Llywodraeth Cymru
Welsh Government

Health and Social Care Regional Integration Fund

First year annual report 2022-23
including priorities for 2023-24

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Contents

Foreword

We are one year on from the launch of the five-year Health and Social Care Regional Integration Fund. This report reflects on progress made over the last year and highlights priorities and plans for 2023-24.

The Welsh Government wants people to be able to live their best life as independently as possible in their own communities.

The ability of health and social care organisations to work together as a 'whole system' is essential as more people live for longer, sometimes managing multiple health conditions and with diverse care and support needs. We are committed to driving change and transformation, and to enable this, learning about best practice needs to be shared across Wales.

Managed through Regional Partnership Boards (RPBs), nearly £145 million has been invested through the Regional Integration Fund over the last twelve months.

Despite the significant system pressures experienced over the last year, and an increasingly challenging financial landscape, Regional Partnership Boards have continued to build on the foundations of 'A Healthier Wales' and create an environment in which health and social care partners actively embrace and deliver service transformation.

We want to thank all the staff across health and social care for all their hard work and dedication as they continue to serve the needs of the people of Wales in challenging circumstances.

For our Regional Partnership Boards this first year has been one of transition, as we amalgamate previously separate funding streams to create greater alignment of resources, so that we maximise impact and reduce administrative burden.

The Regional Integration Fund is also helping us to deliver other key priorities including the NYTH/NEST framework, implementing a whole system approach to mental health and wellbeing services for babies, children and young people.

The Regional Integration Fund investment over the remaining 4 years will greatly support our ambitions to move further, faster towards an integrated community care system for Wales.

There is also a clear expectation that a minimum of 20% of the Regional Integration Fund is invested in delivery through social value sector organisations, helping to support our agenda on rebalancing the care and support market.

We recognise that Regional Partnership Boards and their partners have been working to maximise the impact of the Fund at a time when wider system pressures and recovery from COVID-19 have impacted massively on statutory partner resources and capacity.

In this context, and at the request of our partners, Welsh Government reviewed the tapering and match funding requirements of the fund.

In December 2022, we agreed to relax these arrangements in the short-term, whilst not losing sight of the longer-term aspirations of the Regional Integration Fund to establish sustainable mainstreamed services.

Learning and improvement is an important part of our ethos for the development of health and social care. In the first year we have appointed the University of South Wales in a collaboration with Old Bell 3 and Bangor and Swansea universities, to undertake the evaluation of our Regional Integration Fund.

It is evident that in its first year the Regional Integration Fund has started to further a true partnership approach to investing in integrated services for the long term.

We will continue to hold Regional Partnership Boards to account for delivery of the Regional Integration Fund plans, ensuring there is clarity on how they are maximising the fund to establish and mainstream at least six new national models of care.

We look forward to further progress in year two as we work together to improve integrated care so that the people of Wales, wherever they live, can be assured of an effective and seamless service experience.

Eluned Morgan MS
Minister for
Health and Social Services

Julie Morgan MS
Deputy Minister for
Social Services

Lynne Neagle MS
Deputy Minister for
Mental Health and Wellbeing

Mission statement

By the end of the five-year fund, we will have established and mainstreamed at least six new national models of integrated care 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 services.
- Accommodation based solutions.

The Regional Integration Fund builds on the progress made under the previous Integrated Care Fund (ICF) and Transformation Fund (TF), whilst also responding to the recommendations from the respective independent evaluations and Audit Wales reports.

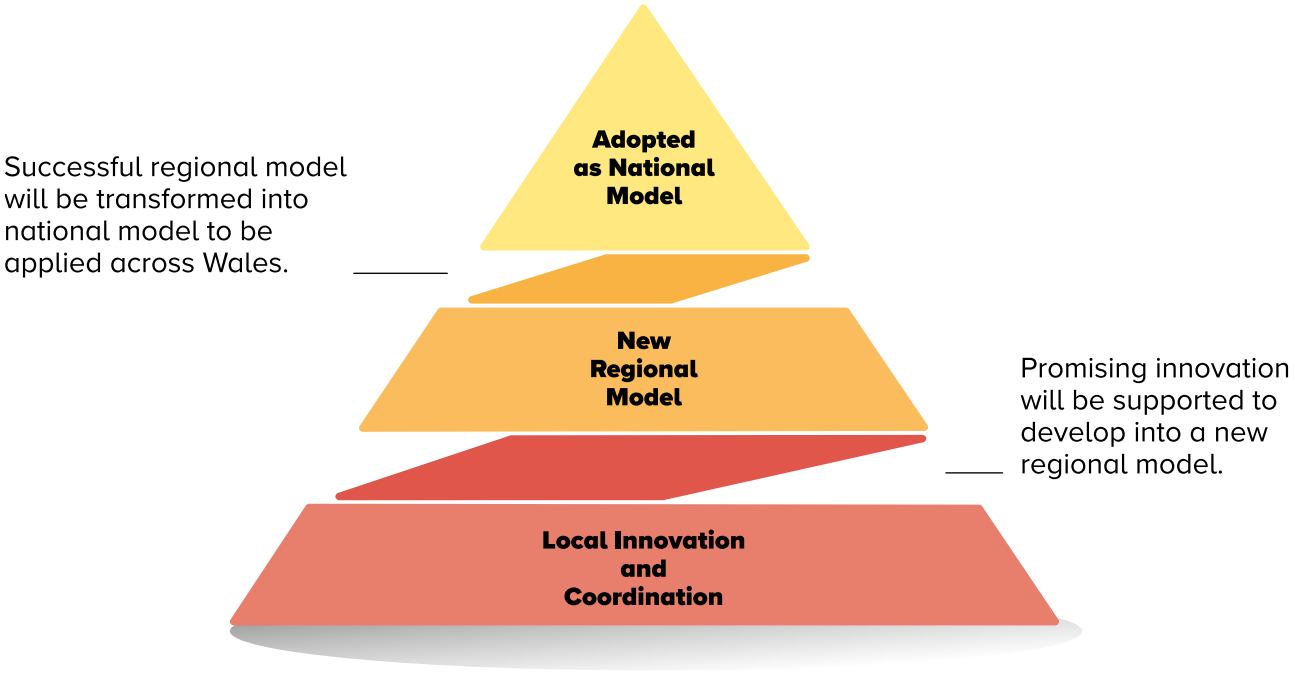
This vital learning has helped us to shape the Regional Integration Fund which includes four key features:

- 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, making use of tapering and match funding levers to support mainstreaming and sustainability.

As set out in A Healthier Wales, our vision of a whole system approach to health and social care will require a whole system effort. The previous Integrated Care Fund and Transformation Fund have supported the development of local and regional services and models of care.

Our challenge now is to move those successful models towards national adoption and embedding.

Figure 1: Transformation approach to the development of National Models



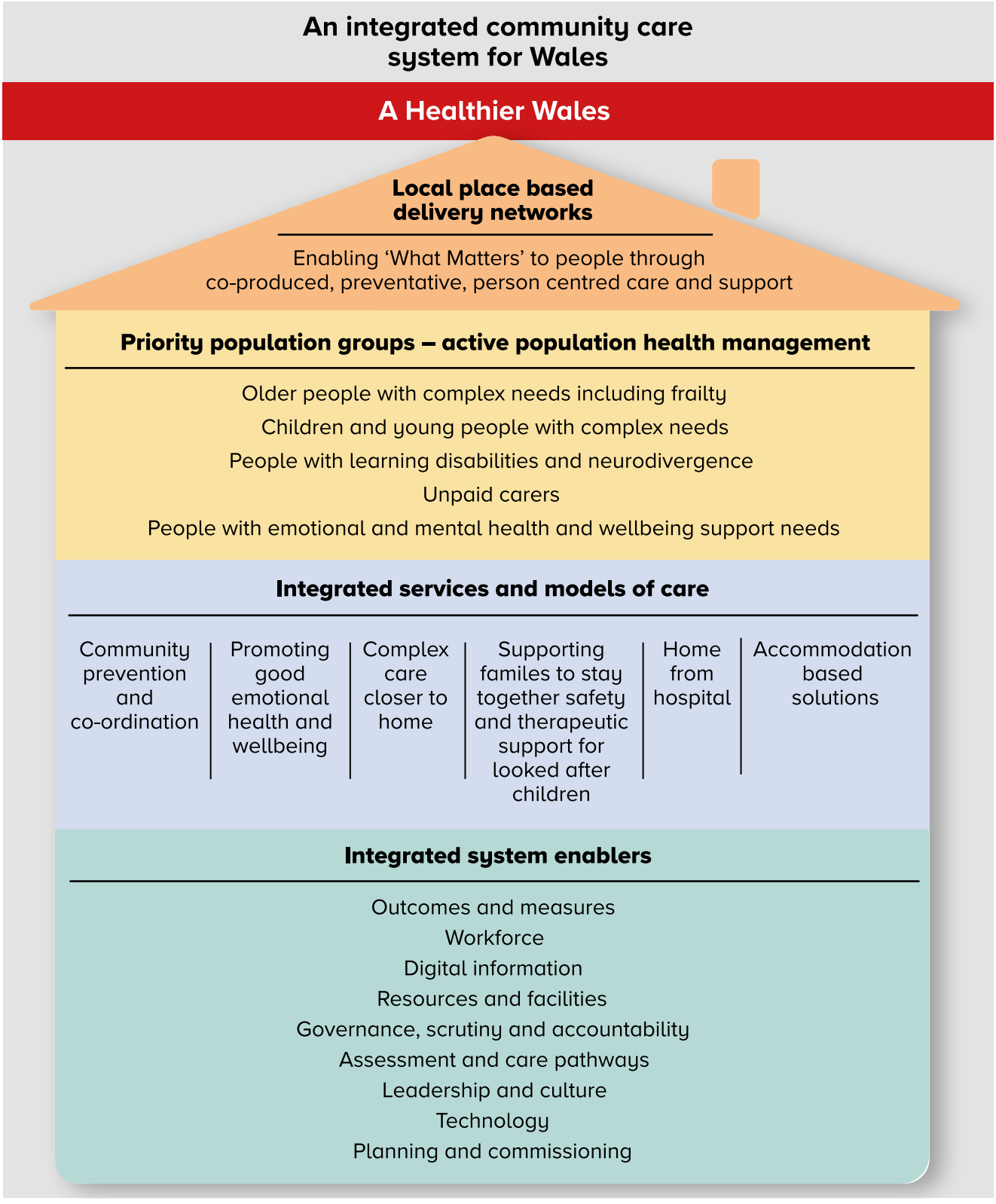
The Regional Integration Fund is a significant and substantial investment, and funding must be targeted to new, seamless models of health and social care that will deliver enhanced value, with the aim of speeding up their development and demonstrating their value.

At the end of the five-year programme, we expect to see these national models of care embedded across Wales.

Creating an Integrated Community Care system for Wales

The Regional Integration Fund is one of several programmes of work currently supporting the establishment of an Integrated Community Care System Blueprint for Wales, (others include the Urgent and Emergency Care Six Goals programme, the Strategic Primary Care Programmes, the Social Prescribing Framework and capital programmes such as the Housing with Care Fund and the Integration and Rebalancing Capital Fund).

Figure 2: Emerging Integrated Community Care System Blueprint for Wales



The emerging blueprint for an Integrated Community Care System (see fig 2) is rooted in helping people achieve '*what matters to them*' and incorporates the six national models of integrated care set out in the Regional Integration Fund.

It is intended to strengthen the capability and capacity of our 'out of hospital' health and social care system. Working across primary and community health, social care, housing and the third sector it aims to build a joined up seamless care and support offer for people helping 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;
- support safe and swift return home from hospital for those who really need secondary care.

The Integrated Community Care System Blueprint describes a whole system approach to providing seamless out of hospital health and care services and identifies the key enablers 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.
- 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.

Investment through the Regional Integration Fund and the other key programmes listed above has already begun to identify and embed some of the key components/services within each model of care as illustrated in figure 3.

Figure 3: component parts and services identified within each Model of Care

A Healthier Wales

Six Models of Integrated Care

Prevention and community co-ordination

- Social prescribing
- Local community co-ordination
- Befriending
- Home support services
- Unpaid carer respite services
- Conveyance avoidance – advanced paramedic practitioners
- Community wellbeing officers
- Information (service directories), Advice and assistance
- Community infrastructure
- Allied Health Professional
- Accelerated clusters

Promoting good emotional health and wellbeing

- Single point of access (24 hours)
- Early help and advice services
- Community-based treatment support (including third sector support)

Complex care closer to home

- Integrated community resource teams
- Telecare service
- Single handed care package programmes
- Care home outreach (admission avoidance)
- Integrated community equipment stores
- Reablement and falls prevention services
- Stay well at home models
- Assistive technology
- Home adaptations

Supporting families to stay together safely and therapeutic support for care experienced children

- Team around the family/early help type models
- Family group conferencing
- Trauma recovery model
- Edge of care models

Home from hospital

- Discharge to recover and assess
- Trusted assessors
- Front door turna-round/admission avoidance/un-scheduled care
- Enhanced community care
- Community transport
- Pre/post admission support
- Step up/step down
- Non clinical support (PIVOT type models) Pathways 0 and 1
- Home adaptations
- Nursing specification

Accommodation based solutions

- Step up/step down facilities/ intermediate care
- Fast track home adaptations
- Extra care
- Safe accommodation
- Independent living wrap around provision

Measuring outcomes

The full outcomes framework for the Regional Integration Fund can be found in Appendix one. However the table below illustrates the two high level outcomes that each Model of Care will be contributing towards.

Reporting mechanisms are being tested that will enable regions to report against the agreed outcomes and indicators and measure impacts. More detailed analysis will be reported in the second annual report.

Model of Care	High Level Outcomes
Community based care: prevention and community co-ordination	1. People's well-being needs are improved through accessing co-ordinated community-based solutions.
	2. Local prevention and early intervention solutions support people to avoid escalation and crisis interventions.
Community based care: complex care close to home	1. People are more involved in deciding where they live while receiving care and support.
	2. Complex care and support packages are better at meeting the needs of people and delivered at home or close to home.
Promoting good emotional health and well-being	1. People are better supported to take control over their own lives and well-being.
	2. People have improved skills, knowledge, and confidence to be independent in recognising their own well-being needs.
Supporting families to stay together and therapeutic support for care experienced children	1. Families get better support to help them stay together.
	2. Therapeutic support improves and enhances the well-being of care experienced children.
Home from hospital	1. People go home from hospital in a more timely manner with the necessary support in place at discharge.
	2. People have a better understanding of the discharge process and are more involved in pre and post discharge planning.
Accommodation based solutions	1. People are more involved in the design of accommodation to meet their needs.
	2. People have more choice about where they live and with whom.

A year in review

Total regional allocated funding and projects by model of care

Community Based Care: Prevention and Community coordination

Allocated Funding

£36,197,384

Number of Projects

Percentage of Funding allocation

Community Based Care: Complex care closer to home

Allocated Funding

£24,327,739

Number of Projects

Percentage of Funding allocation

Promoting good emotional health and well-being

Allocated Funding

£8,384,628

Number of Projects

Percentage of Funding allocation

Supporting familes and therapuetic support for care experienced children

Allocated Funding

£18,982,717

Number of Projects

Percentage of Funding allocation

Home from Hospital

Allocated Funding

£29,674,596

Number of Projects

Percentage of Funding allocation

Accomodation based solutions

Allocated Funding

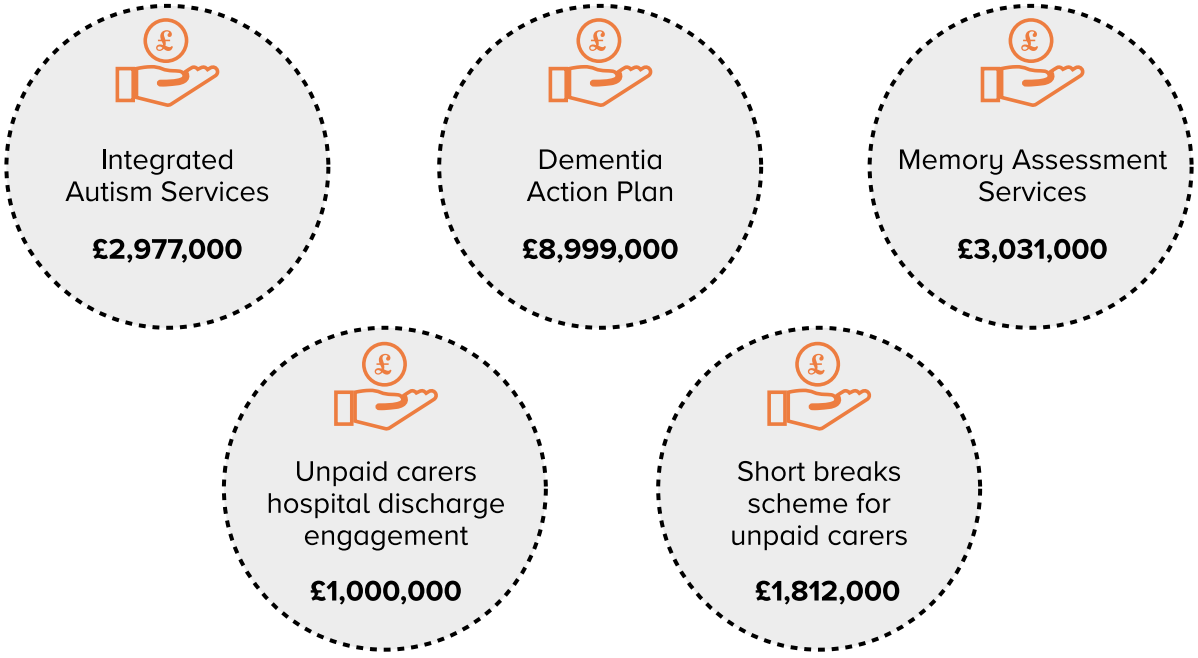
£2,564,176

Number of Projects

Percentage of Funding allocation

Total regional allocated ringfenced funding

Regional Partnership Boards were allocated 100% funding to deliver against national ministerial commitments. This is referred to as ringfenced funding.



Promoting the social value sector and direct support for unpaid carers

In 2022-23 Regional Partnership Boards were expected to invest a minimum of 5% of the Regional Integration Fund into direct support for unpaid carers and 20% in delivery through social value sector organisations.

Total investment in social value	Total investment in unpaid carers
£24,686,000	**£12,321,109**
1% **below** Minimum Investment	5% **above** Minimum Investment

Total investment in Regional Integration Fund infrastructure and programme management costs

It is essential that all Regional Partnership Boards have adequate resources and infrastructure arrangements to support delivery against the collective duties and expectations placed on them under the Part 9 duties of the SS&WBA.

As a minimum Regional Partnership Boards are expected to ensure their regional infrastructure arrangements include the following core resources and roles:

- Enabling the Regional Partnership Boards to meet Part 9 duties – (Regional Partnership Boards development and support, scrutiny and performance management, thematic programme development and oversight, Population Needs Assessments, Area Plans and Market Stability Reports).
- Integrated business intelligence and performance management.
- Communications and Engagement (including dedicated support for carer, citizen, third sector and provider engagement in the work of the Regional Partnership Boards).
- Pooled Budget development and oversight.
- Facilitating joint commissioning/planning of services.
- Promoting the social value sector and facilitating the social value forum.
- Financial management (non-programme related).
- Integrated Workforce Development in support of integrated care models.

These infrastructure costs do not include programme management or delivery costs associated with the Regional Integration Fund or other funds. These programme costs should be drawn proportionately from the acceleration or embedding fund.

Total investment in RIF infrastructure		Total investment in programme management
£4,700,343		**£2,505,783**

Tapering and match funding from regional partners

The fund architecture for the Regional Integration Fund has been co-designed with Regional Partnership Boards to further encourage the testing, embedding and mainstreaming of national integrated models of care.

Partner match funding is expected from year one with 10% expected for accelerating change and 30% for embedding models.

Total investment in RIF infrastructure		Total investment in programme management
£2,505,783		**£4,700,343**

Regional successes in year one by model of care

During 2021-22 an extensive co-design exercise was undertaken with a wide range of internal and external stakeholders to ensure that the successor fund was able to reflect and respond to the learning from the ICF and the TF. This exercise included responding to findings from the Audit Wales report into the ICF and the formal independent evaluations of the ICF and the TF.

Following this co-design process, in April, Welsh Government launched the new and ambitious £144.7m Health & Social Care Regional Integration Fund (Regional Integration Fund).

Each Regional Partnership Board has designed its Regional Integration Fund Investment plan and is making good progress towards testing and developing critical components of our six national models of care.

As we increasingly evidence the best practice from across the country this will be built into national service specifications that will ensure greater consistency of standards and experiences across Wales.

We have developed an Outcomes Framework for the Regional Integration Fund which will support Regional Partnership Boards in gathering both the quality-of-life experiences of people who are benefitting from a Regional Integration funded activity and the numerical information to understand the impact of these models of care and the outcomes achieved for people.

Communities of Practice were established in March 2022 which are aligned to the models of care, The Communities of Practice ethos is inclusive with broad membership of individuals and organisations across sectors and includes citizens and unpaid carers.

All the Communities of Practice are nearing 100 members, with between 30 and 40 attending each meeting. The Communities of Practice role is to share learning and best practice, promote action learning, be solution focused and identify the likely core components of each model of care, thereby supporting the develop of a national specification for each of the models.

The following pages of the report are set out to demonstrate the level of Regional Integration Fund investment each Regional Partnership Boards has made towards each model of care. It will also provide a spotlight on each of the regions, providing a deeper dive on some of the fantastic work that has been undertaken in the first year.

Prevention and Community Coordination

People should be supported to live their lives to the fullest. By focusing on prevention and early intervention we can enhance people's well-being and make the public services that people need more sustainable.

The following breakdown provides details on the allocation of funding by region including the number of projects submitted through the investment proposals.

Cardiff and The Vale	Cwm Taf Morgannwg	Gwent	North Wales
Allocation of funding	Allocation of funding	Allocation of funding	Allocation of funding
£9,742,079	£11,879,939	£4,149,306	£3,736,453
Number of Projects	Number of Projects	Number of Projects	Number of Projects
8	7	2	10

Powys	West Glamorgan	West Wales
Allocation of funding	Allocation of funding	Allocation of funding
£989,712	£2,945,628	£2,754,266
Number of Projects	Number of Projects	Number of Projects
6	6	8

Regional spotlight

Region: **Cwm Taf Morgannwg**

Project: **Resilient Families Service (RFS) – Community support**

The project aims to:

- Establish visible points of access into RFS within communities and provide ongoing community-based support and intervention for families to engage, participate and contribute to the communities in which they live following involvement.
- Improve community-based access to early intervention and prevention services that seek to increase individual and family resilience to prevent children, young people and families requiring statutory intervention.
- Reduce the number of children becoming known to statutory services by increasing the number of families with improved resilience through involvement and active engagement in community life.

What is being done differently?

The service has been able to build more positive working relationships with local community groups and services while ensuring a wide reach of residents within local communities and developing community-based support mechanisms for families who have then been referred to receive interventions with RFS.

- The project supported **1,225** families during 2022-23, of which **574** were new families.
- This number equated to **4,266** individuals that were supported during the year.
- The majority of these families were supported via community-based drop-in sessions (**28**) and one to one sessions (**2,836**).
- In addition to these sessions **332** individuals were supported following a step down from children's services.

Engagement activities are undertaken to obtain service user experience and feedback information. This feedback has shown that users have experienced a positive life change.

> **"I have made many changes. My confidence and outlook on life has changed. I feel different."**

> **"Nobody realises how good you are. They really don't. Out of all my workers you have been my fairy Godmother."**

Regional spotlight

Region: **Gwent**

Project: **Connected Communities**

The Connected Communities Programme provides a whole system approach to community support, early intervention and prevention using a triad of support - building on the established links within local communities via community connectors, support delivered through Information, Advice and Assistance teams, and projects that support prevention, well-being and health inclusion. The programme ensures that the well-being of people is maintained or improved, and that social isolation and loneliness are avoided or reduced. It intends to reduce the impact of loneliness and isolation by fostering community well-being spaces and approaches, establishing locality links, networks and creating community-based solutions.

What is being done differently?

Over the 2022-23 period, the programme has assisted **25,276** people in various capacities. Of these, **7,706** received information, advice and assistance (IAA), **7,109** received early help and support, and **308** received intensive targeted support. Additionally, **400** people received training.

605 people were supported by the Prevention and Mitigation of Sight Loss Project which increases confidence and well-being, financial and personal independence allowing people to remain in their own homes. This lessens the impact of the need for social care from the local authorities and entry into secondary care.

The Falls Response Service responded to **902** incidents across Gwent. Where fallers and older people have accessed the Welsh Ambulance service via 999 emergency services. Of the incidents attended **74** were immediately life-threatening, the remaining **828** were other priority types with a falls specific code or frailty presentation.

Of the **828** responded incidents **681** of those were supported to remain at home without conveyance to the hospital, demonstrating a non-conveyance rate of **82%**.

> **“You got me out, if it wasn’t for you, I wouldn’t have taken that step. I think you do an excellent job and you have done me the world of good. You gave me that gentle nudge that I needed. Give yourself a pat on the back, you’re a good one.”**

> **“The befriending scheme offers an essential lifeline to those isolated from the community. I’m so pleased that we are able to give beneficiaries access to a much needed community.”**

Regional spotlight

Region: **Powys**

Project: **Community Connector Service**

The Community Connector Service supports people to access community-level services and activities that help them to maintain independent lives and prevent the need for higher level health or social care services and promote early discharge from hospital.

Originally developed under the Integrated Care Fund, the Community Connector Service has further developed its delivery to meet the changing needs of the population and health and care priorities.

What is being done differently?

The Community Connector service aims to:

1. Make best use of community strengths and the physical environment to support people to maintain their health and wellbeing.
2. Focus on early intervention to support the independence and participation of people.
3. A more coordinated approach to managing long term conditions that gives everyone an opportunity to build on their strengths.
4. Help people to overcome loneliness and social isolation and be an active member of their community.
5. Support health and care teams to work seamlessly with older people to get things right first time and prevent needs from escalating.
6. Engage with a range of stakeholders to continually monitor and revise the offer as necessary, ensuring we meet the needs of the population.
7. Engage with health and care professionals through regular meetings and an annual survey.

Key outcomes include?

- **570** referrals or signposts to third sector and community activities/groups.
- **199** referrals made to social care & health for additional support not found in the 3rd sector.
- **885** clients supported including 19 with dementia and 48 who identify as a carer.
- Connectors attended **241** Virtual Ward/Multi Disciplinary Team/ASSIST Screening/Care Practice Forums & Patient Flow meetings inputting third sector information into discussions with Health and Social Care Colleagues.
- **162** direct referrals received for additional support for client via these meetings.
- **69** clients supported who reported social isolation, loneliness or companionship as a presenting issue.
- **71** clients signposted or referred to Powys Befriending Service.
- Supported **19** clients who were in hospital.
- **501** referrals received from Health & Social Care.
- **199** referrals made to social care & health for additional support not found in the third sector.
- Engagement with the third sector carried out via the 13 locality network meetings that were facilitated and supported by the Community Connector team.
- Professional annual survey carried out in Q4 **100%** of respondents found the service was helpful or very helpful, **100%** responded that the CC service understood their question or enquiry.
- **100%** of professionals responded that the Community Connector service was able to provide them with the information they required or answered their question.
- **90%** of respondents found the information helped them support the patient/client that they were working with.
- For those that accessed the Community Connector service for client/patient, **50%** responded that the information provided made a difference to their health and wellbeing.

COMPLEX CARE CLOSER TO HOME

Helping people to have their health and social care needs met as close to home as possible in a seamless and integrated way.

The following breakdown provides details on the allocation of funding by region including the number of projects submitted through the investment proposals.

Cardiff and The Vale	Cwm Taf Morgannwg	Gwent	North Wales
Allocation of funding	Allocation of funding	Allocation of funding	Allocation of funding
£3,758,887	£1,716,500	£9,687,087	£6,924,083
Number of Projects	Number of Projects	Number of Projects	Number of Projects
5	3	4	7

Powys	West Glamorgan	West Wales
Allocation of funding	Allocation of funding	Allocation of funding
£247,269	£84,343	£1,909,569
Number of Projects	Number of Projects	Number of Projects
4	2	6

Regional spotlight

Region: **Gwent**

Project: **Place Based Graduated Care**

The Place Based Graduated Care programme supports adults aged 18 and over who need information, advice, or assistance (IAA). It focuses on providing strength-based, relationship-focused support that draws on community assets. The programme's team is knowledgeable about the demographics and resources of the local community and responds directly to individuals who need advice or assistance.

The programme included a step-up/step-down aspect that provides transitional care between hospitalisation and home for people who require additional rehabilitation and recovery. This service enabled earlier discharge from hospital and supported people to remain at home with tailored rehabilitation to their needs. The step-up/step-down beds aim was to reduce unnecessary admissions to acute hospitals, reduce premature admissions to 24-hour care settings, and promote independence.

The programme also supports the provision of respite care to individuals in residential homes, which help alleviate pressures on family and informal carers and reduced pressure on statutory care providers.

What is being done differently?

The programme has aided many individuals over the past financial year of 2022-23, with a total of **9,849** referrals received and **215** new people accessing the service. In total, **12,498** individuals accessed the service in total, resulting in **15,034** contacts with the programme team.

The programme's support is tailored to the individual's needs and delivers support across the whole of the prevention continuum, with **742** people received universal support of IAA, **420** received targeted early help and support, **3,501** received intensive support, and **8,707** received specialist interventions.

There's a positive reflection on the difference made to those accessing the services within the programme, with **328** individuals reporting a good experience with the support they received, and **568** individuals maintained or improved their emotional health and wellbeing, along with **414** individuals increased their knowledge of services and support available to them, and **1,227** individuals feel they have achieved their personal outcomes thanks to the programme's support.

"I was really worried when I was discharged from hospital, I wondered if I would be able to manage on my own. Then these wonderful carers came each morning and night, I called them my Guardian Angels, they helped me to do things gave me confidence to do things I didn't think I could do, they never rushed me, it was these girls that helped me to get better, I don't have them anymore as I am improving every day, thanks to these guardian angels."

Regional spotlight

Region: **Cardiff & The Vale**

Project: **Care crisis and home based response**

The ambition of the intermediate care project is to form a regional approach which brings together the various elements of intermediate care to allow for a broader scope in the development of the service as a whole.

The project aims to:

- Develop a regional approach which aligns services to the approach illustrated above and informs a single Intermediate Care Delivery Plan for 6 Goals, 1,000 beds and Discharge to Recover and Assess requirements.
- Utilise the local modelling capability to understand the capacity and demand for services to allow a 'rightsizing' approach.
- Develop preparatory work for an integrated 24/7 crisis response service which utilises best practice and learning from regions across Wales.

What is being done differently?

Across the year, an average of **363** new people received support by the service every month for step up support. **174** new people received support each month for step down care.

These services were provided using a mix of Regional Integration Fund and core funding.

In addition, **105** people were supported with accommodation-related issues to facilitate their ongoing recovery. This included **18** people who were provided with temporary accommodation to facilitate their recovery with a hospital setting whilst changes were made to their permanent homes.

95% of cases reported improvement in reducing activity limitation, client distress, impairment and increasing participation.

74% of cases reported a reduction in carer distress.

93% of cases reported an improvement in client wellbeing.

100% of the people using our step-down accommodation felt that it was beneficial in achieving their discharge from hospital.

192 hospital discharges were assisted because of the step-down accommodation provision.

Promoting Good Emotional Health and Wellbeing

Complementing existing investment in acute mental health services, the Regional Integration Fund aims 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, support communications and engagement around good emotional health and wellbeing and support the implementation of the NYTH/NEST framework for babies, children and young people.

The following breakdown provides details on the allocation of funding by region including the number of projects submitted through the investment proposals.

Cardiff and The Vale	Cwm Taf Morgannwg	Gwent	North Wales
Allocation of funding	Allocation of funding	Allocation of funding	Allocation of funding
£568,061	£1,177,223	£1,174,462	£1,203,936
Number of Projects	Number of Projects	Number of Projects	Number of Projects
5	3	3	4

Powys	West Glamorgan	West Wales
Allocation of funding	Allocation of funding	Allocation of funding
£1,809,566	£1,243,490	£1,207,888
Number of Projects	Number of Projects	Number of Projects
6	12	8

Regional spotlight

Region: **West Glamorgan**

Project: **Promoting Good Emotional Health and Wellbeing for Carers**

A significant focus in the Carers Programme is around the model of care for promoting good emotional health and wellbeing for carers and includes 4 themes:

1. Flexible respite and short breaks.
2. Community counselling and wellbeing support.
3. Community Support for Young Carers.
4. Community Support for Black, Asian and Minority Ethnic carers.

These projects include a wide range of support for different groups of carers including young carers, parent carers, dementia carers and older people carers.

What is being done differently?

Flexible Respite/Short Breaks

Under this theme there are 16 projects that offer a range of flexible respite/short breaks options. These include sitting services, emergency respite, giving you time back schemes, which offer help at home, home improvement, handy person services, decluttering, gardening, and cleaning support, vouchers for short breaks, grants to fund short breaks, short breaks for parent carers and residential trips for young carers.

1,486 carers received respite and short breaks in 2022-23, though many of these schemes did not start till mid-way through the financial year. **117** carers and **85** young carers were supported with a short break/residential trip to enable carers to have a life alongside caring and maintain their own health and wellbeing.

Community Counselling and Wellbeing Support

Under this theme, the Regional Integration Fund funds 8 projects to provide community counselling and wellbeing support, provided to a range of carers including families with neurodiverse young people with additional needs and male carers. **1,102** carers have been supported through the following range of support:

- Regular wellbeing calls with links to professional networks if further support is needed.
- Bereavement support.
- Support at the end of the caring role, including workshops and one-to-one. mentoring/coaching to support carers to return to employment or education.
- One to one counselling sessions.
- Group counselling sessions.

Community Support for Young Carers

Supporting and identifying young carers is a key priority for the Carers Programme. In Neath and Port Talbot and Swansea there are projects that deliver awareness raising sessions within schools, colleges, and community groups and aims to ensure young carers are identified, recognised, and supported. The project aims to ensure our society are aware of who young carers are, what challenges they may face and how they can be supported, with training provided to professionals and staff in schools. It is essential for society to have knowledge and skills to identify and support young carers to ensure they receive the help they need. **162** young carers have been supported and **14,213** children and young people have had awareness raising sessions in schools, colleges and community setting across West Glamorgan. The project in Neath and Port Talbot reported **99.4%** (497/500 evaluated) of children and young people attending awareness raising sessions stated they know where to go for information, advice, and assistance in the future. **96.4%** (54/56) of young carers felt the keeping in touch service/engagement events has helped them.

A regional project has enabled **81** young carers across Swansea and Neath Port Talbot to apply for a Young Carers Grant. This grant has supported opportunities for Young Carers to access services and items that enabled them to have a meaningful break from their caring role- either physically or mentally. This has enabled these young carers to have opportunities to have time for themselves, socialise with family and friends and support their overall wellbeing.

Community Support for Black, Asian and Minority Ethnic Carers

It is recognised that poorer health inequalities are deepening among unpaid carers and in particular carers from ethnic minority backgrounds. There is a key project for 'Community Support for Black, Asian and Minority Ethnic carers' which identifies carers, brings them together, finds out their needs and provides support to equip Black, Asian and Minority Ethnic carers with coping strategies and the confidence/assurance in their ability and skills in providing care, whilst looking after their own wellbeing. This project offers specialist support for Black, Asian and Minority Ethnic carers, recognises different cultural nuances, and is aware of the issues associated with language barriers, to gain the trust of carers in different communities. The project supported **163** Black, Asian and Minority Ethnic carers in 2022-23, with **98** of those receiving an internal assessment and 100% of those who responded said that they felt their needs were met.

SUPPORTING FAMILIES TO STAY TOGETHER SAFELY AND THERAPEUTIC SUPPORT FOR CARE EXPERIENCED CHILDREN

Working with families to help them stay together safely and prevent the need for children to become looked after. Regional Partnership Boards will be required to work within a shared strategic context which comprises of and works to achieve local authorities' children's services priorities.

The following breakdown provides details on the allocation of funding by region including the number of projects submitted through the investment proposals.

Cardiff and The Vale	Cwm Taf Morgannwg	Gwent	North Wales
Allocation of funding	Allocation of funding	Allocation of funding	Allocation of funding
£1,954,913	£458,765	£3,249,247	£9,144,261
Number of Projects	Number of Projects	Number of Projects	Number of Projects
2	3	3	8

Powys	West Glamorgan	West Wales
Allocation of funding	Allocation of funding	Allocation of funding
£610,000	£1,894,177	£1,617,353
Number of Projects	Number of Projects	Number of Projects
6	4	4

Regional spotlight

Region: **North Wales**

Project: **Intensive residential support for children with complex needs**
Step up Step Down – Enhanced Foster Care model

The project aims to promote placement stability and prevent placement breakdown, prevent escalation into residential placements for children at risk of this, and facilitate 'stepping down' from residential settings.

Enhanced Foster Care project is provided by CAMHS with a specific psychology element and is embedded within Children's Services. This project includes:

- Training and development.
- Contribution to assessments or provision of complementary standalone developmental assessments to inform placement and care with particular attention to defining the kind of therapeutic input that would be appropriate.
- Developing pathways and facilitating access to CAMHS, neurodevelopment and other services.
- Integration of the network, joint casework with Social Work colleagues, supervision of relevant, specialist elements of Social Work colleagues' casework, and provision of a psychological perspective to the network when requested although not involved in casework.
- Robust pathways have been re-established for looked after children, CAMHS and the Neurodevelopmental Team including establishing a handover model after an intensive intervention.

What is being done differently?

The total cumulative number of cases stood at 35 covering a period of 6 months. The types of work completed include: transition work into or between placements, detailed assessments supporting placement stability and screening for other support such as Play Therapy.

The psychological input has enabled a better understanding of a child's motivation for their behaviour and tailored approaches accordingly. Social Workers have gained more clarity around cases and confidence "*to be able to progress forward and be clear in terms of what may be needed – CAMHS intervention/life journey work/understanding of behaviours and responses and how foster carers can further understand and guide their responses*". 100% of those who took part in training delivered by the psychologist felt more informed, learned how to take an empathic approach to address issues as well as preventing escalation.

"The project has provided better insight into how we work directly with children and young people as well as being able to explore different strategies and levels of support. It has strengthened our links with health professionals and allowed a more reflective space to explore areas of need and how we manage concerns we may have within a more therapeutic way."

Regional spotlight

Region: **West Wales**

Project: **Edge of Care Service**

This project provides structured, evidence-based interventions that enable families to develop problem solving skills, build resilience and achieve positive, sustainable behaviour change. Trained and experienced staff provide a rapid response to children and families in crisis, enabling them to address and overcome the difficulties that have led to the family being at risk of breakdown, and prevent further escalation and referral to care proceedings.

Whether it's to limit the risk of children being moved into care, to address complex multiple needs across a family unit or to support the re-unification of families post care order, this project is committed to develop and deliver innovative and impactful solutions that meet identified needs with the aim of improving the lives of children and families affected.

Each county is contributing elements of the project to implement on a regional level.
In Carmarthenshire they are working with colleagues to break the intergenerational cycle of care. A clinical analysis of family history, strengths, difficulties, and common themes are explored to ensure that generational factors are tackled.

The relationships that we develop helps to break down the barriers enabling a more honest approach to tackling the issues whilst also be there to recognise the strengths and achievements families make and be able to celebrate this in a meaningful way.

In Pembrokeshire they are providing intensive support with continuous in-house training and peer supervision to support families to build on their strengths to improve relationships and increase support networks to enable children to remain (or be returned to) living within their family network safely.

In Ceredigion an Edge of Care Support Worker is working within the local authority and Health Board, alongside Children and family Assessment Teams, safeguarding, Education, Community Mental Health Team, Child & Adolescent Mental Health Service, acting as a single point of contact. In the county they have developed an Edge of Care Step-up/step-down provision which is now established, and being tested as a good practice example.

What is being done differently?

Carmarthenshire: From October 2022 – March 2023, **31** Families and **84** children were supported. During this period 9 became looked after with 1 being rehabilitated at home.

- **13** with family and friends' arrangements.
- **8** children were reunited with their birth family.
- **51** children were maintained with their birth family.
- A family of 6 children have exited the pre proceedings process and names removed from the Protection Register following intensive work.

Pembrokeshire: In the year 2022-23, **87%** of children remained (or were returned to) their family network following Edge of Care intensive support. In reviewing the long-term outcomes 12 months after intervention (2021 to 2022) **81%** of the children remain cared for within the family network.

Feedback from children and families in Pembrokeshire is that they felt supported throughout and they formed good working relationships. Parents report they did not feel judged, and they really enjoyed having someone to talk to and having someone who really listened. They felt supported and in control of their lives to make decisions to make things better for their families.

The project continues to improve the Edge of Care service, striving to further improve bridging the gap between children's and adult services as well as partners in health and external agencies so families are getting the right support at the right time which is a critical aspect for families who are in crisis.

Home from Hospital

Where possible care and support should be offered to help people stay well at home. However, recognising that some people will always require acute assessment/treatment in a hospital environment, it is vital that we create a national model of care that helps people be discharged to recover at home as quickly and safely as possible.

The following breakdown provides details on the allocation of funding by region including the number of projects submitted through the investment proposals.

Cwm Taf Morgannwg

Allocation of funding

£458,765

Number of Projects

2

Gwent

Allocation of funding

£3,249,247

Number of Projects

3

North Wales

Allocation of funding

£9,144,261

Number of Projects

8

Powys

Allocation of funding

£610,000

Number of Projects

6

West Glamorgan

Allocation of funding

£1,894,177

Number of Projects

4

West Wales

Allocation of funding

£1,617,353

Number of Projects

4

Regional spotlight

Region: **Cwm Taf Morgannwg**

Project: **Hospital Discharge Programme**

The aim of the hospital discharge programme is to create a better flow of people out of hospital. By basing discharge coordinators at key hospital sites, people can benefit by being able to have a fuller conversation about their discharge at a sooner point, thereby helping to improve hospital flow as well as improving the experiences of clinical staff and patients.

The programme improves communication and information sharing between health and social care, and facilitates timely discharge, particularly for complex cases. It helps to plan and expedite timely discharges by providing early intervention to the discharge process.

This programme has a preventative ethos, signposting and directing individuals by providing information, advice and assistance at the point of admission to the wards and complements the Stay Well at Home team.

What is being done differently?

The project takes a more proactive approach to hospital discharge, by seeking to identify those people at risk of becoming 'stuck' within secondary care – an outcome likely to have a detrimental impact upon their ability to return to independent living.

To improve the flow of patients out of hospital, social care needs accurate and timely information about the needs of the person in the community.

This is what enables the programme to find support mechanisms, which sometimes includes a package of care and other times could be about finding solutions from community groups, voluntary organisations and third sector partners.

The changes introduced centred around the information supplied about the person, and a knowledge of the services available that could support them upon discharge.

Social care workers needed to be present in the hospital setting to speed up the process of gathering the necessary information; identifying potential for reablement early on; assessing the level of need at an early stage and educating ward staff on the various services in the community.

This project, and the Employee Assistance Programme (EAP) model, significantly reduced the amount of time our Single Point of Access (SPA) spent chasing missing information with wards, and there is anecdotal evidence that it improved the experience for individuals.

It stands to reason that hospital discharges were processed in a more efficient manner using these models compared to SPA managing a hospital discharge over the phone.

Activities that have taken place

- **1562** referrals were received during 2022-23.
- **1094** requests for an assessment were received, with **100%** being complete (hospital and community).
- **1538** discharges were facilitated.
- **253** care home placements were secured.

What has changed for people?

- **888** people supported to move back home.
- **635** people supported to live independently.
- **2632** people receiving what matters discussions.
- **668** people supported to improve finances/access benefits.
- **1562** No of people with access to the information, advice and guidance they need.
- **1538** people signposted to additional/relevant services.

The programme supports the sustainability of assessment and care management services at the hospital/community interface. It has supported reduction in delays to timely discharges from hospital maintaining reducing Pathways of Care Delays (PoCD) and a reduction in hospital length of stay.

The support workers have enabled an improved ability to manage patient flow and maintain current level of service, reducing pressures on the community/hospital interface.

The discharge programme has facilitated improved arrangements in hospital discharges and better access to permanent placements and or placement of choice.

The programme has been very successful in responding to the needs of people with complex problems at the hospital interface and has also been helpful for ward staff in that their knowledge of legislation and community situations is excellent.

Regional spotlight

Region: **West Wales**

Project: **Carers Discharge Support**

The Carers Discharge Support Service is delivered by third sector Carers Services who will offer a continuum of support for unpaid carers to aid the timely discharge of a patient from hospital by supporting and involving the unpaid carer in the discharge process for the person they care for.

Ensuring timely discharge of patients from acute and community hospital settings not only impacts on patient care and treatment outcomes but contributes to value based healthcare and better use of financial and staff resources by increasing patient flow. The Carers Discharge Support Service delivers direct outcomes for unpaid carers, complementing the direct community based support provided to the patient, and the continuum of support for unpaid carers will deliver seamless and integrated support pre-admission, on admission and post discharge.

The service networks continually with hospital staff and other organisations, e.g. Stroke Association and Age Cymru to provide the best possible service for the carers they support. The hospital carers officer liaises with existing discharge related services including nurses, PIVOT in Pembrokeshire and the Blue Amy in Glangwili General Hospital and Prince Philip Hospital. The Carers Officers also work alongside the existing Carers Information outreach workers in each county to ensure best practice is adopted. Reports and updates are provided to senior nurse managers.

Activities that have taken place

- **259** unpaid carers were supported during the discharge of their cared for person.
- **168** new referrals were made mainly via ward staff, OT's social workers etc.
- **52** Valuing Carers training sessions were delivered with 146 attendees.

What is being done differently?

Many carers do not get included in the discharge planning process however through this project many more carers are supported directly with this and after their cared for have returned home.

Carers' wellbeing is now being measured through the Carers Discharge Support service. Wellbeing scores are now recorded at the beginning and then at the end of the support provided. In all cases carers say that their wellbeing has increased due to the Carers Officers interventions.

The service has supported carers through the hospital discharge process, ensuring the carer's voice is heard and their needs are met with positive feedback from the carers that have been supported. Carers have been made aware of their rights and services that are available so they can continue caring while looking after their own health and wellbeing.

What has changed for people?

The service has developed positive working relationships with key hospital staff and is an excellent example of cross sector collaborative working. The Carer Officers are becoming valued team members with a regular flow of referrals; however, further awareness is needed to identify carers at the earliest opportunity and to fully embed the service within discharge planning.

One carer said that the referral made by the Carer Officer for a Carer's Needs Assessment has improved their quality of life, without the Carers Officer's knowledge and support they would be finding it very hard to manage their caring role.

Help with the discharge planning is appreciated by many of the carers which then helps alleviate the stress and anxiety of their cared for coming home. There are also networking opportunities with other health, social care and third sector staff. The cared for can go home from hospital in a timelier manner with the necessary support in place at discharge and supported by their family carer. The carer in turn also has support in their own right.

Feedback from front line staff attending training sessions:

> **"It will be a lot easier to recognise a carer and signpost for support."**

> **"This has given me a good understanding of the support available."**

> **"Increased awareness of the support available for unpaid carers and grants etc. thank you very much."**

Accommodation Based Solutions

Developing accommodation that can support people's independent living and meet their care and support needs in a domestic or residential environment is an important part of our health and care system.

The following breakdown provides details on the allocation of funding by region including the number of projects submitted through the investment proposals.

Cwm Taf Morgannwg	Gwent	North Wales
Allocation of funding	Allocation of funding	Allocation of funding
£530,000	£3,736,453	£1,370,008
Number of Projects	Number of Projects	Number of Projects
2	4	3

Regional spotlight

Region: **West Wales**

Project: **Intermediate and Step-down accommodation**

The project provides dedicated accommodation and staffing resources to support people on discharge from hospital and/or those at risk of admission to hospital or residential care. It involves bed spaces identified in, or close to residential care settings. Accommodation provided by the project enables people to be supported within the community as an alternative to hospital admission and will help to reduce the average length of stay in hospital as well as improving hospital patient flow. This means that more people will be able to live independently resulting in more people who can return to their own home, thereby reducing the level of ongoing domiciliary support required.

The project mainly supports older people (including people with dementia and people with learning disabilities and neurodevelopmental conditions) and unpaid carers.

Accommodation is located at:

- Havenhurst Residential Care Home, provision of 2 bed bungalow.
- Hillside Residential Care Home, 7 intermediate care beds, 2 bed bungalow.
- Ty Pili Pala (TPP – forms part of residential care), 14 reablement beds. Llanelli Step Down Scheme for those with Mental Health needs.
- 'Spot purchase' of beds in the independent sector residential homes across Ceredigion.

Activities that have taken place:

- **33%** of individuals stepped up from Community.
- **67%** of individuals stepped down into TPP from Hospital.
- **83%** of people leave TPP with no requirement for long term care and support.
- **9%** of people leave TPP who require Long Term Care & Support.
- **100%** returned to own home to live independently – Havenhurst.
- **60%** returned to own home to live independently – Hillside.

What is being done differently?

Key aspects of the project include:

- Support from a multi-disciplinary team and appropriate specialists.
- Focusing on reablement so people can return home safely and prevent future hospital admission.
- Specialist provision for those with mental health needs.
- The bungalow accommodation has been installed with an array of assistive technology designed to support people to live as independently as possible.
- Timely assessment enables all those involved with the care to have a voice in the long-term planning decisions.
- Outreach support and assessments from Home First Therapy Staff.
- Part of a wider, person centred Home First pathway.

Successes for people

Front line staff at Ty Pili Pala have stated that they feel very proud to work there. Specific feedback includes the value of working within an Multi Disciplinary Team environment and working so closely with therapies is felt to be hugely positive. There is growing confidence in the service and that it is appropriate for long term care planning and implementation.

Managers of the facilities report having good working relationships with the team, demonstrating trust and mutual respect.

91% of Ty Pili Pala clients return home after a short-term period (no more than six weeks) in a residential care bed.

The project is proceeding as planned, with improved outcomes for individuals, reduction in length of stay and bed days and reduced social care commissioning.

The scheme has enabled patients to be assessed in a timely fashion, this has enabled both patients and their carers/families to have the time to come to terms with realistic options for longer term care needs and the time to consider solutions to challenges. For some users of the scheme, this has meant an appropriate and safe place of care for end of life.

Learning and Evaluation of the Regional Integration Fund

Regional Integration Fund Communities of Practice

As part of the Regional Integration Fund, Communities of Practice have been established in some key areas of transformation and are aligned to the development of the six Models of Integrated Care.

The Communities of Practice have brought together groups of practitioners across sectors to promote productive discussion and encourage collaborative solutions to overcome common challenges as well as contribute to the development of a national "blueprint" for, and implementation, of six national models of integrated care.

The Communities of Practice programme of work commenced in March 2022.

Six Communities of Practice are currently up and running and meet bi-monthly, each focused on one key area of transformation identified in the national Regional Integration Fund implementation guidance:

- Community-Based Care
- Technology-Enabled Care
- Emotional and Mental Health
- Hospital to Home
- Supporting Families and NEST
- Accommodation-Based Care and Support.

Responsibilities of each Community of Practice

- To provide a forum where colleagues with enduring interest, experience, and responsibility in the subject area from across Wales can meet, compare learning, and share good practice.
- To support the development and implementation of a national "blueprint" for models of integrated health and social care.
- To share learning more widely with colleagues across Wales.

Governance, facilitation and meetings

The Communities of Practice are facilitated by the Institute of Public Care (IPC) at Oxford Brookes University. IPC are the contract-holders for this programme of work for the lifecycle of the Regional Integration Fund.

The Communities of Practice are based around online workshops, supported by ongoing email updates and information sharing. Membership remains unrestricted: groups are all open to practitioners, leaders, service users, carers, and citizens more widely.

We simply ask that participants can offer knowledge, experience or responsibility in the area covered by the Communities of Practice.

During each workshop, colleagues are invited to share case studies and examples of local challenges in an action learning problem-solving format.

The Communities of Practice each have around 100 people on their mailing list, mainly professionals with operational or strategic responsibility in Local Health Boards, Local Authorities, private or third sector organisations, as well as service users and unpaid carers.

Initial "Summit" Meeting 2023

In May 2023 a 'Summit' meeting was held involving colleagues from all 6 Communities of Practice and Welsh Government representatives. The Summit involved a detailed look at emerging national policy and what the Communities of Practice see as important elements to be included in the development and content of the planned national models of integrated care.

Progress to date

Community Based Care Community of Practice

This Community of Practice is concerned with the transformation of 'place-based' community health, care and wellbeing services and with helping to avoid hospital admittance and care via application of the principles of 'A Healthier Wales,' to secure more effective, seamless and co-ordinated care in local communities across areas such as primary, community and social care.

- The Community of Practice has linked with the national Strategic Programme for Primary Care and the Community Infrastructure Programme as well as with Regional Integration Fund activities and has contributed to resources produced by them.
- It has explored the challenges facing the implementation of integrated community hubs and produced a discussion paper looking at how to apply principles of best practice in this area as part of a future model of integrated care.
- It has explored what qualities might be needed from an integrated practice model for community-based care.

Technology-Enabled Care Community of Practice

This Community of Practice provides the opportunity for those who are at the forefront of developing and delivering technology-enabled community health and social care to share learning and good practice, and to produce resources which will help others realise the potential of this area in the future.

The Community of Practice has explored some of the key challenges facing technology-enabled care related to the Regional Integration Fund programme and identified several areas where future thought-leadership and resources might be valuable including:

- Capturing people's lived experience of working with technology.
- Data capture and information sharing.
- Responsiveness of tech companies to consumer needs and preferences.
- Standardising approaches to technology research and evaluation.
- The role of the national Technology Enabled Care project register.

Emotional and Mental Health Community of Practice

This Community of Practice is concerned with how best to design and deliver emotional and mental health support for people of all ages across Wales.

The Community of Practice has made strong links with colleagues in the NHS Wales Health Collaborative and HEIW and has provided 'sounding board' support to their work in this area, as well as sharing examples of good and emerging practice.

The Community of Practice has begun its contribution to national thinking about integrated care models by looking carefully at arrangements for single points of access for mental health services. It has produced a discussion paper proposing key principles which should guide the design and development of single points of access across Wales.

Hospital to Home Community of Practice

This Community of Practice has been established for a considerable time and it produced national 'Discharge to Recover and Assess (Discharge to Recover and Assess)' guidance in 2021.

It is supporting the implementation and further development of this work on models of good practice in delivering effective services between hospital and home, and supporting national programmes concerned with Hospital to Home and the Urgent and Emergency Care Six Goals and the NHS Delivery Unit Unscheduled Care Programme.

- The Communities of Practice is working closely with the 6 Urgent and Emergency Care Goals programme offering feedback on emerging resources and planned developments, and support in distributing and embedding good practice.
- Colleagues in the Communities of Practice have explored how to ensure that the 'What Matters' approach, enshrined in legislation and a key commitment of the 'A Healthier Wales' plan, is fully delivered in practice. They have developed a report to help local and regional partners to develop more robust approaches to 'What Matters' conversations as core elements of the Discharge to Recover and Assess/Home from Hospital process, and to explore some of the implementation challenges that many partners are facing across Wales.

Supporting Families and NEST Community of Practice

The Supporting Families and NYTH/NEST Community of Practice draws on the extensive work on the NYTH/NEST framework over recent years in different parts of Wales and is concerned with developing a national model of integrated care concerned with supporting families to stay together safely. It is relevant to a wide range of colleagues involved in work around early help, family support, mental health, wellbeing, domestic violence, substance misuse, edge of care, perinatal, mental health transitions, education, play, youth work, sport, safeguarding and therapeutic care services across Wales.

Accommodation-based Care and Support Community of Practice

Working with the National Commissioning Board, this Community of Practice is exploring arrangements that can support independent living and meet care and support needs in a domestic or residential environment for people of all ages. Linking with housing, registered social landlords, residential care providers and other key partners, including those who can support home adaptations will be vital to delivering this model of care, colleagues are able to share information and ideas, help each other tackle knotty issues, and contribute to a national model of integrated care in this area. The Communities of Practice is concerned with supporting the Regional Integration Fund including both the practice improvement projects and the use of the capital programme.

Using a Theory of Change to inform Regional Integration Fund reporting processes

Responding to conclusions and recommendations from the ICF final evaluation report, an outcomes framework was agreed as part of the Regional Integration Fund development process. This sets out 2 high-level, person-centred outcomes for each of the 6 Models of Care. The framework is underpinned by a detailed outcomes-focused reporting mechanism that will enable Regional Partnership Boards (and Welsh Government) to develop a substantive qualitative evidence base for the Regional Integration Fund.

Doing so will make it possible to tell the story 'behind' the regions' quantitative data, to provide a clear picture of the system change via which the new Models of Care will evolve. Using a 'Theory of Change' enables data to be used as a means of building the layer underneath the standard Results Based Accountability (RBA) mechanisms that are already established.

Using this approach will enable us to understand exactly what needs to be in place in order for a service or intervention to work effectively. It will also improve evaluation work, by making it possible to measure progress towards achieving the longer-term goals of our Models of Care.

Simple outcomes-focused maps are provided to the Regional Partnership Boards as part of their 6 monthly reporting documentation. These are based on the established 'Matter of Focus' model: (Matter of Focus home of OutNav (matter-of-focus.com) – these maps are used alongside RBA to support the collection and reporting of qualitative data.

There are many benefits to adopting this outcomes-focused approach.

- It provides a clear and accessible way of demonstrating the process of change as it pertains to projects/services/models of care and in terms of wider social change: it has been acknowledged that doing so has so far proved challenging. The framework enables change to be demonstrated in a progressive (as opposed to simple and linear) way.
- It separates outcomes into different levels: this helps capture the complex change mechanisms that underpin people-based work in terms of e.g., reactions, knowledge and skills, changes in behaviour and practice and around longer-term social change.
- It allows for a broader conceptualisation of 'learning', i.e., being inclusive of information about what didn't work, as opposed to focusing only on what did.
- It supplements outcome-focused reporting strategies, by helping to show how projects and models of care are making a difference through telling the story of the journey(s) involved.

Table of the Health and Social Care Regional Integration Fund Outcomes Framework can be found in Appendix one.

National Evaluation

About the evaluation

A contract for the National Evaluation of the Regional Integration Fund – with a total value of more than £1m across 5 years – was awarded in March 2023. The evaluation work is being conducted by a partnership led by the Welsh Institute for Health and Social Care (WIHSC), based at University of South Wales (USW), and the three-year programme of work is a collaboration between USW, Swansea University, Old Bell 3 Research, supported by health economists from within Wales.

The programme of work is designed to deliver an independent, rigorous, and comprehensive evaluation, which will assess the aims, implementation, and impact of the Regional Integration Fund. It aims to understand the impact of different models of care, investigating the economic costs and benefits of those models and how far they are delivering the right outcomes for people. The study has initially been commissioned for a three-year period but may be extended for a fourth year.

The evaluation will pay regard to demonstrating how and in which ways the Regional Integration Fund has had a positive impact for the fund's priority population groups, by clearly articulating the story of change brought about by its implementation, including a comprehensive understanding of why certain aspects have been successful or less successful, and how challenges have been addressed or overcome.

Governance

The programme of evaluation work is supported by a Steering Group (ESG), an Expert Reference Group (ERG) and, most recently developed, a service-user, carer and citizen co-design group. The study team will be supported and challenged by the ESG and ERG) – each group will meet 2-3 times per year.

NYTH/NEST Framework Implementation

The NYTH/NEST framework works to create a whole system approach to mental health and wellbeing services for babies, children and young people.[1] Implementation of the NYTH/NEST framework is an underpinning driver of all work funded by the Regional Integration Fund concerning babies, children, young people and their families. Significant progress has been made in implementing the framework, including:

- All Regional Partnership Boards working to regional NYTH/NEST implementation plans.
- Annual reporting on progress using the NYTH/NEST self-assessment and implementation tool which is currently being co-produced and piloted.
- Co-production of NYTH/NEST and children's rights training developed nationally to support regional implementation.
- NEST 'in action' case study document to support sharing of good practice.[2]

1 NEST framework (mental health and wellbeing): introduction | GOV.WALES
2 Good practice projects using the NYTH/NEST framework: case studies | GOV.WALES

Priorities for year 2 (2023-24)

The first year of the Regional Integration Fund has been one of transition for Regional Partnership Boards, as we amalgamate previously separate funding streams to create greater alignment of resources, so that we maximise impact and reduce administrative burden.

The priorities for 2023-24 build on the progress made against the objectives to date. To maintain the momentum and maximise the Regional Integration Fund, we will focus on:

1. **Reviewing all projects** to ensure they continue to meet the needs of the population in the respective regions, whilst adhering to the requirements of the Regional Integration Fund and its outcomes framework.
2. **Further supporting the move towards** more consistent regional projects and service designs.
3. **Improving the level of qualitative data** being reported and bring together the 'story of change' though person centred engagement for the lifetime of the project.
4. **Improving the capture of quantitative performance data** to allow for a more consistent understanding of impact as well as cross project and regional comparisons.
5. **Improving the reporting at model of care level** to demonstrate how the projects are collectively contributing towards the development and embedding of the six national models of integrated care.
6. **Match funding requirements** and financial sustainability of mainstreamed projects beyond the lifetime of the Regional Integration Fund.
7. **Sharing best practice** and learning will remain a key aspect of the Regional Integration Fund. The Communities of Practice will play an integral role in shaping the Models of Care.
8. **Developing national specifications** for our models of care and some of the key component parts.

Appendix 1: Regional Integration Fund Outcomes Framework

Table 1: Health and Social Care Regional Integration Fund Outcomes Framework

Context:

- Influencing and driving system change across health and social care.
- Development of a cohesive and integrated infrastructure.
- Developing and delivering six national models of care.
- Embedding new models of care in communities.

Model of Care High Level outcomes	**Indicators for each Model of Care** *(They can be both qualitative and quantitative, but expect a focus on the qualitative in the 4th quadrant of the Results Based Accountability)*	**Performance Measures** *(Priority population group level) In the 3rd quadrant of the RBA reporting, we expect to see the difference made to the priority population groups: How much did we do?*	**Relevant Frameworks and Measures (not exhaustive)**
Model of care: Community based care: prevention and community co-ordination			
1. People's well-being needs are improved through accessing co-ordinated community-based solutions.	• Presence of and an appropriate range of opportunities to ensure they connect with their target priority population groups. • Evidence that the social capital in communities is being utilised. • Evidence of drawing upon social value organisations in community co-ordination. • Choice of activities to support well-being both digitally and face-to-face through a '*single door*' (e.g., integrated community hubs, accelerated cluster development). • Experiences of improved well-being outcomes for people.	• Increased number and percentage of people with care and support needs are accessing and using services that provide community-based solutions. • Increased number and percentage of people with care and support needs are accessing and using services that support Discharge to Recover and Assess pathway 0. • Reduced number and percentage of readmissions to hospital. • Number of new social value sector activities delivered (Section 16[3]) to the priority population groups.	• Performance and Improvement Framework of Social Services (Adult, Children and Young People and Unpaid Carers – adult and young carers metrics). • NHS Wales activity and performance data (e.g., PROMS/ PREMS). • Annual National Survey. • Health and Social Care National Outcomes Framework. • Dementia Plan High Level Performance Measures (Annex 3) dementia-action-plan-for-wales.pdf (gov.wales). • Integrated Autism Service reporting framework.
2. Local prevention and early intervention solutions support people to avoid escalation and crisis interventions.	• Evidence that local activities and solutions are preventing escalation and emergency responses from health and social care. • Experiences of being able to easily access community-based prevention and early intervention solutions.	• Reduction in number and percentage demand for crisis interventions through decrease in referrals to social care and specialist health provision. • Reduced number and percentage of unplanned hospital admissions.	

3 Social Services and Well-being Act, 2014 Section 16 defines social value organisations as not for profit types such as third sector, user-led, co-operatives and social enterprises.

Model of Care High Level outcomes	**Indicators for each Model of Care** *(They can be both qualitative and quantitative, but expect a focus on the qualitative in the 4th quadrant of the Results Based Accountability)*	**Performance Measures** *(Priority population group level) In the 3rd quadrant of the RBA reporting, we expect to see the difference made to the priority population groups: How much did we do?*	**Relevant Frameworks and Measures (not exhaustive)**
Model of care: Community based care: complex care close to home			
1. People are more involved in deciding where they live while receiving care and support.	• Existence and evidence of 'What Matters' conversations. • Positive experiences of people feeling involved in decision-making as to where care and support is delivered. • Presence of integrated planning to develop a flexible range of options to meet people's needs.	• Increased number and percentage of people with care and support needs having 'What Matters' conversations. • Increased number and percentage of people with care and support needs who are satisfied that they have been involved in decisions that affect and impact on their lives.	• Performance and Improvement Framework of Social Services (Adult, Children and Young People and Unpaid Carers (adult and young carers metrics). • Six goals for urgent and emergency care: Goal 3 – clinically safe alternatives to admission to hospital. • NHS Wales activity and performance data (e.g., PROMS/ PREMS). • Annual National Survey. • Health and Social Care National Outcomes Framework. • Dementia Plan High Level Performance Measures (Annex 3). • Integrated Autism Service reporting framework.
2. Complex care and support packages are better at meeting the needs of people and delivered at home or close to home.	• Use of technology enabled support is maximised at home or close to home to promote independence. • Evidence and experience of not-for-profit provision. • Quality of people's experience in the delivery and receipt of care and support packages.	• Increased number and percentage of people with care and support needs are accessing clinically safe alternatives to hospital admission. • Increased number and percentage of care and support packages delivered at home or close to home. • Number and percentage of people using technology enabled support. • Increased number and percentage of people satisfied with their care and support package. • Increase number and percentage of people with care and support needs are accessing services that provide not for profit social value sector support (Section 16 – see definition: footnote on page 8).	

Model of Care High Level outcomes	**Indicators for each Model of Care** *(They can be both qualitative and quantitative, but expect a focus on the qualitative in the 4th quadrant of the Results Based Accountability)*	**Performance Measures** *(Priority population group level) In the 3rd quadrant of the RBA reporting, we expect to see the difference made to the priority population groups: How much did we do?*	**Relevant Frameworks and Measures (not exhaustive)**
Model of care: Promoting good emotional health and well-being			
1. People are better supported to take control over their own lives and well-being.	• Evidence that individuals are able to access and engage with a range of services that provide emotional health and well-being support. • Positive experiences of delivering and using services that support people's emotional health and well-being.	• Number and percentage reduction in people feeling lonely and isolated. • Number and percentage of people reporting improved emotional health and well-being score for children in Wales www.statswales.gov.wales/Catalogue/Well-being/strengthsanddifficulties questionnaire. • Number and percentage of children and young people who feel they have a good relationship with a trusted adult. • Number and percentage of children and young people who did **not** require onward referral after the completion of counselling sessions. • Increased number of children and young people accessing other activities (e.g., youth and play type) preventing need for further support.	• Mental Health Outcomes Framework. • Mental Health (Wales) Measure. • Six goals for urgent and emergency care: Goal 4 – rapid response in a physical or mental health crisis. • NYTH/NEST Framework, including No Wrong Door. • sCAMHS (Specialist Child and Adolescent Mental Health Services). • Performance and Improvement Framework of Social Services (Adult, Children and Young People and Unpaid Carers (adult and young carers metrics). • Annual National Survey. • Health and Social Care National Outcomes Framework. • Dementia Plan High Level Performance Measures (Annex 3). • Integrated Autism Service reporting framework. • Children and Young People's Plan priorities. • Schools Health Research Network (SHRN) School Health Research Network (shrn.org.uk).
2. People have improved skills, knowledge, and confidence to be independent in recognising their own well-being needs.	• Evidence of activity that is sufficient/appropriate in enabling people to become independent and to maintain their own wellbeing. • Positive experiences of people feeling able to recognise and address their own wellbeing needs.	• Number and percentage of people reporting that they feel nurtured, empowered, and safe. • Number and percentage of people who report actively seeking help and support for their own emotional and mental health. • Number and percentage of people who report being able to identify and approach suitable services (at the right time) for help and support with their emotional and mental health.	

Model of Care High Level outcomes	**Indicators for each Model of Care** *(They can be both qualitative and quantitative, but expect a focus on the qualitative in the 4th quadrant of the Results Based Accountability)*	**Performance Measures** *(Priority population group level) In the 3rd quadrant of the RBA reporting, we expect to see the difference made to the priority population groups: How much did we do?*	**Relevant Frameworks and Measures (not exhaustive)**
Model of care: Supporting families to stay together and therapeutic support for care experienced children			
1. Families get better support to help them stay together.	• Evidence of holistic social functioning and positive social behaviours. • Experiences of families developing future ready skills that they feel are helping them to stay together.	• Number and percentage reduction in the rate of looked after children per 10,000 of the population aged under 18 years (Health and Social Care National Outcomes Framework).	• Performance and Improvement Framework of Social Services (Children and Young People metrics). • NYTH/NEST Framework. • Local Authority School Counselling Services Collection. • Children and Young People's Plan priorities*. • All children and young people should receive the support they need to stay together or come back together with their family, if possible.
2. Therapeutic support improves and enhances the well-being of care experienced children.	• Experience of therapeutic support that is delivered in accordance with the NEST framework. • Service delivery that is experienced as being cohesive, coordinated and co-operative.	• Number and percentage of children who received counselling services in 2020-21 – 2021-22 Counselling for children and young people: September 2019 to August 2020 | GOV.WALES Counselling for children and young people (gov.wales). • Number and percentage of children waiting for Local Primary Mental Health Support Services assessment. • Number and percentage of children waiting for Specialist CAMHS. • Number and percentage of monthly referrals for a Local Primary Mental Health Support Services (LPMHSS) assessment www.statswales.gov.wales/Catalogue/Health- and-Social-Care/Mental-Health/Mental- Health-Measure/Part- 1/referralsforalpmhssassessment-by-lhb-month.	

Model of Care High Level outcomes	**Indicators for each Model of Care** *(They can be both qualitative and quantitative, but expect a focus on the qualitative in the 4th quadrant of the Results Based Accountability)*	**Performance Measures** *(Priority population group level) In the 3rd quadrant of the RBA reporting, we expect to see the difference made to the priority population groups: How much did we do?*	**Relevant Frameworks and Measures (not exhaustive)**
Model of care: Home from hospital			
1. People go home from hospital in a more timely manner with the necessary support in place at discharge.	• Evidence that key stakeholders and delivery partners are utilising local community assets and co-ordination to support 'Home First'. • Positive experiences of timely hospital discharge with the necessary support at home already in place.	• Number and percentage of patients with care and support needs returning home from hospital with satisfactory discharge plans in place. • Number and percentage of people accessing Discharge to Recover and Assess pathway 0.	• Six goals for urgent and emergency care: Goals 1, 2, 3 4, 5 & 6. • Performance and Improvement Framework of Social Services (Adult, Children and Young People and Unpaid Carers (adult and young carers metrics). • NHS Wales activity and performance data (e.g., PROMS/ PREMS). • Annual National Survey. • Health and Social Care National Outcomes Framework. • Dementia Plan High Level Performance Measures (Annex 3). • Integrated Autism Service reporting framework.
2. People have a better understanding of the discharge process and are more involved in pre and post discharge planning.	• Evidence that pre-admission planning has been considered in discharge processes and Discharge to Recover and Assess pathways (where appropriate). • Positive experiences of involvement in pre- and post-discharge planning and in the discharge process. • Family/unpaid carers have been involved in the discharge planning process.	• Number and percentage of people (patients) in hospital who are involved with their family/ unpaid carers in discharge planning at the point of admission. • Number and percentage reduction in re-admissions to hospital.	

Model of Care High Level outcomes	**Indicators for each Model of Care** *(They can be both qualitative and quantitative, but expect a focus on the qualitative in the 4th quadrant of the Results Based Accountability)*	**Performance Measures** *(Priority population group level) In the 3rd quadrant of the RBA reporting, we expect to see the difference made to the priority population groups: How much did we do?*	**Relevant Frameworks and Measures (not exhaustive)**
Model of care: Accommodation based solutions			
1. People are more involved in the design of accommodation to meet their needs.	• Evidence that safe accommodation is available across the key population groups. • Evidence that integrated care and support systems are in place within the design of accommodation systems. • Experiences of people feeling involved in designing/identifying accommodation that meets their needs.	• Number and percentage of adults who use care and support services (either for themselves or for the person they care for) who strongly agree or tend to agree that their accommodation is suitable for their needs*.	• Dementia Plan High Level Performance Measures (Annex 3). • Homelessness Outcomes Framework. • Integrated Autism Service reporting framework. • Health and Social Care National Outcomes Framework: accommodation suitable for needs*.
2. People have more choice about where they live and with whom.	• Positive experiences of accommodation-based solutions that are person-centred and offer a '*support for a good life*' approach.	• Number of people who report that their accommodation is suitable for their needs.	