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Qualitative interviews report

Implementation of the Regional Integration Fund Supporting evidence report for the national evaluation of the Regional Integration Fund

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Qualitative interviews report

Implementation of the Regional Integration Fund

Supporting evidence report for the national evaluation of the Regional Integration Fund

This is the qualitative interviews report which is the document providing supporting evidence for the implementation report of the national evaluation of the Regional Integration Fund.

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Glossary

ANP advanced nurse practitioner

CAMHS Children and Adolescent Mental Health Services

CoP Community of Practice

CYP Children and Young People

D2RA Discharge to Recover and Assess

ICF Intermediate Care Fund

IFFS Integrated Family Support Service

MoC Model of Care

MDT Multi-Disciplinary Team

NEST Nurturing, Empowering, Safe and Trusted

NIC National Insurance Contribution

OT Occupational Therapy

P-FE Principles-Focused Evaluation

RBA Results Based Accountability

RIF Regional Integration Fund

RPB Regional Partnership Board

SSWBA Social Services and Well-being (Wales) Act

TF Transformation Fund

TUEC Transforming Urgent and Emergency Care

VR Virtual Reality

Executive Summary

Findings in terms of design and development

Some of the sampled RIF projects have been informed by robust needs assessment and data and shaped by ongoing service user feedback, to refine and improve practices.

Very few of the sampled projects have adopted learning from other similar projects and greater emphasis was placed by sampled projects on adapting and tailoring provisions to accommodate local needs and circumstances.

RIF has been used as intended to support a wide spectrum of services, from acute care interventions to preventative measures.

Most of the sampled RIF projects existed prior to the programme, but there is good evidence that projects are evolving to operate in a more regional, integrated way.

Strong partnership working and joint management are key components of effective RIF projects.

Third sector organisations play a vital component within RIF projects in some regions by enhancing services and addressing gaps, although their ongoing role depends on funding availability and sustaining partnership working.

RIF funding contributes in varying proportions across projects, from fully funding key roles in smaller initiatives to supplementing specific positions within larger, multi-component projects.

The flexibility of RIF funding and the regional infrastructure and resource put in place has enabled projects to innovate and adapt to changing needs.

RIF reporting processes have improved as a result of streamlined reporting, increased trust and reduced scrutiny, although challenges remain at project and regional level.

Findings in terms of implementation to date

RIF is enabling an increasingly person-centred approach to the delivery of earlier intervention and prevention activity including community-based development.

Well-established projects are continuing to increase integration, but it continues to take a long time to embed change.

The RIF delivery model has reduced workforce recruitment and retention issues within many projects using innovative methods to make roles attractive, but gaps in key specialist posts continue to hinder the ability of some projects to deliver as intended.

Operational challenges are amplified within the current climate of intense resource pressures.

Innovative technology and digital solutions support project delivery in places, but limited opportunities for wider adoption is hindering regional integration efforts.

Recognition and integration of the social value sector is inconsistent. While there were examples of third sector involvement enabling strong community focused responses, there are were also many missed opportunities for deeper collaboration and innovation as statutory services increasingly focus on bolstering core funding.

The Models of Care hold little meaning or relevance to projects delivering on the ground. Projects are more likely to focus on their response to local or regional priorities or on supporting other national goals and policy drivers.

Findings in terms of the Communities of Practice:

Current CoP members attend CoP sessions fairly regularly despite competing workload pressures and contribute effectively but target membership is unclear, with questions raised about breadth of representation.

Those who attend feel that the CoPs are well-organised with only minor suggestions for improvements made.

Attending CoP meetings allows members to keep up to date with policy development, share learning and facilitate engagement between different sectors

From the perspective of their members, CoPs are seen to support problem solving, innovation and the development of a common narrative.

Whilst CoPs have evolved since their inception, there is no clear understanding amongst members or wider RIF stakeholders of the overall objectives of the CoPs and if or how the learning from discussions inform national models of care.

1. Introduction

1.1. Background

The Welsh Government has commissioned a partnership led by the Welsh Institute for Health and Social Care, University of South Wales to evaluate the Regional Integration Fund (RIF). The evaluation is intended to assess the aims, implementation, and impact of the RIF.

The aim of the review is to assess the extent to which 6 new national models of integrated care have successfully been developed, embedded and 'scaled up,' with their core components clearly identified and the extent to which the RIF's high-level person-centred outcomes have been met.

The review is being undertaken in 3 stages – conceptualisation, implementation, and realisation as part of a Principles-Focused Evaluation (P-FE) approach. The first phase of the evaluation (conceptualisation) considered the extent to which meaningful and evaluable principles of the RIF have been articulated and understood.

This report forms part of the second stage, implementation, which seeks to address the question 'if principles have been articulated, to what extent and in what ways are they being adhered to in practice?'

This report draws upon a series of qualitative interviews conducted with Regional Partnership Board (RPB) leads and project and/or strategic leads from a purposive sample of 24 RIF funded projects. It provides supporting evidence for an overarching Implementation Report for the study, which also includes key findings from a Realist Review of the evidence.

1.2. Structure of this report

This report is structured as follows:

- Chapter 2 outlines the methodology used to arrange and undertake the qualitative fieldwork
- Chapter 3 explores how RIF projects have been designed and developed
- Chapter 4 considers the implementation of RIF to date
- Chapter 5 discusses engagement with the Communities of Practice (CoPs)
- Chapter 6 summarises our key findings
- Annex A sets out the various research instruments used.

2. Methodology

This chapter sets out our approach to undertaking the qualitative research, which forms one aspect of the implementation phase evaluation.

2.1. Research instruments

Research instruments were developed to inform the qualitative research, and these are set out at Annex A. They included:

- a discussion guide to interview Regional Partnership Board (RPB) leads
- a discussion guide to interview RIF project representatives
- an 'aide-memoire' to guide workshop discussions at Community of Practice (CoPs) meetings, and
- a bilingual survey tool for distributing to members of CoPs.

In addition, an information sheet, consent form and privacy notices were prepared and distributed as appropriately to all contributors.

2.2. Fieldwork with RPB leads

All RPB leads (7) were approached to contribute to this phase of the evaluation, and interviews were held with 6 of them. No response was received from one RPB lead.

2.3. Fieldwork with RIF projects

It was intended that this element of the evaluation would draw upon the views of a sample of 24 RIF funded projects and a purposive sampling approach was adopted to select the sample. It was agreed with the Welsh Government that the projects would be drawn from 3 of the 6 MoCs, these being the MoCs which were most developed in terms of the progress being made across CoPs, and which were prioritised within Further Faster [footnote 1] and within the context of the development of the Integrated community Care System (ICCS) for Wales:

- Hospital to Home
- Community Based Care – prevention and community co-ordination
- Community Based Care – complex care closer to home

Using the findings of a mapping exercise undertaken by the Welsh Government to identify the most common components of these MoC, it was agreed that the sample projects would focus on two components of activity within each MoC. This would allow the evaluation to explore comparable activities, given that 4 projects per component could be included in the

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[1] Now known as Building Capacity through Community Care [Building Capacity through Community Care]()

sample. The sampling framework adopted is described at section 2.3.1, with between 3 and 4 projects selected from each region.

2.3.1. Proposed sampling approach

Model of care: hospital to home

- The components identified for this model of care were step down and discharge to recover and assess (D2RA).
- Four projects were sampled for this model of care.
- This model of care has regional coverage with 3-4 projects per region.

Model of care: community-based care (prevention and community coordination)

- The components identified for this model of care were community resilience and wellbeing/mental health support.
- Four projects were sampled for this model of care.
- This model of care has regional coverage with 3-4 projects per region.

Model of care: community-based care (complex care closer to home)

- The components identified for this model of care were: falls response and independent living.
- Four projects were sampled for this model of care.
- This model of care has regional coverage with 3-4 projects per region.

The evaluation team accessed a database, populated by the RPBs, which mapped their RIF funded projects against these MoCs and respective components. In using this database to select similar projects from the identified components above, it became apparent that there were insufficient projects within some components to achieve the sampling approach as originally planned. It also became evident that the original proposed sample would not provide appropriate coverage across all key RIF population groups. As such the sampling approach was adapted as shown in section 2.3.2.

2.3.2. Revised sampling approach

Model of care: hospital to home

- The components identified for this model of care were step down and discharge to recover and assess (D2RA)
- Four projects were sampled for this model of care
- This model of care has regional coverage with 3-4 projects per region

Model of care: community-based care (prevention and community coordination)

- The component identified for this model of care was wellbeing/mental health support.
- Four projects were sampled for this model of care.
- This model of care has regional coverage with 3-4 projects per region.

Model of care: supporting families and NEST

- The component identified for this model of care was building family resilience.
- Four projects were sampled for this model of care.
- This model of care has regional coverage with 3-4 projects per region.

Model of care: community-based care (complex care closer to home)

- The components identified for this model of care were falls response and independent living.
- Four projects were sampled for this model of care.
- This model of care has regional coverage with 3-4 projects per region.

This database was then used to select at random a sample of 24 projects, in line with the sampling framework set out above.

The sample was agreed with the Welsh Government and shared with RPB leads, who were asked to note if there were any issues which might preclude the evaluation team from undertaking fieldwork with the selected projects. RPB leads highlighted issues with 10 of the 24 selected projects:

- the main issue raised (for 3 of the selected sample projects) was that the selected projects were very broad workstreams, which were not easily defined for the purposes of undertaking project level evaluation interviews. In these cases, it was agreed with the RPBs that we would focus on an element of the workstream which would lend itself to a meaningful conversation with a project lead
- in 3 cases, the issues raised by RPB leads were unique and all 3 projects were substituted with an alternative option: in one case, the project had not yet started; in another, there had been very little activity in place; and in a third, the project had been merged into a larger model (which was selected as the substitute project)
- in the case of the final two projects where RPBs raised issues, the selected projects were in fact reported under the Accommodation Based Care Solutions MoC, as they had a capital funding element. The evaluation team agreed with the Welsh Government that these would be retained within the sample, as their

revenue delivery components aligned with the MoCs which were of interest to the study.

Three of the original 24 sample projects were substituted with an alternative project, suggested by the RPB leads in line with the sampling framework.

RPB leads were asked to supply the evaluation team with contact data for key individuals involved in managing, co-ordinating and delivering these projects, as well as any contact data for staff who had a strategic overview of these projects.

A total of 41 interviews were held between October and December 2024 with 65 project representatives in attendance. These included project managers, project co-ordinators, service managers, and front-line staff. Interviews were conducted and recorded and/or transcribed (with permission) via Microsoft Teams and on average were one hour in duration. A note of the interview was prepared by researchers, drawing as appropriate upon the Microsoft Teams recording.

2.4. Fieldwork relating to Communities of Practice

A 30-minute feedback session was requested to be facilitated by the research team at each of the 5 Communities of Practice that are organised every 3 months by the contracted facilitation provider. This was achieved at 3 Communities of Practice (Community Based Care; Hospital to Home; and Supporting Families and Nurturing, Empowering, Safe and Trusted [NEST]). The full agendas for the remaining two did not allow for sufficient time to be made available for such a facilitated session. In these two CoPs a short introduction to the evaluation and a link to the survey was provided by a member of the research team, encouraging CoPs members to provide their views.

The fieldwork relating to the CoPs also involved distributing a bilingual survey, via the Welsh Government contracted facilitation provider, to those on the CoPs distribution list. The survey link was made available via an email to a total of 682[2] contacts for a 6-week period between mid-October and the end of November 2024, and members received up to two reminder messages to encourage their participation.

A total of 51 responses were received from respondents who were members of all 6 of the CoPs, as shown at Table 2.1. A higher number of respondents were members of the Community Based Care CoP whilst only one respondent was a member of the Technology Enabled Care CoP[3].

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[2] There is likely to be some significant duplication of individual contact details on these distribution lists with many individuals from Welsh Government, the regional partnership boards, health boards and local authorities on several or all distribution lists.

[3] This community of practice is currently on hold and there has been no activity over the past year.

Table 2.1: Number of survey respondents who are members of each Community of Practice

Community of Practice	Number	Percentage
Community Based Care	25	49%
Supporting Families and NEST	18	35%
Emotional and Mental Health	16	31%
Accommodation Based Care Solutions	13	25%
Hospital to Home	10	20%
Technology Enabled Care	1	2%
Total number of respondents	51	

Source: OB3 web survey November to December 2024, n=51

Table 2.2 shows in what capacity survey respondents were involved with a CoP. It shows that over a quarter (14 respondents) were involved with a RIF funded project. Most of the remaining respondents were representatives of a local health board, a third sector organisation, another health organisation or a local authority. Only one response was secured from a citizen representative.

Table 2.2: Capacity in which they are a member of the Community of Practice

Capacity	Number	Percentage
Involved in RIF funded project	14	27%
Local health board representative	9	18%
Third sector organisation representative	8	16%
Other health body/organisation representative	8	16%
Local authority representative	7	14%
Member of a regional RIF team	6	12%
Welsh Government official	2	4%
Citizen representative	1	2%
Other	7	14%
Total number of respondents	51	

Source: OB3 web survey November to December 2024, n=51.

2.5. Analysis and reporting

The findings of the fieldwork were analysed, and this report was prepared. Survey responses and interview write ups were analysed thematically using the discussion guide questions.

2.6. Methodological considerations

This is one of several reports produced by the evaluation team and is intended to provide supporting evidence to inform the second-year implementation evaluation of RIF. It should be considered in conjunction with other implementation reports prepared during the second year of the evaluation, including an updated Framework for Change report which provides an updated policy context and considers the scheme's overall implementation (Verity and Llewellyn, 2025); a Rapid Realist Review of the literature (Tetlow et al., 2025); and a Group Concept Mapping report (Wallace and Wallace, 2025).

The findings of this report draw upon feedback from a sample of RIF projects and as such, the evidence does not necessarily reflect the views and delivery of all RIF projects.

3. Key findings: design and development

3.1. Introduction

This chapter considers the design and development of the sample of RIF projects interviewed. It first discusses projects' operating structures, the evidence of need which underpin them and any learning from elsewhere which has informed their services. It also considers the extent to which projects are delivered in partnership with other stakeholders, including with third sector organisations. Finally, the chapter sets out the projects' funding, monitoring and reporting arrangements.

The findings of this chapter primarily draw upon interviews with RIF project representatives, as well as feedback gathered from interviews with RPB leads.

3.2. Project set up and operating structure

The profile of the sampled projects in terms of priority population groups was largely informed by the sampling approach adopted, hence why over half of projects supported older people. Some projects straddled more than one priority population group, in that these were regarded as the project's main beneficiary group e.g. projects provided emotional and mental health support to children and young people with complex needs:

- over half, 13 of the 24, were focused on supporting older people including people living with dementia and older people with frailty. These were primarily hospital to home and place-based care interventions
- five (of 24) supported children and young people with complex needs
- four (of 24) supported people with learning disabilities and neurodevelopmental conditions.
- two (of 24) supported a cross-section of people, with one of these being focused on deprived communities.

Furthermore, 6 (of 24) also supported people with emotional and mental health well-being needs. Whilst none of the sampled projects were primarily focused on supporting unpaid carers, a small number reported this cohort as a secondary beneficiary group.

An analysis of the 24 RIF projects who contributed to this evaluation is set out at Table 3.1. We have categorised the projects according to their main population group and have used 3 cohorts to do so (older people, children and young people, and people with learning disabilities and neurodevelopmental conditions). It is important to note that since some projects straddle more than one population group, the categorisation set out below is our best fit approach.

At section 3.2.1 the key components of the sampled projects are set out and what they typically involve. The number of projects in each component area ranges from 1 to 5, with a higher concentration in the integrated intermediate community care response category. For components where only a single project is identified, the characteristics described are specific to that particular operation.

The findings also suggests that RIF is used to support a wide spectrum of services, from acute care interventions (such as bedded care and urgent response) to preventative measures (such as emotional well-being services). Nearly every component highlights health and social care integration as a feature, whether through multi-disciplinary teams (MDTs), joint reviews by health and social services, or collaboration with different sectors such as housing, private sector, community groups and carers. Many components prioritise preventing crises, such as avoiding hospital admissions and re-admissions, keeping children out of care, and providing early support for emotional health and family resilience. Several components also mention bespoke interventions, holistic approaches and person-centred care plans. Support for carers was also crucial, as one project representative noted: ‘So, sometimes it's about the well-being of the family as well as the patient, isn't it?’ Furthermore, some components make use of technological and innovative solutions such as the use of Enhanced Community Care (previously known as virtual wards) and shared data platforms.

Some components, such as integrated intermediate community care projects, appear to be more consistently defined. The 5 sampled projects which deliver these services reported having elements such as multi-disciplinary and multi-agency involvement, integrated community virtual wards, use of community resource teams, and services available 7 days a week. In contrast, others - notably projects which support young people which perhaps are less well established compared to Community Based Care projects - show less uniformity suggesting that more localised approaches are being taken by RPBs across this space. This finding was confirmed by RPB leads, who suggested that their portfolio of RIF projects which support older people, often under their ‘Ageing Well’ banner, were the most mature and defined. In contrast, some RPB leads recognised that the RIF projects which operated under their ‘Starting Well’ banner were more varied in their nature, with organisations more focused on immediate pressures rather than long-term planning.

3.2.1. Key components of sampled RIF projects

Population group: older people (13 out of 24 sampled projects)

Project numbers: 1,7,8,22
Key components: bed accommodation supporting step-up and step-down provision to prevent hospital admissions and aid quicker hospital discharge and community care. The following activities are typically involved:

- RIF capital investment in new facilities and/or use of existing accommodation at care homes and supported housing
- short-term reablement and rehabilitation accommodation, but challenge to move patient’s home
- sits within broader intermediate approach, such as ‘Home First’ approach

- integrated senior management team
- discharge from hospital to assess in a more suitable setting
- single point of access triaged through multi-disciplinary teams (MDT).

Population group: older people (13 out of 24 sampled projects)

Project numbers: 3, 9, 16, 19, 24

Integrated intermediate community care response, to prevent hospital admissions by de-escalating crisis and support quicker hospital discharge. The following activities are typically involved:

- multi-disciplinary and multi-agency response
- triaged through MDT
- integrated community virtual wards and use of Community Resource Teams (CRT)
- intermediate care therapies, rehabilitation, and reablement, available 7 days a week
- discharge planning
- central co-ordination
- use of Advanced Nurse Practitioners (ANPs)
- urgent care services and falls response e.g. response within two hours of need
- [bedded care provision].

Population group: older people (13 out of 24 sampled projects)

Project number: 12

Patient flow hub, to reduce hospital stay and support quicker hospital discharge and appropriate care at home/community. The following activities are typically involved:

- co-located health board staff in a single hub, managed by a dedicated hub manager
- single point of access and information
- clear discharge pathways
- shared patient data platform for health board and local authority staff
- collaboration with hospital discharge liaison officers working on hospital wards, who reduce clinician workload
- collaboration and problem solving with third sector community connectors, to provide community-based services such as social prescribing and home care help.

Population group: older people (13 out of 24 sampled projects)

Project number: 15

Front door hospital-based therapy team, to avoid hospital admissions by adopting a home first approach. The following activities are typically involved:

- dedicated physiotherapists and occupational therapists located in hospital emergency departments
- identification of patients who do not require admission, or who can be discharged quicker
- arranging appropriate community support for patients in their home.

Population group: older people (13 out of 24 sampled projects)

Project numbers: 6, 13

Third sector community services which aim to prevent hospital admissions and support hospital discharge. The following activities are typically involved:

- early intervention, preventative, and holistic community-based support
- virtual community wards and MDT approach
- locality based
- a brokerage service, providing information, advice and signposting to third sector services, and local authority social services.

Population group: young people (6 of 24 sampled projects)

Project numbers: 11, 18, 21

Support for children on the edge of care to prevent children entering care and support those in care to return home. There is less consistency in terms of the activities that these services involve, but they include:

- early, preventative, therapeutic and intensive support to referred families and children and young people (CYP)
- bespoke and tailored intervention to strengthen family capacity and resilience
- short term intervention e.g. up to 8 weeks; as well as longer-term intervention
- No Wrong Door policy and alignment with NEST principles
- support following hospital discharge on physical and mental health issues
- triaged with input from health, social care, education and third sector to identify needs.

Population group: young people (6 of 24 sampled projects)

Project numbers: 14, 20

Emotional health and well-being services for young people, to address increased needs following the COVID-19 pandemic. Activities typically involved are:

- co-ordinating the input of professional services to work closely together
- early intervention including support such as therapeutic services and trauma informed therapy
- supporting CYP not in support of statutory services such as Children and Adolescent Mental Health Services (CAHMS)
- support for looked after children and carers whose placement is at risk of breaking down, including via commissioned services.

Population group: young people (6 of 24) sampled projects

Project number: 23

Support for children and young people with complex needs to transition into adult services. There is less consistency in terms of the activities that these services involve, but they include:

- transitioning support for CYP with learning disabilities or blended diet requirements into adult services within social care
- collaboration between children and adult local authority care services
- development of transition pathways
- a needs-based approach to support CYS with neurodiversity issues
- training to education staff.

Population group: learning disabilities and neurodevelopmental conditions (3 of 24 sampled projects)

Project number: 10

Supporting people who receive commissioned care services to progress into independent living accommodation. Activities typically involved are:

- joint and timely reviews undertaken by health and local authorities
- person-centred care plan
- develop properties to better suit the needs of individuals
- support to progress individuals into more independent living.

Population group: learning disabilities and neurodevelopmental conditions (3 of 24 sampled projects)

Project numbers: 4, 17

A community-based service within a local community to empower and promote independence amongst people with learning disabilities. Activities typically involved are:

- provision of educational, environmental, creative, and cultural activities and community provision by the local authority and third sector partners
- a community hub facility drawing on local assets to support service delivery within the community
- service user involvement, with their input guiding the developing of community-based activities rather than traditional support services
- a focus on modernising traditional statutory services.

Population group: whole population (2 of 24 sampled projects)

Project numbers: 2, 5

A placed based programme providing integrated preventative and early wellbeing intervention to communities. Activities include:

- place-based collaboration
- development of community-based hubs
- working co-productively with people who deliver services and support
- providing easy access to wellbeing information.

3.3. Evidence of need

The fieldwork with RIF projects suggests that a minority were informed by robust evidence of need. Just over a third of projects noted that their local population needs assessment had been used to inform the development of their project. In one case, the timing of preparing the population needs assessment had been ideal in that it was completed just as RIF was being introduced and therefore offered timely evidence.

> “the population needs assessment for [name of region] was fundamental” and shed light on aspects such as an “ageing population [and the] frailty index that we see.”

Population needs assessment played a less obvious role in the development of the remaining two-thirds of projects, such as in the case of a front door hospital service project and an emotional health and well-being service for young people project, both of which also drew upon other sources of information:

> “I guess we had the evidence regarding the situation in the acute sites. There were various papers which we used where people had already had front door emergency department teams.”

> “the evidence base we used...there were huge amounts of data that formed that bid in terms of evidencing the need. The population needs assessment was one element of that, but there were lots of others.”

Some project staff did not know how or whether their population needs assessment had informed their project, as they were not in post when the project was designed and developed.

3.4. Information sources used to inform RIF projects

Two key sources of information were identified by RIF projects as having informed their projects: data, and practice wisdom and knowledge built up over time.

Given that many of the interviewed RIF projects focused on reducing pressure on hospitals, the data around this issue was thought to be well documented. Projects often drew upon hospital admissions and discharge data as the rationale for their need. For instance, one project spoke about the need to focus on the two per cent of hospital patients who were found to account for 40 per cent of delayed discharges.

> “I think it was recognised that a small percentage of individuals were contributing disproportionately to the number of delayed discharges ... it’s looking at that cohort in detail and the opportunities to work with those.”

> “We talk about it all the time, but the shift... keeping people out of hospital.”

Most of these projects were intended to ease pressures elsewhere in the system. These interviewed projects noted that their preventative intervention was intended to help avoid escalation which in turn would alleviate demand for statutory services. One project emphasised the need to improve patient flow e.g. to reduce the reliance on commissioned residential care placements by progressing service users to supported living accommodation. Other projects spoke about how they were able to provide more intensive support to complement statutory provision, such as supporting social workers with particularly challenging cases. In addition, there were projects that were strongly rooted in an ethos of supporting people in their ‘community’ context, by providing practical help, and enabling emotional and social connections to bolster people’s health and wellbeing in their own homes. These projects also provide intensive hospital step down support for people leaving hospital to get accustomed to their new environment:

> “The programme allows people to do – essentially what it gives people to do after they’ve had an acute period in hospital, is time to find their feet again, if you like.”

Interviewees from projects, particularly where those projects had been in place prior to the RIF programme, regularly reflected upon the knowledge they as practitioners and project managers had built up over time. For instance, one community wellbeing project had evolved since its inception during the COVID-19 pandemic and learnt over time by reflecting on its own activities and developments. The project has an active internal improvement system to learning from practice and to inform new developments.

New projects which have been developed and introduced over the course of the RIF programme appear to have been designed effectively to address specific needs and gaps within the region. One such example is set out at section 3.4.1:

3.4.1. Case study: addressing regional gaps and needs

One intermediate community care response project was designed and developed as part of RIF to address the lack of urgent community-based intermediate care response in the region, in order to reduce unnecessary hospital admissions:

> "Best practice would suggest that you want that crisis response to respond to urgent need within a two-hour time frame, and that was something that we just did not have capacity for within our region at all. So it became clear quite early on that that was an area that we really needed to focus in on."

Data showed one hospital emergency department received approximately 174 unnecessary weekly admissions. The project set out to design a better and more urgent community response service, and identify what components needed to be put in place to reduce unnecessary hospital admissions. The project design was scoped by a range of representatives, including clinical staff, over a period of several months which led to a 'multi professional response team that could provide an urgent response in the community.' The project was soft launched at the start of 2024, delivering a minimal service led by RIF-funded advanced nurse practitioners (ANPs) to test the response model and staff skill-set required. It expanded over time and now operates at a higher capacity, with ongoing staff training to strengthen their community-based decision-making capabilities.

3.5. Service user feedback

In terms of service user feedback, interviewed projects frequently emphasised how they had co-designed their services with service users, either at the point of design or as the service evolved, to gather views and feedback. One community project delivered by a third sector organisation is one such example where engagement with communities at the outset showed that people were confused about where to go for information and uninformed about what was available to them. In another case, the project used participatory budgeting as an approach to engage their target community to discuss and decide upon their living arrangements. In a third case, co-production was an ongoing process that was intrinsic to the nature of the relationships the service had with the people they work with.

There was good evidence that some projects had been informed by the input and views of service users. The use of service user led groups and forums were commonplace for projects which supported learning disabilities e.g. one project which supported people with learning disabilities to return to work had drawn upon service user voice whilst in another, a regional partnership had informed the project from the perspective of those with learning difficulties, but less so by services users with mental health issues. In another project focus group sessions with young people were held as part of the process to recommission counselling service.

3.5.1. Case study: co-production with service users

One project which supports people with learning disabilities and neurodevelopmental conditions was designed from the outset by service users. Users had expressed a desire to participate in more community-based activities rather than traditional, building-based services, and this feedback was used to develop a pilot project:

> “we've got the [name of] project, which is very much service user led, everything that's done has rooted from what our service users have asked us or requested… instead of historical services in buildings, individuals were telling us that they wanted to be out in the community doing different activities. And the project has developed from there.”

Following the delivery of the pilot project feedback from users was captured and used to better tailor activities to meet their needs:

> “I think the pilot is a good example where there was a desire from individuals, we had plenty of volunteers that wanted to do it and then we tracked their progress and did an evaluation at the end with those. What did we learn? What were the barriers? What were the positives? What were their views?”

Regular reference was made to person centred plans by a range of projects. In the case of one project support provided by a support worker to children and young people with complex needs is informed by discussions with a social worker and family members and is highly tailored according to need and set out within a support plan. Regular reference was also made to ‘What Matters’ conversations as a means of tailoring services.

There was good evidence that projects capture feedback from service users on an ongoing basis, to refine and improve practices as well as from wider partners and practitioners. In some cases, these processes were being introduced for the first time at the time of our fieldwork. In this case, feedback forms had been developed and family members and social workers are asked to complete them to provide feedback about what has gone well, what difference the support has made, and what could be improved about the service in the future. In another project, feedback from school staff as well as service users is captured to inform future offerings. Projects supporting older people also capture patient experiences e.g. through CIVICA patient satisfaction surveys.[4] Projects which struggled to capture feedback from service users reported that they did not typically have an ongoing relationship with their service users, due to the episodic nature of the intervention provided.

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[4] Patient experience software | Civica

3.6. Learning from elsewhere

Five projects reported adopting learning from similar approaches elsewhere in Wales, or further afield. These included a community connectors project which had learnt from a similar Blaenau Gwent model; a Supporting Families and NEST project which had learnt from the Baby and Me service in Swansea; and an intermediate care crisis response project which had visited similar projects in Carmarthenshire and Neath Port Talbot to see how they managed crisis response services, as well as a more developed service in Bradford.

Whilst acknowledging the value of learning from other models, projects stressed the importance of adapting their services to accommodate local needs and circumstances and to base adaptations on insights from service evaluation and quality improvements. Projects based in rural areas were particularly vocal about this point, noting that urban-based solutions were not always well suited to rural areas.

3.7. Project development and evolution

An analysis of interviewed projects suggests that:

- 8 of 24 were existing projects, and include those which were previously funded by the Intermediate Care Fund (ICF) or the Transformation Fund (TF), and where the service provided has remained broadly the same over time or minor tweaks have been adopted
- 10 of the 24 were evolving projects, in that several aspects of the project previously existed, but there have been significant changes or spread as part of RIF
- 6 of the 24 were emerging projects, in that the project/service did not really exist in its current form previous to RIF.

Existing projects which were selected for interview were more likely to be place-based care projects, including those which provide mental health and wellbeing support. Some had previously existed as separate projects but were amalgamated into a single project for the purposes of reporting into RIF; albeit that they continue to be managed and delivered as distinct interventions. They also include projects which have been in place for a number of years, for instance 10 years in the case of one project but have been unable to develop a successful business case for mainstream funding.

These projects have often introduced additional elements or services e.g. in one project which previously delivered counselling support to children and young people, RIF funding is used to expand the service to offer additional group work counselling:

> “There used to be some 'missing middle' money, and that was there to try to target some of that need just below threshold [for CAMHS]. But it was very short-term funding, and all of that was rolled into RIF. When RIF came about, the project took on some of the successful elements of the 'missing middle' project, built on that, and enhanced it even further.”

Evolving projects which were interviewed would include those which existed previously, but whose services are now configured in a very different way and have a much stronger degree of integration to them, including projects where staff have been co-located .

For instance, in one project unscheduled care co-ordinators have been co-located in a single hub to provide a single point of access for information to the health board, whereas previously they were geographically spread out and managed by different service managers. In a similar manner, they include projects which have been given dedicated resources e.g. one project now employs dedicated physiotherapists and occupational therapists at its hospital emergency department, rather than this resource being called upon when needed.

They include projects which have been expanded e.g. to offer a 7-day service. Many of these evolving projects have built upon good practice and lessons learnt from pilot approaches. For instance, one project has been through several different iterations as it strengthens its integration with health colleagues and is now linked into the integrated discharge hub.

Evolving projects also include those that have a greater element of partnership working and regional co-ordination in place. By way of example, one project whose previous iterations had received ICF support, was now aligned to a regional rather than local authority footprint and had additional elements such as occupational therapy included:

> “It's a project that's sort of been rumbling along for years in that there's always been something that goes out and reviews people in placements and tries to step them down to save money. [Under ICF] the money was used as a resource to provide some additional staffing in each of the local authorities and in the health team to do some additional reviews. And it was sort of dressed up as a regional project. But I think from a RIF perspective, it's genuinely more regional. It's generally more coordinated. It's about working together trying to make sure that we're focusing on the same groups of people...as opposed to paying a bit of lip service to all that under ICF.”

Emerging projects which were interviewed were more likely to be those which supported families, such as two projects which support children in care or on the edge of care, as well as intermediate bedded care facilities which also received RIF capital investment. Other examples were identified as well, such as one region which had introduced a dedicated crisis response service as part of the region’s intermediate care model. In this case, the previous Acute Response Team had lost resource and capacity over time and was no longer able to address the need. Consequently, the RIF was utilised to retrain existing Acute Response Team practitioners and employ additional advanced nurse practitioners, in order to implement a two-hour crisis response team.

> “This is new. ICF allowed us to enhance our community resource services, but that was still referral, see you in 48 hours. This is a 2-hour response to patients when their acute needs are escalating and we're stepping in to try to make a difference.’

3.8. Partnership and collaboration

Across the sample of interviewed projects, there was extensive partnership working between local authorities and health boards, and third sector organisations were found to play an important role including with the provision of step-down support, emotional support and community-based services. In one case, interviewed staff highlighted effective partnership working with the private sector. In a few cases, however, RIF projects did not satisfy the programme guidance about collaborative working, in that they did not have any element of collaboration between these key partners, such as one front door hospital focused provision which employed physiotherapists and occupational therapists to avoid hospital admissions. In another case, interviewees noted that the relationship between local authorities and the health board were fairly dysfunctional whilst in a third project the third sector was not considered to be an equal partner in the project's decision-making process.

Collaboration was considered to work well across projects where the team was being managed by one clinical lead. For instance, in one project where 'it all sits as one team under one manager, one clinical lead' staff representatives thought that they operated a more streamlined process for providing rapid responses and collaborative decision-making.

There was also a plethora of examples of projects which adopted joined-up triage assessment and used multi-agency groups and panels, which met on a regular basis to discuss individual cases and agree upon collaborative solutions. For instance, in one project this panel was composed of representatives from a range of services such as Children and Adolescent Mental Health Services (CAMHS), youth services, probation services, education authorities, health services, carer representatives as well as third sector groups. There were also good examples of projects which had introduced, or were reliant upon using, a single point of contact and information for service users and practitioners.

In some regions, whilst there has been an effort to amalgamate several small projects into larger 'umbrella' projects, they have remained distinct interventions without much collaboration and partnership working across the umbrella project e.g. in one project, 7 different strands have been grouped into one RIF funding stream but are still delivered individually and managed by different people/teams. In another such project, staff do meet up to share experiences, but interventions as still delivered as independent operations. Projects which support children and young people appear to be the most disjointed, with approaches differing across local authority areas within a region.

3.9. The role of the third sector

The involvement of third sector organisations across the sample RIF projects varied. Projects which had strong third sector input stressed the importance of co-producing services with input from the sector, otherwise services were found to operate less effectively. There were examples of projects using community development values and approaches, such as a neighbourhood-based community assets approach.

In some cases, third sector providers are fully embedded into care pathways, as illustrated in the example set out at section 3.9.

3.9.1. Case study: embedded third sector support

In one integrated community response project, the third sector has become an integral part of the local authority's response service. Previously, third sector contributions were delivered by multiple organisations and operated somewhat outside the intermediate care pathway. Following recent recommissioning, the third sector is now fully embedded in the rapid response service. For instance, in urgent falls response calls, a third sector representative may accompany a paramedic to assist a patient who has fallen.

In other cases, third sector organisations are included in multi-disciplinary team (MDT) meetings led by statutory services. By way of example, in one project the third sector is a member of the triage panel, and young people and families are referred to them for support, often to access support around substance misuse, domestic abuse and mental health support.

There are other occasions within the sample of projects where third sector organisations are the sole recipient of the funding, and they provide a complete service. In one such project the third sector organisation has built on its reputation for work in the learning disability field to run an entire RIF project. They have referral partnerships with the public sector, but in effect deliver the project entirely on their own.

Some projects draw upon the input of the third sector to address gaps and specific needs. For instance, one project supporting young people had used some of its RIF funding to fund the costs of provision at a third sector-run café, so that young people could use the space as a meeting point and learn about food:

> “It’s a great example of how we work with third-sector organisations to respond to young people’s needs in real-time. We get so much added value from these partnerships, and the Youth Café has been very successful in meeting the demand.”

There was some suggestion that projects had struggled to work with third sector housing providers, such as in the case of one project. In this case, it was thought that housing providers did not consider the project’s target audience a priority group, as they were already accommodated within short term care settings and not homeless. As a result, this project was struggling to move service users onwards from limited care settings. However, improved understanding which has come about as a result of more consistent relationships, has helped in this case. The project has invested time and effort to build relationships, raise awareness and discuss issues, in order to ensure that housing providers understand and can better accommodate the project’s objectives.

Two projects were both led by third sector organisations. One was a community connectors project, which refers and signposts people to community-based resources. The team play a key role in identifying unmet needs and gaps in provision, such as the need for shopping and prescription delivery services, as well as supporting social prescribing. The other was a hospital to community care discharge programme:

3.9.2. Case study: a third sector led project

One third sector led project was developed during the COVID-19 pandemic. The project supports people leaving hospital and returning home by providing appropriate support and reconnecting users with their community and social networks. The service is person centred and uses problem solving and lateral thinking to support people through discharge to home and community care. It has gone through various iterations whilst retaining its primary objective of supporting people in transitions home from hospital, and with support for wellbeing and health once home. It is marked by distinctive community development processes, and creative and flexible approaches.

> “They need a bariatric bed, and they can't go home until you know that's in place or like a suitable chair or, you know, some people that go in, they have nothing. So, when they come home, carers can't go in and heat up a meal because they don't have a microwave. They don't have a kettle. They don't have crockery, so we're able to… support them in the community when they get home.
>
> And we often problem solve to try and find solutions, and we've got that flexibility. Often it could be really, really minimal things like somebody's, you know they're clinically optimized, but they're in hospital because they don't have anybody that can move their bed from upstairs to downstairs. And it's like nobody does that. So, who can do that to get that person home?”

3.10. Attribution of RIF funding

The fieldwork with project representatives revealed that RIF contributes to a broad range of project costs, with proportions varying from less than one per cent to 100 per cent. These variations are particularly evident in umbrella projects comprising multiple components. For instance, in one umbrella project RIF funds one member of a team within a component of its delivery whilst in another project, RIF funded 5 staff members out of a total of 22.

Broadly, RIF appears to make a larger proportional contribution to sampled projects that focus on children and young people, as well as those led by third-sector organisations. For example, one component of a youth-focused project receives over £80,000 annually from RIF, covering 100 per cent of its funding. This funding supports the employment of 4 support workers who operate flexibly across 7 days to provide tailored assistance to service users. Similarly, in a third-sector community connectors project, RIF funding supports nearly all 17 staff members, making it integral to the project’s delivery.

Feedback from project representatives suggests that RIF funding supports critical components of health and social care services. The funding has been used to employ a wide range of posts such as support workers, advanced nurse practitioners, community connectors, therapeutic workers, occupational therapists, project managers and project co-ordinators. RIF funding was viewed by project representatives as an important enabler, particularly in terms of allowing them to trial new approaches, enhance their capacity and deliver better services.

In several instances, RIF funds are not allocated to standalone 'projects' but rather to services, where it makes a financial contribution. In these cases, projects can identify specific postholders funded by RIF, often one of several similar roles within the service. In these cases, RIF plays a vital role in bolstering team capacity and improving coordination in highly complex operating environments.

Match funding from other sources is also essential, including contributions from the Transforming Urgent and Emergency Care (TUEC) Fund, D2RA, Further Faster, as well as core health board and local authority funding.

3.11. RIF governance arrangements

The Welsh Government provides £750,000 infrastructure funding per annum to each RPB to put appropriate governance arrangements in place and oversee the implementation of the RIF. Each RPB contributes a further £250,000 per annum towards these costs. The funding is used by RPBs to fund key roles such as the RPB lead, RPB deputy lead, programme managers, finance and communication officers, as well as administrative and reporting posts.

RPB leads generally adopt a strategic oversight role, including forward planning and partner engagement. Where RPB deputy leads are in place, they typically adopt responsibility for RIF programme reporting and assurance whilst programme managers take responsibility for aspects of the RIF programme delivery, such as those projects which fall under their Starting Well, Living Well, and Ageing Well banners.

The infrastructure investment was considered instrumental in allowing RPBs to deliver RIF as programme management consumes a lot of time around governance, convening partners, supporting partners, administration and reporting.

Achieving the appropriate balance between strategic planning and operational duties was deemed challenging and RPB leads noted that their capacity is insufficient. Long-term strategic planning suffers as a result of this stretched capacity.

Overall, project representatives reported that they have been afforded good flexibility in terms of how RIF can be used, and this flexibility was acknowledged for enabling innovation and responsiveness. Broadly, projects have had autonomy to use the RIF as they see fit, and this point was emphasised by emerging and evolving projects. For instance, one third sector led project highlighted the flexibility afforded to them, as they could allocate the funding as they saw fit to best address the needs of their users. In this case, the project had also more recently been awarded capital funding which they could utilise as appropriate for meeting user needs:

> “So if a patient needs an item, a piece of equipment to get out of hospital and that's what's stopping them from getting out, we've got the funding to be able to purchase that.”

Another project, which had been previously funded via ICF noted that they had been able to start off within RIF with a ‘blank slate’:

> “When we were bringing in the rest from ICF, we had a blank paper really. The need was much different to before COVID, and we actually used the [RIF] guidance to meet the actual need at the time. So yeah, we've got a lot of flexibility.”

There was some suggestion that projects were gaining greater flexibility over time. For instance, one such project reported that having been unable to recruit to an occupational therapist role, they were allowed to convert the role into a therapeutic worker position.

A couple of projects however felt that they had been afforded less flexibility by their RPB to use RIF in this way because they were running legacy projects, which had been established prior to RIF and had too little lead in time to implement any changes:

> “The problem, I think, was that it came so late in the day with the confirmation of the funding.”

Concerns were expressed by projects and RPB leads about the future of RIF projects due to funding uncertainties, and interviewees would welcome greater clarity about future funding. Third sector led project representatives were particularly concerned about the short-term nature of their project funding, despite the longer-term nature of the RIF programme:

> “We can't plan because we don't know if there's going to be funding for the year ahead. You support the service to build it up, and it does really well. Then they have to scale back because if the money does drop, they can't guarantee that they get that. So, they can't scale up.”

Projects which were expected to drop to a 50% RIF contribution in the forthcoming year were also concerned about this:

> “That's one of the gripes about RIF … to try to demonstrate sustainability and look at exit approaches by somehow bringing matching which was going to then replace the RIF. But the reality is, we're evidencing match from existing resources. It's not necessarily bringing in any new resource to the project. It's not helping with mainstreaming the project.”

Many project representatives expressed concerns about transitioning from RIF to core funding, and these concerns had led to one aspect of an intermediate community project requesting a very small amount of RIF support because of the difficulties this would pose at the end of the programme period for them. In this case, the service had requested just under £100,000 per annum to support the employment of 1.6 FTE staff. In this case, RIF funding accounts for less than one per cent of the service’s budget, which employs a community nursing team of circa 200 staff. RIF funding has supported the expansion of an existing service across one local authority area, to enable it to deliver community health services 7 days a week, between 8am and 8pm every day.

3.12. Reporting

Interviews with strategic RPB leads indicate that RIF reporting processes have improved over time. The recent Welsh Government decision to agree to a more streamlined 6-

monthly project updates, which includes case studies, was widely welcomed. RPB leads also appreciated the increasing trust afforded to them from the Welsh Government for projects with a history of robust progress reports. This ‘lighter touch’ approach was seen as creating space for regional and local reporting systems to mature:

> “Because we did such good reporting, we’re now on the good step for the first time ever.”

Despite these improvements, RPB leads still view the reporting requirements as overly ‘mechanical’ and heavily focused on quantitative data, which often fails to capture meaningful, person-centred outcomes. One RPB lead highlighted that multiple projects might serve the same individual, yet their outcomes are reported repeatedly across all projects. Efforts to develop common metrics for RIF-funded projects had reportedly made good progress but were currently on hold.

Despite the Welsh Government progress reporting template having a specific question around lessons learned, RPB leads also perceived that RIF reporting is currently geared towards showcasing successes. Inefficiencies remain in terms of reporting processes, and the lack of digital infrastructure such as integrated care records, hampers data sharing and joint analysis across projects. Additionally, RPB leads indicated that the significant staffing resources required for reporting detracts from their ability to focus on strategic priorities.

RIF projects predominantly prepare reports which are shared with their RPB, who then share with Welsh Government officials. Feedback from RIF projects suggests that whilst many have shifted to providing 6-monthly progress reports, others are still required to submit quarterly updates to their RPB. Projects which have shifted to 6-monthly reporting mostly welcomed the lighter-touch approach adopted by their RPB, as this has reduced the administrative burden required of them, and reported a sense that RIF reporting had ‘settled down’:

> “The balance between data and narrative seems right now, and it allows us to show the true impact of our work.”
>
> “I think we have got to the point where we know what we have to record because at some point it was changing each quarter. We needed some consistency and hopefully we've got to that point now.”

Projects which were less supportive of the lighter touch reporting requirements placed upon them by their RPB, thought that the new template did not allow them to demonstrate the success of their work:

> “Now it's a giant spreadsheet with a few numbers and one case study. I don't think that the Welsh Government will ‘get’ [our project].”

It is common for projects to provide a qualitative narrative, case study material and quantitative metrics as part of their progress reports. Projects commonly thought that service user case studies worked well as a mechanism for showing the difference their service could make, as these could also account for wider contextual circumstances. They also welcomed the use of stakeholder case studies, as these allowed them to show how their services were positively impacting upon other aspects of the health and care system.

There was a suggestion that some projects found it difficult to provide the 'story of change' reporting, with one such project describing the challenge of articulating how everything fits together:

> "We know our project inside out... but I really struggle with the 'story of change' report. Bringing in how all the different projects make a whole is a real challenge. It was often left to one person to communicate the partnership view, which wasn't very helpful."

Projects commonly report on service outputs, qualitative outcomes and satisfaction levels although it is less common for them to report data such as cost savings. Tools such as Recovery Star, Storytelling, Cycle of Change and Most Significant Change are used by projects to track progress and measure difference made whilst one RPB team supports projects with Ripple Effect Mapping to demonstrate their impact. By way of example, in one third sector community-based project, front line staff are each required to develop a service user case study and agree upon one which represents the Most Significant Change in order to include it in their 6-monthly report.

One project has introduced a new client relationship management system for capturing better data and overall, there was a sense that project monitoring data was being more efficiently captured via online and automated systems:

> "The reporting is much more efficient these days…everything's done and submitted online, which is much easier for me…"

Several projects were candid in that they reported on all of their service achievements, even in cases where RIF only accounted for a very small proportion of their funding. One element of a project for instance where RIF accounted for less than one per cent of their budget noted that they reported all of their outputs:

> "Because you can't divvy it out, it's just really difficult."

One of the main issues raised by projects was that some reporting indicators are irrelevant or overly health-focused, and do not reflect the broader, preventative work of some projects – particularly community-based services. These projects called for more project-specific metrics which are better aligned with their objectives. Project representatives also raised concerns about the difficulty of reporting any changes in project delivery from one reporting period to the next. This issue was particularly evident for well-established projects, even when reporting on a 6-monthly basis, as these projects often lacked new developments or updates to highlight.

Another other key issue raised by projects and RPB leads related to the fact that multiple funding streams require separate reports, leading to duplication of effort and inefficiency of staff resource. This is often compounded by limited resources and high workloads and a sense that RIF reporting requirements is not commensurate with the level of grant funding awarded. One RPB lead suggested that this issue was particularly challenging for third sector organisations across their regions, who were disproportionately impacted by the reporting requirements compared to the amount of funding received.

4. Findings: implementation to date

4.1. Introduction

This section considers the headline findings from fieldwork with key staff from 24 projects and the strategic leads at the Regional Partnership Boards (RPBs). It covers their views on what has been working well to date, main successes and the barriers and challenges faced. It also considers the extent to which RIF's identified key enablers contribute to project progress, the extent to which projects are driving greater integration between health and social care, and their alignment with their relevant Models of Care (MoC).

4.2. Earlier intervention and prevention focus

RIF guidance requires RIF project delivery to be underpinned by the 5 fundamental principles of the Social Services and Well-being (Wales) Act (SSWBA) namely voice and control, prevention and early intervention, wellbeing, co-production and multi-agency approaches. Within our sample of 24 projects, there is good evidence of RIF funded projects with a focus on earlier intervention, often centred on preventing longer than necessary hospital stays or readmission, and community-based preventative projects seeking to minimise the escalation of critical need.

Almost all hospital to home projects illustrated early intervention approaches to get patients out of hospital sooner or avoid ambulance call outs and hospital stays altogether. Complex care closer to home projects invariably included a crisis rapid response element with earlier intervention aimed at lowering hospital admissions rate and reducing demand on emergency services by supporting patients in their own homes. For example, one flagship project was making effective use of advanced nurse practitioners to provide a rapid in-home crisis response.

4.2.1.1. Case Studies: earlier intervention to prevent escalation

Project 18 demonstrated the power of preventative care by addressing potential family crises in the community before escalation. The early intervention team work with families with neuro-developmental needs whilst they are often awaiting assessments and experiencing challenging behaviour in the meantime.

The team helps to develop parental understanding of neurodevelopmental conditions, helps with neuro-profiling and offers training and support to parents. Social groups for neurodivergent young people to build their confidence, self-esteem and life skills are also delivered.

In implementing the No Wrong Door strategy there has been a shift towards a more proactive, prevention-focused approach to children and family services. A multi-agency panel meets regularly to discuss cases, and there is a strong culture of mutual support between practitioners.

Project 2 represents a whole-community and whole-system approach to prevention and early intervention that brings together a holistic range of well-being assets on a place-basis. Networks are aligned to small towns or areas within a larger city or borough and enable people to find support when they need it and strengthen community capacity, supportive social networks and assets.

At its heart the network seeks to strengthen place-based wellbeing through the collaboration of local partners and communities by:

- encouraging partnerships between local practitioners from differing agencies
- promoting care for service users which is more holistic and preventative
- linking service users with sources of support in the community beyond medical interventions
- devolving autonomy and financing for some of the activities to localities through participatory budgeting, an approach designed to build trust in communities and their relationship with public bodies
- strengthening community resilience and assets that can keep people well and
- acting as a bridge for local care systems to work alongside.

There is also some evidence from the fieldwork of projects focussed upon putting the individual and their needs at the centre of their own care, and the opportunity to co-produce the design and delivery of services. Projects offering support aimed at building family resilience consistently outlined a proactive, person-centred approach to delivery. For example, one project described how support was co-produced with service users (young people), with flexibility built in to adapt to emerging needs. Similarly, an RPB lead described how a project provided an intermediate crisis response for emotionally dysregulated children and young people in their region. Co-designed with families and psychologists, it delivered wraparound specialised care tailored to individual needs, reducing unnecessary hospital admissions and crisis incidents.

Two hospital-to-home projects also highlighted how their integrated service was ensuring that patients were receiving holistic person-centred care. One of the projects described how the use of step-up, step-down accommodation was providing a ‘stop-gap’ that was outside a hospital setting which provided more time for social care staff to gain a greater understanding of patient need, and for patients and their families to consider the right care options available to them.

Another project exemplified a flexible, community-based and holistic approach to supporting people move home from hospital. Their work illustrates the practical things that can be done to overcome some of the obstacles that can hold up hospital discharge and getting people settled back home (i.e., getting someone to look after the cat, moving the bed downstairs, helping someone access a phone, getting a microwave). As interviewees said, good networks and a community assets approach supported the work.

> “I think for me it's about the third sector being valued more because the breadth of services and the amount of support that is available in the third sector and in people's communities, people aren't aware of, you know.″

4.3. Integration across health and social care

Collaboration across health and social care sectors has been pivotal in ensuring holistic support for service users. Evidence collected from the fieldwork highlights the importance of integrated services, such as connecting hospital teams with community care providers to address complex needs. Success stories include projects that have effectively bridged gaps between acute and preventive care. However, instances of limited cross-sector engagement were also reported, emphasising the need for better alignment of goals and practices among stakeholders.

Contributors to the fieldwork felt that RIF had helped to continue an integration process that had started originally with the Intermediate Care Fund (ICF) or Transformation funding. As such, whilst RIF could not be credited with driving integration alone, it had continued to support projects in their quest for increased integration between health and social care:

> “I think it is probably fair to say that RIF has helped continue what had already started, moving from co-location to actually working in an integrated manner. Whilst RIF has supported integration, it is part of a much larger journey.”

Analysis of the projects suggests that almost all had strengthened integration during the RIF delivery timeframe thus far but that they are at different “stages” of integration. Around half of the projects analysed provided different kinds of integration. These projects typically highlight:

- opportunities to meet regularly to discuss patients with other departments or sectors
- increased collaboration and communication between partners or
- delivery of a service within one sector (such as within a local authority or health) but with improved interaction across departments or professionals in that setting (e.g. between clinicians and therapists within a health setting).

For example, one project described how regular meetings between all partners had improved coordination and broken-down barriers between different services and organisations, resulting in reduced duplication and improved referrals. In another project, 3 local authorities had commissioned a joint service but operated very differently and had discrete requirements of the external provider.

The other half of projects studied point to more advancement in the integration between health and social care. These typically have a more integrated delivery model that includes at least some of the following elements – co-location, equity in access to data and information, a single project manager, multi-agency teams, single point of access and pooled budgets. Project leads also often described these as being seamless from the patient's viewpoint.

> "It's important to consider that people have different interpretations of integration. From the end user's perspective, if they are receiving a seamless service…only have to tell their story once – then a level of integration has been achieved."

In another project integration with the local hospital had increased to the extent a service worker attended an 'integrated discharge hub', which had strengthened ties with the Health Board.

Collaboration and integration have been central to the ethos of the RIF, focusing on breaking down traditional silos between health and social care. Key successes included collaborative care pathways for individuals transitioning between hospital and home. Project leads suggested that these pathways have reduced unnecessary hospital admissions and ensured continuity of care. In other projects, a single point of access has improved efficiency in referrals and decision-making, enhancing patient flow.

Projects that achieved meaningful collaborations often start with a shared vision and well-defined objectives. For example, those that established integrated community care teams comprised of professionals from diverse sectors saw measurable improvements in patient outcomes, particularly in managing chronic conditions. These community MDT models were considered by project leads as being effective in reducing hospital admissions, supporting post-treatment care, and maintaining a focus on person-centred care.

4.3.1. Case study: intermediary care multi-disciplinary team (MDT) model

The MDT approach, implemented in a local authority and in the process of being scaled up across a further two has emerged as a flagship success story utilising RIF funding in the region. These teams integrate health and social care professionals to streamline care, prevent hospital admissions, and enable post-treatment support within the community.

The project has prevented over 800 unnecessary hospital contacts through triaging and service signposting and reduced average hospital stay duration, ensuring timely discharges. Cost-benefit analysis revealed weekly savings of £926 per bed.

Strong clinical leadership and coordination which unified previously fragmented efforts has proved to be a strong enabler, whilst the utilisation of telehealth and befriending services expanded access to care while maintaining efficiency. This model has garnered widespread recognition as a practical and scalable approach to integrated care.

There is evidence from our data that most RIF projects could locate themselves somewhere on the spectrum of integration – from joined up through to fully integrated services – and have made steps towards integration (as outlined in the Part 9 Code of Practice, Social Services and Well-being Act). However, these steps towards integration have not been uniformly achieved. Many projects cited difficulties in aligning priorities across health and social care. For example, while health services prioritised acute care, social services often focused on preventive measures or crisis response, leading to divergent approaches and increased tensions of late. One project which described effective joint working between health and social care agencies pointed to some systemic limitations that remained in place such as bureaucratic challenges in reporting, and separate administrative and funding structures that sometimes hinder integration efforts. Another project has direct experience of these barriers. Its work has been focused on facilitating earlier discharge from hospital following clinical decisions having been made. However, there is a significant and widening division between the hospital-based parts of the service and the community services. These tensions are mirrored at the partnership level and there is a competition for resource is that is contrary to the spirit of the intended integration.

4.4. Workforce requirements, recruitment and retention

A resilient, integrated workforce is seen as a critical enabler to the successful delivery of the RIF's national models of integrated care. RPBs are expected to develop and deliver plans that support this, thereby creating the conditions to promote the necessary system, process, practice and culture change to provide seamless, integrated services. The role of the workforce in the success or failure of projects cannot therefore be overstated. Several themes have emerged from the evidence gathered from projects.

Firstly, almost a third of interviewed projects highlighted the delivery teams as one of their main assets, highlighting the good communication, positive attitude and flexibility of staff members. The multi-professional provision and flexibility offered by multi-disciplinary teams (MDTs) was particularly celebrated for its delivery of place-based care for prevention and community coordination and for complex care closer to home projects.

Most projects reported no major recruitment issues. A few had experienced some initial staff capacity issues that had since been resolved. The longer-term commitment of RIF funding was deemed to have made recruitment easier in many cases, particularly when compared to previous experience of recruiting under ICF or Transformation funding. One RPB reported how the situation felt more stable under RIF, attributed to a regional decision to consider projects as contributing to important, long-term change programmes that would require 5 to 10 years to come to fruition. The region gave projects as much certainty as possible which allowed longer-term staffing contracts to be deployed. Without having to focus their attention on recruitment and retention issues, RPB-based roles were also now able to spend more time convening people and undertaking their coordination and planning role more effectively.

However, one third sector-run project in our sample had experienced a different situation, with their allocation only being confirmed on a year-on-year basis. This has adversely affected the organisation's ability to retain its staff team, with a large turnover of staff on an annual basis. This was a similar issue for another third sector project, as an interviewee noted:

> “…it's great that they want to support the sector, but we need that long term investment. If you really want to make that difference, you've got to have that long term investment.”

Some projects attributed the strong reputation of the team or the innovative and dynamic nature of their approaches to making roles more attractive to potential candidates. However, it was acknowledged that in some cases, a tendency to pull staff across into these exciting RIF projects was creating vacancies elsewhere in the region.

> “Recruitment is not an issue. The project is popular among rotational Band 6 positions and sought after. It is a good learning opportunity and they find it rewarding.”
>
> “There are plenty of people available for the work as it is a lovely role. People enjoy the role, so retention of staff is not an issue. They can see the impact they are having.”

Where a few RIF funded projects had faced some initial recruitment issues, several had facilitated innovative strategies aimed at attracting potential skilled, specialist professionals from the limited recruitment pool to ensure sustainability and stability in their services. One region was using collaborative recruitment strategies and had made efforts to rationalise terms and conditions across organisations. For example, one health board had collaborated with a local authority on job evaluations to offer attractive terms, particularly for domiciliary care roles. In another project, the recruitment of specialised professionals, such as advanced nurse practitioners to provide in-home crisis responses was reported to have significantly lowered hospital admission rates.

Other projects had resolved recruitment or capacity issues by contracting out services which had resulted in improved capacity and consistency. In one instance, the sharing of skills and knowledge from the contracted-out service had resulted in the upskilling of the wider local authority workforce in understanding trauma-related behaviour and responding to the needs of the child.

Projects looked to offer enhanced training opportunities or deployed innovative training and development approaches in order to make roles attractive and contribute to workforce stability too.

Innovation in training provision was particularly notable in projects aimed at supporting families or building emotional resilience. For example, one project had appointed 4 support workers to a family resilience support service, each with different backgrounds and expertise. It had then organised team training sessions to better equip all 4 to work across the target group cohorts. Another similar-focused project lowered the required qualifications needed for posts and then provided multi-agency training to upskill existing staff so that they could fully embrace the NEST framework. A third example described a strong culture of training and development in the team, with staff encouraged to seek specialised training opportunities around the Safe and Together model and positive behaviour support. This project had also started to focus on a ‘train the trainer’ approach.

4.4.1. Case study: upskilling existing staff

Project 22 had found it increasingly hard to recruit social workers, as a result of a national shortage. As such they had moved to a Trusted Assessor model with Occupational Therapy (OT) staff. OTs were now able to prescribe care and take on low level support requirements on behalf of patients. This had led to a reduction in the demand for Domiciliary Care support.

They had also trained their social workers on functional aids. As a result, social workers, when visiting a patient to assess mental capacity, were also able to undertake a functional assessment, avoiding the need to arrange a separate visit for that purpose.

By now, demand for OTs was becoming stretched, and the project was increasingly reliant on the Wellbeing Service delivered by a third sector organisations to undertake some functional assessments too.

This adaptive approach, in response to demand, was described as an autonomised decision within the project that was enabling them to continue to deliver the appropriate level of care in the community.

Although most RIF projects did not highlight major issues, where recruitment challenges remain, these were either identified as being reflective of the general challenges facing NHS and social care recruitment currently or reported to be associated with particular specialist or rural roles. Some projects had struggled particularly to fill key vacancies for in-demand domiciliary care, clinical and therapy positions. One project raised a backfill issue with seconded occupational therapist positions which was causing problems in staffing the service.

Some of the workforce instability and staff insecurity issues that remained were reported to have been due to funding uncertainties and fixed-term contracts. A community service partnership model described how it had been unable to operate a 7-day working model as was originally planned due to the cautious approach by the health board only offering fixed-term, two-year posts. As a result, it had proved difficult to attract people and the project was unable to deliver the proposed new delivery model due to too many unfilled posts ongoing.

> “I’ve got very little of what the original ambition was in terms of the clinical health aspect of the project. The huge potential of the funding offered hasn’t been realised, and case load capacity hasn’t been realised. I understand the caution, but we missed an opportunity.”

Most projects in the sample did not report any major recruitment issues, however one RPB representative described how, at a regional level, there had been delays within some RIF funded projects, usually as a result of recruitment challenges. Health board recruitment would often take a long time, with tight governance processes slowing things down considerably. While local authorities might recruit staff within 6 to 8 weeks, the health board in the region could take 6 months or more. These delays affected the entire project and was frustrating for partners. Even if a project was well-established, any changes or decisions had to go through multiple committees at the health board which creates further delays.

4.5. Barriers and challenges

Barriers to implementation highlighted during the fieldwork were multifaceted, with financial challenges often at the forefront of the issues raised.

Uncertainty in funding cycles has caused delays in project initiation and difficulties in retaining staff for a couple of interviewed projects. Short-term funding decisions made at health boards level (12-month or fixed-term funding) was also reported to be leading to planning difficulties and job insecurity in another couple of interviewed projects. Some health board posts, in particular, continue to be funded on an annual cycle or short-term contracts of two years or less. In these cases, the uncertainty has resulted in retention issues, increased recruitment costs, and, at times, a sub-optimal offer to patients as continuity of care e.g. people with learning difficulties in the community were impacted by the constant staff turnover. These projects reported how such funded posts became unattractive offerings in an already competitive market for specialist roles, resulting in crucial roles within a delivery model remaining unfilled for the duration of the RIF funding cycle. Some of this was attributed to a risk-averse culture within the wider financial teams at health boards, or a lack of understanding of the potential impact of decisions relating to RIF funding when utilised within wider, complex funding structures.

A lack of certainty about of the future of RIF at the end of this current funding cycle was also beginning to impact confidence and continuity in some projects. One health board was implementing a freeze on recruitment, which meant that RIF projects were likely to deliver with gaps in key posts for the foreseeable future.

Challenges in transitioning from the ICF were highlighted as having posed some challenges. Local authority-based staff in one region described how they proceeded ‘at risk’ to maintain continuity within the existing workforce. The match-funding and tapering requirements originally expected from projects that had been previously funded through the ICF had also added to the complexity in adapting projects to align to RIF requirements with little lead-in time to plan and prepare for the transition.

Project leads described how budgets across health and social care were being squeezed with services finding it increasingly difficult to fund integral services alongside the statutory services that require continual funding. Some project leads were grateful for the protection that had been afforded thus far to the funding of their services via RIF. However, local authority-based project leads emphasised the upcoming impact of recent pay offer agreements and the increase in employer national insurance contributions (NICs) which would further diminish the reach of their current RIF funding. In a few cases, the current financial pressures were now likely to result in redundancies and fewer funded posts on RIF supported projects from April 2025.

Financial and operational constraints are also resulting in insufficient funding to scale services (e.g., in transitioning to a 7-day model and increasing out-of-hours availability) to meet referral volume and complexity. For example, a project aiming to increase therapeutic capacity at hospital wished to adjust its hours in order to help manage peak demand within the emergency department, but the team were currently only able to work regular working hours due to a lack of staffing.

High demand was often reported to outstrip the supply of services, bedded units, and social care capacity. In two projects, patients waiting for long-term care packages could not be supported as capacity issues in one part of the system were having a knock-on impact by restricting patient flow. In another project, the sheer volume and complexity of referrals was causing difficulty in maintaining the service at its current level.

All 3 projects providing emotional resilience support to young people reported growing waiting lists as current capacity was not able to meet the demand for the services. Similarly, community-based projects in several regions highlighted the growing demand and overstretched capacity of their project delivery team as a result of increased recognition of the services being offered.

Tensions between the priorities of acute care providers and those of preventive or community services were beginning to emerge as a result of competing agendas, with the financial climate driving more competition for resource that was contrary to the spirit of integration. Wider pressures in unscheduled care and a lack of capacity in domiciliary care was also making it more difficult for improvements funded through RIF projects to be realised. One project reported how emphasis on hospital discharge over community-based support and prevention was causing systemic stresses.

> “It feels that the focus is always on hospital discharge. The conversations are all about hospital discharge, and less about keeping people in the community…There is a need to change that drive to be about reducing the demand for hospital care in the first instance because it is detrimental to the whole system. The focus should be on avoidance.”

RPB representatives also noted how project leads, heads of service and central RPB staff often lacked the headspace and capacity within their working day to engage in long-term strategic planning discussions and decision-making due to the constant need to respond to operational pressures, often described as ‘firefighting.’ Whilst project leads based at health boards and local authorities were described as capable individuals with a desire to plan for the future, and whilst there were plenty of identified opportunities for longer term solutions, it remained difficult to do so when so many were working ‘at crisis point.’

4.6. Use of technology and digital solutions

RIF guidance recognises the increased role of technology in supporting people to live independently and keep track of their wellbeing and care needs. As such it expects RPBs to consider how technology can be harnessed in the delivery of the 6 national models of integrated care using digital reporting solutions, virtual advice and consultation, self-care apps and smart home technology.

Across the projects interviewed, just under a half described examples where the use of technological or digital solutions had been integrated into delivery. In these examples, digital tools and technology were integral to their success, offering opportunities to enhance efficiency and accessibility.

The integration of technology has proven instrumental in enhancing the reach and impact of some RIF projects, particularly those working on providing complex care closer to home or supporting independent living. One project described how it had invested in tablets, Echo devices, virtual reality (VR) headsets and projectors to facilitate interactive activities. Another project was making use of technology in remote assessments for speech and language support. Projects utilising assistive technology for individuals with learning disabilities and telehealth solutions for chronic care management demonstrated reduced demand on emergency services and increased independence for service users through remote monitoring and personalised interventions.

4.6.1. Case study: making use of digital solutions

Project 10 works with an assistive technology and telecare service. The project puts in place person-centred progression plans to enable people with learning disabilities and neuro-developmental conditions to live independently.

The assistive technology and telecare service used can provide automated reminders for service users to take their medication and also provides a telephone support service if needed. The local authorities were also using an activity monitoring system, through ‘Just Checking’ devices. In some instances, the use of these digital tools had enabled some patients to progress and become completely independent from their previous care support package.

The use of shared electronic care records in some regions enabled project partners to access real-time patient data, fostering better coordination and decision-making. Improvements to client relationship management (CRM) or data tracking systems, put in place after learning from good practice from other projects across Wales, was resulting in staff being better able to monitor caseloads and workloads, managing client details and accessing improved data to evidence project outputs in 4 of the projects interviewed.

On a broader level than the projects included in our sample, one RPB stated that an AI-powered digital process automation platform was being utilised in their region to connect performance and financial data for more efficient data management and reporting. The region was also making use of Power BI to create dashboards and visualise data making it easier to monitor and analyse performance. Digital automation tools were also being used to streamline the reporting process, reducing the reliance on manual data entry and Excel spreadsheets.

4.6.2. Case study: developing a shared patient data platform

Project 12 improved communication between partners through access to shared patient data which helped to identify barriers to discharge, accelerating solutions.

Digital systems were overhauled to reduce the time spent on collating patient flow information manually. Project 12 is now maintaining information on a Microsoft BI dashboard hosted on SharePoint to improve real-time data access by all partners across health and social care. As a result of the introduction of a shared patient data platform, the health board and the local authority access a single dataset of patients and see the same information about the patient status and requirements.

> “We co-own it. Every patient who's in hospital, what their journey is and what we're doing with them. It’s just transformed everything – its brilliant, really excellent. It's really instrumental in everything that we do.”

One Hospital to Home project pointed to a whole technology enabled care approach that had been created by their RPB across a range of projects, utilising RIF funding. Three specialist posts, funded by RIF, were training staff on how to use technology-enabled care for medicine prompts and to remotely monitor movement. As a result of seeing the benefits achieved through this investment, local authorities were now expanding their own investment in such enablers.

However, in the other half of projects interviewed at this stage, digital and technology solutions had not been a prominent feature or was not enabling progress in a meaningful way.

Some of these projects referred to use of existing digital tools or platforms, such as a project based on supporting mental health and wellbeing of young people using the ‘Meic’ support platform[5]. Another project described how they were utilising existing falls prevention tools.

Others noted that digital and technology opportunities were currently under-utilised even though they had the potential to drive improved delivery and integration if adopted. For example, one project had plans to expand their use of digital solutions in future, including the development of a community information system to capture project-specific data. They were also exploring telehealth options, with a business case currently underway to make greater use of tools for remote monitoring and tracking of patient health to allow them to remain at home for longer.

The remaining projects did not identify any particular digital solutions that would enable them to work more efficiently or effectively. In some cases, the need for face-to-face interaction, for example in projects providing therapeutic services for children and young people, limited the suitability of digital approaches.

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[5] https://www.meiccymru.org/

Two RPB representatives also felt that whilst some good examples of technology use existed, digital solutions could be better utilised within RIF-funded schemes, beyond those projects which supported older people and people with learning disabilities. It was suggested that recent investment in digital technology across the preventative and early intervention space had been largely non-existent within the health and social care sector more broadly, with a lack of national policy direction and clarity of ambition. Moving forward, it was deemed critically important that projects reached a position where they could maintain joint data records and undertake more sophisticated modelling and business analysis to demonstrate the value of new ways of working. In one RPB a Digital Technology Board had recently been established to drive this agenda forward.

4.7. Involvement of the social value sector

RIF revenue guidance states that social value models of delivery have an important part to play, particularly in enabling community-based, preventative support services to be delivered. As such, the guidance places an expectation on RPBs to invest a minimum of 20% of their RIF allocation to delivery through social value sector organisations. Social value sector involvement varies significantly across projects. In some, it plays a vital role, while in others, it is minimal or largely absent.

One region described how it has consistently exceeded its RIF social value targets by collaborating closely with third-sector partners. A project in the region which supports micro-enterprises to provide community-based care for those who do not qualify for statutory services was highlighted as an example. This social value approach is fully utilised, with the provider’s caseload full – an indication of the high demand and its success in addressing preventative care needs in the region.

In 8 of the projects interviewed, there was direct involvement of the social value sector in project delivery. In these cases the integration of the third sector into complex care closer to home type projects enhanced social value by improving community-level impact and resource efficiency, bridging the gap between acute and community care. Within prevention and coordination model of care funded projects, community hubs and community navigators were often run by local third-sector organisations who knew the area well and were best placed to deliver services.

4.7.1. Case study: integral role of the social value sector

Project 14 focuses on supporting the emotional health and wellbeing of young people and includes several partners including a third-sector counselling service which works alongside the local authority’s youth intervention service, children’s services and health services.

Funding for the therapeutic positive attachment aspect of the project had recently been redirected to a local third sector provider which had proved successful in providing an additional level of capacity, and better value for money, when statutory services did not have the capability to deliver as planned.

A youth café had also been established in a local town too, after young people requested a space where they could gather. A local charity provided the space whilst the project funded the food and drink.

> “It’s a great example of how…third sector organisation respond to young people’s needs in real-time. We get so much added value from these partnerships.”

The social value sector tended to make a key contribution to specific policy areas. One RPB lead contributor described how the third sector was instrumental in the delivery of dementia services, where partnerships with organisations such as the Alzheimer’s Society and Carers Trust deliver comprehensive care pathways in place-based care projects delivered in the community. Emotional health and well-being services for children, as well as bespoke support for individuals with learning disabilities, also typically relied heavily on third-sector expertise, with early intervention and prevention services often delivered by small, independent social value organisations as well as larger third sector organisations.

Three other projects described a strong partnership approach to delivery alongside third sector organisations. Of these, one project described how the social services team at the local authority had a robust, informal partnership with a local support organisation which facilitated co-production and closer collaboration through funding to develop community activities for individuals with learning disabilities. In another project, local authority staff and third sector partners offered joint visits as part of a family resilience project. This collaboration helped to ensure all involved were fully equipped to handle complex cases and advocated local community groups and services that were on hand to help. The close collaboration between one complex care closer to home project and its third sector partners was strengthening its ability to deliver comprehensive care to patients by addressing both clinical and social needs.

The social value sector often provided step-down or preventative care, attending meetings (e.g., patient flow hubs) and filling gaps where statutory services lacked capacity. However, most interviewed projects, particularly those focused on specific statutory service delivery had little direct funding allocated to third-sector organisations, despite recognition of their potential cost-effectiveness and impact. In some of these examples, project delivery was solely within a hospital setting with few if any partners outside of health delivering the RIF-funded service and therefore were unlikely to meet the RIF funding criteria set out in the RIF Guidance. These projects either stated that there was no social value sector contribution in place or that it was limited to the signposting, facilitating links or raising awareness of services on offer by the third sector.

Strategic integration and recognition of the social value sector remained inconsistent, with some regions noting missed opportunities for deeper collaboration and innovation. One interviewed project voiced their frustration and felt that the social value sector could deliver a better value service for them but was currently underutilised:

> “I don’t think we are including [the sector] enough. We don’t recognise that we need them. We have core business to deliver. We need to be more innovative and explore what they can do for us – and they will be cheaper.”

One RPB readily admitted that whilst the third sector were always involved in discussions, they were far from hitting the 20% social value sector target outlined in RIF guidance, recognising the importance and influence of ‘strong voices’ from public sector partners in discussions and decisions (P4). To provide projects in the region with stability, they were given a single pot of funding and autonomy to utilise it as they saw fit. The perceived ‘flip side’ of this approach was that asking projects to then shift more investment into the third sector was challenging. New care models were being built, and the health board was described as becoming dependent on the RIF-funded investment to deliver the model. The region recognised that this was an issue that needed to be addressed, and efforts were underway to analyse overall commissioning from the third sector in the region to identify areas for improvement, highlighting a need for better cultural and operational alignment between statutory bodies and third-sector organisations.

One strategic leader posed this challenge in the form of a question: ‘Has the 20 per cent for the third sector been a floor rather than a ceiling? Has anywhere in Wales given the third sector more than 20 per cent?’ This view was mirrored in the views of other participants. One respondent identified that the good relationships and partnerships developed across the public sector had the unintended consequence of exerting a negative influence when ‘you’re trying your best to kind of get consensus’ (P4) which impacted negatively on the third sector. Another noted that the pressures on services and resources were a particular barrier for good partnership with the third sector:

> “We are trying to reach out to the third sector and include them more in a genuine dialogue and decision making, but often there is a grab and run mentality around the 20 per cent that is intended for them. Once it's gone, it's gone.”

4.8. Alignment with Models of Care

Most projects had limited knowledge and understanding of the Models of Care and described them as being largely irrelevant. Indeed, during interviews, there were several instances where project leads asked the interviewer to clarify to them which MoC their project was associated with or reported under. They were often unclear about how they were meant to contribute to their development and struggled to align definitively with the specific RIF-defined Models of Care (MoCs) under which they reported and attributed this to a lack of clarity or overlapping categories. This creates difficulty in attributing outcomes to one model, especially when services span multiple domains (e.g., emotional health, complex care, and prevention).

In our analysis of 24 projects, 5 projects felt that they had strong alignment with the model of care under which they reported. Twelve projects reported a partial alignment to their allocated MoC. A further 7 projects did not identify with their allocated MoC as shown in section 4.8.1 below.

4.8.1. Case study project fit with allocated Models of Care

Projects that align with their current model of care:

Community-based care – complex care closer to home

- Projects 3, 17 and 24 align with their model of care

Supporting families model of care

- Projects 18 and 21 align with their model of care

Projects that partial align with their current model of care

Community Based Care – prevention and community coordination

- Project 2 identified with the current model of care and aspects of emotional health and wellbeing model of care
- Project 13 reports under current model of care but also contributes to Place based care – complex care closer to home, Hospital to Home and Emotional Health and Wellbeing models of care
- Project 23 is an umbrella for several different strands of work that are not particularly related to one another and also contributes to Supporting Families and Emotional Health and Wellbeing models of care

Hospital to home model of care

- Project 1 reported a fit with both the current model of care and place-based care – complex care closer to home
- Project 5 felt it aligned with both current model of care and Place-based care – prevention and community coordination
- Project 6 did not know which model of care it currently reported under. Project seems to have elements that fit with Place-based care – prevention and community coordination too
- Project 15 clearly contributes to current model of care Place based care – complex care closer to home also relevant
- Project 22 aligns with current model of care but also contributes to Place-based care – complex care closer to home

Community Based Care – complex care closer to home model of care

- Project 9 fits with current model of care but also inherently supports the Hospital to Home model of care

- Project 16 reports under current model of care but this was seen as a somewhat random decision. Alignment might become clearer when models of care are more defined

Supporting families model of care

- Project 11 identifies with current model of care and Place based care – prevention and community coordination
- Project 14 identifies with current model of care but also see a fit with Emotional Health and Wellbeing

Projects that lack alignment with their current model of care

Community Based Care – complex care closer to home model of care

- Project 4 identified more with both Place-based care – prevention and community coordination and Emotional Health and Wellbeing models of care
- Project 7 identified with Hospital to Home model of care
- Project 10 mentioned that it actually reports under Accommodation Based Care Solutions but has some elements of Place-based care – complex care closer to home too

Community based care – prevention and community coordination model of care

- Project 20 reports under Place-based care – prevention and community coordination, but see their fit with the Emotional Health and Wellbeing model of care

Hospital to home model of care

- Project 8 mentioned that actually reports under Accommodation Based Care Solutions due to capital investment involved but feel they fit better with Hospital to Home.
- Project 12 reports under Hospital to Home but project think they align with Community Based Care – complex care closer to home model of care
- Project 19 reports under Hospital to Home but feel that they align with Community Based Care – complex care closer to home model of care

Of the 5 projects that are currently content with their MoC allocation, all were either within the Community Based Care – complex care closer to home or the Supporting Families MoC, suggesting that these provide a more recognisable or defined description that fits well with certain types of projects.

No clear pattern emerges for the remaining projects who do not see themselves completely aligned with the current MoC which they report under. However, it seems that there are some unclear boundaries or overlap between activity under the Hospital to Home and Community Based Care – complex care closer to home models.

Projects described being assigned to a MoC to report under, for a number of reasons. In some cases, a ‘closest fit’ approach was taken, where projects had components that seemed to straddle more than one model of care. In some instances, it was suggested that MoCs were allocated due to a lack of other RIF projects across the region reporting under a particular one, with a perceived need to spread existing projects more evenly across all 6 MoCs. In a few cases, projects were a number of small, distinct projects ‘bundled together’ under one heading. As a result, no one MoC was a perfect fit for all. Furthermore, in a couple of cases projects had been classified into particular MoCs based on of their RIF capital funding contribution.

One interviewed RPB lead felt that the Community Based Care– prevention and coordination MoC was relatively well-developed with greater clarity established around what it looked like and about the key components that should be contained within it. Similarly, the Supporting Families MoC was described as being relatively clearly defined, whilst the Emotional Health and Wellbeing MoC was deemed a more challenging MoC to convey.

An RPB lead and two project leads also felt that whilst the Hospital to Home and Community Based Care – complex care closer to home MoCs were the priorities for their region, they expressed concern that separating the services being delivered into two separate MoCs did not align with their on-the ground experience. They questioned the current structure where multiple models overlapped in practice and suggested a need to streamline these into one overarching MoC to better support integration and provide greater clarity for teams delivering services that were essentially supporting people to remain safe and well at home for longer.

Similarly, another RPB representative noted that they were able to recognise many of the features included in the various MoCs, but that these fed into a wider, integrated community care system in their region that was enabling them to manage people with complex needs in the community, keeping them stable and out of hospital.

> “Pulling these components out as isolated models of care is not really possible – but you could find them within our overarching integrated community care system that we’re building. You’d see it all there but you wouldn’t describe them as models.”

Several project leads described how the MoCs were mainly being used to streamline funding lines and for reporting purposes and that they were not particularly well sighted on the MoCs or did not take them into consideration in any great detail otherwise.

> “The challenge with aligning the project to one specific model is that there is then pressure to attribute project outcomes to a particular model which isn’t really correct.”
>
> “I don’t really think about the MoC – I leave the MoC stuff to strategic level staff.”
>
> “Strategic staff say the project sits within the community-based care MoC, but it is an arbitrary decision somewhat.”

RPB leads also reported how they seek to articulate what is happening locally in a way that resonates with the strategic priorities of the Welsh Government:

> "That's my main job. It depends where you sit on how you engage with policy. I try to mitigate the complexity that is being created and the administrative burden of the planning and reporting. I try to keep it simple and straightforward for those who are delivering."

4.9. Alignment with other national priorities and policies

Some projects noted that they were more familiar with and more likely to align with other models, frameworks or policy drivers. Two Supporting Families projects were aligning their approach with the NEST framework for mental health and wellbeing[6]. Similarly, two integrated community care projects observed that they were adopting the key components expected of their service as set out within the 6 goals approach for urgent and emergency care[7]. As a result, they thought that their service, as well as other similar services in other regions, reflected national policy expectations:

> "They [other projects] should be similar because lots of what we're doing is to deliver on other Welsh Government objectives. A key component for community nursing is that they've got to increase capacity at weekends. Some of the Further, Faster8 money has been used to increase that. A key component of the RIF [is to support project] coordination…[it] enables us to do that so. That's an all Wales ask."

One edge of care project introduced for the first time using RIF support, had built upon the national Integrated Family Support Service (IFSS) model of working[9] and recalled accessing good practice from other local authorities who were implementing the IFSS, particularly in terms of data collection and monitoring methods. Others, such as a third sector led community connectors project drew upon the good practice shared at the Connectors' network for community connectors and social prescribers[10]

RPB leads described a perceived disconnect between policy makers and the integration and partnership teams at times, and whilst they fully embraced the aspirations of all the policy developments in the integration space, felt that they were adding pressure on the system at a time when maintaining existing services was incredibly challenging.

The complexity of the policy landscape was described as difficult. For example, in addition to the RIF, the Strategic Programme for Primary Care, the Care Action Committee priorities, the Six Goals for Urgent Emergency Care were all highlighted as policy priorities aimed at earlier intervention, a more joined up way of working and doing more in the community, yet all had their own specific models that they wished to see implemented on the ground.

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[6] NEST framework (mental health and wellbeing): introduction | GOV.WALES

[7] Six goals for urgent and emergency care: policy handbook for 2021 to 2026 | GOV.WALES

[8] Now known as Building Capacity through Community Care Building Capacity through Community Care

[9] See examples such as Integrated family support services - Hywel Dda University Health Board and Directory-of-Services-IFSS-Aug-2013

[10] Connectors' Network - CGGSC~CAVS

> “So, we just kind of carry on. That is one of my main jobs – that local sense making. Given all of those policy drivers in the early intervention space, what does it look like in terms of how we deliver it locally?”

4.9.1. Case study: aligning with wider policy priorities

Project 24 is focused on frail individuals at risk of hospitalisation and provided rapid response services to prevent ambulance usage and emergency department admissions.

Project delivery leads see the project as aligning closely with the Six Goals framework and this is their main focus in terms of alignment with wider policy priorities.

They are currently exploring opportunities to integrate their provision with other community resources like community beds and urgent care centres and believe a cultural shift towards community-based care is essential for the model to succeed.

Project 24 was inspired by cross-regional learning, particularly from successful implementations in another region of Wales. On-going communication and study visits between the regions continue to happen regularly.

Some projects noted that Welsh Government's current MoC structure could benefit from simplification and better integration with other Welsh Government policy frameworks to reflect real-world delivery. Collaborative efforts, such as integrated discharge hubs and step-up community beds for example, demonstrate promising frameworks that could be adopted nationally.

Contributors to the fieldwork suggested that MoCs should be viewed more as guiding principles rather than rigid frameworks or models. Project leads often prioritise service delivery principles, such as prevention, person-centred care, and integrated community-based support, over strict adherence to defined MoCs. Projects also highlighted the importance of aligning services with broad goals like supporting people to remain safe and well at home, rather than adhering to what was perceived as fragmented models.

Projects generally recognised the potential for scaling up, with interest in specific models and approaches underway at other regions. However, scalability was often contingent on local needs, availability of community resources, and contexts. Critical components that were seen as ripe for replication included tailored, person-centred interventions, 7-day availability, effective client management systems and strong partnerships between health boards, local authorities, and third-sector organisations.

4.9.2. Case study: potential for scale up

Project 19 has had an integrated community services model utilising MDTs since 2011. The RIF funding is therefore allowing it to build upon a strong platform and expand on the integrated work already underway.

The project is becoming more proactive and getting involved upstream (before crisis) more than ever before and their model and resources allow them to do that.

Whilst this delivery model is only being used within the boundaries of one local authority currently, they are looking at the optimum model for the whole region and there is interest within the other local authorities for this scale up to happen.

Interviewed RPB leads pointed to activity that was currently underway between RPBs to compare schemes and models and consider what was being done similarly and differently through a national comparator project. It was hoped that this would provide an opportunity going forward to identify what is working well in one region and share the learning across others. Several RPBs and project leads also noted that innovative projects in one region were being identified and explored further by others. For example, a mental health service mainly delivered by the third sector in one region was being considered by others looking to adopt a similar approach.

5. Findings: Communities of Practice

5.1. Introduction

This section draws on interviews with RIF-funded project-level and strategic leads, Communities of Practice (CoPs) member survey data and discussion groups carried out with members during 3 CoPs. It presents key findings relating to attendance and membership; organisation of the CoPs; the value of the CoPs; applying learning from the CoPs; and the contribution of the CoPs to national models of care.

5.2. Attendance at CoPs sessions

It is common for CoP members to have been involved since the beginning of the CoP or for at least 6 to 12 months, with fewer having joined only recently, as shown in Table 5.1.

Table 5.1: Since when respondents have been a member of the Community of Practice

Time period Community of Practice	Since the beginning	For at least 6-12 months	Only recently joined
Accommodation Based Care Solutions	6	6	1
Community Based Care	9	15	1
Emotional and Mental Health	6	9	1
Hospital to Home	5	5	0
Supporting Families and NEST	4	10	4
Technology Enabled Care	0	1	0
Total number of respondents			51

Source: OB3 web survey November to December 2024, n=51

The data from the CoP member survey suggests that around two thirds of members attend regularly or quite regularly, while around a third rarely or never attend.

Table 5.2: How regularly respondents have been attending Community of Practice sessions

Frequency Community of Practice	Regularly	Quite regularly	Rarely	Never
Accommodation Based Care Solutions	5	4	1	2
Community Based Care	5	10	7	1
Emotional and Mental Health	8	4	1	2
Hospital to Home	3	4	3	0
Supporting Families and NEST	6	2	4	1
Technology enabled care	0	0	1	0
Total number of respondents				51

Source: OB3 web survey November to December 2024, n=51

The main barrier to regular attendance cited by members during the fieldwork was competing workload pressures. Members cannot always attend meetings due to scheduling conflicts, staff absences, working patterns or annual leave commitments, and/or demanding workloads. As such, these members reported that they were more likely to attend when agenda items seemed more directly relevant to their work or when they are in a position to prioritise CoP attendance over other responsibilities.

> “I have a busy diary and unfortunately they are meetings that aren't top priority in my diary although I do get benefit from them when I attend.”

Of the 24 RIF-funded projects engaged during this stage of the evaluation, half (12) had engaged with at least one CoP, although the individual who attended the CoP was sometimes a strategic lead with oversight responsibilities for the project rather than someone involved in the direct delivery of the project on the ground. Those who had not engaged with a CoP had, in the main, not been aware of the opportunity and expressed some level of interest in being involved.

As such, questions were raised about how invitations to the CoPs are circulated to potential members. Some members and project leads noted that, from their perspective, information about CoPs seems primarily to have been circulated via word of mouth or through existing contacts, rather than through a formal mechanism for reaching all RIF-funded projects, for example. At a national level, therefore, they believe that membership of CoPs seems to have been established on a somewhat ad hoc basis, without targeted invitations and purposeful decisions about which types of roles would be best represented at the CoPs.

Members engage in fairly active discussions during CoP meetings, either through presenting their own work, or contributing to discussions orally or in the chat bar, with many also actively listening to discussions. CoP observations indicate that, particularly when membership numbers are high, some members will choose to actively listen without directly contributing to discussions. Given that members value CoPs as opportunities to keep up to date with national and regional policy developments, share good practice and share learning (see section on the value of CoPs in section 5.5 below), active listening alone will prove valuable for some members.

5.3. CoPs membership

Given the potentially broad appeal of the CoPs to those involved in RIF-funded projects either operationally or strategically, members queried the most appropriate target membership for the CoPs. Inconsistency in who attends each CoP meeting was also highlighted as a barrier to effective national working.

One RPB representative expressed concerns about the size of the CoPs and suggested that they may be too broad for effective learning. Instead, this region has been focusing on developing localised, “mini" CoPs within the region, as they feel that it is crucial for staff within different counties to learn from each other locally before engaging with a national forum. This regional approach allows for knowledge-sharing and reflection within specific themes or areas, such as integrated community care and preventative work. They value the CoPs but believe they should focus on a more manageable, regionally relevant scale.

However, members were keen to ensure that a breadth of sectors and experiences continue to be represented within CoPs. A few noted that certain sectors were missing from particular CoPs (such as not many RPBs being represented in one particular Supporting Families / NEST CoP meeting) and others emphasised the need to ensure that the third sector and those with lived experience are adequately represented.

> The CoP is very “health heavy and I’ve often been the only third sector represented when I’ve attended.”
>
> “Myself and [my colleague] are in the same team but not many health board representatives here today. What is the membership like? I hoped to see more health board representations. It might be worth seeing who is attending. Our RPB is not here either. Is it that they are not invited or not attending?”

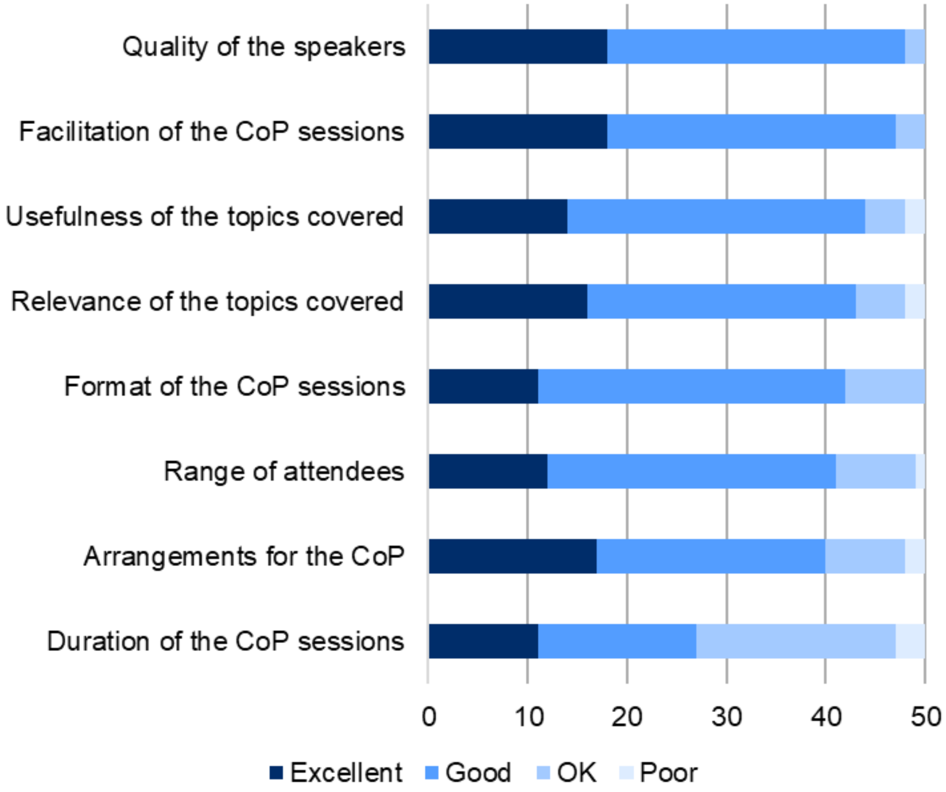
The consideration of the most appropriate membership for the CoPs aligns closely with decisions relating to the overall objectives of the CoPs and the balance between operational and strategic content, discussed further in section 5.4 below.

5.4. Arrangements and organisation of the CoPs

Members who responded to the CoP survey were broadly positive regarding many elements of the CoP’s organisation, including the quality of the speakers, facilitation of the sessions, usefulness and relevance of the topics covered, and format of the sessions. Figure 5.1 presents their feedback on each element of the CoP’s organisation. However, it was a minority of respondents in each case who felt that each aspect of the organisation was ‘excellent,’ as opposed to ‘good.’ Members were least positive regarding the duration of the CoP sessions, with around half stating that the duration is ‘ok’ or ‘poor.’

> “Thanks to those who have organised and facilitated- not an easy task to do that across health, social care and third sector- people have felt engaged and able to contribute. Well done.”

Figure 5.1: Number of survey respondents rating each aspect of the CoP from excellent to poor



Description of figure: This chart shows how CoP members rated various aspects of the CoPs' organisation. The majority of CoP members rated each aspect as good or excellent, except for the duration of the CoPs.

Source: OB3 web survey November to December 2024, n=50.

This was echoed during interviews and discussion groups, where members were particularly positive regarding the facilitation, usefulness and quality of the CoP sessions. All feedback provided on the CoPs suggested that there are some key changes which could be made to the way that CoPs are structured and organised in order to make them more effective.

Members often identified a need for the CoP agenda and timetable to be set and circulated much further in advance. This would allow them to identify agenda items most relevant to their own work and make it easier for them to set aside time in their diary in advance to attend.

> “Purely on a practical basis, maybe having a yearly schedule in advance just because January is set now but I have missed the last couple because things were in my diary already. Anything to help us forward plan as much as possible would help.”

The length of the CoP meetings was another common challenge identified by members. The duration of the meetings was considered too long for those who are facing other competing workload pressures and, in some cases, members felt that the CoPs try to include too much detail into one session. They recommended shorter, more frequent sessions which could be set out a year or so in advance, to allow them to attend more regularly or at least prioritise which sessions to attend.

Alongside this, they recommended introducing variety and flexibility into how the sessions are structured. For example, some suggested annual face-to-face meetings would be more beneficial for encouraging close collaborative working. Others suggested more practical workshops on occasion or opportunities for members to drop in and out of sessions.

Acknowledging the current length and density of the CoP sessions, as well as the difficulty in attending regularly, members identified a need for a centralised repository of information from the CoPs. This repository could cover content from the sessions, case studies, frameworks, recordings and other useful information as well as brief, easily accessible ‘snapshots’ of learning which could be accessed instantly and shared with colleagues. They felt that this would make the CoPs accessible to a broader audience.

> “Sometimes presentations, most of the presentations, are really brilliant and it would be lovely if they were done in a way that they could be snipped and actually shared when there are things we want to share with others in the locality….to enable good practice to be more widely shared.”

> “Something like The Knowledge Hub for the WCVA11 where people can contribute around themes and topics would be useful. There is also a lot of stuff out there already, like Gwella in the Health space. Bringing that across sectors and departments would be challenging but useful.”

Members value opportunities provided by facilitators to contribute to the CoP agendas and priorities, including identifying specific challenges or perspectives they would wish to discuss in the sessions. They also identified a need for more input from those with lived experience, more of a focus on RIF-funded projects and ensuring that action learning sessions are directly relevant to attendees.

> “What I would value is hearing about what’s working well but also hearing more about challenges and what’s not working well. Perhaps those challenges could be identified and shared with policy leads involved in the conversation so we can choose some key barriers we can address across the system…in short, would be nice to unpick some of those system barriers together. I think they are coming to light but we need to dedicate some time to discuss them.”

However, members expressed mixed views as to whether they wished for agendas to be more operational or more strategic in nature. For example, some would prefer the CoP to be practical, focusing on specific questions or challenges that those working in the sector are facing or undertaking more ‘deep dive’ workshops to tackle specific issues. Others question

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the value of such issue or project-specific discussions and would prefer a stricter focus on national integration or RIF. This issue relates closely to the extent to which the CoP contributes to the development of national models of care, as discussed further from section 5.6 of this report.

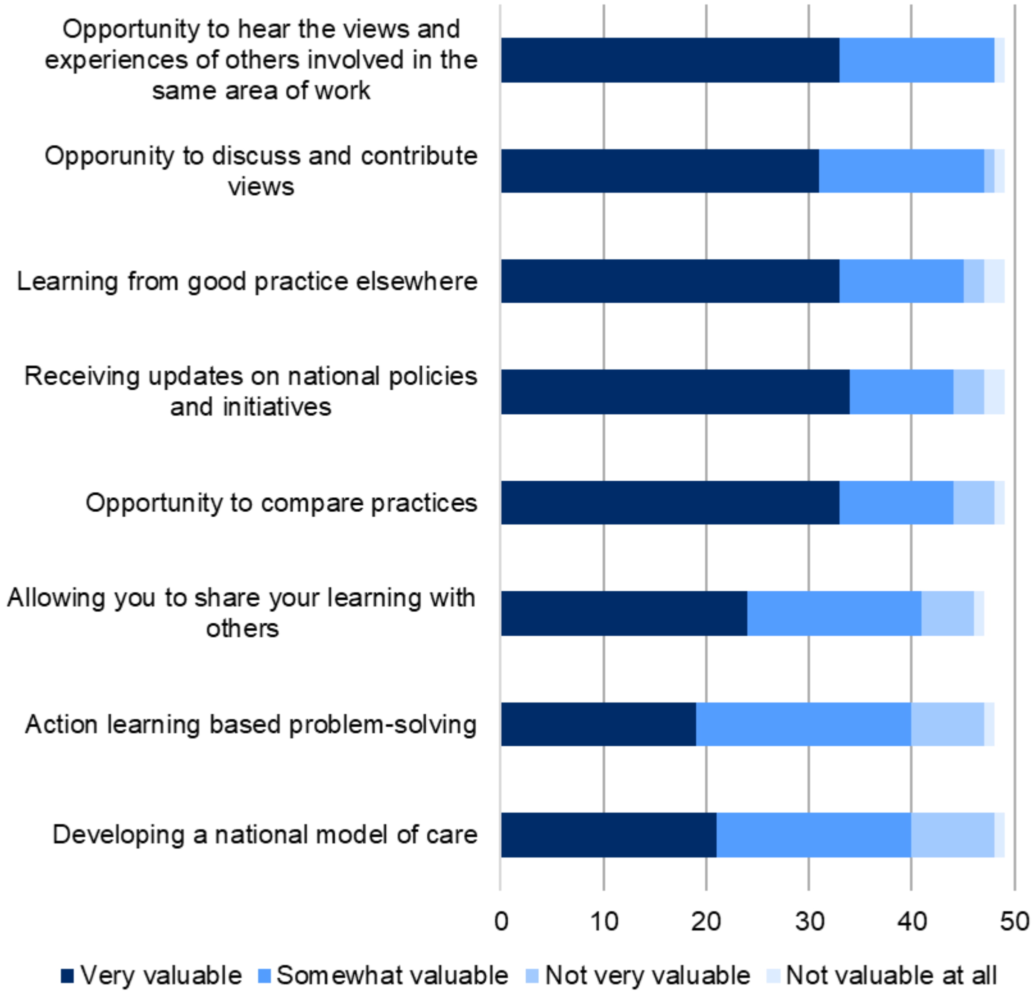
> “It'd be good to use the CoP group for more practical aspects with a clear question or challenge put to the group and breakout sessions where more interactive and engaging activities can take place.”
>
> “[The sessions] sometimes seem too divorced from the reality of working on the frontline of service delivery, particularly in very poor neighbourhoods.”
>
> “Could be better linked into decisions making structures across health and social care so that it can really impact the system. Needs a clearer definition of 'integration'. Needs a clear definition of emotional health and well-being. This would then make sure the right topics for the agenda can be covered by the CoP.”

5.5. The value of the CoPs to members

In their survey responses, many (or most) members felt that all aspects of the CoP sessions were either somewhat or very valuable, as set out at Figure 5.2. The most valuable features of the CoPs, according to members, were the opportunity to hear the views and experiences of others, the opportunity to discuss and contribute views, learning from good practice elsewhere, receiving updates on national policies and initiatives, and the opportunity to compare practices. These are discussed further below in this section.

Members were somewhat less positive regarding the value of action learning based problem-solving and developing a national model of care (the latter of which is discussed further in section 5.6 of this report.

Figure 5.2: Number of survey respondents who find each aspect of the Community of Practice valuable or not valuable



Description of figure: This chart shows how valuable CoP members find each aspect of the CoP sessions. The majority find each aspect of the CoPs very or somewhat valuable.

Source: OB3 web survey November to December 2024, n=49

Members report that CoPs are helpful platforms for staying informed about national and regional policy developments, enabling participants to better align their work with evolving priorities. Members frequently cited the value of receiving consolidated updates during CoP sessions, which often include Welsh Government briefings on strategies, funding, and policy changes. These summaries are appreciated for their clarity and efficiency, saving members from having to navigate multiple sources of information.

> “I find it very beneficial to learn on developments across Wales. Understand good practice, where things have not gone as planned. Update information from WG is always useful and share good practice from my area. Also hopefully influence national direction in areas of development.”

CoPs also play a role in the exchange of best practices and operational insights. Participants noted that discussions often highlight innovative approaches from other regions, inspiring them to adapt and implement similar methods. For instance, attendees from various sectors described learning from presentations about successful projects elsewhere, which helped them refine their own practices. This shared learning environment fosters a culture of continuous improvement and helps members ensure their work aligns with good practice from elsewhere.

> “I've found them really helpful actually. Having that point of contact from the Welsh Government to give updates on the national overview has been really helpful. We're getting that heads up on any changes that potentially may be coming, particularly around the refunding and the requirements around that, so that we're prepared for those. it's interesting to see the innovation that's happening in other health board areas as well.”

Another strength of CoPs identified by members is their ability to bring together professionals from diverse sectors, such as health, social care, and the third sector. Members frequently noted the value of this cross-sector representation, emphasising how it provides a richer, more comprehensive understanding of shared challenges and opportunities. The integrated nature of these forums allows participants to view issues through multiple lenses, which is often instrumental in developing balanced solutions.

> “To find out what is going on around rehabilitation across health, social care and third sector, make connections and learn from others’ experiences.”

> “It’s been invaluable to be part of this Community of Practice because sometimes you can be a bit of an outlier when you’re in the third sector and it’s really important to be integrated with health and social care. I’ve found this a really good conduit to be integrated into what everyone is doing in health and social care. We’ve also had the opportunity to showcase some work that we’re doing.”

Members described the discussions as particularly enlightening, with the mix of perspectives encouraging deeper dialogue and collaboration. For instance, attendees appreciated hearing how other sectors approached similar challenges, which not only broadened their horizons but also reinforced how interconnected their work can be. This inclusivity was seen as a unique aspect of CoPs that participants were eager to preserve and build upon.

Networking and camaraderie emerged as recurring themes in discussions about the value of CoPs. Members expressed appreciation for the opportunities these forums provide to connect with colleagues facing similar challenges. This sense of shared experience was described as both reassuring and motivating, fostering a supportive environment where participants could exchange ideas and resources.

> “I think that the CoPs are helpful, sufficiently informal to provide a safe space to pose and discuss challenges.”

The connections formed through CoPs occasionally extended beyond the CoP sessions themselves, with members maintaining contact to collaborate on shared interests. Participants also noted that hearing others' struggles and successes helped them feel less isolated in their roles, reinforcing the value of belonging to a community of professionals dedicated to similar goals.

> "I've definitely made some good relationships... people have come to me, and I've shared things they've requested outside of meetings. There's that sense of "we're all in the same boat," and hearing similar struggles from others can be reassuring."

CoPs are regarded as spaces for collaborative problem-solving and the generation of innovative ideas. Members reflected on how these forums allow them to explore challenges collectively, leading to creative solutions that might not have emerged in isolation. The structure of CoPs encourages open dialogue and the exchange of ideas, which participants found conducive to identifying practical strategies.

> "The CoPs are an amazing, consistent space. It is not pinned on to any one event. It is here on a permanent level and can be used in different ways to tackle problems through different perspectives. It is helping us to get to the root of the problem."

Moreover, CoPs contribute to the development of a common narrative by aligning diverse efforts toward shared goals. Many members highlighted the value of these forums in fostering a sense of coherence across regions and sectors, particularly when implementing frameworks like NEST. By bringing stakeholders together to discuss and refine approaches, CoPs help ensure that different initiatives complement one another, avoiding duplication and strengthening collective impact.

> "I also think it's valuable as it's beneficial to hear other group's perspective and how we're coming together to develop a common narrative around this work."

5.6. Disseminating and applying the learning

CoP members were able to provide some examples of how they had taken learning from the CoPs and applied it to their own work, projects or services. In particular, members noted in general terms how learning from CoP sessions had led them to challenge and review their own thinking and strategic planning. Others provided specific examples of elements of their work which had been improved by engagement with the CoPs, such as:

- supporting them to decide on models for community hub development
- learning about better ways to evaluate their services
- small improvements to patient flow processes

> "There was definitely something that I bought back from the Community Based Care CoP … it was a tweak on what we were already doing within the patient flow hub and it did make a difference."

- learning from a Hospital to Home project and the importance of engaging with the housing providers to better facilitate this transition
- amending the age range of their wellbeing provision for children and young people to align with learning from elsewhere
- undertaking project visits to see which projects can be piloted in their own areas.

However, it was more common for members to report that they disseminate learning and good practice from the CoPs. Members frequently explained that they share learning and good practice with colleagues working in their sector and region to ensure that this information reaches those involved in the design and delivery of services. This includes disseminating information to appropriate strategic and planning groups, as well as various delivery partners and colleagues within their team. Members also highlighted the impact that CoP membership has had on their own professional development and knowledge, even if they did not specify how this had translated into direct action.

> "Sharing with colleagues (nationally and locally) who have a role in developing services and linking in with regional systems so that they can use insights in their work."
>
> "I have shared with partners (I see myself as a conduit of information shared back to our partners)."
>
> "Perhaps not consciously used it for a particular purpose, but the information from the CoPs have increased my understanding and knowledge of the subject area and therefore helped me in my professional development."

On occasion, CoP members (particularly those working at strategic level within their region) noted that discussions within CoPs do not often translate into direct action. As a result, a few queried the value of the CoPs is contributing to purposeful change within the health and social care system. They felt that CoPs prioritise exemplifying good practice, which is valuable, but did not see much evidence of this practice being actively rolled out elsewhere and noted a lack of national guidance on how to roll out such good practice. Such comments feed into the subsequent discussion of the extent to which CoPs are contributing to national models of care.

> "If there is good practice…Wales is tiny…and yet we don't learn from good practise. You know, we should say "that's really good" so the funding now goes for you to replicate this. Don't go off and spend months doing your own protocols…This is what we need to do. You've got to roll it out."

5.7. Informing development of Models of Care

Currently, there is limited evidence that the CoPs are effectively contributing to national MoCs. Firstly, CoP members themselves do not fully understand the extent to which CoPs are, by design, intended to contribute to national MoCs. Strategic regional leads also expressed confusion as to the intention behind the CoPs. Although there is general agreement that the CoPs are intended for sharing learning and good practice (and are effective forums for doing so) there is limited consensus on the responsibilities of the CoPs beyond this.

> “I'm not sure - other than by sharing practice, some of which may be incorporated into the Model of Care. The CoP doesn't seem to have (yet) had an active role in developing the Model of Care.”
>
> “I really do not know. I am still not clear what is meant by 'model of care' and how this will impact on future planning, funding or procurement.”
>
> “The CoP is mostly a place where national orgs give updates on their work to a random audience of attendees. It is not related currently to the RIF projects in any way and has not done any work on models. People also bring random practice problems to ask for advice from across the sectors.”

Secondly, there is limited understanding amongst CoP members and regional leads about which practical mechanisms and processes are in place to facilitate CoPs’ contribution to national models of care. While a few CoP members highlighted how sharing good practice naturally contributes to some regional and national consistency in provision of care, others highlighted a need for clearer steps to guide them towards the development of a national model of care. Some expressed a need for clearer guidance from Welsh Government on how discussions within CoPs should be harnessed and shaped into national MoCs, with a few believing that the ultimate responsibility for developing national MoCs lies with more senior strategic leads at national level.

> “We’re learning from each other and of course we’ve got all the policies and processes so we know what they want us to do but I don’t think there’s any influence from Welsh Government, we’re all just getting on with it in our own way and we’re sharing information with each other.”
>
> “Case studies are useful to be shared, however I think it would be beneficial for the CoP to detail its emerging blueprint in support of the MoC. A summary of what’s been shared to date etc. This is linked to a wider theme around the development of the MoC. At a point in time, the national picture should be able to share the current blueprint of MoC.”

In particular, those working at a more strategic level (such as RPB representatives) were more likely than those at project level to be critical of the CoPs’ contribution to national models of care. Overall, they felt that CoPs are fairly disconnected from work being undertaken at regional and local level and the CoPs lack a mechanism for formally evaluating and consolidating these insights into a cohesive national framework. As noted in section 5.1 above, this has led to one region developing local ‘mini’ communities of practice to guide regional models of care at a more manageable scale.

> “I think the communities of practice haven't been successful thus far. I've attended a few of them and I find it not a very effective use of my time at all. But I think it's probably because they were too soon. They were too early in the scheme of things.

> I'll be honest, I haven't been to one for a while because I didn’t feel they were particularly useful, but the last one I went to there was the presentation on highlights of good practice and it was somebody doing a presentation on “this is what we do” and it was a topic that everybody has one of and has had for years and years and years. I think some of those earlier communities of practice were, as I say, not effective at the time because we just heard people presenting good practice that schemes that we all already had and didn't hear anything new or different.”

However, there was some acknowledgement amongst CoP members and regional leads that CoPs are still relatively new forums and are still evolving. For example, one RPB representative noted that, while initial CoP sessions had been challenging and somewhat unclear in purpose, the group had since evolved to become more fruitful in fostering shared learning across regions. This evolution appeared to involve better-defined objectives and an increased focus on best practices that could be adopted regionally.

A few CoP members believe the Supporting Families and NEST CoP is somewhat further ahead than other CoPs in terms of its contribution to a national model of care. Focusing discussions on the NEST framework has allowed members to prioritise rolling out the framework within their regions and to compare delivery models. For example, a RIF-funded project in one region described how they have adopted and made use of the framework at a regional level, which has brought the local authorities together.

> “This is less clear in relation to the [mental health and emotional wellbeing] CoP but clear re: NEST.”

> “NEST is the clearest CoP in my view - the CoP purpose is closely aligned, perhaps EMHWB is the hardest to define without a final strategy.”

However, members of the CoP express similar concerns to others regarding the next steps in establishing and rolling out a national MoC.

> “I still don’t feel clear about what we are going to do with a Model of Care when we get one. When we don’t understand what the end of goal. I wonder whether Welsh Government are finding information from this they can amalgamate in the background. But as a participant I am not quite seeing that yet.”

As shown in Table 5.3, the majority of CoP members are either highly or fairly likely to attend CoP sessions in future, although a few were not very likely to attend.

Table 5.3: How likely respondents are to attend the Community of Practice in future

Likelihood Community of Practice	Highly likely	Quite likely	Not sure / don't know	Not very likely	Not likely at all
Accommodation Based Care Solutions	6	3	1	1	2
Community Based Care	10	12	2	1	0
Emotional and Mental Health	6	7	1	2	0
Hospital to Home	3	5	1	1	0
Supporting Families and NEST	10	4	2	1	0
Technology Enabled care	0	1	0	0	0
Total number of respondents	50				

Source: OB3 web survey November to December 2024, n=50.

Those who were likely to attend explained that they gain value from sharing best practice in the CoPs, find the CoPs to be an effective forum for sharing information and believe the content to be relevant to their roles.

> "They continue to provide an effective forum for knowledge and information sharing, which typically within health and social care, [we] struggle to achieve."
>
> "Because I have missed several sessions because of clashes with operational issues and I feel they have a potential that is unwise to miss."

Others felt that the CoPs do not make effective use of their time, as the design and structure of the CoPs do not seem to work towards a clear objective, reiterating points already raised in this report regarding the CoPs lack of clear contribution towards national models of care. A few reiterated that workload pressures and timetabling make it difficult to attend CoPs regularly.

> "It's a useful network to connect with, however I do feel it might benefit from stronger governance or having a stronger role in influencing change. It's informal nature for sharing learning is helpful but sometimes leads to a lack of clarity about what action will be taken as a result, or how good/best practice identified in the group can be scaled and spread."
>
> "Lacking focus - focus has drifted - there is no real sense of developing along structured areas that are being informed or influenced."
>
> "Capacity and the way in which they are set up is not conducive to sharing best/good practice."

While CoP members and regional leads were uncertain about the extent to which CoPs contribute to national models of care, they reported that they do play a clearer role in developing common approaches and narratives across Wales. The CoPs are seen as a structured way of sharing successful strategies and of avoiding 're-inventing the wheel.' CoP member value the opportunity to see whether their work can be amended to align with the work of other areas and regions and are keen to ensure that they aren't developing strategies and services in isolation. While this does not amount to a national model of care, CoP members do see this alignment of service delivery models as a positive step forward.

> "Hearing about the various projects based around Wales and having the opportunity to discuss and network with organisations who are RIF funded allows me to share ideas and perhaps develop services that I know works and prevents re-inventing the wheel."

One weakness highlighted by CoP members was the lack of formal engagement between each of the CoPs, as well as lack of formal engagement with other existing regional and national forums. Members explained that they have very limited knowledge of discussions occurring in other CoPs, unless they also happen to attend more than one CoP (which, for most, would be difficult to due competing workload pressures). For example, one member noted that the relationship between Hospital to Home and Community Based Care models needs to be seamless. This also applies to other existing regional or national forums, such as the IFSS (Integrated Family Support Services) network. This lack of engagement was seen to hinder the development of effective national models of care, since there may be significant cross-over between each model and a risk of duplication. At the least, mechanisms to share information more effectively between CoPs would support the development of aligned models of care.

> "There's just a bit of disconnect for me at the moment, because what I'm hearing in this forum I'm not necessarily hearing in other forums, which is how you inform and influence…I feel there isn't that wider influence, it's about how we pull these threads together and feed them back up. Having shorter things that could be fed into other meetings. Because they're longer meetings, that limits who can give their time."

> "A little more clarity is how it feeds into the national models and updates and linkages to the other CoPs and how we link with those. That would make a difference and give more clarity as to what happens to the information. A colleague attends one other CoP, but we are so busy it is hard to keep track."

6. Conclusions

6.1. Key findings in terms of design and development of RIF projects

Some of the sampled RIF projects have been informed by robust needs assessment and data and shaped by ongoing service user feedback, to refine and improve practices. There is scope to expand service user involvement across RIF projects, particularly in terms of their evaluation activities, to ensure that they remain responsive to user needs. Achieving this might be more challenging for those projects which provide more episodic interventions, and it would be worth exploring innovative approaches to gather feedback from users of such short-term services.

Whilst the evaluation found examples of knowledge exchange and learning between projects, this was not widespread amongst the sampled projects. Overall, greater emphasis was placed by sampled projects on adapting and tailoring provisions to accommodate local needs and circumstances. Despite Communities of Practice (CoPs) being a key component of the RIF programme to share learning across the sector, the evidence gathered from sampled projects suggests that there is scope for greater cross-project learning to share delivery insights, successes, and challenges.

RIF has been used as intended to support a wide spectrum of services, from acute care interventions to preventative measures. Some sampled projects, particularly those focused on integrated intermediate community care, share greater similarities, with common elements in their delivery. In contrast, sampled projects supporting families and young people tend to be more diverse in their design and approach. This diversity of intervention, if true of all projects funded under the Supporting Families and NEST MoC, may make it more challenging to transition activities to align with the national MoC already being developed by the Supporting Families and NEST CoP.

Most of the sampled RIF projects existed prior to the programme, but there is good evidence that projects are evolving to operate in a more regional, integrated way. The analysis of interviewed projects suggests a spectrum of progression across the programme, encompassing existing, evolving and emerging projects. On the one hand existing projects have been primarily built upon long-standing service models, often integrating minor enhancements to meet current demands and needs. On the other, emerging projects have been introduced to address gaps in service provision and appear to adopt innovative solutions. Over the remaining duration of the programme, greater consideration needs to be afforded to the sustainability of well-established existing projects and how these are expected to continue beyond the RIF programme.

Strong partnership working and joint management are key components of effective RIF projects. Partnership working between local authorities, health boards, and third-sector organisations is prevalent, though its effectiveness varies, with some projects showing strong collaboration and others struggling with coordination. Sampled projects managed under a single clinical lead or with joined-up triage and multi-agency panels were found to foster more cohesive decision-making and efficient service delivery. There has been an effort to streamline RIF projects across some regions by amalgamating smaller initiatives into larger umbrella projects. Whilst this has improved reporting structures, the fact that smaller interventions have retained their distinct approaches means there is a lack of full integration. It would be worth considering how distinct interventions funded within umbrella projects can be better integrated, via unified leadership or single points of management, to develop a more consistent implementation model.

Third sector organisations play a vital component within RIF projects in some regions by enhancing services and addressing gaps, although their ongoing role depends on funding availability. Sampled projects which have strong third sector input used this resource effectively by embedded it into care pathways and utilising the capacity to address specific gaps and needs. In regions where the third sector was found to be less embedded across sampled projects, there is scope to explore how the sector can contribute in a more meaningful way to care pathways and multidisciplinary teams, although this will become more challenging as RIF funding comes to an end.

RIF funding contributes in varying proportions across projects, from fully funding key roles in smaller initiatives to supplementing specific positions within larger, multi-component projects. The programme has been instrumental in increasing capacity, especially for projects targeting children and young people, and third sector initiatives. However, the nature of the funding means that it is very hard to be able to discern the impacts of RIF as a discrete fund when it accounts for a proportion of the staff members involved in delivering a wider service.

The flexibility of RIF funding and the regional infrastructure and resource put in place has enabled projects to innovate and adapt to changing needs. The programme’s flexibility was praised by funded projects although uncertainties regarding their longer-term funding poses a risk to their ongoing sustainability. The withdrawal of RIF funding threatens the continuity of many sampled projects as securing mainstream funding continues to be highly challenging. Addressing this issue should become a priority for the programme over its remaining delivery period. At a regional level, challenges persist for RPB leads to achieve a balance between strategic oversight and operational delivery, due to capacity constraints. This should be reflected upon in any future programme, to ensure that RPB teams are adequately resourced to undertake both roles effectively.

RIF reporting processes have improved as a result of streamlined reporting and increased trust in regional reporting, although a number of challenges remain at project and regional level. The positive evolution of RIF reporting processes has allowed for improved efficiency and reduced administrative burdens for projects. Projects value the balance between the quantitative data and qualitative narratives required of them. The feedback suggests that there is a need for better alignment of reporting metrics with project goals, particularly for community-based and preventative projects. There is also a need to address ongoing inefficiencies associated with projects needing to meet other reporting requirements in addition to those set out by the RIF. Furthermore, there is scope to further simplify and reduce the reporting burden for projects which are in receipt of relatively small amounts of RIF funding.

6.2. Key findings in terms of RIF projects' implementation to date

RIF is enabling projects to deliver earlier intervention, particularly community-based responses aimed at supporting patients in their own homes to reduce the demand on emergency services and hospital admissions. It is also demonstrating an approach to delivering services for supporting families in particular that is flexible and responsive to the needs of the service user.

Projects are acutely aware of the need to integrate services and connect health and social care teams more closely where possible. Whilst there are some examples of projects that have successfully achieved this, bridging gaps between acute and preventative care, integration remains a somewhat elusive outcome. Well-established projects are able to demonstrate a continuing shift towards increased integration, particularly those originally established under the prior funding of the Intermediate Care Fund (ICF) or the Transformation Fund (TF).

The fieldwork has highlighted the long time it takes to embed the system-wide behaviour change and service integration that RIF ultimately aspires to facilitate and achieve. In most cases, RIF funded projects achieve partial integration, for example through co-location of teams, a single project manager or improved joint access to patient data. However, the traditional silos between health and social care that exist due to systems-wide limitations such as bureaucratic processes and incompatible or inflexible funding structures and decisions remain.

Ensuring a strong, resilient and integrated workforce remains a crucial enabler for the effective delivery of RIF intended outcomes and there is a notable improvement in this area when compared to the many recruitment and retention issues experienced under the ICF and TF. Most projects report improved recruitment and retention leading to improved stability, attributed to the longer-term financial certainty provided to posts as a result of RIF's design.

There are several examples of projects, often acutely aware from the outset of the workforce recruitment and retention issues they were likely to face, applying innovative strategies to improve the situation. This includes rationalising terms and conditions across organisations, upskilling existing staff or other roles within teams, contracting out services, enhancing training opportunities, and developing a positive culture within the team to make it an attractive proposition for others to want to join. Whilst the use of such innovative methods to make roles attractive has been successful in many of these examples, challenges in filling gaps in key specialist posts has continued to hinder the ability of some projects to deliver as intended. This has often meant that projects have not been able to successfully transition to a 7-day model or have not been able to increase out-of-hours availability as a result.

Operational and strategic challenges are amplified within the current climate of intense resource pressures. Project staff routinely describe working under intense pressure, making it difficult to strategically plan for the longer term when constantly responding to important, short-term demands on their time. Some of the recruitment challenges faced are reflective of the wider shortfalls within the NHS and social care in Wales at the moment, for domiciliary care, clinical and therapy roles in particular. However, there are also continued examples where RIF monies are allocated via RPBs or directly from the health board as a year-on-year allocation, thus inhibiting a projects ability to plan effectively, retain staff and deliver in a timely manner. Slow recruitment processes or having to navigate complex governance structures in order to agree changes or adaptations to delivery structures also continue to cause delays which impact heavily upon project delivery in places.

Uncertainty about the future of RIF funding is likely to generate more gaps in key posts and increase recruitment and retention issues for projects over the final two years of this current funding cycle, if no clear decision is made in the near future.. Similarly, the recent pay offer agreements across health and social care, and the impact of the employer national insurance contributions on local authorities and the third sector are also likely to substantially raise workforce costs above what was originally planned for. A more acute squeeze on project finances is anticipated from next year onwards which may create tensions between project partners, and increased competition for scarce resources.

The fieldwork identifies examples of projects using innovative technology and digital solutions to deliver more efficient and accessible services to patients, particularly in supporting individuals with learning disabilities or those needing to manage chronic conditions. Other projects have made great strides in improving CRM systems or patient data sharing processes resulting in improved integration of project teams and the streamlining of reporting processes. However, these remain only pockets of best practice, with most other projects noting that potential opportunities to adopt digital or technological advancements are not currently being fully realised.

Recognition and integration of the social value sector is inconsistent across RPBs. Whilst some RPBs are able to exceed their RIF social value targets, others demonstrate missed opportunities for deeper collaboration and innovation. Under current resource pressures, statutory services, somewhat understandably, seem to increasingly focus on using the RIF to bolster core funded services, with the third sector somewhat sidelined as a result.

Projects only demonstrate limited knowledge of the Models of Care, and they hold little meaning or relevance to RIF funded staff delivering on the ground. In addition, projects staff often do not feel that their projects align with the Model of Care under which they report or feel that their project activity contribute across more than one, or other Models of Care.

Projects are more likely to focus upon their strategic fit with identified local or regional priorities and needs, often articulated on a population-based approach (e.g. Start Well, Age Well) or on how they were supporting other national strategic goals and policy drivers. The Six Goals for Urgent Emergency Care and the NEST Framework are more often referred to and more widely understood by the relevant RIF funded projects. A palpable disconnect between the complex policy landscape and the realities of delivery on the ground was articulated by many project staff, with a desire for greater simplification going forward.

Whilst projects often recognise opportunities for scale up within their region, from one cluster or local authority area to another, such opportunities are often only realised where available resources and a suitable local context enable this to happen. Only a few tangible examples of learning being shared and explicitly replicated across RPBs were noted to date.

6.3. Key findings in terms of the Communities of Practice

Members attend CoP sessions fairly regularly and contribute effectively but competing workload pressures and a lack of awareness are barriers to engagement. Members cannot always attend meetings due to scheduling conflicts, staff absences, working patterns or annual leave commitments, and/or demanding workloads. As such, these members reported that they were more likely to attend when agenda items seemed more directly. In addition, some members and project leads noted that, from their perspective, information about CoPs seems primarily to have been circulated via word of mouth or through existing contacts, rather than through a formal mechanism for reaching all RIF-funded projects.

Members engage in fairly active discussions during CoP meetings, either through presenting their own work, or contributing to discussions orally or in the chat bar, with many also actively listening to discussions.

The CoPs’ target membership is unclear, with questions raised about the appropriate scale of the meetings and the breadth of the sectors represented. Inconsistency in who attends each CoP meeting was also highlighted as a barrier to effective national working. Members were keen to ensure that a breadth of sectors and experiences continue to be represented within CoPs.

The CoPs’ organisation is generally considered good or excellent but could be improved by setting a schedule further in advance, reducing the session duration and introducing flexibility into the CoP session structure. Members were broadly positive regarding many elements of the CoP’s organisation, including the quality of the speakers, facilitation of the sessions, usefulness and relevance of the topics covered, and format of the sessions. Members often identified a need for the CoP agenda and timetable to be set and circulated much further in advance and the length of the CoP meetings was another common challenge identified by members. Alongside this, they recommended introducing variety and flexibility into how the sessions are structured (such as annual face-to-face meetings) and identified a need for a centralised repository of information from the CoPs.

CoPs allow members to keep up to date with national and regional policy developments, share good practice and share learning. Summaries provided during CoP sessions are appreciated for their clarity and efficiency, saving members from having to navigate multiple sources of information. Participants noted that discussions often highlight innovative approaches from other regions, inspiring them to adapt and implement similar methods.

CoPs facilitate engagement between different sectors, providing opportunities to hear a mixture of perspectives and a sense of camaraderie. Members believe that CoPs are able to bring together professionals from diverse sectors, such as health, social care, and the third sector and noted the value of this cross-sector representation, emphasising how it provides a richer, more comprehensive understanding of shared challenges and opportunities. This sense of shared experience was described as both reassuring and motivating, fostering a supportive environment where participants could exchange ideas and resources.

CoPs are seen to support problem solving, innovation and the development of a common narrative. Members reflected on how these forums allow them to explore challenges collectively, leading to creative solutions that might not have emerged in isolation. Members highlighted the value of these forums in fostering a sense of coherence across regions and sectors.

Members have applied some learning from the CoPs but discussions within CoPs are not regularly translating into actions; dissemination and networking are the primary outputs so far. Some members noted in general terms how learning from CoP sessions had led them to challenge and review their own thinking and strategic planning or make amendments to their project delivery but more frequently reported disseminating information to colleagues and partners.

CoP members (particularly those working at strategic level within their region) noted that discussions within CoPs do not often translate into direct action. They felt that CoPs prioritise exemplifying good practice, which is valuable, but did not see much evidence of this practice being actively rolled out elsewhere and noted a lack of national guidance on how to roll out such good practice.

CoPs have evolved since their inception but there is no clear understanding of how CoP discussions are informing national models of care. Firstly, there is limited understanding regarding the extent to which CoPs are, by design, intended to contribute to national MoCs. Although there is general agreement that the CoPs are intended for sharing learning and good practice (and are effective forums for doing so) there is limited consensus on the responsibilities of the CoPs beyond this. Secondly, there is limited understanding amongst CoP members and regional leads about which practical mechanisms and processes are in place to facilitate CoPs' contribution to national models of care.

Overall, those working at strategic level within regions report that CoPs are fairly disconnected from work being undertaken at regional and local level and lack a mechanism for formally evaluating and consolidating these insights into a cohesive national framework.

CoPs do reduce isolation and duplication and encourage alignment across Wales but greater alignment between each CoP is needed. The CoPs are seen as a structured way of sharing successful strategies and of avoiding 're-inventing the wheel.' While this does not amount to a national model of care, CoP members see this alignment of service delivery models as a positive step forward. One weakness highlighted by CoP members was the lack of formal engagement between each of the CoPs, as well as lack of formal engagement with other existing regional and national forums.

Annex A: Research instruments

Topic Guide: RIF project staff

Project background

1. Tell me about:
    - Your role
    - Your organisation

2. Tell me a little about your RIF funded project/service
    - What is it trying to achieve?
    - How was the project established?
    - When was the project established / fully up and running?

3. How much funding do you have to support delivery?
    - How much / what percentage of the funding is RIF?
    - How much autonomy do you have to use the RIF funding as you see fit to deliver the project?

4. How does the project operate?
    - Who is involved in delivery? Probe re:
        i. Staffing structure and capacity
        ii. Key partners
        iii. Third sector involvement *[where there is third sector involvement probe about the nature, effectiveness and level of involvement]*

5. When the project was established, what need was it looking to address?
    - What evidence of need was considered?
    - How did it make use of evidence from the population needs assessment?

6. Which population groups are most supported?
    - Probe re: older people, 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 wellbeing needs or other
    - To what extent was the project/service co-produced with or considered input from these service users and carers?

7. What previous work it is directly building on (if any)?

- Probe: re prior involvement of project under Transformation Fund or ICF
- Was the project/service in existence prior to RIF? If so, what is different about the current project/service?
- What were the underpinning ideas or frameworks that informed the activity?
- What informed the project approach, including learning from other models within Wales / further afield?
- Has the project replicated or adapted any learning or approach from elsewhere. If so, how did you use this?

Project implementation and delivery

8. How are service users referred to your service/project?
    - How do they access the information, advice and care they need?
    - Are they supported in their own home or in local hubs/centres/community spaces?
9. What is working well?
    - What would you describe as the main successes to date?
10. What is not working as well?
    - What barriers or challenges have you faced?
    - What delivery changes, if any, have been made to the project over the RIF funding period?
11. What use is made, if any, of technology and digital solutions within your project/service?
    - e.g. self-care apps, digital reporting, home technology, virtual information/advice/consultation
12. How does the project help deliver a more integrated service across health and social care?
    - How are multiple agencies/organisations working together?
    - On what basis does the project deliver a more integrated service?
    - To what extent would you describe it as a seamless service?
    - Do you have necessary workforce to provide the service?
    - How are staff working across health and social care?
    - What contribution is your project making to the development of the workforce? (e.g. training, skills)
    - How is your project promoting the social value sector?

13. Which Model(s) of Care does your project fit within?

    - How does your project contribute to the development of the Model of Care which it's been assigned to for the purposes of RIF reporting?
    - How could your project contribute to the development of the Model of Care in future?
    - In what way could the project/service be adopted elsewhere?
    - What are the key components of your project that are required to make it work elsewhere?
    - How is this being considered or discussed?
    - With whom? (Probe: re local, regional, national)

Involvement with Communities of Practice

14. Has the project engaged with any RIF CoP?
    - If so, which one?
    - If so, in what way have you been involved?
    - If so, how useful /valuable is being involved in a Community of Practice to you/your project?
    - If not, why not?
    - What have you learned from others? How have you applied this?

15. (If relevant) How could the support provided by the Community of Practice be improved?

Reporting

16. How do you report on your project's progress and difference made?

    - To whom?
    - How often?
    - What data and evidence do you provide?
    - How do you find the reporting process?
    - What barriers or problems do you face when collecting data and evidence?
    - How could it be improved?

Topic Guide: RIF strategic leads

Introduction

1. [If interviewing for the first time, otherwise confirm any changes] Tell me about:
    - Your role
    - Your organisation
    - Your involvement with the RIF programme

Implementation and delivery

2. What resource and infrastructure arrangements have been put in place at your RPB to deliver the RIF?
    - How are you utilising the up to £750k infrastructure support available towards RIF infrastructure costs?
    - How is this helping with the programme management of RIF?

3. What progress has been achieved to date in your region?
    - What projects are up and running?
        - [Where relevant] Why have some projects started before others?
        - Were they already in operation?
    - Have there been any delays to date. If so, why?
    - Have any projects been withdrawn? If so, why?
    - What progress is being achieved in the development of each Model of Care and for whom?

4. What accounts for successful delivery of RIF in your region?
    - Which projects would you identify as successful ones and why?
    - How could they be adopted in the upscaling and spread of models of delivery?
    - To what extent is this being considered?

5. What barriers and challenges have been encountered by RIF projects in your region, particularly in delivering integrated care?
    - Which projects have encountered the most challenges and why?
    - How were any challenges overcome?

6. What workforce issues and challenges have been encountered by RIF projects in your region?
    - What evidence is available of this?
    - What implications did these issues have?
    - How were they overcome?
    - How is the third sector involved in RIF project/service delivery in your region?
    - How are you reaching the 20% social value target?

7. To what extent are funded RIF projects focused on prevention and early intervention?
    - Which projects are particularly focused on this and how?

8. Which of the Models of Care are the biggest priorities for your region and why?
    - How are the Models of Care being considered?
    - How are they being embedded?

9. Which priority population groups are most important to your region and why?
    - Probe re: 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 wellbeing needs
    - How is RIF funding distributed/balanced across the needs of the priority population groups?
    - How have service users and carers been involved in the design of RIF-funded services?
    - What projects would you identify as examples of this?

10. Which projects are particularly innovative and transformative in your region and how?

11. What use is made, if any, of technology and digital solutions within your programmes and projects?
    - e.g. self-care apps, digital reporting, home technology, virtual information/advice/consultation
    - What evidence is available to demonstrate this e.g. do you have any evaluations of these projects?
    - Which projects would you identify as examples?

12. In what way (if any) has the fund enabled better integration of health, social care and other key services in your region?
    - What evidence is available to demonstrate this?
    - Which projects would you identify as examples, and why choose these?
    - What, if any, would you identify as barriers to better integration across health, social care and other key services?
    - How is the current policy landscape supporting integration of services?

13. How do the projects in your region contribute to the development of the Models of Care?
    - How could the projects in your region contribute to the development of the Model of Care in future?
    - Which projects/services would you highlight as those that could be adopted elsewhere?
    - What are the key components of these projects/services that could be replicated elsewhere?
    - How is this being considered or discussed?
    - With whom? (Probe: re local, regional, national)

Involvement with Communities of Practice

14. How has your region engaged with the Communities of Practice?
    - Who typically from your region attends each Communities of Practice?
        - Do you/Have you attended? *(Note: most Regional Leads have noted in past interviews that they do not attend)*
        - Which one/ones do you attend?
    - How does any Community of Practice engagement feed back into the work of the region?
    - What do you gain from your involvement with the Communities of Practice?
    - What are the Communities of Practice helping to achieve?
    - How are the Communities of Practice contributing to the development of Models of Care?
    - How are the Communities of Practice helping you to learn from others?
    - How have any papers or resources produced by Communities of Practice helped to develop your RIF programme and projects?

15. What if anything needs to change about the Communities of Practice?
    - What support might be useful to you, and why?

Reporting

16. What are your views on the monitoring and reporting processes adopted across the RIF programme?
    - What works well?
    - What could be improved, and how?

Topic Guide: RIF Community of Practice

Aide-memoire for facilitation of a short feedback session

1. How valuable is being involved in this Community of Practice to you?
    - In what way?
    - Why do you attend?
    - How would you describe the purpose of the Community of Practice?
    - What need is it fulfilling?
    - Probe re: value of:
        i. detailed updates on national initiatives
        ii. action learning based problem-solving sessions
        iii. working on national models of care to share learning more widely across Wales
    - What have you learned?

2. What reports or resources has the Community of Practice produced?
    - Have you used any of the reports/resources produced by the Community of Practice? In what way?

3. What works well about this Community of Practice?
    - What elements work well, and why?
    - To what extent is it a space where you can:
        i. share ideas?
        ii. compare practices?
        iii. develop your thinking about future models of care?
    - How is it actively supporting the development and embedding integrated models of care?

4. What, if anything, needs to change about the Community of Practice?
    - What would you like to see more of?
    - What would you like to see done differently?
    - What else would be useful?

Community of Practice - survey of participants

Available upon request