizens needs and what is important to them.

Access – All Hubs should be easily accessible by walking, public transport or supported by community transport links.

Identifying key success factors and demonstrating impact

Having only been established in 2022, the IRCF is still very much in the early stages in terms of the outcomes and successes of the programme. It has however, made significant progress through the RPBs approach of enabling partners across sectors to work together to develop and implement 10-year Integrated health and social care strategic capital plans. These plans have and will continue to demonstrate the investment needed to make the PfG commitments a reality over the short, medium and longer term. From the perspective of the model of care high-level outcomes of RIF, the establishment of hubs across Wales aligns to:

- People's needs are improved through accessing co-ordinated community-based solutions through the services delivered from a hub.
- Local prevention and early intervention solutions support people to avoid escalation and crisis interventions from the range of provision based within communities that are accessed through the front door of health, social care and well-being hubs. *(Community Based Care: Prevention and Community Co-ordination Model of Care).*

An IRCF Benefits (Social value) Framework is being developed to capture the benefits identified for the Programme in meeting its objective to help people to remain active and independent in their own homes and to live longer, healthier and happier lives, reducing the need for hospital care; deliver at a local level a future-proofed, whole system Operating Model for a more accessible and integrated approach to health and social care service and deliver services closer to home, designed around people's needs in the locality.

Working Towards Whole Life Net Zero Carbon

The Welsh Government is committed to a carbon neutral public sector by 2030 and a 100% reduction in emission of greenhouse gases in Wales by 2050.

As outlined within the IRCF Guidance health-and-social-care-integration-and-rebalancing-capital-fund-ircf-guidance-2022-25.pdf (gov.wales) all new–build projects requesting funding support through the IRCF, that have not yet reached OBC stage, are required to demonstrate delivery of Net Zero Carbon in operation plus a 20% reduction on the amount of embodied carbon – that is the carbon emitted through construction materials and the construction process.

CASE STUDY

Region: **Flintshire, North Wales**

Project: **Croes Atti Residential Care Home**

Work is underway on Ty Croes Atti, a new residential care home to be opened in Flint in 2025.

Ty Croes Atti will house 56 older people on the site of a former community hospital when complete. The scheme has a value of approximately £18 million and has received just over £11 million in funding via the Welsh Government's Integration and Rebalancing Capital Fund (IRCF) and Housing with Care Fund (HCF) capital programmes. The remaining funds provided through Flintshire County Council's capital programme.

It will see an existing care home in the area relocated and expanded from its current 31-bed capacity. Integrated social care and health care services will be delivered by Betsi Cadwaladr University Health Board (BCUHB) and Flintshire County Council social services teams.

Ty Croes Atti will help build the community capacity needed to help people live well at home, prevent them needing to be admitted to hospital and supporting them to return swiftly home where they have been admitted.

Also funded through Housing with Care Fund, Ty Croes Atti supports the commitment to create innovative housing developments that ensure care and support needs are met as close to home as possible across Wales.

CASE STUDY

Region: **West Wales**

Project: **Carmarthen Hwb**

Funding of £10.8m through IRCF has enabled work on a new Health and Social Care Hub in Carmarthen town Centre, Carmarthen Hwb which is due to be open in January 2026.

This is a partnership between Carmarthenshire County Council, Hywel Dda University Health Board and the University of Wales Trinity Saint Davids on the new Health and Wellbeing Hwb.

The former Carmarthen Debenhams site is being refurbished to deliver a wide range of health, wellbeing, educational, leisure and customer services. At this integrated facility, Carmarthenshire residents will be able to access medical services, and the University of Wales Trinity Saint David's will be supplying students who are studying Nursing or Health and Social Care with a diverse teaching space, hotdesking and break out rooms for students to utilise to further their studies.

Alongside medical services, the re-purposed building will partner with Actif Sport and Leisure to facilitate a new 24-hour gym, which will include top of the range equipment, and flexible fitness suites for group and individual workouts.

Funding has also been provided through the UK Levelling Up Fund (LUF).

Regional Integration Fund (RIF) Overview and Spotlights

Regional Integration Fund (RIF)

We are now moving from the second to the third year of the Health and Social Care Regional Integration Fund (RIF)'s five-year duration. This report reflects on progress made since the initial annual report was published (March 2024) Health and Social Care Regional Integration Fund: year 1 annual report | GOV.WALES.

The design, architecture and aims / objectives of the RIF respond to the recommendations from evaluations of the Integrated Care Fund and Transformation Fund, and Audit Wales reports of those funding programmes.

By the end of the RIF's five-year duration, six new national models of integrated care will have been established and mainstreamed, so that citizens of Wales, wherever they live, can be assured of an effective and seamless service experience in relation to:

- Community based care – prevention and community coordination.
- Community based care – complex care closer to home.
- Promoting good emotional health and well-being.
- Supporting families to stay together safely, and therapeutic support for care experienced children.
- Home from hospital support.
- Accommodation based solutions.

In support of this aim, the RIF includes four key features:

- A greater focus on six national models of integrated care.
- A clear outcomes and measurement framework.
- Opportunities to share learning through communities of practice.
- A longer-term investment horizon to support mainstreaming and sustainability.

As set out in ***A Healthier Wales***, our vision of a seamless health and care system will require a whole system approach and effort. Our challenge is now to build on the local and regional good practice developed and move maturing models of integrated care towards national adoption and embedding.

Evidencing progress and impact

In the first two years of the fund good progress has been made towards developing our six integrated models of care, and there are many successes to report across the three funds covered in this report. Additionally, the unique design of the RIF has facilitated cross sector and regional learning to help us identify and share 'what works.'

Regional successes, in the form of 'spotlights' across the six models of integrated care are presented further on in this report to illustrate the breadth and scope of positive progress to date and also the extent to which projects and services funded through RIF, IRCF and HCF are already making a positive difference to the lives and experiences of people across Wales.

The National Evaluation of the RIF was commissioned in 2022 and has now completed the first year of activity. This is a comprehensive independent study which is being conducted by a partnership led by the Welsh Institute for Health and Social Care (WIHSC), based at the University of South Wales (USW) in collaboration with Swansea University and Old Bell 3 Research, supported by health economists from within Wales.

Using an innovative methodological approach, the focus of the work is on exploring how the RIF's underpinning principles are understood by key stakeholders and, importantly, it seeks to clearly demonstrate the difference that the RIF is making to people's lived experiences.

A series of formal written reports from the first phase of the evaluation are in the process of being published. Findings to date will also inform ongoing development of the fund and its delivery.

The second year of the evaluation work will focus on analysing the set of 20 core performance measures that have been developed, the health economic aspects of the research, and qualitative interviews with people engaging with / accessing RIF funded projects, including staff and service users to ensure breadth of views and experiences are captured.

A Year In Review

Total regional allocated funding by model of care

Community Based Care: Prevention and Community coordination

Allocated Funding

£32.8 million

Percentage of Funding allocation

27.2%

Community Based Care: Complex care closer to home

Allocated Funding

£20.6 million

Percentage of Funding allocation

17.1%

Promoting good emotional health and well-being

Allocated Funding

£9.7 million

Percentage of Funding allocation

8.1%

Supporting families and therapeutic support for care experienced children

Allocated Funding

£20.9 million

Percentage of Funding allocation

17.4%

Home from Hospital

Allocated Funding

£34 million

Percentage of Funding allocation

28.2%

Accommodation based solutions

Allocated Funding

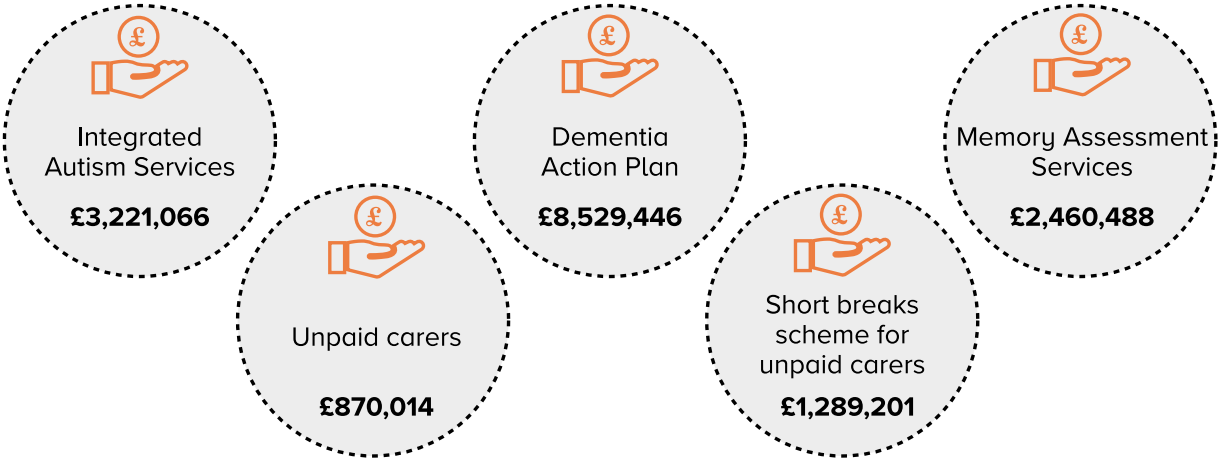
£2.4 million

Percentage of Funding allocation

2%

Total regional allocated ringfenced funding

Regional Partnership Boards were allocated ringfenced funding to deliver against national ministerial commitments.



Total investment in social value

£24,802,665

20% Investment

Total investment in unpaid carers

£9,391,273

5% Investment

Tapering and Match funding

One of the original design principles of the RIF was to draw in core match resources from partner organisations whilst over time reducing or 'tapering' the contribution from the RIF until it reached a 50:50 government funded and locally funded arrangement in order to support the longer term sustainability of key successful projects and services.

It is recognised that the time and effort needed to negotiate match resources across the partnership is a challenge at this time with all partners heavily focused on building community capacity and maintaining service provision.

RPBs do have a clear understanding of the importance of continuing to work with local partners to draw in match funding to enhance and build on the successful work of the RIF, ensuring we can help more people to live well and stay well at home.

However, since the RIF was first designed, the economic climate has shifted significantly and with the increased complexity of health and social care demand in a post covid world, the risks of tapering funds from key projects and services has been acknowledged.

In January 2024, after careful consideration, following representation from RPBs and their delivery partners, Ministers agreed to remove the tapering element of the fund in its entirety. RPBs have continued to deliver match funding for the three National Models of Integrated Care that will directly support community capacity building (community co-ordination, complex care closer to home and home from hospital), drawing in wider core resources as match funds for these priority areas.

Understanding The Data: How Much We Did and What Difference it Made for People

A bespoke outcomes-focused reporting mechanism, with its own person-centred outcomes framework, was developed for the RIF. Results Based Accountability™ (RBA) provides the basic foundation for the approach.

However, this is supplemented with an important focus on the collection and reporting of robust qualitative evidence, to facilitate the development of a clear **story of change** that will demonstrate the impact of and "difference made" by the RIF throughout its five year term. A core set of 20 performance measures has been established and all regions were asked to report against those measures.

While we continue to develop the consistency of using these measures, some of the more mature data has been included in this report.

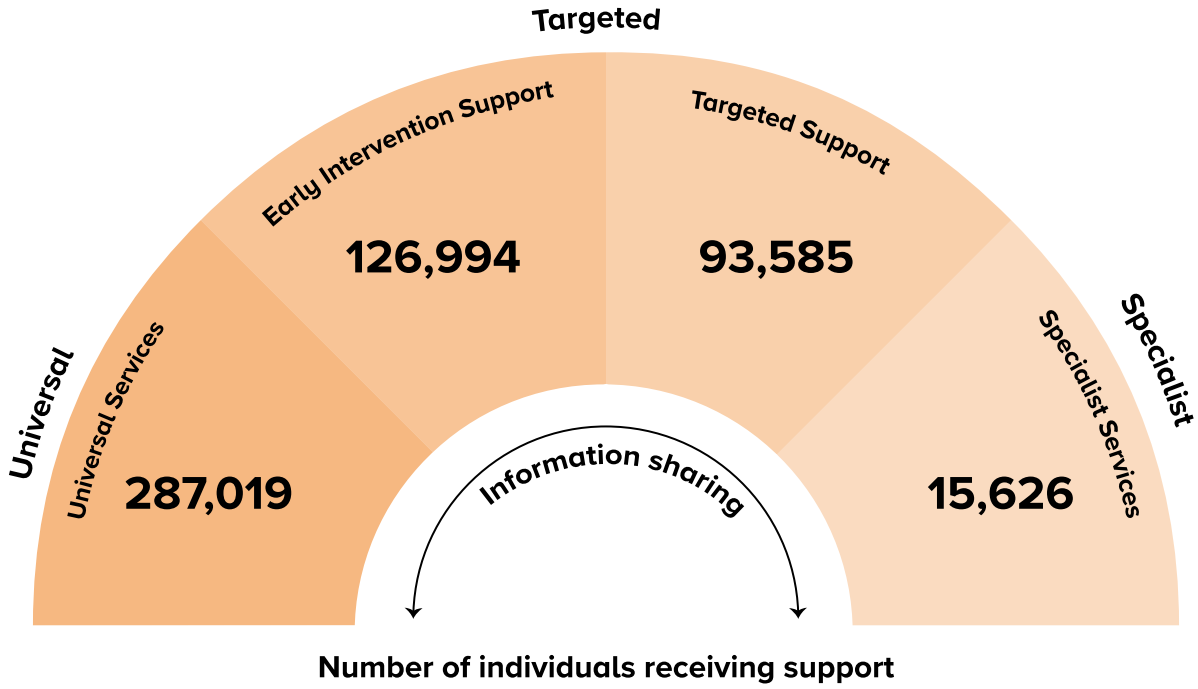
At the end of year two, the data provided is an indicative example of the scope and power of a national RBA performance view of the RIF. A more comprehensive summary will be available during year three of the RIF.

National Core Performance Measures

Measures of how much we did

Number of new individuals accessing the RIF funded project for the first time	Number of referrals received across RIF funded projects	Number of individuals accessing RIF funded projects	Number of contacts / multiple contacts per individual across RIF funded projects
190,381	304,221	628,326	1,009,582

Projects and models of care developed by the RIF range right across the spectrum of intervention, from universal through to specialist. The diagram below illustrates the spread of activity across the four levels of intervention by showing how many people were supported at each level.



Measures to show the difference we made for people

The difference made measures are recorded following feedback and completion of surveys, and represent a sample of total people receiving support.

All Wales Model of care level data

Number of individuals feeling less isolated as a result of project support 37,623	**Number of individuals maintaining or improving their emotional health and well-being** 125,263	**Number of individuals who feel they have influenced decisions that affect them** 95,910
Number of individuals whose independence has improved or remained the same with the support of the project 96,728	**Number of individuals who feel more confident accessing services following project support** 118,530	**Number of individuals who received support that has prevented them from escalating their level of need** 90,053

Models of Integrated Care

Prevention and Community Coordination Model of Care

By focusing on prevention and early intervention, enhancing people's well-being and making public services that people need more sustainable will support our population to live their lives to the fullest.

The two spotlight projects explore the range of activity funded under this model of care and how they are meeting the needs of two specific populations groups.

Community Based Care
Prevention and Community Coordination Model of Care

Cardiff & Vale

Allocation of funding

£5,282,876

Cwm Taf Morgannwg

Allocation of funding

£10,850,801

Gwent

Allocation of funding

£4,947,625

North Wales

Allocation of funding

£3,856,104

Powys

Allocation of funding

£1,299,261

West Glamorgan

Allocation of funding

£3,397,008

West Wales

Allocation of funding

£3,214,920

Number of individuals accessing support

227,612

Regional spotlight

Region: **Cardiff & Vale**

Project: **Dementia: prevention and compassionate communities**

This is an excellent example of a project that is providing guidance for people and supports them in using preventative strategies to reduce their risk of dementia by adopting a healthier lifestyle.

It also aims to develop a carer friendly region which can recognise, understand and support individuals living with dementia in the community.

Successes and progress

There are several successes to report which include the establishment of a Dementia Champions Network: an independent open group led by people affected by dementia, and a multi-partner engagement planning group, which includes representatives from primary, secondary and tertiary care, and community support including the third sector.

A range of partners are helping to deliver several elements of the project which includes the two local authorities, the Health Board and several well-known third sector organisations such as the Alzheimer's Society, Mental Health Matters and Cardiff and Vale Action for Mental Health.

Key activities

- Significant improvement in connecting with businesses to become dementia-friendly, with an average of 23 business pledges per quarter in 2022-23 to 100 organisations pledging to becoming dementia friendly per quarter in 2023-24.
- A further 925 organisations have been supported towards pledging between Q3-4 of 2023-24. This rate is significantly higher than in the last reporting period. The success of this work means that about 403 organisations have pledged to be dementia friendly with 1,916 businesses connecting to the work and 8,708 people are dementia aware.

- New referrals to the Memory Assessment Service Memory Link Worker have increased with an average of 188 new referrals in 2023-24, as compared to 179 in 2022-23 per quarter. This has resulted in the Link Worker carrying out a total of 7,031 reviews (1,147 direct and 5,884 indirect) which meant 214 referrals to community Team Around the Individual (TATI).
- Team Around the Individual (TATI) clinical team made a total of 5,139 contacts in 2023-24 with the people needing these services, within the community.

Likely components and activities of a national Model of Care for Community Based Care – Prevention and Community Coordination:

- Multi-disciplinary team of professionals (clinical decision makers plus multi-skilled support workers) to provide advice, shared decision making and wrap-around support.
- Ongoing focus on the individual and on 'what good looks like'.
- A dedicated Dementia Learning and Development team to focus on developing the skills and knowledge of both paid and unpaid carers.
- Ongoing engagement to inform training needs and co-production to inform dementia training resources.

Qualitative evidence

Two case studies were collected (Appendix 1), focusing on two key elements of delivery.

These capture the views and experiences of front-line staff members.

REGIONAL SPOTLIGHT

Region: **Gwent**

Project: **Carers Short Breaks – Bridging the Gap Gwent including a Voucher Scheme**

Based on the award-winning North East Wales Carers Information Service (NEWCIS) model, Bridging the Gap Gwent was established by Newport City Council in collaboration with NEWCIS and the 4 other local authorities in Gwent.

The overarching goal of this project is to enhance the wellbeing of unpaid carers. It focuses on supporting people with everyday life alongside their caring responsibilities, whilst also identifying and valuing carers. The project takes a person-focused approach, which involves unpaid carers directly involved in the selection of services that meet their specific needs.

Bridging the Gap Gwent operates as a voucher system, giving eligible unpaid carers a £400 code to spend over 6 months with approved providers. This gives them flexibility and choice in arranging respite care and wellbeing activities to take a well-being break from their caring role. The project aligns with the Carers Short Breaks Fund guidance and the Welsh Government's Unpaid Carers Strategy.

Successes and progress

The voucher scheme has been successfully established and has seen referrals increase dramatically since Q3. Numbers have risen steadily since the launch of the project in August 2023.

There has also been an increase in the number of providers signed up to the scheme, doubling since October 2023. This has enabled the scheme to offer further choice, variation, and ideas for carers to access a fulfilling break.

Key activities

Local Carers Short Breaks projects offer a range of tailored, additional short breaks designed to meet the unique needs of each locality area.

These projects seek to expand the selection of the most in-demand and popular activities in each local authority area (as identified by carers leads).

Examples of these activities include leisure memberships, provision of pantomime tickets for young carers and their families, participation in seasonal events, and engagement in art and other wellbeing related activities.

The following figures represent the region's Unpaid Carers Programme as a whole, including the Bridging the Gap Gwent project.

- Data at the end of year two indicates a high level of access and engagement.
- 3,145 people accessed the projects, with a good proportion (675) being new participants. This suggests the workstream is successful in reaching new unpaid carers across the region.
- The high number of referrals received (563) and contacts made (3,431) further highlights its visibility and accessibility.
- Early Help and Support was provided to 3,103 people, intervening early to prevent burnout and ensure their well-being.
- The 100% referral acceptance rate signifies a smooth referral process, ensuring that unpaid carers receive the support they need without unnecessary delays.

This project demonstrates that it has improved peoples' lives in the following ways:

- 100% of respondents reported feeling less isolated, improved emotional health and well-being, and more confident accessing services. This suggests the workstream is effective in promoting carer wellbeing and empowering them to navigate the care system.
- 100% of respondents also reported that their independence improved or remained the same and that the support prevented them from escalating their level of need, supporting them to maintain their own independence while caring for others.

Qualitative evidence

A case study described how Bridging the Gap Gwent pooled together voucher codes for parent carers of children with learning difficulties attending a local school.

A gap in service provision was recognised through promoting the service with the disabled children's team.

As a result, it was recognised that there were no options available for the children to interact outside of school because the previous club provided had been unable to remain open due to sustainability problems.

Re-establishing this important provision to offer parent carers some respite demonstrates the project's creative approach.

Personal outcomes from the experience were very positive, and it was highlighted that "[the after-school club] is working really well and there are currently 5 families benefiting from it... In turn, the parents / carers are receiving respite".

Complex Care Closer To Home Model of Care

Helping people to have their health and social care needs met as close to home as possible in a seamless and integrated way is a key aspect of this model.

The project presented addresses the need for 24/7 provision where individuals need an immediate response whilst avoiding conveyance to hospital.

Community Based Care
Complex Care Closer to Home

Cardiff & Vale	Cwm Taf Morgannwg	Gwent	North Wales
Allocation of funding	Allocation of funding	Allocation of funding	Allocation of funding
£2,345,418	£1,811,500	£7,688,633	£6,845,438

Powys	West Glamorgan	West Wales	Number of individuals accessing support
Allocation of funding	Allocation of funding	Allocation of funding	
£226,591	£158,810	£1,588,975	107,634

Regional spotlight

Region: **North Wales**

Project: **Response Service**

This project provides a locality-based Response Service in Ynys Môn.

The service enables individuals to remain in a community setting with bespoke provision that will support them to remain as independent as possible. The service is designed to reduce ambulance call outs; empowering individuals to take control of their care package, It also supports preventing hospital admissions and overnight falls, as well as support for care package crisis, end of life, hospital discharges and access to community support.

The Response Service is available 24 hours a day, 7 days a week and provides a point of contact for health and social care professionals when an immediate response is required. It also supports the Health Board to carry out Welsh Ambulance University Service NHS Trust (WAST) calls and reduces ambulance call outs due to care needs being met in the community setting and the availability of night calls.

This service has a multi-agency approach to providing immediate response when needed It has been jointly planned and services commissioned to meet needs. It promotes the support of third sector organisations, and the workforce have received training to provide the required interventions, working in an integrated way in the community.

The Local Authority is the main delivery partner, supporting the local Health Board by decreasing the amount of Ambulance calls as the Local Authority staff are trained to assess any falls before requesting ambulance support / assistance.

Successes and progress

The project:

- Has contributed to enabling individuals to reach their personal outcomes, and to remain in the community, preventing unnecessary hospital admissions.
- Supporting reducing ambulance call outs.
- Supported timely discharge to community and residential settings, relieving pressure on acute settings.
- Provides added capacity to facilitate bespoke services for individuals who wish to be supported at home for as long as possible. Individuals remain fully involved with family and friends, as well as part of the wider community.
- Contributed to discharging individuals in a timely manner and has prevented individuals from re-admission due to the bespoke night-time support available. Night calls have complemented Gwent's Falls Prevention scheme, and this has contributed to a reduced number of falls during the night.

Key activities

- 123 individuals accessed the project during the year, and 279 people accessed them for the first time in this period.
- 376 referrals were received.
- 100% of referrals were accepted by the programme, and 209 people reported a good experience with the support that they received.

This project demonstrates that it has improved peoples' lives in the following ways:

- 153 individuals felt less isolated, and 276 believed that they had achieved their personal outcomes, which was 100% of those providing feedback.
- Data from the dementia specific measures showed that 90 unpaid carers were supported as part of the project, and of those providing feedback, 23 felt supported to carry on their care.

The project has proved to be a great success in keeping individuals independent in the community and in their own homes. During Quarter One of 2023/24 the Response Service:

- Attended 24 WAST calls.
- Prevented 5 individuals from being admitted into a residential setting by carrying out check calls and night care support.
- Supported the timely discharge to 20 individuals into step down beds within care homes.
- Supported 8 individuals within step down placements in a community setting.

Qualitative evidence

A case study submitted for the project provided additional evidence of the positive outcomes listed above. It describes how the extra capacity provided to facilitate bespoke services for individuals who wish to be supported at home for as long as possible meant that individuals met their set outcomes and enabled individuals to be fully involved alongside their family, friends and remain part of their community.

It promoted voice, choice and control for people and, importantly, empowered them to decide where they want to live whilst receiving care and support.

Promoting Good Emotional Health and Wellbeing Model of Care

The development of this model of care complements existing investment in acute mental health services.

The aim of this model is to support individuals to take more responsibility for their own emotional health and wellbeing, allow organisations to support individuals or groups with emotional health and wellbeing needs, and supports communication and engagement around good emotional health and wellbeing.

The iCAN programme exemplifies how a regional approach has created access to equitable provision across North Wales.

Promoting Good Emotional Health and Wellbeing Model of Care

Cardiff & Vale	Cwm Taf Morgannwg	Gwent	North Wales
Allocation of funding	Allocation of funding	Allocation of funding	Allocation of funding
£546,635	£1,084,843	£1,633,408	£1,270,781

Powys	West Glamorgan	West Wales	Number of individuals accessing support
Allocation of funding	Allocation of funding	Allocation of funding	
£2,306,885	£928,138	£1,940,725	98,639

Regional spotlight

Region: **North Wales**

Project: **iCAN Community Hub Development**

This service provides support for people with emotional and mental health wellbeing needs. Having developed the beginnings of iCAN community hubs with funding from the Transformation Fund there are now iCAN Hubs and outreach iCAN services across North Wales.

The hubs are managed and delivered entirely by third sector partners and are embedded in the community with local partnerships including with social care, Child and Adolescent Mental Health Service (CAMHS) and Community Mental Health Teams. They deliver a range of interventions and support for people and have become an essential part of Tier 0 provision within mental health services, working as the first point of contact for both professionals and the public.

Every hub has developed and nurtured strong relationships with local third sector service providers and have grown their local offer based on their local population needs and resources available.

There is already a consistent service specification and scope for iCAN Community Hubs across North Wales.

There are a range of referral routes into the service:

Self-referrals:
For any individual 18 years and over who recognises that they may have mental health and wellbeing issues and are keen to have an informal chat within their community, with a member of the iCAN hub. One provider (GISDA, Gwynedd) can also support individuals from age 16. Where more formal help is needed, the iCAN hub can connect and refer people to other statutory or third sector services.

Other Referrals:
Individuals can be referred in from GPs, Primary Care OTs (which is a separate iCAN strand to the programme funded by Betsi Cadwaladr University Health Board (BCUHB)), Community Mental Health Teams, the new 111 press 2 service, and other third sector organisations.

Successes and progress

- Being a regional initiative, iCAN is gaining momentum and understanding and is truly embedded in local communities.
- Developing this innovative early intervention and prevention pathway has laid a foundation that provides seamless connections to community provision, reinforcing strong links with GP surgeries and primary care.

Key activities

- 9 third sector organisations are currently funded, some of which have more than one physical location.
- There are 14 iCAN Connector roles in total across the hubs. These roles are match funded by the Health Board. iCAN connectors work with individuals to develop goal-based management plans and facilitate / provide activities and resources to support to people who are experiencing poor mental health or have been stepped down from primary / secondary care services.
- More than 850 people access iCAN support every month, avoiding on average 50+ GP appointments.

This project demonstrates that it has improved peoples' lives in the following ways:

- 4,310 individuals said they felt less isolated as a result of support from the projects.
- 4,462 people felt that their emotional health and wellbeing had either been maintained or improved (this represents 79% of those providing feedback on this measure).
- 1,470 people (64% of those providing feedback on this measure) felt that they had increased their knowledge of services and support available to them.
- 4,530 people felt that they had achieved their personal outcomes from participating in the projects, representing 81% of those providing feedback on this measure.

Qualitative evidence

Individuals who present at the iCAN community hubs receive a holistic person-centred approach where staff are trained and skilled in dealing with the low to moderate level of mental health and wellbeing challenges. They always treat individuals with respect, giving due regards to the diversity, background, and individual needs of people, particularly in respect of age, disability, and their cultural, religious, and linguistic background.

The individual is fully involved in developing their support plan, which is built around a model of listening, communication and understanding of needs at any given time.

They are given the opportunity to lead and shape what that support plan looks like, so that it is truly owned by them.

Some direct feedback quotes were provided from iCAN service users, describing their positive experiences and outcomes such as:

> **"I've learnt that I am not the only person struggling with anxiety and depression and that it's better to talk. I am hoping this year I will get back to work."**

Supporting Families and Therapeutic Support for Care Experienced Children

The key rationale for this model of care this that working with families to help them stay together safely prevents children needing to become looked after.

The model needs to be considered within the context of the NYTH / NEST framework as well as ensuring that the therapeutic needs of children and young people are met.

The ENFYS, Goleudy, and the Edge of Care projects are examples of the NYTH / NEST framework in action.

Supporting Families and Therapeutic Support for Care Experienced Children Model of Care

Cardiff & Vale

Allocation of funding

£2,061,727

Cwm Taf Morgannwg

Allocation of funding

£926,796

Gwent

Allocation of funding

£3,512,079

North Wales

Allocation of funding

£9,920,441

Powys

Allocation of funding

£610,000

West Glamorgan

Allocation of funding

£2,419,828

West Wales

Allocation of funding

£1,492,495

Number of individuals accessing support

48,538

REGIONAL SPOTLIGHT

Region: **Cardiff & Vale**

Project: **ENFYS / Goleudy**

This project provides a therapeutic support service supporting children and young people who are on the edge of care, looked after or in hospital.

This support is delivered alongside wrap around support services to create conditions for change for young people and to reduce further placement breakdown.

There are two aspects of the project with specific aims and activities. ENFYS is a developmental trauma service, which works predominantly with foster carers and social workers to help them understand the child and respond to needs in a therapeutic way. It provides psychology-led support to care experienced children and their carers to support placements and reduce the likelihood of placement breakdown.

The Goleudy project, meanwhile, provides therapeutic support to children and young people on edge of care and who are looked after.

The project was named by young people themselves: 'Goleudy' means lighthouse in Welsh, and this name was chosen to describe the service as a guiding light that is always present during stormy times. This hospital element funds a multi-agency workforce to deliver the Goleudy service for children in hospital beds as a place of safety due to professional concern about risk due to self-harm or suicide attempts that are linked to trauma.

Where young people have extended stays in hospital (as a result of not being able to return home safely), the multi-agency team from hospital, social services, education and the young person and their family come together to develop a joint safety plan of support and services will mobilise to enable the young person's safe discharge from hospital once a joint safety plan has been agreed and the necessary support is in place.

What is being done differently:

- An integration of therapeutic services across Adolescence Resource Centre (ARC) and Goleudy which supports a whole system approach, providing consistency for young people under the leadership of ENFYS.
- Actively addressing the service delivery gaps for children and young people who require a multi-agency response or specialist approach.
- Young people have been involved in telling their story through film to support foster carers to be more culturally aware and what is important to them.
- Engaging harder to reach young people through strong third sector relationships and good working practice (Goleudy / ENFYS).

Successes and progress

ENFYS continues to deliver at capacity: the volume of current waiting lists means that additional external therapy has needed to be commissioned to meet the growing number of young people looked after who need access to therapeutic support.

Goleudy is supporting several young people through a therapeutic support team. A review of learning from delivery so far was completed and has indicated that in-house hybrid support work teams hosted in each of the two local authorities will provide greater alignment with the wider support offer for this group of children and young people.

Goleudy supports children and young people in being safely discharged from hospital following an episode of emotional distress. This has enabled partners from Cardiff and Vale to develop shared planning approaches at a strategic and operational level. It has also enabled testing of regional approaches to some commissioning tools, such as a market sounding event that was co-delivered by Cardiff and Vale of Glamorgan Councils and the health board.

The work of ENFYS and ARC both demonstrate that young people have more stability through reduced placement moves.

The Goleudy model especially exemplifies the Trusted Adults, Safe and Supportive Communities Easy Access to Expertise and principles of the NYTH / NEST framework in action.

Key activities

- A strong focus on developing and maintaining strong relationships and communication, not only with the children and young people being supported, but also with partners working across health and social care to deliver the service – this includes psychologists, trusted adults and case managers.
- Specialist workforce development and training, supported by a clinical psychologist from the Enfys team.
- Skills training for foster carers and residential staff.
- Shared trauma informed practice and training across all services supported by ENFYS.
- 33 children received therapy from ENFYS.
- 838 consultation sessions were provided: an increase from 272 for last year.
- 21 training events were provided (an increase of 3).

Likely components and activities of a national Model of Care for Supporting Families and Therapeutic Support for Care Experienced Children

- Access to specialist therapeutic input alongside a peripatetic staff team.
- A multi-agency outreach staff team and an accommodation solution to provide support and a safe space for young people to stabilise following their emotional distress and become ready to start the intensive therapeutic work that addresses the cause(s) of their distress (included in the original model for the Goleudy Service).

REGIONAL SPOTLIGHT

Region: **Powys**

Project: **Children on the Edge of Care**

***NB: The following figures represent the region's Start Well Partnership programme as a whole, including this specific project.**

This project helps children, young people and their families to support children at the "Edge of Care".

Through evidence-based early intervention approaches, it aims to support families to stay together and keep children at home safely.

Key activities

- 99% of children / young people referred to the service for support around family breakdowns remained with parent.
- 100% of children / young people referred to intervention and prevention for placement stability remain in their placement.
- 84% of young people who use the intervention and prevention services demonstrated positive progression.
- The service has trained a total of 6 practitioners in Positive and Adverse Childhood Experiences (PAACE's), formally known as ACE's.
- 2 staff have recently trained in DDP (Dyadic Developmental Psychotherapy) level 1 which is a therapy parenting approach and evidence-based practice model.
- 5 staff are currently undertaking 'Theraplay' training which is a dyadic child and family therapy which supports to build and enhance attachments, self-esteem trust and engagement with children and their caregivers.

Successes and progress

- At the beginning of Quarter 3, 93 children's names were placed on the Powys child protection register by the end of Quarter 4 this had decreased to 82.
- Most of the children being placed on the register during Quarter 3 and 4 were under the category of neglect. This is a reduction of 9 and is in line with a consistent downward trend over previous quarters of child protection registration figures.
- Assessment Team: In Q3, 37% of referrals were received from the assessment team and in Q4 58% referrals have been received from this service showing that we are identifying those in need at the earliest opportunity.
- Care and Support: In Q3 the referral rate was 57% of referrals were referred by the care and support teams.

Qualitative evidence

Feedback from the staff team reports that this structure is felt to be important in creating a stable and supportive work environment for the team.

Wellbeing is seen as pivotal in creating a productive and positive team: this achieves the best outcomes possible for the children / young people and their families that the service seeks to support.

NYTH / NEST Framework

NYTH / NEST framework – a key enabler for the delivery of a whole system approach to regional children's work funded through the Regional Integration Fund.

The NYTH / NEST framework supports the implementation of a whole system approach to mental health and wellbeing services for babies, children, young people and their families. NEST is a long-term ambition of culture change, to move away from specialist help being seen as the only option, to children's wellbeing needs being held in their communities and the wider determinants of mental health being recognised and included in clinical approaches.

NYTH / NEST implementation is being taken forward locally by Regional Partnership Boards who all have NEST leads and NEST implementation plans. RPBs are required to submit an annual NEST self-assessment which forms the basis for the annual National NYTH / NEST implementation update and National NEST report and action plan which provides further details of the impact of NEST implementation.

NYTH / NEST informed projects commissioned by RPBs are already demonstrating that early intervention and prevention as well as addressing the wider determinants of mental health have a positive effect on outcomes for individuals and reduce the amount of health or social care support needed.

A NYTH / NEST Self-Assessment and Implementation Tool and NYTH / NEST and children's rights training module have been co-produced to support the implementation of the framework. This tool and training form a core part of the national actions for NEST implementation.

REGIONAL SPOTLIGHT

Region: **West Wales**

Project: **Early Years Integration Team (EYIT)**

The Early Years Integration Team (EYIT) is a joint project between Hywel Dda University Health Board (HDUHB) and Carmarthenshire County Council (CCC).

It covers the semi-rural / rural Gwendraeth valley area. The area is poorly serviced with infrastructure, transport, and commerce.

The EYIT project is underpinned by theories of transformation which promotes prudent but effective and sustainable care for both health and social care. EYIT are an integrated team made up of the existing Health Visitors and Midwives already working in the Gwendraeth Valley area of Carmarthenshire, together with a local authority support team.

We always consider the family as our primary partner, and we actively seek their voice within the work that we do. We believe that the best way to support the child is to support the family and that the needs of each family are both different and changeable depending on circumstance. We aim to build supportive communities, and resilient families that are knowledgeable about accessing health and wellbeing enhancing activities, and who are able and confident to do so at a point that is most beneficial, and that prevents escalation.

What works well?

The Midwives and Health Visitors are a crucial part of our team. As universal providers they are in the homes of every pregnant woman and every family with at least one child under five years old. As such they are able to identify children or families in need of support at the earliest opportunity. This will often be for 1:1 work to support a specific area such as development delay, speech and language, toileting, behaviour, housing, complex social needs, mental health or even isolation.

While targeted intervention is often for those most in need of support, keeping people well is also important. We offer groups which may be closed if for a specific area of support such as speech and language support or anxious parents, plus a rolling programme of drop-in groups.

For families receiving 1:1 support we aim that they are on a trajectory whereby they move to a closed group then onto drop-in groups that they access as needed.

We firmly believe in integration rather than segregation and try actively to integrate families across social class, culture and background. Everything that we offer is free to all families.

We form close working relationships with services already working in the area, we actively seek out opportunities to work with third, public and private sector partners to create, deliver, facilitate or promote activities that support health and wellbeing for children and their families.

Although the support team are local authority, their work supports the health team. 1:1 support is often replacing a visit that the health professionals would need to do without the support team. For example, when supporting breast feeding, mental health, financial challenges, housing and child development.

What doesn't work so well?

As a multi-agency team, we would ideally be co-located. This has not been possible, so we currently have the health team located in a local medical centre with the local authority support team located in a local authority building. While the entire team works well to ensure communication is maintained co-location would lead to seamless working across the Gwendraeth Valley.

Integrating IT across both organisations is extremely difficult with health IT equipment not working in a local authority building and vice versa.

We do not have any systems or programmes that can be used across both organisations which will often mean repetition of data entry into each system.

A case study can be found in the Appendices (Appendix 4).

NYTH / NEST priorities

- Developed in partnership: with health, local authority and families.
- Developed in response to need: constantly searching for health and wellbeing needs and for effective avenues of support to address identified need.
- No Wrong Door: ensure joined up working and effective communication between services to support families in need.
- Co-produced: with all stakeholders including families.
- Be creative and innovative: finding solutions and support options that are free and accessible to all families, while also targeting those most in need of support.
- Take the whole child / family / context into account. The best way to support a child is to support the family.
- Nurturing / Empowering / Safe and Trusted: providing holistic support that is non-judgemental and effective. Identifying strengths in family and working with them to support children.

Home from Hospital Model of Care

The aim of this Model of Care is that, where possible, care and support should be offered to help people stay well at home.

Whilst recognising that some people will always require acute assessment / treatment in a hospital environment, it is vital that we create a national model that helps people to be discharged to recover at home as quickly and safely as possible.

Two short examples are provided.

Home from Hospital Model of Care

Cardiff & Vale	Cwm Taf Morgannwg	Gwent	North Wales
Allocation of funding	Allocation of funding	Allocation of funding	Allocation of funding
£5,897,181	£3,521,642	£5,792,096	£3,725,125

Powys	West Glamorgan	West Wales	Number of individuals accessing support
Allocation of funding	Allocation of funding	Allocation of funding	
£679,199	£8,468,958	£5,953,352	145,322

Regional spotlight

Region: **Cwm Taf Morgannwg**

Project: **Care and Repair project (Home adaptions and aids programme)**

This programme is delivered by Care and Repair across the region and is provided in collaboration with GP Clusters and other statutory organisations, creating a comprehensive multi-disciplinary team (MDT) to address the unique housing needs of vulnerable members of the community.

The main objective of the programme is to prevent accidental injuries that could result in hospitalisation or the need for long-term care.

By proactively identifying potential risks and implementing necessary adaptations, the programme aims to promote positive health and wellbeing among the vulnerable people that they support.

In addition to this preventative role, working with Hospital to Home services, Care and Repair also works to ensure a seamless transition for individuals returning home after a hospital stay including those with dementia. Referrals for support are received from health and social care partners through the assess and install service, ensuring that those in need receive prompt and effective assistance. By delivering fast-track adaptations and improvements to the home environment, the programme aims to facilitate a smooth transition back to the home.

What's different about this project?

This client-centred problem-led programme starts with a visit to the person's home, where an assessment is conducted alongside a technical assessment of the living environment. From there, a personalised package of home improvements is created to support the individual's choice to age in place within their own community.

Unlike traditional one-size-fits-all approaches, this programme is tailored to each individual's specific needs and preferences. It utilises a mix of statutory assistance, privately arranged services, locally brokered resources, and cost-effective solutions to ensure that informed choices are made every step of the way.

Additionally, this holistic approach doesn't stop at home improvements. It also includes referrals to other providers in the statutory and third sector to ensure that a comprehensive package of solutions is secured to support the individual's independence and wellbeing. Individuals are empowered to live comfortably and safely in their own homes, maintaining their dignity and autonomy for as long as they choose. It's a creative and compassionate way to address the challenges of aging with grace and respect.

Key activities

- 1,878 individuals are accessing the project.
- 946 people accessing the project for the first time.
- 843 referrals received.
- 1,742 contacts (includes multiple contacts from a single individual).
- 1,742 people receiving early help and support.

The project demonstrates that it is improving people's lives in the following ways:

- 48 individuals reported feeling less isolated as a result of project support.
- 288 people reported that they were maintaining or improving their emotional health and wellbeing.
- 409 people said they felt that they had influenced decisions that affect them.
- 1,265 people reported that their independence had improved or remained the same with the support of the project.

REGIONAL SPOTLIGHT

Region: **West Glamorgan**

Project: **Bon-y-Maen House (Home First Service)**

Bon-y-Maen House is a 24-bed specialist residential unit which provides support to individuals across the region upon discharge from hospital or as a step-up service if someone is struggling at home.

When an individual is admitted to Bon-y-Maen House they are provided with a period of reablement by a multidisciplinary team from across Swansea Council and Swansea Bay University Health Board.

A team of nurses, therapists, social workers, and care staff work together to help individuals regain lost abilities or learn new ways to remain independent and co-produce a care plan with the individual to meet their goals.

The service helps to improve patient flow through the system, recognising that hospital beds are not ideal for long-term care planning.

The key features of Bon-y-Maen House are:

- 29 reablement assessment beds.
- A homely environment for up to 6 weeks of reablement care.
- Individuals have control over their daily lives and encouraged to set their own outcomes with staff support.
- Care workers promote independence through personalised plans and risk assessments.

Key activities

Between the months of January 2024 and July 2024, 345 individuals were admitted to Bon-y-Maen House, out of those 345 individuals 175 returned home independent of care with 45 requiring a small community reablement package of care in their usual place of residence.

This means that 63% of the individuals that entered Bon-y-Maen house between January 2024 and July 2024 were supported to avoid long term care.

The project demonstrates that it is improving people's lives in the following ways:

The service helps individuals who need short-term care to regain the skills and confidence they need to return home and live as independently as possible.

Since 2019, it has become a vital part of the health and social care system in West Glamorgan, fostering a strong, trusting relationship between the health and social care teams and providing the people of West Glamorgan with a flagship service.

Accommodation Based Solutions Model of Care

This model of care focuses on developing accommodation that can support people's independent living and meet their care and support needs in a domestic or residential environment.

It offers a place of choice to people from supported living through to extra care provision.

Accommodation Based Solutions Model of Care

Cardiff & Vale

Allocation of funding

£150,000

Cwm Taf Morgannwg

Allocation of funding

£532,543

North Wales

Allocation of funding

£742,316

West Glamorgan

Allocation of funding

£15,329

West Wales

Allocation of funding

£1,006,237

Number of individuals accessing support

581

REGIONAL SPOTLIGHT

Region: **North Wales**

Project: **Regional Learning Disability Accommodation**

This project aims to develop specialist health and social care provision aimed specifically at supporting people with a learning disability and / or autism.

The development of a specialist provision will enhance and strengthen partnership working with housing, community learning disability services and local authorities.

It also includes the planning of accommodation needs across the 6 Local Authorities through identifying individuals who will require accommodation, and tailoring support provision accordingly. It also aims to develop workforce skills to facilitate support for people with more complex needs.

It will undertake scoping and addressing the care needs of people with learning disabilities across the region enabling a reduction in hospital admissions and better step-down support for people with complex needs.

The project is focusing on reconstructing an existing facility within the West locality to support the enhancement of community provision and provide accommodation and an environment that is safe and fit for purpose.

There will also be continued support for delivery of health checks and health screening to people with Learning Disabilities through provision of an administrative post to support the coordination of health liaison nurses across the area.

Delivery partners work together in the following ways:

- Delivery partners in this project are Betsi Cadwaladr University Health Board (BCUHB), the 6 North Wales local authority areas, family members, third sector colleagues and care providers.
- Via a pilot initiative to change existing processes through which Ynys Môn and BCUHB commission and jointly fund services for adults with learning disabilities, revised pooled budget, review and decision-making processes and financial contributions will be aligned with the aim of establishing a more efficient and agile system that enables people with learning disabilities to achieve good outcomes.
- In collaboration with the health checking champion role within the third sector, the project works with Conwy Connect to produce easy read resources that explain processes in relation to various health conditions and procedures called, Get Checked Out North Wales. The work also includes collating and co-producing other bilingual materials aimed at promoting health for people with Learning Disabilities and publish links and posts on social media to raise awareness and promote discussion.

Successes and progress

- The BCUHB are planning for the step-up step-down resources to begin supporting individuals within months. The hope is that individuals placed out of area will be enabled to move closer to home within the next year.
- The health board are now considering staffing their own core and cluster move on resources. This is a significant service development that will make additional resources available within the BCUHB area where individuals with complex needs can be supported by skilled health staff. This will prevent individuals from having to move out of area in the future.
- We have over 100 people in North Wales completing Positive Behaviour Support qualifications and the appetite for the approach is such that a recent PBS community of practice meeting had to be relocated to allow for the demand from all partners.

Key activities

- 682 individuals accessed at least 1 of the 56 training sessions delivered during 2023/24.
- 89 people were satisfied with the information that was provided.
- 228 people reported a good experience with the support that they received.
- 227 people completed targeted training.

The project demonstrates that it is improving people's lives in the following ways:

- 43 people felt that their emotional health and wellbeing had either been maintained or improved as a result of the projects, which represents 100% of those providing feedback on this measure.
- 133 people felt that they had achieved their desired personal outcomes through the project: this represents 100% of those providing feedback on this measure.

Qualitative evidence

A comprehensive case study provided for the project can be found in the Appendices (Appendix 5).

Conclusion and Next Steps

The alignment of the Housing with Care Fund (HCF), Integration and Rebalancing Capital Fund (IRCF), and Regional Integration Fund (RIF) has maximised the use of the funding from Welsh Government and created a synergy across revenue and capital projects and is actively contributing to our ambition to create an Integrated Community Care System for Wales.

The priorities for 2024-25 will ensure further alignment, clarity and greater learning opportunities from across the three funding programmes and will focus on:

1	Promoting further alignment across the three funding programmes to ensure synergy across revenue and capital funding streams.
2	Promoting best practice and successful projects with Regional Partnership Boards and scaling up successful projects to other RPB areas.
3	Improving the level of qualitative data being reported and bringing together the 'story of change' though person centred engagement for the lifetime of the project.
4	Improving the data capture of 20 quantitative performance measures to allow for a more consistent understanding of impact for individuals and the system as a whole.
5	Sharing best practice and learning through Communities of Practice to further develop national specifications for our models of care and some of the key component parts.
6	To showcase good examples of integrated service delivery benefitting from resources across the three funds in a national showcase conference.
7	Continue to develop the regional Strategic Capital Plans to support the integrated planning and delivery of capital investment.

Appendices

Appendix 1

Community Based Care – Prevention and Community Coordination Model of Care

CASE STUDY

Region: **Cardiff & Vale**

Project: **Dementia: prevention and compassionate communities**

The Patient Experience Team and the Dementia Learning and Development Team: staff member perspective

- **About:** a pilot implementation of 'John's campaign' was conducted across a range of different hospital wards, involving face-to-face visits with ward managers and promotional dementia-focused material to encourage their engagement. A training package for ward staff was developed, outlining the campaign's principles and aims.
- An integrated medicine ward was successfully engaged with the campaign and provided appropriate training to their staff. As a result of working together and pooling team resources, project staff have been able to share learning and experience in terms of planning and rolling out new initiatives.
- **Lessons learned and outcomes:** the support provided by the project in implementing the campaign was helpful in encouraging ward staff to embrace the necessary culture change, and also provided them with a valuable opportunity to reflect on their practice. This partnership approach to the coordination of project work was beneficial in facilitating the appropriate sharing of responsibility and ongoing learning processes. Work has also begun on developing a volunteer role to support the ward assessment process for John's Campaign and the wider Dementia agenda.

Dementia – Hospital Support service: Supporting a care home resident

- About:
  A case study focuses on an individual who had been a care home resident for 6 months and had recently been experiencing an escalation in her periods of distress. The care home had asked for input from the service after first approaching the mental health team for support.
- Following careful observation, it was noted that whilst the resident enjoyed exploring her physical environment in the care home, she was often disturbed and distressed by witnessing her reflection in windows and mirrors. Staff understood that enabling the person in question to continue exploring her environment was important to their well-being and was a significant part of "what mattered" to them. An action plan was devised to enable the person to continue exploring, by adapting the environment to cover the reflective surfaces that had been causing problems. The staff team also considered whether some additional activities could be devised, to help occupy the persons time and energy.
- Lessons learned and outcomes:
  The resident was able to continue exploring their environment with the periods of distress significantly reduced. Involvement in the observational and reflective discussion work was valuable for staff, allowing them greater insight into the resident's own perspectives, experiences and feelings and therefore enabling them to respond more effectively to her individual needs and provide appropriate support. This success can now be used as the basis for supporting other care home residents living with dementia and experiencing similar difficulties. The reflective nature of the process in this case study will also help staff to improve the quality of their person-centred care in the short and longer term.

Appendix 2

Supporting Families to Stay Together Safely and Therapeutic Support for Care Experienced Children Model of Care

CASE STUDY

Region: **Powys**

Project: **Children on the Edge of care**

This case study is an account of one child receiving their support.

Having been looked after since the age of 4 and spending much of their early life in foster care, the child was returned to their birth parent aged 11, after the parent had made significant lifestyle changes to enable this. There were considerable concerns around the transition for both parties, with a vulnerable child at potential risk of exploitation, a tendency towards angry behaviour and other challenges including school refusals, and uncertainties around the parent's abilities to keep the child safe. They were referred to the service by a social worker to support this transition back into the parent's care.

A strengths-based intervention plan was developed to support the parent in developing their skills and confidence in their parenting abilities.

The service worked directly with the parent, providing support, guidance and information around effective parenting strategies and approaches, encouraging a solution focussed approach to empower and equip them to manage challenging behaviours and situations that could potentially lead to crisis.

The service also developed a plan of intervention to support the child and promote stability of his care. The key factor in this was establishing and building a trusting relationship with them, which enabled the intervention to progress and to be meaningful and effective.

Several positive person-centred outcomes were reported from the service users. These included:

- The child no longer engaging in antisocial behaviours and returned to education with good attendance rates and an improved ability to manage their emotions.
- The parent using effective parenting strategies and feeling confident in their ability to keep the child safe.
- The child and their sibling are now happy and settled at home with their parent and are safe in their care.
- The parent was committed to the support offered to them from the Intervention and prevention Team, with good engagement with the intervention worker.
- The child engaged well with his Intervention worker and has worked hard to change their behaviours and make better choices, everyone is really pleased that they are now back at school and doing really well.
- With such positive outcomes being achieved the next steps are Local Authority seeking to revoke the care order for this child.

Appendix 3

Home from Hospital Model of Care

CASE STUDY

Region: **Cwm Taf Morgannwg**

Project: **Care & Repair**

One service user newly diagnosed with dementia (and under state pension age) and her husband were referred to Care & Repair by the Older People Mental Health Occupational Therapists where joint working took place to ensure that a streamlined and efficient service was provided.

The service user had reported finding it difficult to come to terms with the loss of her independence and the diagnosis of Dementia at such a young age.

Whilst she previously enjoyed socialising and cooking, the progression of her condition has meant these are no longer manageable. She was had reported experiencing a low mood and worsening mental health as a consequence and had also become increasingly dependent on her husband.

The service provided support in a number of ways:

- Grant for an Alexa Show.
- Referral to BAVO (local County Voluntary Council) for group activities in her local area.
- Referral to Alzheimer's Society.
- Support to complete a Personal Independence Payment (PIP) application.
- Grant for an Orientation Clock.

There were several very positive outcomes reported following support from the service.

These included:

- The Alexa Show being used to help with cooking (it can be asked to set times and read out recipes) and enabling the lady to keep in contact with friends and family.
- BAVO has arranged for activities with people of a similar age in similar circumstances to help reduce the lady's isolation.
- Alzheimer's Society have provided emotional support and advice and guidance.
- A PIP application was successful with a higher rate awarded.
- Provision of an orientation clock to help with keeping track of the time, days, months, and years. The client described Care and Repair as a "4th emergency service".

The service user experience captured in the second case study describes a woman with dementia and limited mobility, who is living alone (with daily support from a relative) and requires use of a wheelchair outside the home.

She was referred to Care and Repair by her stepdaughter to have an assessment for adaptation to the steps in her garden.

A greater scope of need was identified during the initial assessment conducted by a caseworker. These included:

- A need for needed urgent repairs to the heating system.
- Realisation that she was receiving an incorrect benefits income.
- The need for a Community Occupational Therapist referral for access issues to the front of the property and a new front door.
- The need to inform her GP regarding an increase in falls.

The woman's stepdaughter experiencing stress due to her caring responsibilities whilst on a waiting list for a package of care with social services.

The service provided support in a number of ways:

- Referral to Carers Centre.
- Referral to Alzheimer's Society.
- Support to get on correct income (DLA higher).
- Support to complete NEST application to improve her heating.
- Referral to the Community Occupational Therapists.
- Home First grant for adaptations to steps in the back garden.
- Enabled grant for a new front door.
- Register with National Grids priority list.
- Letter to GP regarding the risk of falls.

There were several very positive outcomes reported following support from the service. These included:

- Carers Centre provided support to prevent unpaid carers strain and voucher for a new fridge and microwave.
- Alzheimer's Society provided advice and guidance about dementia and about activities that can be safely undertaken at home.
- £6,000 Personal Independence Payments were backdated.
- NEST attended urgently and provided a new boiler and 5 x new radiators.
- Community Occupational Therapists assessed for access issues.
- Adaptations to steps in the back garden were completed.
- A new front door was installed.
- Registered with National Grids priority list.

Appendix 4

Early Years Integration Team (EYIT)

CASE STUDY

Region: **West Wales**

Project: **Early Years Integration Team (EYIT)**

- Two parent family. 5 children aged 3 months – 15 years.
- Youngest child – unexpected Downs Syndrome.
- Long history of mental health issues with both parents.
- Long history of poor engagement with support services.

Mum was referred by the Midwife for support from the EYIT Preparation for Parenthood Support Worker (PfPSW) because she had some concern that mum was unaccepting of the Downs diagnosis for her new baby, and she thought that bonding was interrupted by the diagnosis. Mum didn't want to go out with the baby at all.

When the PfPSW made her initial contact, mum told her that she did not want support. Mum was reassured that she didn't have to accept support, but the PfPSW asked if it was OK to drop in some written information. Mum agreed to this. When the information was taken to the mum, she was keen to talk and invited the PfPSW into the home where she stated that she did not like professionals because she felt judged and had several bad experiences over the years. She said that she had felt let down and that she had to keep repeating her story, but no one actually helped.

She admitted that she was struggling a bit with the new baby although she was an experienced mum, everything was different this time. She expressed concern for the baby's future development and said that she didn't know how to handle him. She also said that she was anxious about how he would be received and accepted in public.

Mum had a long history of non-engagement with services that have been put in over the years but after an initial unplanned two-hour visit, she requested a second. The nature of support that mum wanted was discussed and tailored to the families' individual needs. Mum has focused on a loving, nurturing, stimulating relationship and wanted to learn to read the new baby's cues. She has engaged in every planned home visit and has started coming to group activities and events. The family even attended a trip as part of our Summer of Play. She has been referred to the disability team to help support future engagement with health and education services, but we also continue to support. In mum's own words:

> *"You have helped me understand the importance of talking to my baby and bonding. You have been non-judgmental, helpful and friendly. You have helped my anxiety, and I feel more confident and positive about future. Thank you."*

Appendix 5

Accommodation Based Solutions Model of Care

CASE STUDY

Region: **North Wales**

Project: **Regional Learning Disability Accommodation**

This case study shares an account of an individual supported by staff skilled in Positive Behaviour Support (PBS).

At 22 years of age, C has a learning disability and has been diagnosed with a generalised anxiety disorder, such that they can have extreme anxiety throughout the day and will often communicate this through behaviours of concern. They reported a history of having only limited engagement with activities whilst at school, leading to feelings of isolation.

The project identified a new service where C could attend during the daytime 5x per week and a unique opportunity arose in a small property on a temporary basis. Staff worked with C to co-produce a transition plan and with involvement from family, education, health, and existing support providers wrote a holistic personal plan. The property was prepared to cater for all C's preferences and needs. Regular meetings were planned which everyone contributed to. This was a very nervous but exciting time for all.

A functional assessment was conducted, to understand what C was communicating through their behaviours of concern.

Staff identified what primary prevention strategies needed to be implemented, understanding slow and fast triggers, what was reinforcing the behaviour and what strategies were already implemented which were working and which ones weren't. The service was able to build a trusting relationship by giving C voice, choice, and control of what their day looked like. Through conversation, staff identified activities C would like to do and considered how to build on activities that C had not yet experienced.

In this situation, PBS was used with C during her transition from school to adult life. The approach was used as the basis for her support, ensuring her needs were fully communicated by her, understood by, and met by staff and respected by all those around her. The success of the approach meant key staff within the Local Authority were committed to spreading and embedding the approach in future services with other individuals.

In North Wales, this has led to the embracing of the approach in services due to be delivered over coming months and years. Staff within the new children's home setting will all undertake NWT funded coaching and practitioner courses through the British Institute of Learning Disabilities.

This will enable consistent person-centred approaches to be put in place across an entire and newly developed service, meaning all staff at all levels of the organisation are aware of the need for effective communication and understanding of the individual. In turn, this minimises the need for behaviours to be utilised as a way of communicating discomfort and unhappiness.

The use of PBS with this individual achieved a reduction in behaviours that caused concern for family members and staff. It increased her ability to communicate distress and upset and to have choice and control over her life in a way that meant she was able to both communicate her needs when able to do so and also to have her needs pre-empted when she was not able to articulate choice and control.

The individual involved in this case study continues to be supported by staff who are qualified and experienced in the delivery of positive behaviour support.

She is increasing in independence and no longer requires some of the restrictive approaches used when she was a child, at school, etc. For example, she no longer requires a harness to prevent her from running away from staff in public places.

This, in itself, makes C feel more in control when she is out with staff. The use of PBS means she is sufficiently in control of her own activities that she does not feel the need to express unhappiness through trying to "run away" from staff.

C reported many positive outcomes after receiving support from the service, reporting improved confidence and improved quality of life. There has also been a significant decrease in behaviours of concerns. C now participates in a wide range of activities.