



# West Wales Regional Partnership Board

---

Annual Report 2024 - 2025

---

## FOREWORD



As I reflect on my first full year as Chair of the West Wales Regional Partnership Board (WWPRB), key to our success has been finding a balance between responding to the changes needed to develop preventative, integrated and sustainable care and support services, whilst continuing to prioritise the needs of the region and what works for our people and communities in West Wales.

I am grateful for the continuing involvement of people and partners from across the region in delivering the priorities of West Wales Regional Partnership Board and its sub groups, who work tirelessly to ensure services respond to the needs identified in strategic work such as the Population Needs Assessment (PNA) and Market Stability Report (MSR) and for the commitment demonstrated by members of the Citizen and Third Sector Engagement Board, which is essential for informing our joint area plan.

The WWRPB and Regional Partnership Team continue to respond to the changes and challenges of regional working and recently, have appointed a Strategic Commissioning Manager, to support development of joint regional commissioning and a NYTH-NEST Project Manager to support development of and compliance with the framework. Ensuring our services are commissioned to align with need and respond to demand and giving our children and young people the best start in life, will ensure we are developing healthier communities of the future.

During the year, in response an increasing emphasis on integrated and re-balanced community care services, a need to eliminate profit from children's services and ever increasing demand in the system, we have developed a refreshed Capital Strategy that strengthens alignment between our capital and revenue programmes and began the process to refresh our PNA and our MSR, to provide further evidence for future planning.

At our Annual Conference and Awards Ceremony held in March, the increasing commitment to regional working was visible from the partners, speakers and delegates who participated and expertly demonstrated not only by those who were presented with awards, but by the quality, breadth and volume of the nominations.

The demands on our workforce continue, with our focus on streamlining and integrating systems where possible and sharing learning between our teams, to relieve pressure and respond to demand on services.

As we understand and respond to the evolving needs of our communities and our people across the region, it is my belief that it is the collective commitment to excellence and improvement of our stakeholders, colleagues, partners and communities that allows us to develop and deliver the sustainable services needed to keep our communities healthy now and in the future.

On behalf of the West Wales Regional Partnership Board members, I thank you all for your commitment, achievements and support.

More information on the work of the Partnership can be found on our website [West Wales Regional Partnership Board – Working together to plan and deliver services for adult and children with needs for care and support. \(www.rpb.org.uk\)](http://www.rpb.org.uk) or by contacting the Regional Partnership Board Team, contact details for which are provided at the end of the report.

***Hazel Lloyd Lubran – Chair, West Wales Regional Partnership Board***



## CONTENTS

FOREWORD .....	0
<b>Part 1: OVERVIEW OF WEST WALES REGIONAL PARTNERSHIP BOARD .....</b>	<b>4</b>
Purpose .....	4
The role of West Wales Regional Partnership Board (RPB) .....	5
Membership, operating structure and governance .....	5
Funding - The Area Plan and Regional Integration Fund .....	7
Breakdown of revenue funding.....	8
Innovation in Social Value .....	9
Communication .....	9
Celebrating success .....	11
<b>Part 2: THE PROGRAMMES .....</b>	<b>13</b>
<b>Prevention and Community Coordination .....</b>	<b>13</b>
<b>Complex Care Closer to Home .....</b>	<b>17</b>
<b>Promoting Good Emotional Health and Wellbeing.....</b>	<b>21</b>
<b>Supporting Families and therapeutic support for care experienced children.....</b>	<b>24</b>
<b>Home from hospital .....</b>	<b>32</b>
<b>Accommodation Based Solutions.....</b>	<b>37</b>
<b>Dementia &amp; Memory Assessment Service .....</b>	<b>37</b>
<b>Unpaid Carers .....</b>	<b>44</b>
<b>Learning Disabilities &amp; Neurodevelopmental Conditions .....</b>	<b>50</b>
<b>Integrated Planning and Commissioning.....</b>	<b>51</b>
<b>West Wales Capital Programme .....</b>	<b>52</b>
<b>Innovation and Technology .....</b>	<b>55</b>
<b>Workforce Development and Integration.....</b>	<b>57</b>
<b>PART 3: REFERENCES &amp; LINKS .....</b>	<b>60</b>
<b>Appendix 1 .....</b>	<b>61</b>

# Part 1: OVERVIEW OF WEST WALES REGIONAL PARTNERSHIP BOARD

## Purpose

The West Wales Regional Partnership Board region covers the geographical footprint of Hywel Dda University Health Board (HDdUHB), bringing together representatives from the local authorities of Ceredigion, Pembrokeshire and Carmarthenshire, Hywel Dda University Health Board along with third sector and independent organisations, service users and unpaid carers. Furthermore, wider partners involved in health and social care such as Social Care Wales are also engaged with the collective aim of transforming and enabling enhanced ways to deliver integrated, community health and care services in West Wales, through collaborative working.

The overarching commitment of the West Wales Regional Partnership Board remains that people needing care and support in West Wales receive the right help, at the right time, in a joined up and seamless way, so that they stay well and independent for as long as possible and can do what matters to them. This aligns with the aspiration within the national plan for health and social care ‘A Healthier Wales’, for an integrated community care approach to health and social care, which is focussed on health and wellbeing and on preventing illness.

Figure 1. below helps depict how, through working regionally, locally and at cluster level, the Regional Partnership Board helps influence the integration of community services. In instances where local innovation and coordination have worked well, this can provide opportunities for successful regional models to be developed into national models, which can then be applied across Wales.

## Refining Regional Partnership Board Scope



Focussing our efforts to make integration happen for community services  
– working regionally, locally and at cluster level

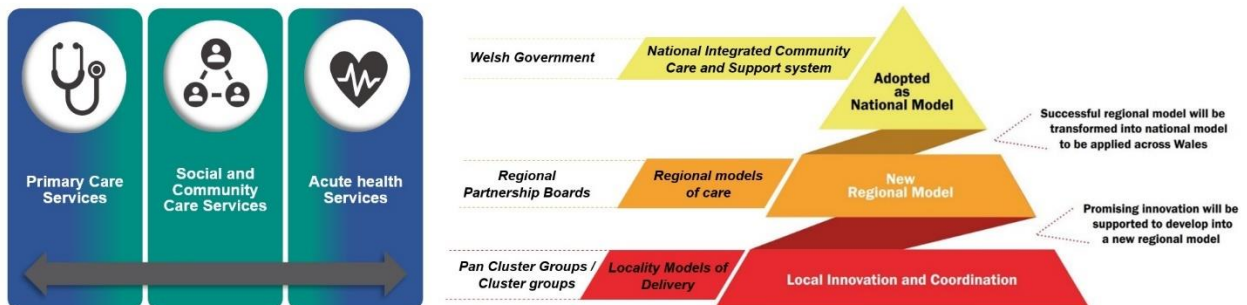


Figure 1. Refining Regional Partnership Board Scope

## The role of West Wales Regional Partnership Board (RPB)

The RPB govern the direction of the partnership to fulfil the statutory duties introduced in Part 9 of the Social Services and Wellbeing (Wales) Act 2014 which include:

- Promoting the integration of key services such as those for older people, people with a learning disability, carers and children with complex needs
- Establishing partnership arrangements for specific services and pooled funding arrangements where appropriate
- Ensuring arrangements are in place to meet core statutory duties such as the provision of Information, Advice and Assistance and advocacy services
- Improving outcomes for people needing care and support and their carers
- Ensuring available resources for RPBs are utilised in line with the guidance and deliver our vision of integrated health and care in West Wales

## Membership, operating structure and governance

In response to the RPB self-assessment undertaken at the end of 2023 summarised below, the updated Part 9 Guidance of the Social Service and Wellbeing Act and to ensure the WWRPB is effective, West Wales RPB members undertook a review of their ways of working during 2023-24, facilitated by YMA, which includes a review of the Terms of Reference that will be published on [www.wwrpb.org.uk](http://www.wwrpb.org.uk) when complete.

### West Wales Regional Partnership Board Self-Assessment Summary

During 2024-25, the RPB has focussed on its potential to move from its current oversight role to one which involves maximises the potential for leading the exploration of future models for services across the region – particularly the specific challenges facing rural areas such as West Wales.

The RPB also identified a wider priority to liaise with other RPBs to share the findings of the self-assessment exercises with each other and with the Welsh Government, with a view to helping colleagues understand and support the RPB priorities and aspirations across Wales. Also, it identified a lobbying role on behalf of partners, between the RPB and the Welsh Government,

There were several specific actions suggested in the self-assessment which the Board are continuing to respond to as follows, with more detail on addressing the finding included in the body of the report:

- Be more visible and improve understanding of the roles and responsibilities of the RPB and how to influence future direction
- Work more closely with PSBs
- Refine MOU across statutory partners to strengthen accountability and governance
- Improve collaboration and integration by enabling systems that speak to each other, clarity on information sharing between agencies and a relentless pursuit to remove system waste and handovers that add no value to citizens
- Simplify the 'complex and fragmented' landscape
- For RPBs to be seen as central to transformation of the health and care system, driving improvement and integration, rather than a bolt on or talking shop. Whilst not fully realised in West Wales, progress has been made and is ongoing'
- Greater integration of data and opportunities to learn from each other
- If it is to be meaningful and sustainable, delivering transformation shouldn't be constrained by a financial year, or the term of a government's administration
- Develop more effective mechanisms for service users, unpaid carers, staff and the wider population to inform our programme of work (e.g. pre and post meets, for volunteers to have a more 'inclusive' role)

### Meetings

- A full list of members can be seen in the reviewed Terms in Appendix 1. The RPB generally meets five times a year however, during 2024-2025 six meetings were planned on the following dates:
- 20<sup>th</sup> May 2024 Cancelled
- 15<sup>th</sup> July 2024
- 21st October 2024
- 20<sup>th</sup> January 2025
- 17<sup>th</sup> March 2025

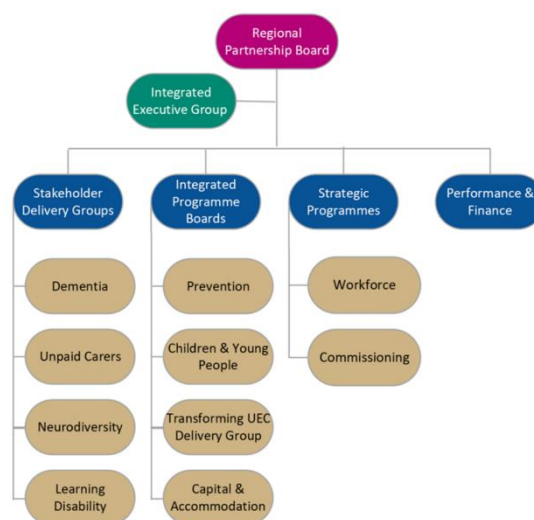
Meeting agendas are available to view on the Partnership website, via the following link: [WWRPB Agendas – West Wales Regional Partnership Board](#)

### Operating Structure

The operating structure of the RPB can be seen on the right in figure 2. It shows the various work programmes, how they report to the RPB and helps demonstrate how the various workstreams interrelate to deliver on the elements of the area plan 2023-2028. In response to the refresh of the Population Needs Assessment and Market Stability Report underway currently, the area plan and regional priorities will be refreshed by March 2026.

A link to the plan and current priorities can be found here:

[Area Plan – West Wales Regional Partnership Board \(wwrpb.org.uk\)](#)



*Fig.2 Operating structure of RPB and supporting workstreams*

### Integrated Executive Group (IEG)

The Integrated Executive Group (IEG) comprises of senior officers from Hywel Dda University Health Board, the three County Councils and the Chief Executive of Ceredigion Association of Voluntary Organisations representing the third sector. The IEG meets regularly and advises the RPB on priorities for integration, monitors progress of the regional programme, deployment of regional funding and tackles shared operational challenges. To correspond with the review at Board level, IEG has reviewed and refreshed its TOR also, to refine and clarify its purpose.

### Stakeholder Delivery Groups

Part 9 of the Social Services and Wellbeing (Wales) Act 2014, requires the RPB to prioritise the integration of services for priority population groups including older people with complex needs and long-term conditions including dementia, people with learning disabilities, children with complex needs and unpaid carers. As such, Stakeholder Groups have been created to focus on the specific needs of identified population groups and to help inform the work of these groups.

### Integrated Programme Boards

Integrated Programme Boards oversee the delivery of our thematic priorities such as Transforming Urgent and Emergency Care (UEC) and in some instances, includes the oversight of the delivery of the Regional Models of Care.

### Strategic Programmes

Strategic Programmes are enablers that impact across all our thematic areas of work and population groups.

## Funding - The Area Plan and Regional Integration Fund

2024-2025 was the third year of the Health and Social Care Regional Integration Fund (RIF), a 5-year funding programme supported by Welsh Government with the aim, of establishing and mainstreaming six new national models of integrated care so that citizens of Wales, wherever they live, can be assured of an effective and seamless service experience in relation to;

- 1) Community-based care – prevention and community coordination
- 2) Community based care – complex care closer to home
- 3) Promoting good emotional health and well-being
- 4) Supporting families to stay together safely and therapeutic support for care experienced children
- 5) Home from hospital services
- 6) Accommodation-based solutions

In West Wales we have organised our work programmes to assist us in delivering these Models of Care. Fig.3 below helps demonstrate how the areas of work interrelate.

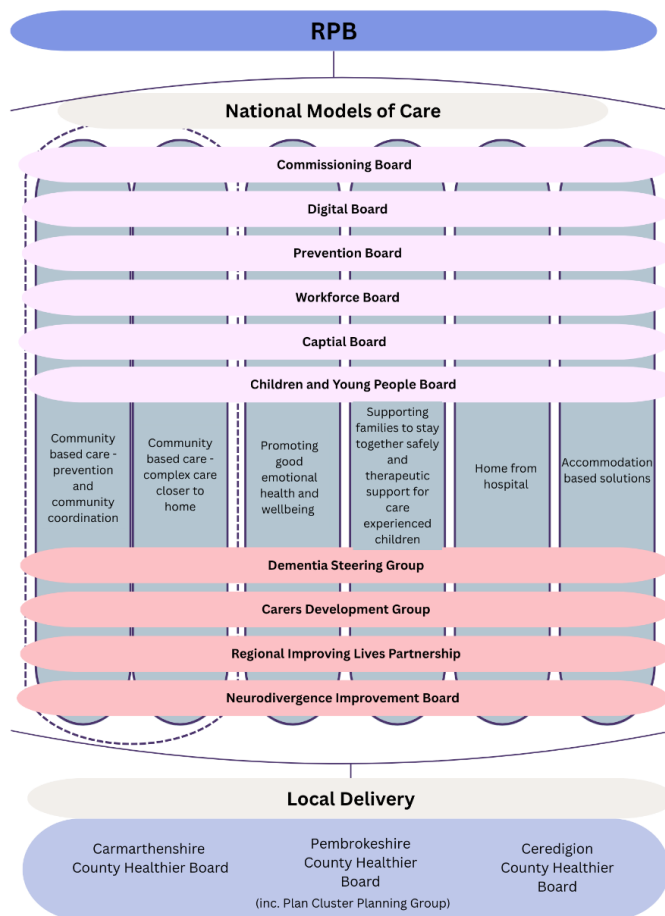


Fig 3. Models of Care and regional delivery

Over the course of 2024-25 there have been a range of projects being supported through this funding, each contributing to the various work programmes as detailed in figure 3 above.

### Breakdown of revenue allocations

**Regional Infrastructure Fund (RIF)**  
(75% up to £750,000)

**£750,000**

**Total RIF funding:**

**£18,816,846**

**Ringfenced**

- Integrated Autism Service (IAS) - £398,000
- Dementia & Memory Assessment Service - £1,733,000
- Unpaid Carers: Hospital Discharge Engagement - £121,000
- Short Breaks for Carers - £162,806

Fig. 4 Breakdown of revenue funding

## Innovation in Social Value

### **Regional Innovation Forum (s.16 forum)**

The West Wales Innovation Forum was set up to support the identification of innovation in social value sector, to identify transformative models of care across the third sector and support the re-balancing agenda. During most of 2024-25, the Forum was overseen jointly by the Regional Partnership Board and the West Wales Regional Innovation Coordination Hub (WWRIC), whilst there was a vacant post for the Workforce Programme and Change Manager. That post being filled, responsibility for the Innovations Forum passed back to the Workforce Programme and Change Manager toward the end of the year.

A chair has now been appointed, Terms of Reference agreed, and the Innovations Forum continues to make progress in setting objectives for the region. The forum reports via the Regional Preventions Board as part of the WWRPB governance arrangements. Current objectives include development of Social/Micro Enterprises, Consortium Models and Innovative Commissioning. The Forum meets currently on a quarterly basis and is considering the development of a regional information sharing platform accessible to all members.

## Continuous Engagement and Communication

### **Listening to others**

The Social Services and Wellbeing (Wales) Act 2014 encourages Local Authorities and Health Boards to implement working practices which embed wellbeing and co-production, giving citizens voice, choice and control over their support needs.

In the past year, we've established a robust framework for inclusive engagement, driven by direct feedback from individuals with lived experience and third-sector organisations. This framework comprises three key components: the Citizen and Third Sector Engagement Board, the West Wales Communication and Engagement Drop-In Meeting, and the Support Groups and Third Sector Network

### **The Citizen and Third Sector Engagement Board:**

The aim of the Citizen and Third Sector Engagement is the bringing together of the voices of lived experience and third sector and community organisations to inform our programme of work. This co-productive approach has been a valuable forum to help inform the development of health and social care initiatives across the West Wales region. These meetings commenced in May 2024 with monthly hybrid meetings for the first 6 months and bi-monthly meetings thereafter. Whilst the purpose of the Board is wider than RPB representation, it follows or enhances the principles and processes set out by Welsh Government for citizen engagement in RPBs.

The feedback and involvement of the board's participants has influenced and directly impacted various workstreams and projects, including the carers strategy 2025 to 2030, development of the Capital Blueprint, and the WWRPB Conference and Awards. The membership of the board consists of 56 individuals and organisations.

The Board is open to recruitment all year round and has enabled citizen and third sector representatives to become involved in additional project work and attend other board meetings, widening the range of expertise and experience of those we engage with.



### **Citizen and Third Sector Engagement Board Member is Developing a Regional Course:**

Peter Clark has been attending the Citizen and Third Sector Engagement Board since May 2024. Peter ran the DEEP Support Group in Ammanford for people living with dementia. Peter and Innovations in Dementia CIC co-director Damian Murphy, presented at the WWRPB Conference at Parc Y Scarlets on the 11th March 2025. Presenting to over 40 attendees on the co-production, design and delivery of A Good Life With Dementia in West Wales.

‘A Good Life With Dementia’ is a post-diagnostic course created by and for people living with dementia. The presentation explained the initial steps of developing and delivering the course in West Wales, with input and help from the voices of lived experience and support from Innovations in Dementia.

The course will help those newly diagnosed with dementia by sharing personal experiences and providing important information during a time of uncertainty and will offer a safe and supportive environment for people living with dementia to answer key questions and to learn from each other.



### **West Wales Communication and Engagement Drop In Meeting**

Every month, we host a brief online meeting on Microsoft Teams, lasting up to one hour. It’s a space for us to share information (always within GDPR rules) about upcoming events and communication campaigns in West Wales. By sharing, we avoid overlapping efforts and work towards more efficient communication. This helps us all reach more people and have a greater impact on our community’s health and wellbeing.

An updated excel document is shared after each meeting which includes communication leads contact information, events and communication campaigns. This meeting is for professionals who handle communication and engagement for their organisation or support group

As of April 2025, there are over 120 members in this meeting.

### **The Support Groups and Third Sector Network**

We have established a support group and third sector network; this enables direct connections with third sector organisations and support groups across West Wales for them to collaborate on projects which are most relevant to them. Members of this network are only contacted when projects directly relate to their area of focus, offering opportunities for consultation or joint development.

Members of this network have the choice for us to facilitate the discussion or we can provide them the material to conduct the consultation or project in their own time. This network has enabled for over 150 carers to be directly involved in the development of the 2025 -2030 carers strategy. As of April 2025, there are over 20 support groups and third sector organisations in this network.

**Newsletter:**

We have continued to publish monthly newsletters, which have been well received and shared throughout the region, with the WWRPB Capital Team having a special edition every quarter. Through these newsletters we have provided information about events in the region, updates on key project developments and further insight into each of the programmes that are governed through the WWRPB.

You can see all our previously published newsletters on the link here: [WWRPB Newsletters – West Wales Regional Partnership Board](#)

**Website:**

The ‘Get Involved’ section of the West Wales Regional Partnership Board website has been updated to reflect the changes that have been made in our co-production efforts. This webpage demonstrates the ways individuals, support groups, and organisations can get involved.

A link to the website can be found here: [Get Involved – West Wales Regional Partnership Board](#)

**Case Studies:**

Within the WWRPB team, we are fortunate to have the skills to produce video case studies on RIF projects as a part of the story of change. View a selection of the 2024-25 case studies [here](#) .

## Celebrating success

On 11<sup>th</sup> March 2025, WWRPB held a Conference and Awards event at Parc y Scarlets stadium, Llanelli. The spotlight this year, was “Integrated Community Care Systems (ICCS)”, emphasising the importance of collaborative and accessible care within our local communities.

The event brought together a diverse range of stakeholders, including health and social care professionals, third sector organisations, volunteers and community leaders, all united by a shared commitment to improving the wellbeing of West Wales residents. With keynote speakers WWRPB Chair Hazel Lloyd Lubran and Children and Social Care Minister Dawn Bowden highlighting both local and national developments and challenges in health and social care.



Throughout the day, attendees engaged in insightful discussions, exploring innovative strategies and best practices for a range of important topics, including:

- Unpaid carers and those living with dementia
- Capital developments
- Workforce challenges
- The home from hospital process
- The effects of AI on children and young people



Later in the afternoon we welcomed the annual West Wales Health and Social Care Awards, which is becoming a not to be missed event in regional calendars. The awards celebrate the individuals and teams whose dedication and compassion are positively shaping our communities and contributing to improving services that secure better outcomes for people.

For more information about the award winners and runners-up: [WWRPB Conference & Awards 2025 summary – West Wales Regional Partnership Board](#).

We were also fortunate to have RADIO BGM broadcasting a highlight of the WWRPB Conference and Awards, which includes recordings of the speakers, the RPB Q&A, information stands and award nominees. The full recording (without the addition of music) can be found on the link here: [WWRPB Conference & Awards 2025 Audio](#)

## Part 2: THE PROGRAMMES

### Prevention and Community Coordination

#### Overview:

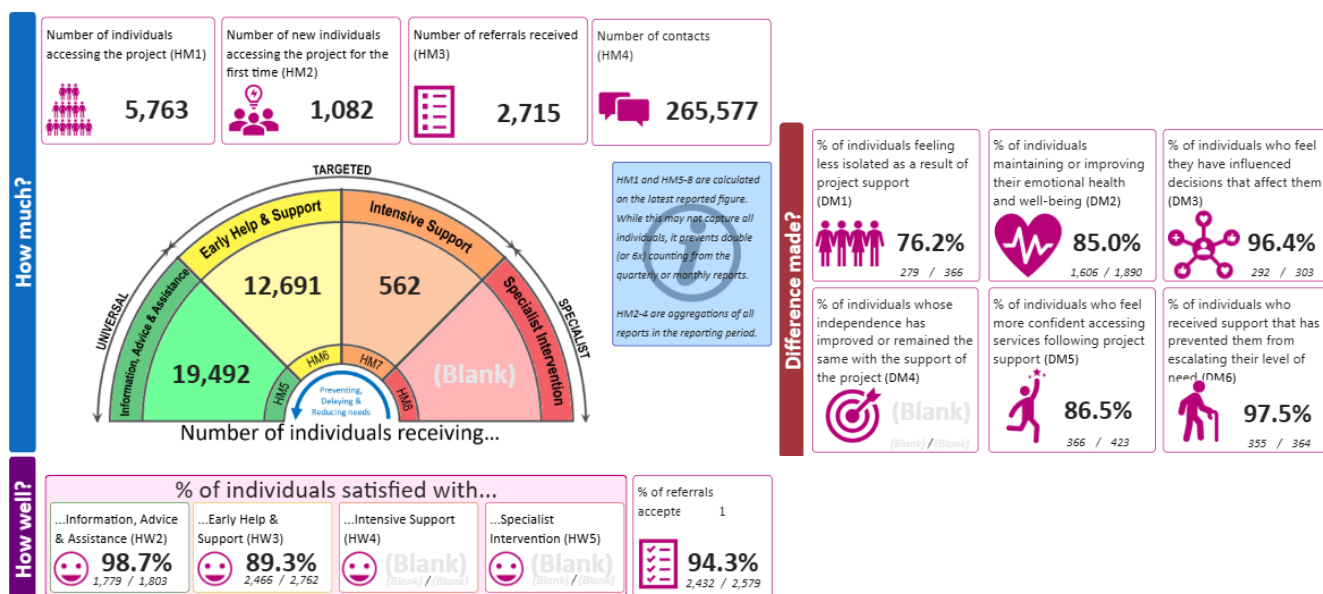
Prevention is a guiding principle within the Social Services and Wellbeing Act, the Wellbeing of Future Generations Act and is core to all model of care approaches.

The Regional Preventions Board was established in 2022 to oversee governance of the Prevention and Community Co-ordination and Promoting Positive Emotional Health and Wellbeing models of care. This regional board is unique in the region in that it spans RPB and PSB (Public Service Board) structures – given a shared agenda in relation to wellbeing and the importance of strong interconnected communities. The vision for the Board is agreed as:

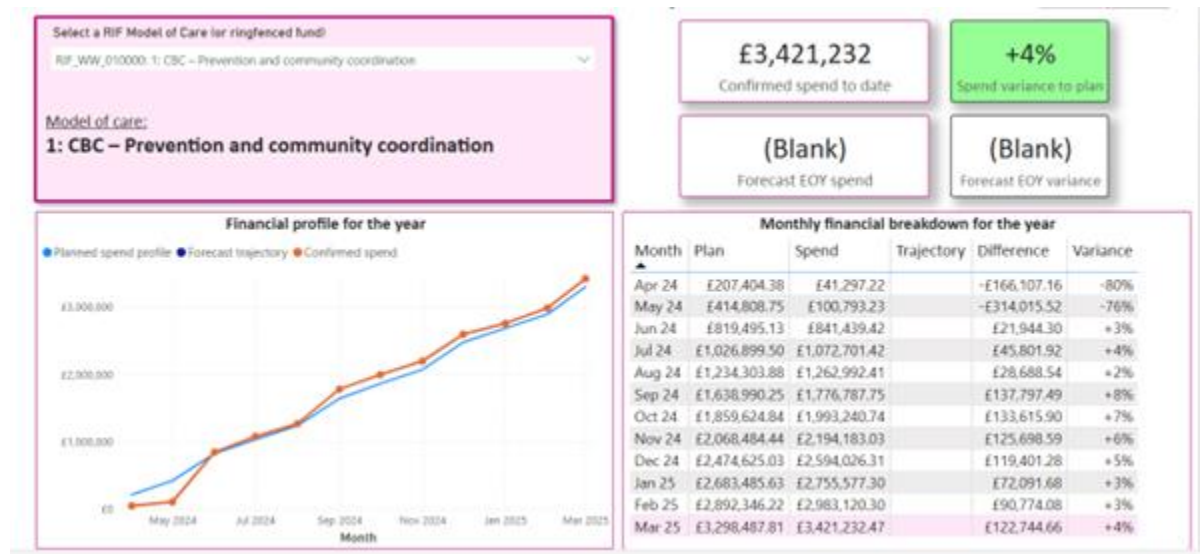
Prevention is about people staying healthy, happy and independent for as long as possible - connected to active, resourceful and kind communities. Supporting prevention means making better choices as easy as possible for people while acknowledging the effect of wider determinants of health and wellbeing – whatever stage of life people are at. When people do need help, they are supported to manage their own health and wellbeing earlier and more effectively and over the course of 2023-24, a range of initiatives have been developed that aim to better support people in remaining independent within communities and closer to home.

Numerous partners are involved in delivery of this model of care, including: local authorities, health boards, a range of 3<sup>rd</sup> sector organisations, as well as service users and carers.

#### How much, how well & difference made in 2024-25:



### Investment 2024-25:



### Examples of projects being delivered during 2024-25

#### Catalysts for Care

This project increases local provision of services and local employment by supporting micro and social enterprises to become established. The enterprises support the take up of Direct Payments, enables people to have greater choice and control through the provision of bespoke, person-centred services, as well as enabling unpaid carers to take a break from their caring role. A range of stakeholders are members of regional and county groups that steer the work of the project and priority population groups have played an important part in helping shape the project.

There are now over 100 enterprises offering care support and wellbeing services in West Wales, employing over 170 people. These are individuals who may have chosen another career path had this opportunity not been available to them. The average Social Return on Investment is calculated at £3.71 for every £1 invested.

Enterprises have clear identities and specialisms and can provide a personalised service. The range of specialisms in West Wales is significant, spanning end of life care, care of older people, learning disabilities, mental health, dementia and support for unpaid carers.

The project has enabled a directory of enterprises to be established to offer services to people across the region, providing support, guidance, resources and tools to do so in accordance with an agreed code of practice. This has increased the potential for citizens with care support and wellbeing needs to exercise choice and control over how their needs are met. Social and Micro enterprises are becoming increasingly visible amongst residents and professionals.

2024-25 has been another important year for rolling the project out from Pembrokeshire and across Ceredigion and Carmarthenshire. Alternative means of resourcing the project are well underway. The business case for this is strengthened by the demonstrable impact in providing person centred and preventative alternatives to traditional care and support.

#### Innovative Day Opportunities

This project is about creating opportunities for people, including adults who have a learning disability and / or neurodevelopment / mental health conditions, ensuring that an asset-based approach is taken, so that people's skills are recognized and valued within their own community, building on existing and new community assets within their own communities.

There are close working relationships between project staff and community connectors and the vision is to have a wide range of opportunities that can meet different interests, strengths, abilities, and needs, and to be able to link communities and individuals, providing a holistic and preventative service. Some small-scale opportunities are already being realised with people accessing community facilities and activities instead of using traditional day services. Experiential information includes:

- Staff report positive role of the programme in supporting what matters to users
- Positive relationships with community connectors and others, including 3<sup>rd</sup> sector are helping to develop and sustain activity
- Users have appreciated the far wider range of volunteering and other opportunities that support confidence, friendships and help users feel valued and respected

### **Innovative Communities**

This project aims to increase the availability of low-level preventative support to people in West Wales who may otherwise require statutory services. A personalised approach is key and people from priority groups have been involved in 'what matters' conversations to help determine what activities and opportunities are made available. Priority groups have also been involved in the micro commissioning of services and in the co-designing of outcome-based service specifications, for elements of the overall project. Experiential evidence includes:

- Feedback statements highlight the importance of meaningful connections with others and the impact this has on personal wellbeing
- Many people told the programme about the importance of being helped to navigate the support that is available, through community connectors, single points of contact, the web-based sites set up through the programme, and, more broadly, through hubs that are establishing as key components of the community infrastructure.
- Community Connectors gather very many stories from users, such as *"I held a lovely end of year Christmas party with my weekly Knit and Natter. An 86-year-old lady is so glad she came to the first one as she looks forward to it every week now. One of the others had acute anxiety at first and was socially isolated but has plucked up the courage to host her first ever stall at a craft market and says her confidence has never been so high."*
- *"My husband smiled at the music – he hasn't done that in weeks"*, during the Living Memories Group in Narberth, an unpaid carer said that her husband had responded visibly to a familiar song creating a heartwarming moment for them both. She saw a glimpse of her husband as she had known him before

### **Technology Enabled Care (TEC) Solutions**

Rolling out TEC (Technology Enabled Care) helps prevent, delay and reduce the avoidable need for statutory services, facilitates earlier hospital discharge and supports earlier intervention.

#### **Projects include:**

1. **Assist my Life** has been developed through working with priority populations. This is most relevant to people with learning disability and or neurodiversity and the project is directly supported by people with lived experience. Carers benefit from the bespoke website and following significant engagement with carers in 2020-21 helped inform this initiative. Carers also take part in website evaluations to ensure it remains fit for purpose.

2. **Carers Support West Wales**

Unpaid carers of all ages in Carmarthenshire, Ceredigion and Pembrokeshire now have access to a new regional website to help support them in their caring role.



The website offers a quick and easy way to find specific information, assistance and advice for unpaid carers in the three counties. The website design, branding and content has been developed through coproduction and engagement with unpaid carers and providers throughout the region.

3. **CONNECT** is open to all, but primarily benefits older adults and works to prevent, reduce and delay. CONNECT is supporting many more people in the 'delay' tier than anticipated (23% of caseload vs 5% anticipated) which directly and positively affects the numbers being placed in care home placements. As of the end March 2025, CONNECT has saved 1,778 bed days (value=£839,216) over the last 12 months (April-March 2025). Significant cost avoidance for falls is also detailed in the tier two report. Patients were discharged 5 days earlier on average. Cost avoidance for the 12 months to March 2025 is calculated as £8.2m (avoided WAST, conveyance, acute bed days and care hours)

Aside from the obvious benefits showing higher levels of preventative outcomes at the front door, enhanced wrap around services gives better outcomes to both clients and the system.

### Outcomes

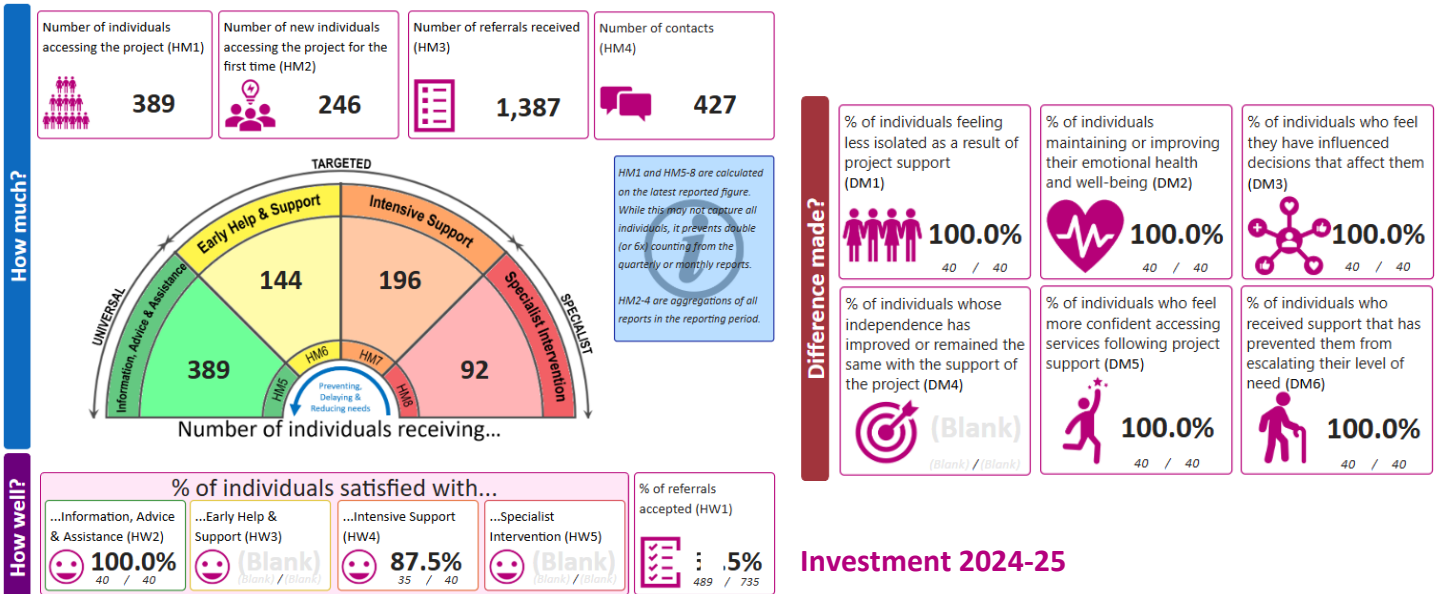
- ✓ People's well-being needs are improved through accessing co-ordinated community-based solutions
- ✓ Local prevention and early intervention solutions support people to avoid escalation and reaching point of crisis
- ✓ Promotion of the services continues to take place to enable more potential users to benefit
- ✓ Work underway in Ceredigion to develop a new model for delivering TEC
- ✓ Assist my Life continues to develop to better meet the needs of people with a learning disability and or autism
- ✓ On-going user satisfaction is being collated and analysed, driving continual improvement of the CONNECT platform

# Complex Care Closer to Home

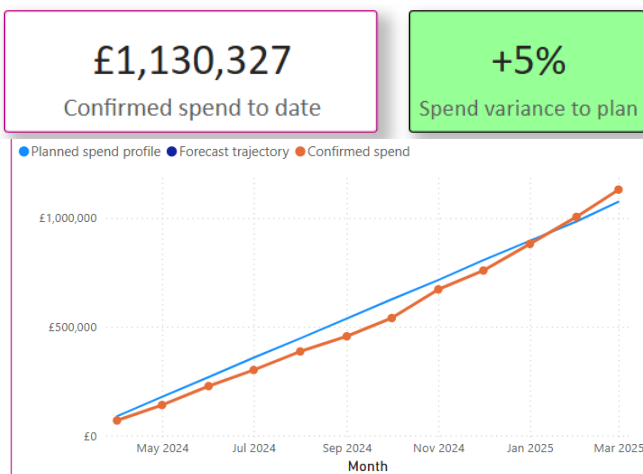
## Overview:

The 'Complex care closer to home' model supports the implementation of the 'Discharge to Recover then Assess' (D2RA) Pathways, helping people to have their health and social care needs met as close to home as possible in a seamless and integrated way.

## How much, how well & difference made in 2024-25:



## Investment 2024-25



## Approach:

Integration of Health and Social Care is a recurring theme through this model of care, to deliver joined up care in the community. Collaborative working allows professionals to work together and share their information helping to remove duplication and unnecessary delays to the patient.

Developing integrated community networks supports strong communities and brings together multi-disciplinary teams to support

GPs in delivering, person centred care in their communities. This approach uses an asset-based approach and local intelligence to build bespoke teams to better meet the needs of their community across the entire spectrum of need. Delivery depends upon excellent partnership working between the third sector, the health board, local authority, private sector, primary care and most importantly communities themselves.

This work aims to provide effective support for multiple health conditions and frailty within the community as well as maximise recovery following a period of ill health or other life events. In so doing, reduce reliance on long-term care, through enablement and community rehabilitation, to maximise independence, reduce admission and long-term care dependence.

In addition, it also provides integrated coordinated care and support at home for individuals with more complex care and support needs for examples integrated Community Response Teams.

There have been several projects delivered during 2024-25 and some examples are outlined below.

### **Examples of projects delivered during 2024-25:**

#### **Accessible Health Checks**

The Accessible Health Checks programme has been using health check champions with lived experience to promote the uptake of Annual Health Checks at GP surgeries using promotional videos and the wider team support the GP surgeries in offering the checks. A new directive from the Welsh Government has made Annual Health Checks compulsory and for them to be offered at each GP surgery. The team are now able to support the GP surgeries to meet this new requirement. The health check champions are now diversifying their offer and producing materials for promoting other health services for patients with learning disabilities in order to help them understand these health checks and reduce anxiety. This programme supports people with learning disabilities and neurodevelopmental conditions to help them understand the health checks they need to live a healthy life.

#### **Forging collaboratives within the Care Sector**

Releasing Time to Care has been a theme through the Forging Collaboratives Within the Care Sector since the commencement of RIF, though it has been mainstreamed in Carmarthenshire and Pembrokeshire. Ceredigion continue with this as a RIF funded project, using it as a broader focus on cultural change within the organisations and with contracted providers. This is done by standardising single handed care with appropriate equipment, using technology enabled care and providing the training and awareness across the workforce on trusted assessor principles to reduce care packages and ultimately get them right first time, leading to improved capacity within the domiciliary care sector. The case study illustrates the approach with an example of how an increased care package was avoided.

Domiciliary Care Medication Administration and Support project has taken some time to gather momentum due to the requirement of training all the partner stakeholders in the use of MAR charts. With a critical mass of trained staff now understanding the system, more patients can receive their medication in this way. The project also reviews prescriptions to ensure compatibility, and the monthly prescriptions with an MAR chart is reducing waste and stockpiling within the home. With the elderly population group as the primary benefactor, this helps them understand their daily requirement. MDS trays would have been the method of managing medication, but these are harder to source and lead to more waste. The MAR charts to manage prescriptions from original packages, in appropriate quantities, saves costs, reduces confusion and risk to the patient, and crucially is an easier implementation that can quickly support timely hospital discharges. When primary and acute care can prescribe medication without consideration of existing prescriptions, this project is a good example of the collaborative integrated working that involves everyone from the prescriber, pharmacy, patient and care providers.

#### **Integrated Community Continence and Physiotherapy pelvic health service**

The Integrated Community Continence and Physiotherapy Pelvic Health Service is a locality trial into integrating a continence specialist into a multi-disciplinary pelvic health team, aimed at identifying early symptoms and providing advice and treatment to minimise the symptoms. This has the benefit of reducing the risk of incontinence related falls as a preventative benefit as well as pharmacy and

equipment for managing the symptoms at a later stage. The project has worked so well that the current staff are unable to keep up with the demand and have a waiting list of patients.

### **Integrated Community Networks**

The Integrated Community Networks programme has a few projects that have been running for some time. The risk stratification approach by GP surgeries to proactively identify patients at risk of escalation of need has been working well for some time within MDTs of some GP clusters. The same principles were drawn into the 50 Day Challenge, though the qualification criteria for that funding required more effort to locate and engage that high-risk cohort. The Proactive Integrated Care Network has been actively managing referrals of those patients that are deemed at risk, without the same constraints as the 50 Day Challenge requirements, so allow the professionals in that area to determine if they could benefit from proactive services. The included case study also shows how the regional programme group is bringing together the projects in this programme to complement each other, so that the workers dealing with a Proactive Integrated Care Network referral are able to challenge care package commissioning that aren't optimised to the principles of the Releasing Time to Care project in another county discussed in the group, and then referred on to the appropriate people in their county to review. Ceredigion's Proactive Care and Enablement project team are using a principle of providing temporary assistance in the community to encourage the service users and their family to get help they need to deal with their current circumstances, and to actively encourage them to regain independence so that the formal care provision can be reduced or removed. The Proactive Care Occupational Therapist project has funded an occupational therapist to be part of the local multi-disciplinary team and has shown the effective input that they can provide to proactively manage the health challenges of those higher risk patients within the community.

- GP visit impact - 72% reduction after occupational Therapy involvement
- Admission avoidance, 5.29% of referrals (these are low numbers now but impact remains with appropriate signposting to ICT on top of these)
- Response time - 89.46% contacted within 48hrs, of these 81% contacted same day
- Assessment - 88% assessed in 5days, of these 70% assessed same day
- Resolution - 92.46% situations resolved within 4weeks
- Reporting functional improvement - 72.61% of 494 people (77% reviewed in last 6 months)
- Reporting increased confidence - 79.64% of 488 people (76.36% reviewed in last 6 months)

The good practice being carried out within these often-localised cluster groups to proactively use the local resources for prevention and recovery is being shared within the programme group to allow ideas to be trialled in other areas across the region by bringing attention to their work. This has also been discussed at a regional UEC Model Redesign workshop event that recognises the importance of local provision of community needs using the available resources to prevent escalations and hospital admissions. It is important to remember with these community networks that we are working to a regional model of care principle, but that does not mean replicating the same setups in every community. The proactive networks are adaptable to the needs of the local population demographic, and geographic infrastructure availability to optimise the care to manage the populations health within that community. Preventative services can be harder to justify the resources required, but the examples within the case studies show how they can be used to prevent further domiciliary care or hospital admission before they reach that threshold level of need.

### **Joint Integrated apprenticeship programme**

This project was set up as a way of attracting apprentices within the social care sector, recognizing the success of the Health Board in recruiting Healthcare Apprentices. The Joint Integrated Apprenticeship

Programme is the first of its kind in Wales. Local Authorities receive less interest in their posts and apprenticeships compared to Health Boards and the joint approach gives candidates the opportunity to experience options across the health board and local authorities and seeing the work within a wider context of opportunity, whilst earning and learning.

**Outcomes**

- ✓ People are more involved in deciding where they live while receiving care and support
- ✓ Complex care and support packages are better at meeting the needs of people and delivered at home or close to home

**Evaluation**

There is recognition that a number of these projects are well integrated into the local system and operational delivery and therefore our focus needs to be on how we can achieve greater impact from these projects.

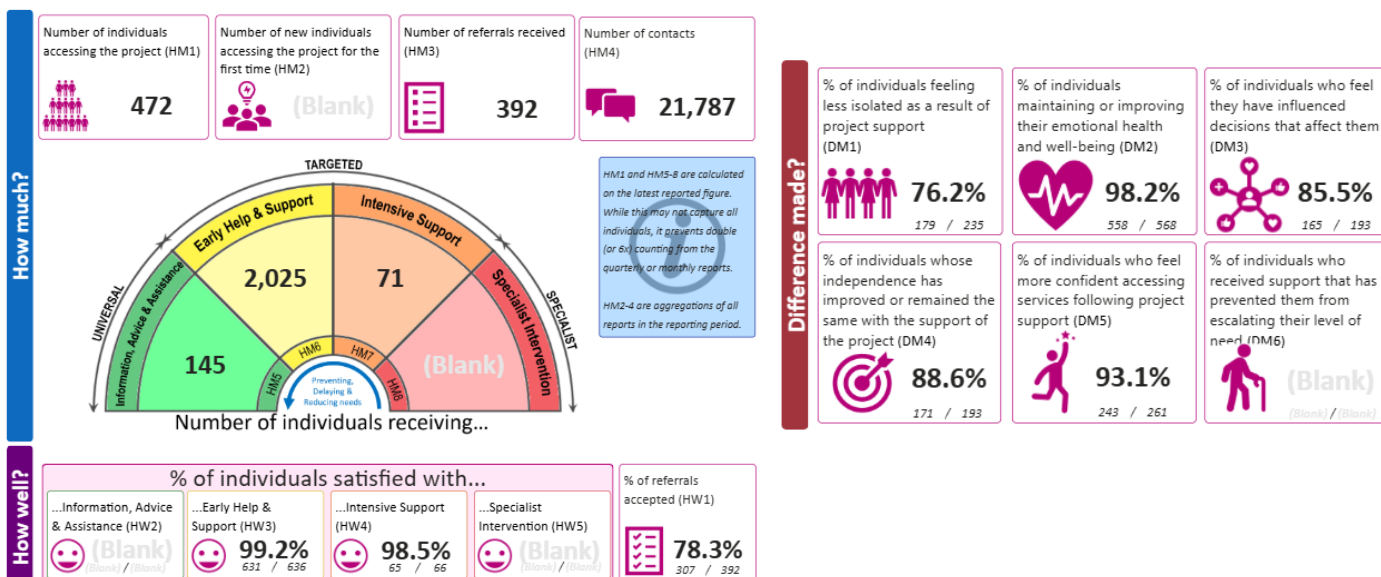
## Promoting Good Emotional Health and Wellbeing

### Overview:

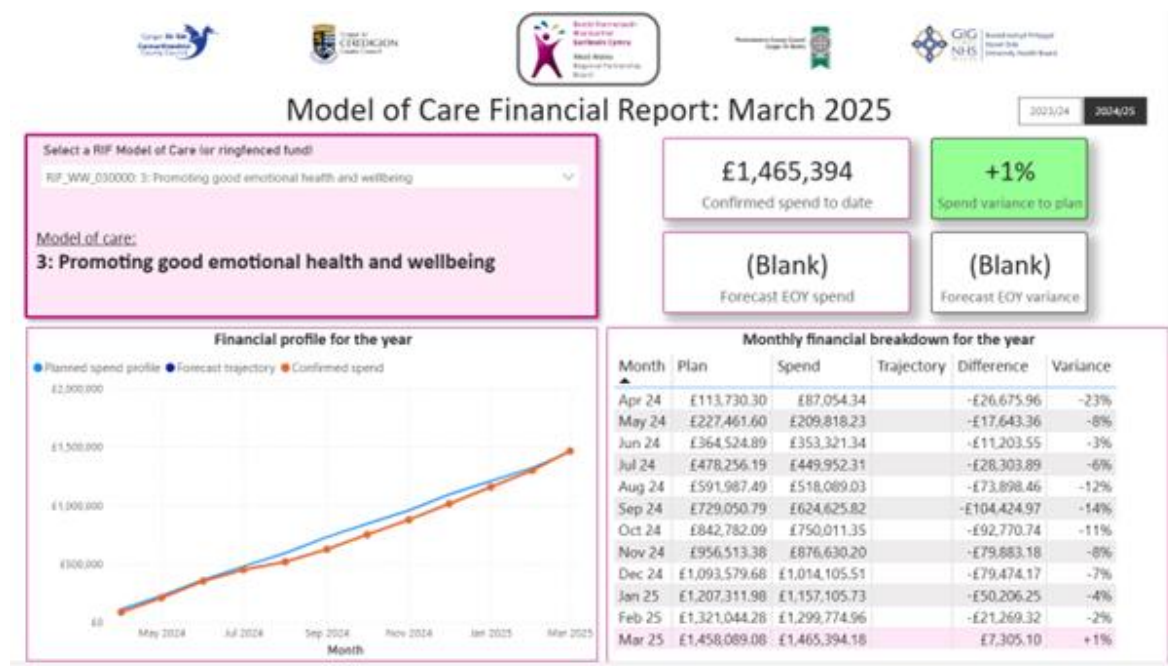
Activity under this model encompasses a range of initiatives that aim to better support people to remain independent within communities, focusing on ‘what matters’ and in so doing, increase the range of services and meaningful activities for people in key groups, to ensure people are well informed about existing services and opportunities. The focus is on the promotion of positive emotional health and wellbeing and reducing demand for statutory services. The beneficiaries and stakeholders include informal carers, people with learning disabilities, low level mental health issues and neurological conditions, who the RPB Team engage with to ensure we plan and deliver services with the people who use them.

- Activity supports people in a range of ways, by:
  - Providing alternatives to statutory care and support
  - Providing employment opportunities
  - Giving a break from informal caring responsibilities

A range of partners are involved in delivery of the model, including: local authorities, HDdUHB, a range of 3rd sector organisations, business delivery partners, DWP, schools, colleges, GP surgeries as well as service users and carers.



## Investment 2024-25



## Examples of projects delivered during 2024-25

### Carer Breaks

This project focusses on the development of a new vision for respite and short breaks, co-produced with unpaid carers and moves beyond respite care. A range of opportunities ensure unpaid carers have access to meaningful breaks, which include discounted or free access to services and activities, and bespoke arrangements that meet need. The project focuses on designing delivery in the context of county structures to ensure impact for carers; engagement activity with carers to ensure needs are met; exploration of commissioning options to ensure needs are met and efficiencies secured and working with providers to ensure a wide range of options are available to carers.

### Investors in Carers

This project works with a wide range of settings (including health, social care, and public, private and 3<sup>rd</sup> sector organisations) to support the early identification of carers and signposting for additional early help and support – one of the key aims of the West Wales Carers Strategy. It is a best practice quality assurance scheme, with themed standards, audit and certification. Training and awareness raising for staff is delivered through the project with 700 people reached over the reporting period. A person involved: *“personally, I have gained great satisfaction from witnessing the difference this work has made for our service users. As a team we have learned so much along this journey and I feel that our services have grown in quality because of the deeper understanding of the carer's needs and services. We actively encourage other organisations to join in with this scheme so that unpaid carers can be supported consistently across the counties”.*

### Exercise Buddies

Often adults with a learning disability and neurodevelopmental conditions have complex health needs and can be compounded by a number of factors such as obesity, diabetes, and sedentary lifestyles all of which have an impact on health and wellbeing. This regional project aims to increase the amount of physical activity that people with disabilities engage in. Since the commencement of this

programme, there has been an increase in people with a learning disability and families and unpaid carers getting more involved in physical activity.

The project helps ensure that many more people who have disabilities can try different activities and build up their confidence to participate in physical activities outside of services as well as form social connections and improve self-esteem. The other aim of the project is to increase the amount of physical activity that parents/carers (paid and unpaid) undertake.

### **Positive Behavioural Support**

The project is designed to work with adults/young adults with learning disabilities and neurodevelopmental conditions benefitting individuals as well as unpaid carers, families and paid carers. This involves intensive work with individuals to develop primary and secondary prevention and reactive strategies where needed to ensure tailored support. The Positive Behaviour Practice Exchange now has 45 members and works collaboratively with existing Psychology, Community Team for Learning Disabilities (CTLD) and Positive Behaviour Intervention Service (PBIS). The approach provides support in line with co-produced Positive Behaviour Plans (PBSs) which harnesses individual skills and talents and set out strategies to avert crisis. Positive Behavioural Support has successfully avoided costs associated with hospital or high-cost placements by supporting individuals at home or close to home. Examples of current individuals supported in high-cost placements vary from £5-6K per week (97 people received intensive support in the period).

### **Pathways to Employment**

This regional project supports employability and progression pathways for individuals living with disabilities with 70 different organisations and specific services referred into the programme to date. It includes development of a regional Employability Plan, which will involve co-productively establishing progression pathways to independence, with close links to further education and local Additional Learning Needs (ALN) provision. Existing supported employment will be embedded forging closer links to supported living and wider skills development and the holistic support provided by the team has meant people have been more willing and able to engage positively in other work-related activities. Importantly, the teams across the region have ownership of the way the support is delivered, can respond to local needs and can develop the skills and knowledge of employability support through delivery. Pathways to Employment is resulting in a per person annual saving of £5,611 on statutory services.

### **Citizen Champions**

This project helps ensure citizens from all priority population groups have a voice in services that meet their needs and people with lived experience are engaged in decision making to improve service outcomes. Seven champions are employed and supported, and active in areas including service co-production, peer support (e.g., keeping fit and healthy), helping deliver Easy Read information provision and citizen-led awareness training. Citizen's Champions are all employed (support is provided through Access to Work). The cost avoidance compared to a day service setting (assuming 1:2 support) amounts to c.£55,500.

### **Partners for the Journey**

This project aims to offer low level mental health support and advice with practical social issues to the community. Citizens Advice and Mind ensure a joined-up process for receiving referrals and assessing how clients can be supported and has consistently yielded a more positive outcome for clients suffering with poor mental health and practical health concerns. Positive feedback has included: "this has been excellent, I can't tell you how much this has helped me, It has been far better than any medication!" and "I feel better than I did before contacting the service. Mentally I feel strong enough

to endure what is ahead and if I feel weak, I know I can call on this service, which helps me to find more strength. I feel I would be alone without this service”.

### **Grow your own Social Workers**

The numbers of newly qualified social workers leaving university continue to decline in Wales. This project aims to address recruitment and retention of social worker issues facing local authorities in West Wales, by developing a cohort of new social workers. At the point of recruitment, existing Social Work assistants are encouraged to progress their career by applying for the Social Work degree via a relevant education provider. The focus is on growing the workforce, so that those supported through the project will use their skills and time working with people with emotional and mental health problems as well as people with a learning disability and those who are neurodiverse.

### **Outcomes**

- People are better supported to take control over their own lives and wellbeing
- People have improved skills, knowledge, and confidence to be independent in recognising their own wellbeing needs

## **Supporting families and therapeutic support for care experienced children**

### Overview:

This model aims to prevent family breakdowns and to reduce the need for babies, children and young people from coming into Local Authority care. The model also aims to support the placement stability of those who are already looked after, by providing therapeutic support to children, young people and families and contributing to the wider system of support for babies, children and young people near to, or on the edge of care.

This model of care is closely aligned to Model of Care 3: Promoting Good Emotional Health and Well-Being and Model of Care 6: Accommodation Solutions.

Activity under this model aims to:

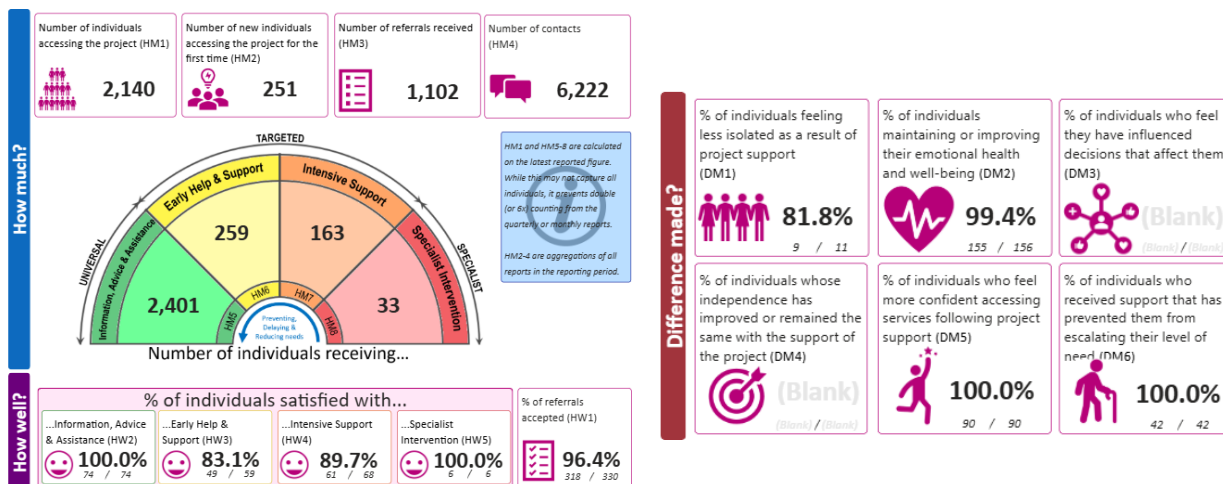
- Reduce the demand for statutory services, family breakdown and the need for babies, children and young people to come into Local Authority care,
- Empower parents and carers with knowledge, skills and resources to access support, at appropriate times, reducing the escalation of need,
- Increase awareness of existing service provision and motivate parents and carers to engage with support services at an early stage and to reduce any stigma of accessing more targeted support,
- Support the maintenance of good quality placements and placement stability for babies, children and young people who become Looked After,
- Provide therapeutic support to children and young people with complex needs, including care experienced children,
- Provide more holistic, targeted assessments and proportionate offers of support enabling children, young people and families to be stepped down from Social Services support when appropriate,
- Add value to the existing system, by building on the evaluation of previously evaluated models e.g. Integrated Family Support Service (IFSS) and increase capacity to offer a broader scope of services to those families which fall outside the remit of IFSS,
- Reduce service gaps, add capacity and value to existing services and the wider support system and increase the reach of services,
- To address workforce challenges by recruiting and training new Social Workers.

Activity under this model supports people in a range of ways, by;

- Providing a wide range of targeted and intensive support to children, young people, parents and carers to strengthen individual and family functioning and resilience,
- Empowering parents and carers, including Special Guardians with the knowledge skills and resources to support the development babies, children and young people,
- Ensuring people are well informed about offers of help and support services and motivated to engage with support services at an early stage,
- Strengthening social connections and networks for families within both geographical and communities of need to create a sense of belonging and long-term peer support,
- Educating professionals and parents/carers including Special Guardians to develop a better understanding of the impact of early childhood trauma on development and to give strategies to support resilience and good relationships,
- Improving the efficiency, care and support planning for children whether subject to early intervention or child protection processes e.g. planning support for the learners through better links with the education departments, for children who become Looked After, and supporting school stability,

- Integrating specialist services within initial assessments and the wider offer of support at the front door such as Substance Misuse, Domestic Violence and Mental Health

**How much, how well & difference made in 2024-25:**



**Investment**

Select a RIF Model of Care (or ringfenced fund)

RIF\_WW\_040000: 4: Supporting families and therapeutic support for care experienced children

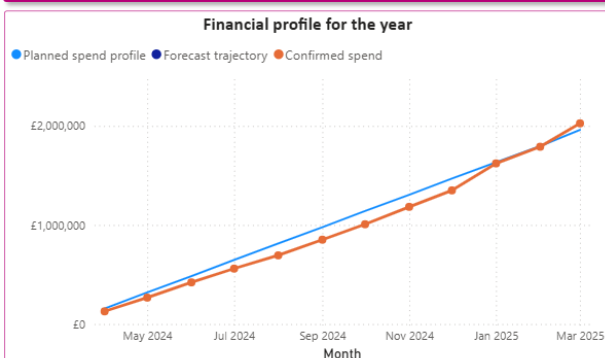
**Model of care:**  
4: Supporting families and therapeutic support for care experienced children

**2024-25**

Confirmed spend to date: **£2,026,562** (+3% Spend variance to plan)

Forecast EOY spend: **(Blank)**

Forecast EOY variance: **(Blank)**



**Monthly financial breakdown for the year**

Month	Plan	Spend	Trajectory	Difference	Variance
Apr 24	£156,461.32	£128,196.02		£-28,265.30	-18%
May 24	£320,494.64	£267,033.18		£-53,461.47	-17%
Jun 24	£484,527.96	£420,715.77		£-63,812.19	-13%
Jul 24	£648,561.28	£559,811.52		£-88,749.76	-14%
Aug 24	£812,594.60	£693,481.09		£-119,113.51	-15%
Sep 24	£976,627.92	£851,914.81		£-124,713.11	-13%
Oct 24	£1,140,661.24	£1,007,661.85		£-132,999.39	-12%
Nov 24	£1,304,694.56	£1,183,554.09		£-121,140.47	-9%
Dec 24	£1,468,726.88	£1,349,650.05		£-119,076.83	-8%
Jan 25	£1,632,760.20	£1,622,164.01		£-10,596.19	-1%
Feb 25	£1,796,793.52	£1,790,127.97		£-6,665.55	-0%
Mar 25	£1,960,826.84	£2,026,561.77		£65,734.93	+3%

**Examples of projects delivered during 2024-25**

**The Edge of Care:**

A significant area of success has been work related to the Edge of Care services.

RIF is used to part-fund Edge of Care Services across the region. Funding for Edge of Care Services is also drawn from core funding and other external sources, albeit that RIF is used in a specific way to integrate, transform and add value to the whole Edge of Care offer across the region. The value added by RIF in relation to the Edge of Care services across the region supports a broader bespoke service for families who fall outside the current scope of IFSS in several ways. For example, it has added capacity to the system by enabling more families to access the service and receive more intensive support, it has improved scope and quality of support by drawing in specialist workers in relation to mental health, domestic violence and substance misuse and it has improved multi-agency, information sharing, professional knowledge development and efficacy in relation to triaging, assessment and providing appropriate and proportionate support. The Edge of Care services are

broader than RIF, as not only does it aspire to contribute to service system change, it also enables the Local Authorities to fulfil its statutory duties within Children's Services more effectively.

One of the most evident examples of success is work undertaken by Pembrokeshire's Edge of Care Service in relation modelling potential cost savings/cost avoidance for the 170 children in the County that remained living at home, with wider support network or returned home from care during 2024/25. This is an important area of work from the recipient of the service but also to note the average yearly cost of the Edge of Care Service, including match funding (over the projected 4 years until 2027) is approximately £450,000 and the cost of just 23 children coming into the young person looked after system would be between £1.2m - £6.5m (approx). Children kept out of local authority care through supportive initiatives such as this can save an average monthly cost of £4333 per child or approximately £143 per day.

In the region, around 85% of children young people closed to the Edge of Care service, remained within their family/family network, including kinship/special guardianship arrangement during 2024-25.

### **Early Years Integration Team**

The Early Years Integration Team (EYIT) transformation programme working in the Gwendraeth Valley continues to build upon its success and improve the lives of babies, children and young people living within this geographical community. The EYIT actively searches for gaps in provision and tests new, innovative, and prudent ways of working to bring a more coherent and joined up approach to the delivery of support for young children and families. There is a focus on prevention and early intervention with the team aiming to be involved with families from the antenatal period onwards. The programme aims to strengthen the community so that health and wellbeing is optimised, and families can ultimately support themselves. The EYIT aims to ensure that parents are knowledgeable about the support on offer, are confident and able to access support at a time that effectively reduces escalation and subsequently the demand of more specialist services. There is an emphasis on collaborative working with the Third sector and other public and private sector partners. Partnerships are actively sought out to utilise skills and services already existing within the community or that can be brought to the community to support an identified need or gap in provision.

The Early Years Integration Team (EYIT) offers a unique, integrated approach to supporting families. Comprised of Midwives and Health Visitors along with a Local Authority Support Team, the EYIT provides universal access to pregnant women and families with children under five. This enables early identification of families needing additional support, leading to prompt 1:1 home-based intervention for issues like mental health, housing, domestic abuse, developmental delays, and isolation. Early support prevents escalation of challenges, which can negatively impact long-term health, well-being, and social outcomes. For instance, addressing toileting issues in a three-year-old, seemingly minor, significantly impacts school readiness and future academic and social success.

While Midwives and Health Visitors deliver national care programs, the wider EYIT provides targeted 1:1 and group support for specific needs such as mental health and child development. Support Officers within the team save significant Midwife and Health Visitor hours by handling direct family support, allowing healthcare professionals to focus on more specialist cases. For example, a Preparation for Parenthood Support Worker saves approximately 20 Midwifery hours weekly by assisting with complex social issues and breastfeeding support. Similarly, Family Support Workers save about 20 Health Visiting hours by addressing common parenting challenges that can have long-term health implications. All EYIT members collaborate to support families with mental health challenges, aiming to reduce the need for more costly specialist services.

### **Emotional Health and Well-Being**

Within Carmarthenshire, the regional Children and Young People Emotional Health and Wellbeing project provides therapeutic intervention to families, carers and professionals working with children and young people who are looked after by the Local Authority (including pre and post adoption), aiming to support placement stabilisation, building healthier relationships with key adults and young people and improving psychological wellbeing. In addition to contributing to placement stability, support is focused on building family strengths and reducing the step up to statutory social care.

Over the last six months, hundreds of professionals have accessed psychological consultation and of those surveyed and 100% have said that they felt the consultation has had a positive impact on their understanding of the families they work with. Examples of training include topics such as helping children feel psychologically safe, developing Trauma Nurture Timelines, genograms and generational patterns of behaviour, harmful sexual behaviours, social graces, big empathy drawings etc. Over the same time period, 200 consultations have been delivered to parents and 100 therapeutic sessions to children and young people and of those surveyed, 100% of parents said they thought the consultations deepened their understanding of their children or the children who they had been matched with for adoption and 75% of children and young people reported that they felt as though they had benefitted from the sessions.

As families are better understood, there is often a longer-term positive change in family functioning leading to a decrease in the numbers of families that need higher levels of involvement from statutory social work teams.

### **Looked After Children Support Team**

Another key successful project demonstrating the importance of strengthening the system by recognising the importance of working with adults who support young people. The teams work to develop a better understanding of the impact of early childhood trauma on development and to give strategies to support resilience and good relationships within school settings. The aim of activities is to improve the outcomes for children who are Looked After and those who are Edge of Care, by delivering a training programme which includes Adverse Childhood Experiences (ACEs) and their impact on childhood development, and an understanding attachment and trauma and the importance of key relationships and resilience.

The project aims to improve understanding in schools and subsequently improve school placement stability. Challenges in behaviour and gaps in understanding by staff and governors can often result in reduced timetables and exclusions. With a child spending less time at school, this can significantly impact their home placement (whether foster care or at home with parents/family). This increased pressure on their placement will often destabilise or end their placement. Governors have a significant role to play when a child is at risk of exclusion so with a better understanding there should be better outcomes when a child or young person is in this situation. The training has resulted in school staff feeling better able informed to Looked After Children and Edge of Care learners in the classroom settings. By working very closely with schools who have any new learners, and identified training and support needs, the team have enabled a better understanding of the environment, staff understanding, learners' education history and an opportunity to capture the learners' views and better able to plan support for the learners through better links with the education departments, specifically the ALN team.

Training across different groups has been well received and has led to a wider impact than just within school settings. As an example, the Actif Sir Gar holiday club and the training of the holiday club staff which resulted in more children being able to access the provision for longer periods of time and when

challenges arose, staff were more able to manage the behaviours and de-escalate situations. The holiday clubs support home placements, particularly during the long summer breaks when children at home for long periods of time can be really challenging in some placements.

### **Special Guardians**

The project aims to identify Special Guardians in Pembrokeshire and to ensure they are supported by completing regular annual support plan reviews, financial reviews and to ensure they can access peer support groups and other services to ensure that placements remain stable and are at a lesser risk of breakdown. The project also aims to identify existing carers currently caring for children under a care order where it would be appropriate for them to look after the children under a special guardianship order instead as this offers greater security and stability than long term fostering. Currently within Pembrokeshire, the project supports 114 Special Guardians caring for 160 children. Given the cost of accommodating children and young people, the project represents potential significant cost savings/avoidance for the Local Authority (as outlined in the section above – Edge of Care). Moreover, the opportunity for many of the children and young people to remain existing family and kinship networks provides greater security, stability and improved longer term outcomes and life chances for children and young people.

One of the major successes of the Special Guardian's project has been the development of a peer support group and working collaboratively with the Local Authority to ascertain their care and support needs and those of the children in their care. The project has worked to connect Special Guardians in Pembrokeshire through regular meet ups, coffee morning and social events enabling them to share their experiences and offer peer support and subsequently improve their well-being. Their views have also been sought through surveys of their emotional health and well-being, and they are now invited to attend training on issues such as trauma, attachment, life story work, contact and family time, as well as having access to Pembrokeshire's online learning portal, wellbeing walks and events, that were previously only available to foster carers

Recently the project developed an innovative 'I AM A SPECIAL GUARDIAN' celebration. Through professionally produced films and sharing their own stories through a script-in-hand performance and panel discussion, participating Special Guardians brought their experiences to life giving around 100 professionals working with children and families a better understanding of Special Guardian families.

### **Young Carers**

As a Carmarthenshire project, the Young Carers Service supports young carers who are in a substantial caring role that is affecting their education, social life or emotional health. The service works with young carers and parents to develop bespoke support plans based on identified need. Support includes peer group support, social opportunities, focussed 1-1 support and advocacy as well as the provision of Young Carer cards. Furthermore, where appropriate, parent/other family members are signposted/referred on to other agencies such as Adult Services, Health sector, Third Sector organisations and Housing, to help alleviate the young carer's caring role.

### **Integrated Triage Service and Trilogy of Risk**

Within Ceredigion, the Integrated Triage service operates at the front door for all children's referrals except safeguarding for the Local Authority. RIF is used to add value to existing system, by adding capacity to directly support children, young people and families and by contributing to Integrated Triage service and to provide specialist support. Within Ceredigion, the step-up step-down support workers sit within the Edge of Care service which is part of the Integrated Triage service. The Family Group meeting service has also recently joined the Edge of Care service. Having all these services

within the front door service area enables the provision of a seamless preventative support, when concerns arise initially.

A related promising approach is the development of Ceredigion's Trilogy of risk model and partnership working with Dyfed Drug and Alcohol Service (DDAS), West Wales Domestic Abuse Service (WWDAS) and Social Care. The model aims to address the issues of domestic abuse, mental ill-health and substance misuse by providing specialist information, advice, and assistance to the person at the point of contact and to provide the right support, at the right time and by the right professional. The step-up-step down support workers contribute to Triage and proportionate assessments with their expertise and refer down to specialist substance misuse and domestic abuse support for those who do not require a social work assessment.

Within Ceredigion, RIF is also used to fund and Education and Safeguarding post which contributes to the Integrated Triage Service by improving information sharing between social services and Education. Advice is provided to schools when concerns raised but also information obtained from schools regarding the child when referrals are received. Out of the 1164 referrals received in the last 6 months, a large amount of those have been received from Education. All these triages have completed a proportionate assessment. The Safeguarding support officer has improved communication with Social Services and Education through sharing outcomes of referrals for consistency of information but also obtaining information from Education such as school attendance or any concerns that Education may have. This has supported the professional decision making ensuring the right information and advice is provided to the family at the point of contact. By completing a robust holistic assessment has also reduced the amount of family that have required a comprehensive assessment as triage is able to a clear understanding of the family's needs for dealation to preventative services.

### **Safe Accommodation**

In West Wales, the RPB have overseen the development of safe accommodation for children with complex, high end emotional and behavioural needs. With the support of capital funding through the Housing with Care Fund (HCF), work has been completed on one such facility during 2023-24, with structural work ongoing in other residential facilities across the region.

The provision of these homes is critical to help prevent escalation of need and facilitate de-escalation from secure inpatient care as well as provide short break respite, periods of observation and assessment.

### **The Regional Children and Young People's Board**

The Board is comprised of representatives from health, social care, education and the third sector. It has met four times during 2024-25 and is currently working on co-producing 5 draft priorities, which are as follows:

1. Ensure the best start in life for children in West Wales through integrated regional delivery and continuous improvement of early years and maternity services and outcomes.
2. Develop and implement a clear, consistent regional approach to equitable support and funding for children and young people with complex health and care needs, including those who are looked after or in the care system.
3. Establish a regional, person-centred transitions model that ensures smooth progression to adult services, supporting well-being and long-term outcomes.
4. Identify, evaluate, and scale innovative, preventative approaches that strengthen the emotional and mental health and wellbeing of children and young people.

5. Deliver integrated, child- and family-centred neurodevelopmental support through coordinated partnerships across health, education, social care, and third sector organisations.

### **No Wrong Door & NYTH/NEST**

Children and their families who seek support for a range of needs often find that they have to navigate a very complex system and as a result may fall through gaps where there are no services to meet their needs, or be on a waiting list for a long time only to be told that they were waiting in the wrong queue, or have been 'knocking on the wrong door' all along. This area of work challenges partners to work better together delivering seamless responsive support to children and young people with emotional and health needs, implementing the NYTH/NEST framework.

### **Outcomes**

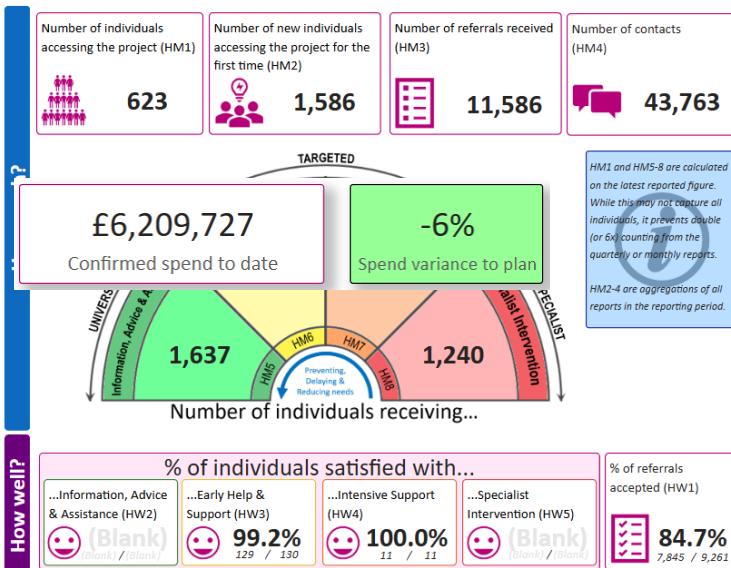
- ✓ Provision of an edge of care service, which aims to strengthen families and improve relationships. This has enabled children to remain living within their family network safely
- ✓ Development of parenting skills for those parents whose children are on the edge of care
- ✓ Support for Special Guardians by completing regular annual support places, financial reviews, and peer support
- ✓ Development of a cohort of new social workers, to meet the rising need for services and working with children and families
- ✓ Working in partnership with mental health specialist workers in the third sector to create recovery plans with families, where there has been concern around substance misuse, domestic violence and mental health
- ✓ Co-production of an achievable response and action plan to the recommendations contained in the No Wrong Door report
- ✓ Co-production of assessment of regional compliance against the principles in the NYTH/NEST Framework
- ✓ Identification of opportunities for children and young people's voices to be heard to inform strategic planning
- ✓ Development of training and awareness raising opportunities for the NYTH/NEST principles
- ✓ Increasing the availability of safe accommodation within the region during 2023-24.

# Home from hospital

## Overview:

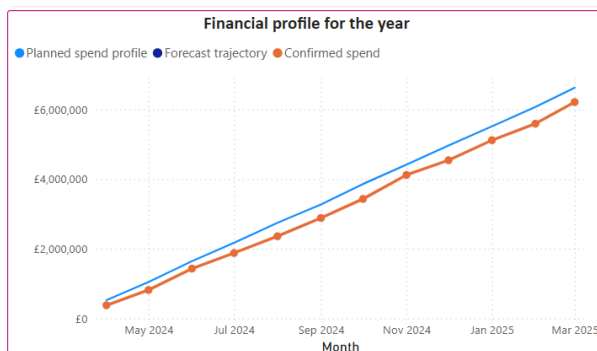
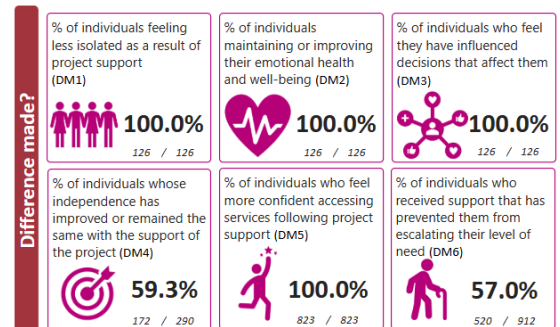
The 'Home from Hospital' model ensures that where possible, care and support is offered to help people stay well at home and that unpaid carers providing informal care are supported. Our national models of 'Integrated Community Care Services' are designed to provide preventative care and where needed, a rapid response to prevent the need for people to be conveyed to hospital. However, some people require acute assessment/ treatment in a hospital environment; therefore, it is vital that we utilise the Urgent and Emergency Care model that enables recovery at home as quickly and safely as possible and that the needs of unpaid carers who provide an informal caring role are also considered during discharge discussions. This will also support the generation of capacity within health and care settings, ensuring that those who do need acute care can access it in a safe and timely manner.

The work undertaken through this intervention has helped people go home from hospital in a more timely manner with the necessary support in place at discharge and people have a better understanding of the discharge process and are more involved in pre and post discharge planning.



## How much, how well & difference made in 2024-25:

### Investment 2024-25



## Examples of workstream delivered during 2024-25

### Home First

The Community Based Support programme has been restructured to reflect the development of the individual projects into integrated whole system approaches that are dependent on each other as critical parts of the approach. The Programme has now been renamed to Home First.

Carmarthenshire's projects have been merged into a single project, as well as Pembrokeshire's projects, including the Community Led Third Sector Support programme that only had PIVOT remaining.

The counties remain as separate projects due to their separate hubs and locality funding, with slight differences in their implementation to suit the county resources and infrastructure, but the experience and learning is shared across the region as the Home First programme progresses.

The Home First programme has benefitted through the last six months of the year by the scrutiny and additional funding put into Pathway of Care Delays and the Care Action Committee priorities leading to the 50 Day Challenge. The additional funding has had a close focus, but these have helped to understand some priority areas and delivery methods that are being implemented into business as usual.

### **Home First Pembrokeshire**

The Porth Preseli Streaming Hub is a physical streaming hub based at Withybush General Hospital, where teams from across the various organisations and sectors involved with Home First Pembrokeshire locate.

This project has a measurable economic impact on the broader system, with aspects of the project focusing on earlier discharge from hospital, admission / conveyance avoidance and potentially a reduction on POCs required.

Data indicated that for every person discharged on the DTRA pathway that on average their length of stay was reduced by 32 days. Data indicates that approximately 20 patients per month are discharged to this pathway, resulting in approximately 640 bed days being saved per month.

Approximately 10 people per month who finish the reablement service independently, negating the need for a package of care. Assuming an average Package of care of 12.25 hours per week, this equates to a significant economic contribution.

Recent developments include the introduction of a hospital at home ward. This activity is a recent addition to the IUIIC service, with data indicating a significant benefit associated with this element of the service, with typically 40 people at any one time being home warded and an average LOS of 4 days. Prior to the induction of this element of the service, these people would have needed to remain or be admitted to hospital to receive the clinical care they require.

- The number of patients being admitted to hospital have reduced and which has supported the service in alleviating winter pressures
- Reduced bed days and therefore freeing up bed capacity for other patients
- An effective and efficient discharge process which avoided discharge delays
- The right teams have been able to provide the right service at the right time
- By having access to third sector organisations, transport services have been provided that alleviate pressure on WAST

Established 5-day working and extending to regular 7-day model. This is seen as an ambition across the region, but requires resourcing, particularly for recruitment, to expand the teams to deliver this aim.

### **Home First Carmarthenshire**

A WG programme driving building community capacity afforded Carmarthenshire the opportunity to work with Hywel Dda UHB and trial a new support worker role within the Health & Care Sector. With investment from both CCC and Hywel Dda, a project team was established and worked on a job description for a support worker who could be employed by either Health or Social Care, was able to carry out personal care but had a rehabilitation and reablement focus.

The benefit of embedding this role within the Home First pathway enabled the roles to be created on a Home Carer job description but could support delegated tasks from Physiotherapists and Occupational Therapists as well as the Registered Manager for Reablement.

- 10 individuals currently in joint support worker posts across the Health Board & County Council
- 100 – 120 hours of direct care delivered per week by the team
- Caseload of 12 to 15 people per week (140 – 200 visits per week)
- Outcomes: The team on average support 21 clients per month (749 visits/ 277 hours of care). This does not consider approximately 6 clients per month who do not require additional support on initial assessment (D2RA)
- Predominantly supporting individuals from hospital to home, but increasingly supporting admission avoidance in community

### **Porth Cere**

Porth Cere commenced its service from 8am to 8pm 7 days a week in July 2024. The service is currently in its initial phase by focusing upon community nursing services aligned with the implementation of the Community Nursing Specifications. This has highlighted an issue in some cases of MDT working across 7 days being limited by the services they require to refer to only being available 5 days a week.

The integrated multi-professional approach to these streaming hubs is highlighting the dependence on each of the disciplines and direct access to services as key factors to ensuring a smooth transition of the patient from the hospital or avoiding admission by providing alternative care at home or in the community. There is a common limitation stated against all these projects, that they need to be 7-day services. The one service that is seven day identifies limitation due to the lack of 7-day availability of other services. This is highlighting the challenge of then requiring every component of these services needing to coordinate their expansion to 7-day services together.

### **D2RA (Discharge to Recover and Assess)**

This refers to care and support offered to patients to leave hospital for ongoing recovery then assessment with an aim of limiting unnecessary time in hospital settings and improving outcomes. This is a priority within the region, and work is being funded through core budgets.

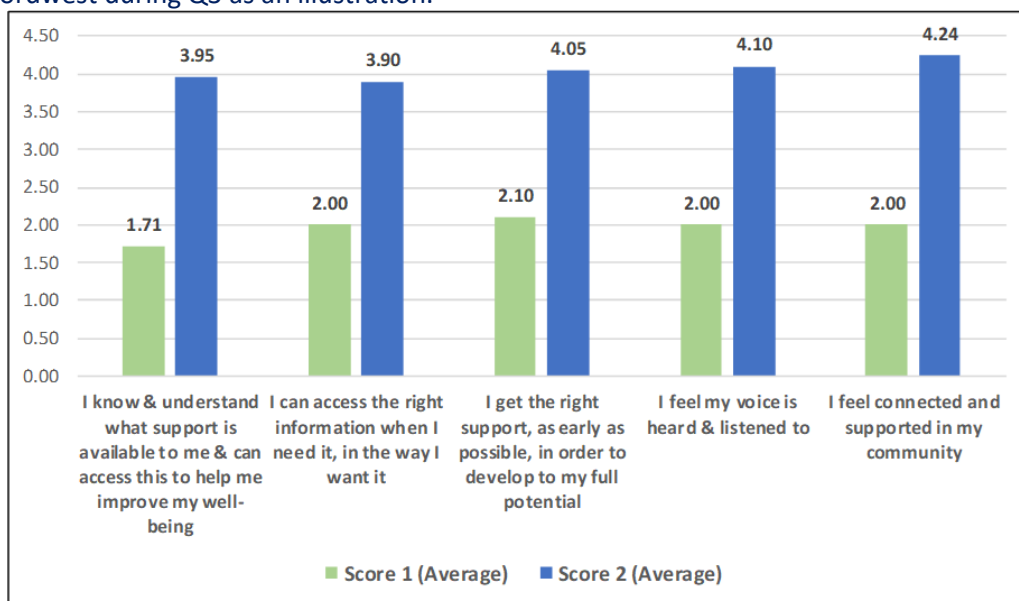
Establishment of a regional Discharge Strategy Group to provide oversight of all current work streams and actions is being undertaken around discharge, as well as work around national and local policies – including; Discharge and Transfer of Care Policy, Reluctant Discharge Policy, Care Home of Choice policy.

### **Unpaid Carers Support Service**

Unpaid carers play a crucial role in assisting a timely discharge from hospital. The support service works with them to establish what care they can provide their loved one, and to support that person going forward to continue providing the required care so that the patient can remain at home. This relieves pressure on the hospitals, and avoiding a breakdown of the care being given by the unpaid carer reduces cases of readmission.

The Carer Officers seek feedback against five wellbeing outcomes when supporting unpaid carers. They ask carers to rate their experiences in line with these five wellbeing outcomes before and after support is given and as part of the “What matters to me” conversation. This feedback mechanism allows the Carer Officers to measure the “distance travelled” by the carer being supported. Below is a

snapshot of the feedback received from a sample of 20 carers in Withybush General Hospital, Haverfordwest during Q3 as an illustration.



The above figure illustrates that, overall, the Service has improved unpaid carers’ understanding of what support is available to them, access to right information in a timely manner, getting the right support early, feeling heard and listened to and feeling connected and supported in their community.

The Service provides support to the unpaid carer whilst the person they are caring for is admitted to hospital, during their stay and particularly on discharge. Traditionally, in practice, hospital staff concentrate on the patient. However, we know that the unpaid carers also need some support themselves. Evidence shows that if an unpaid carer is unable to carry out the support in their own home this can lead to the breakdown of care at home, and ultimately the person they care for being readmitted to hospital or requiring other health and social care funded support.

Whilst the Service is making a positive difference, there are significant numbers of patients being admitted and subsequently discharged from hospital on a daily basis and the Service is seeking to embed increased knowledge of how to identify and support unpaid carers in all hospital settings to ensure the needs of carers aren’t overlooked.

**Other project examples include:**

- **Enhanced community care** - relating to the provision ‘Hospital at Home’ with the formation of Virtual Wards
- **Trusted Assessors** - ensuring a consistent approach to assessment across the region
- **Front door turnaround / admission avoidance / unscheduled care** - Implementation of front door assessment based on a frailty approach at all acute sites
- **Pre/post admissions support** Patient education programme for planned admissions, to help understand the process and option to opt out, with additional post admission support to facilitate an earlier discharge
- **Step up/ step down** Alternative care provision is being created through Capital funding schemes. These include facilities to provide Carers respite, supported living, D2RA and Children’s Assessment centres aimed to de-escalate the need and return them home

**Outcomes**

- ✓ A whole system approach to health and social care; services which are seamless, delivered as close to home as possible; using technology to support high quality, sustainable services where multiple services can be requested from one referral
- ✓ Efficient deployment of resources – working with community service leads as an MDT to establish the most efficient response
- ✓ Facilitate timely discharge from acute and community hospitals, improving patient flow and reducing length of stay in hospital through supported discharge
- ✓ Prevention of admissions through community provision and use of virtual wards
- ✓ Reduction in hospital admissions and readmissions
- ✓ Reduction in WAST conveyance to and from hospital
- ✓ People have a better understanding of the discharge process and are more involved in pre and post discharge planning

## Accommodation Based Solutions

### Overview:

The approach is predicated on reducing demand on acute services by building a robust pathway to support people do what matters to them more effectively in their own communities, keeping them healthier for longer in their preferred residence and those in residential care to access services appropriate to their needs; move onto or return to supported accommodation.

The Model of Care is bolstered by developments outside of RIF funded activity in the form of the enabling regional capital programme supported by the Housing with Care Fund (HCF) and Integration and Rebalancing Capital Fund (IRCF).

There are significant developments in to improve alignment of accommodation planning and capital scheme management with demand for specialist and general needs accommodation. West Wales has benefitted from up to £6.9m of Housing with Care Funding in 2024-2025 for 16 projects across supported living for adults with learning disabilities and children's residential accommodation, delivering an increase of up to 50 units, within the context of the regional 10-year plan for capital investment in accommodation alongside Health and Social Care Hubs.

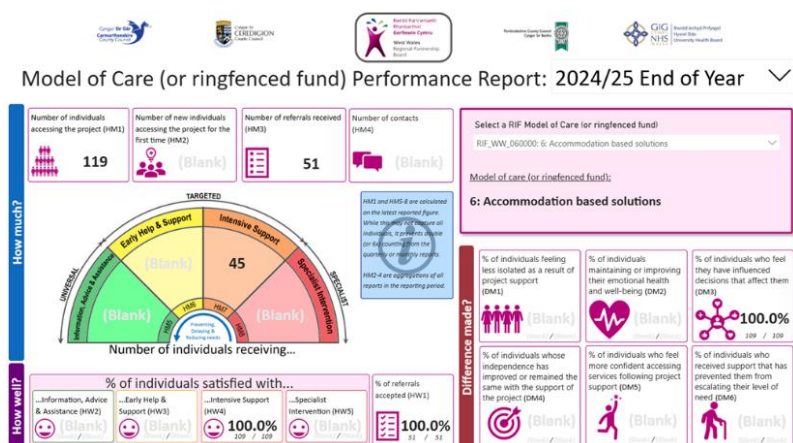
The strategic planning landscape for Accommodation-based Solutions has been heavily influenced by the requirement to submit a refreshed Strategic Capital Plan (SCP) to WG by 31st March 2025. This has provided the West Wales RPB and Strategic Capital Programme Board with the opportunity to review its performance as an enabling work programme within the wider Integrated Community Care System (ICCS) and the emerging blueprint for creating an ICCS for Wales.

The blueprints for developing accommodation projects will be collated during 2025/2026. Whilst much of this work is route through IRCF and the need to develop blueprints for Integrated Health and Social Care Hubs, a blueprint for specialist accommodation will be developed to showcase the key components of the Model of Care.

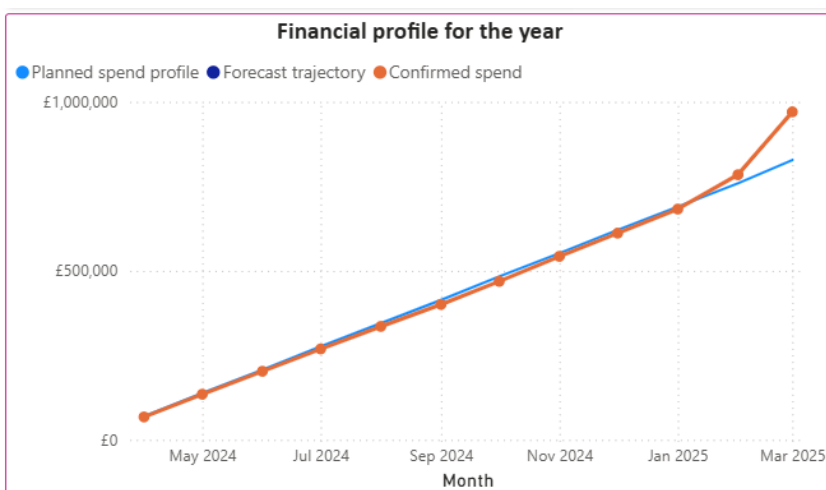
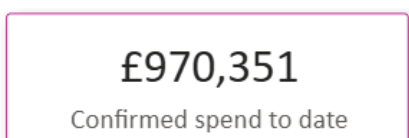
The regional capital programme is bolstered by extra care projects, reablement schemes and several priority schemes under the banner of "care Campi", to ensure the richness of detail for the accommodation blueprint covers multiple accommodation types and population groups. The blueprint development work will also call out other specific enablers described in Model of Care 2, Complex Care Closer to Home such as the role of assistive technology, reablement and falls prevention.

The end of year reporting showcases the outputs of RIF funded projects aligned to Accommodation-based Solutions:

How much, how well & difference made in 2024-25:



Investment 2024-25:



Examples of projects delivered during 2024-25

Intermediate and step-down accommodation:

The Intermediate and Step-Down Accommodation programme continues to yield positive outputs Ty Pili Pala as the bed-based pillar of the Intermediate Care MDT in Carmarthenshire. The programme highlights the key impact of dedicated accommodation and staffing resources to support people on discharge from hospital and those at risk of admission to hospital or residential care. There is a focus on reablement so people can return home safely and prevent future hospital admission. The service will help people identify and attain personal goals set as part of their assessment of needs.

Following data shared at year end, 81% of service users have been discharged home with no further package of care required. This illustrates a successful discharge pathway and is enhancing system flow. The ability of therapies to follow up the patient in their own home from Ty Pili Pala also allows for a smoother transition and ease patients’ anxieties of going home.

Intelligence and learning from existing capital schemes is also being cascaded between Models of Care and other funding streams as appropriate. There is potential to explore a regional model for reablement services, given the successes of Ty Pili Pala and future capital schemes across the region exploring reablement beds within the scope of investment.

### **Progression to more independent living**

The project is aimed at increasing the numbers of people with learning disabilities, mental health and neurodevelopmental diagnoses supported to move from care homes or family homes to their own accommodation, with appropriate levels of support to do the things that matter to them, including managing their own finances, finding employment and expanding their friendship groups and social activities, including exercise.

The project was developed due to an over reliance on commissioned residential care placements for service users and an increasing demand with limited flow through services identified, and having the right services to meet demand. As a result, it became a strategic regional priority to progress individuals who are no longer requiring this level of care to increase throughput and realise efficiencies.

Staff capacity within each of the 3 LA's and the health regional team allows for joint working and coordinated reviews to ensure all parties are involved in developing and progressing plans. Having dedicated staff resource means additional time and support can be provided over and above mainstream care management and there is greater time available to address barriers and ensure individuals personal outcomes are central to the plan.

This programme continues to yield extremely encouraging outcomes and benefits. Total savings recorded for 2024/2025 equates to £2.378m. This includes 26 individuals from 88 new referrals who have received targeted support and have progressed towards more independent living. This demonstrates in addition to progress during 2023/2024 a clear throughput of cases that are suitable for every service user by having a progressive person-centred care plan in place which focuses on maximising their independent living skills.

### **Outcomes**

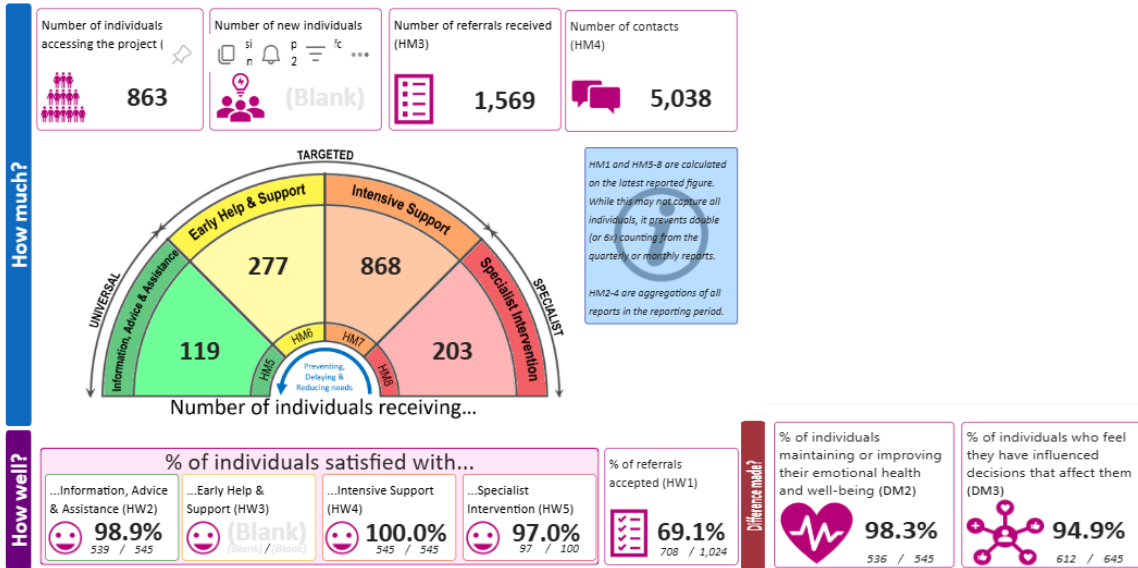
- ✓ Improved rehabilitation and recovery outcomes for individuals, to avoid admission to or support safe repatriation from acute services and increase independence
- ✓ Reduced reliance on statutory services such as domiciliary care
- ✓ Increased numbers of people remaining at home safely for longer
- ✓ Reduced urgent and emergency admissions to acute services
- ✓ Increased and improved alternatives to out-of-county placements including specialist college attendance
- ✓ Increased choice and involvement for people with care and support needs in where they live and with whom
- ✓ Improved identification and provision of associated palliative care needs where required.
- ✓ Reduced breakdown of unpaid care
- ✓ Case studies and testimonials that have been shared by projects and the voice and choice of individuals is key when planning any accommodation

# Dementia & Memory Assessment Service

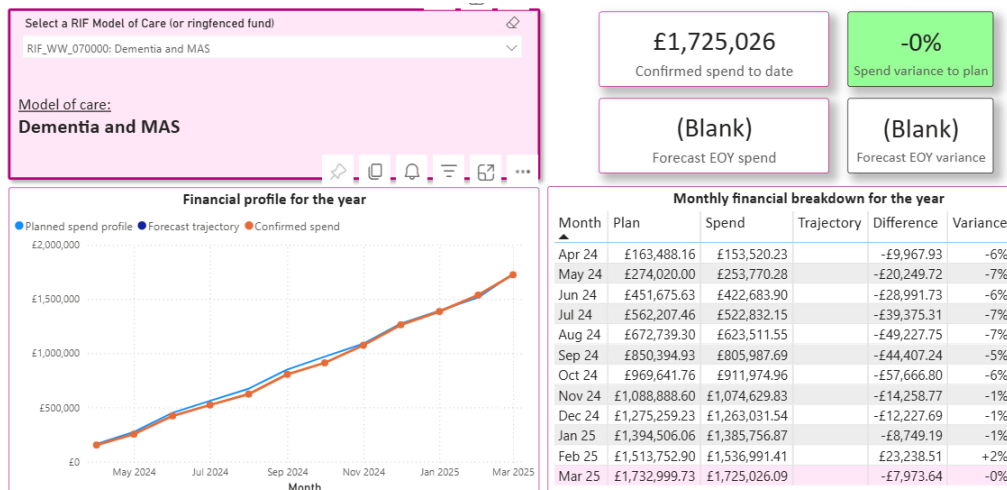
## Overview:

Dementia is everyone’s business. Our vision for West Wales is to support each person living with dementia to live well and independently for as long as possible. The purpose of this programme is to support the development of a holistic dementia wellbeing pathway, which places people living with dementia and their carers at its heart, providing support from diagnosis through to end of life.

## How much, how well & difference made in 2024-25:



## Investment 2024-25



The programme is made up of several interconnected projects that each contribute to the overall goal of creating a comprehensive, person-centred Dementia Wellbeing Pathway in West Wales. While each

project is distinct, they are all interrelated and based on evidence-informed approaches tailored to the needs of people with dementia. Collaboration with the third sector is a key feature, including the launch of the Dementia Wellbeing Connector service in June 2024, which supports the Dementia Steering Group's aim of fostering effective, locally-based, and coordinated care.

### **Examples of projects delivered during 2024-25**

#### **Dementia Wellbeing Connector Service**

This service was commissioned in June 2024 to support people who are newly diagnosed with dementia, providing people living with dementia with a single, named point of contact who provides support from diagnosis through to end of life. Having a dedicated person to link with directly with is important for continuity of care and the development of personalised wellbeing plan within an integrated pathway.

#### **Admiral Nurses**

This service has continued to provide person-centred and relationship-centred support for unpaid carers of people living with dementia, working collaboratively across health and social care pathways when caring is becoming or is complex to prevent / reduce escalation of need.

The team of nurses working in each locality (7 in total) provide complex casework to a caseload of carers with the following expected benefits.

- Through casework carers/relatives of people living with dementia can access dedicated and tailored support when their caring roles are becoming stressful and complicated.
- Carers/relatives of people living with dementia will experience improved Health & Wellbeing following delivery of specialist psycho-social intervention by the Admiral Nurses.
- The Admiral Nurse team also utilises consultation and collaborative working to support best practice with key stakeholders to improve knowledge, skill, and confidence in supporting Carers.

The service was rated highly on all fronts by unpaid carers via the service user experience survey, with the results reflecting that the Admiral Nurse service performs well at enabling carers to feel heard and to be treated compassionately.

All carers surveyed during the period, who were in receipt of Admiral nurse support were satisfied with the intensive support provided (100%), 91% of carers supported by an Admiral nurse felt they have influenced decisions that affect them and 91% stated that the experience of the service was very good.

#### **Community Dementia Wellbeing Service (practitioner wrap around support)**

This service provides wraparound support for people living with dementia, by influencing care across services and sectors of care. It seeks to ensure that people living with dementia have access to appropriate care when and where required, while reinforcing the message that dementia is everyone's business. This service ensures that people living with dementia receive prudent care, thus reducing the stress and distress associated with unmet needs in people living with dementia. Furthermore, it emphasises that a person's rights and individuality do not diminish because of a dementia diagnosis, nor do they become less important as they navigate their journey with the condition. People living with dementia receive prudent care, thus reducing the stress and distress associated with unmet needs in people living with dementia.

The delivery of this service is also reinforcing a psychologically informed model of holistic dementia care. Importantly, Allied Health Professionals working within the project can influence their own

respective professions both locally as well as at a national level. Their work influences the different workstreams around dementia standards.

Furthermore, the team continues to work with care homes and mental health and community services, to deliver a Stepped Care approach to dementia care. This approach draws on evidence-based practice from research across the UK, advocating a needs-led model of care. The aim of the work is to support care homes to feel able and confident in caring for people with dementia with changing needs, to improve wellbeing and quality of life and reduce avoidable hospital admissions or transfers of care. Qualitative feedback indicates that they are more confident and knowledgeable in their approach, which means they can support individuals for longer.

### **Dementia Wellbeing Connectors (Commissioned Wrap Around support)**

This service commenced in June 2024 and is delivered by Age Cymru Dyfed across the region of West Wales. The aim of this service is to support people who are newly diagnosed with dementia, providing people living with dementia with a single, named point of contact who provides support from diagnosis through to end of life. Having a dedicated person to link with directly is important for continuity of care and the development of personalised wellbeing plan within an integrated pathway.

The support that is provided by the Dementia Wellbeing Connectors is dependent on the individual needs at that time and include (but not limited to):

- Support to get and understand the dementia diagnosis.
- Information and advice about all types of dementia and coping strategies.
- Support to understand what the referred is entitled to, including benefits.
- Support to source and signpost/refer to appropriate community groups.
- Refer to any of our services including, Carer's Information and Support Programme, Live Well with Dementia Programme, Singing for the Brain, and our Companion call service.
- Support to understand and navigate through the Health and Social Care landscape.
- Emotional and practical support during transition periods, for example, a move to residential placement
- Despite the service not being run throughout 2024-25, feedback has been very positive.

### **Memory Assessment Services (MAS)**

The project is designed to develop Memory Assessment Services, to improve the experiences of people suspected of having dementia and their carers through the dementia assessment and diagnosis process and facilitating access to post-diagnostic support. This project aims to improve timely access to Memory Assessment Services for assessment (within 28 days), diagnosis (within 12 weeks), and deliver proportionate post diagnostic psycho-social intervention.

The additional MAS ring-fenced funding (£384k) has enabled the four Memory Assessment Services across West Wales to expand current services at key bottlenecks following lean analysis of the current pathway. Whilst this funds a mix of clinical staff and administrative staff supporting MAS across the region, there are additional MAS posts and service costs receiving funding as core health board services.

The latest data received via Improvement Cymru indicates that as of February 2025, Hywel Dda has achieved a diagnosis rate of 51%. This is on track with the target of a 3% increase each year.

The MAS team have successfully launched the Patient Survey questionnaires to obtain further user/carer feedback about the service (PREMS). In this period, **100%** of respondents rated their overall experience of the service 8 and above, on a scale of 1-10, with 0 being Very Bad and 10 being Excellent.

The project has been working to standardise the processes supporting a dementia diagnosis across the four teams, such as assessment documents, formulation meetings and scheduling of clinic appointments. This has enabled greater efficiency and effectiveness within the team and the ability to provide a consistent, timely service across the region, increasing equity and improving experience for people suspected to be living with dementia and their carers.

### **Dementia Steering Group**

The Programme Manager Commenced in role in October 2024 and has been working with the Dementia Steering Group to help deliver on the Regional Dementia Strategy, as well as the Dementia Action Plan for Wales and the All-Wales Dementia Care Pathway of Standards. 4 key workstreams feed into the steering group including, the Memory Assessment Service, Community Engagement, Dementia Wellbeing Connectors, Hospital Dementia Charter and Workforce. There has been an emphasis, through the Citizen and Third Sector Engagement Board, to ensure that the voices of people affected by dementia are heard and that service development reflects the needs and lived experiences of our communities.

A Dementia and End of Life Care Conference was held in April 2024 and feedback received from the day was very positive and importantly was reported as being a thought-provoking, educational, motivating and inspiring day. The Director of Ageing at University College London (Nathan Davies) attended and presented, introducing a range of practical tools and resources developed through research for supporting people with Dementia at end of life.

Preparations have commenced during 2024 to deliver a Dementia Conference in 2025 to raise awareness and understanding as to the work undertaken through the Dementia Wellbeing pathway.

### **Outcomes**

- ✓ Increase access to care coordination, carer support, and opportunities to develop coping strategies
- ✓ Improve wellbeing and quality of life of people living with dementia and their carers
- ✓ Empower people living with dementia and their carers to be heard and feel more in control of their care and support
- ✓ Reduce avoidable hospital admissions and transfers of care
- ✓ People with dementia will receive prudent care, thus reducing the stress and distress associated with unmet needs in people living with dementia

## Unpaid Carers

### Delivery of the West Wales Carers' Strategy 2020-2025

The West Wales Carers Development Group (WWCDG), in collaboration with statutory partners, continues to drive progress on the four key priorities of the Regional Carers Strategy as shown below. At the same time, there has also been preparations, including engagement and consultation in readiness for the launch of the new Strategy in 2025. For the purposes of this report the priorities remain as follows:

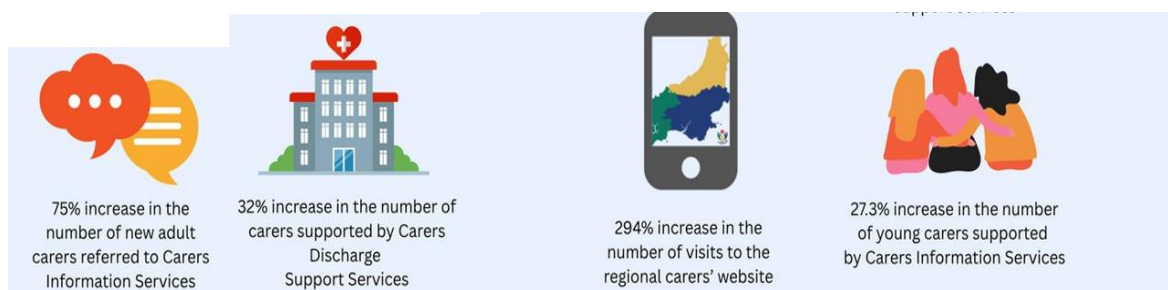
- Improve the early identification and self-identification of carers including young carers and young adult carers.
- Ensure a range of services is available to support the wellbeing of carers of all ages, in their life alongside caring.
- Support carers to access and maintain education, training and employment opportunities.
- Support carers to become digitally included and confident.

The Carers Development Group oversee the implementation of funding from the Regional Integration Fund (RIF) and two other ring-fenced funding streams to ensure the delivery of direct support to unpaid Carers.

### Key achievements in 2024/25

Some of the key achievements are shown above. The remainder of the report will provide an overview of the activities and outcomes achieved during the year against each of the regional priorities.

#### Key Achievements



### Examples of projects delivered during 2024-25:

#### Investors in Carers (IiC)

The Regional Investors in Carers (IiC) scheme, coordinated by Hywel Dda University Health Board on behalf of the West Wales Carers Development Group (WWCDG), promotes a whole-system, early intervention approach to identifying and supporting unpaid carers. The scheme, which operates through bronze, silver, and gold award levels, is being adopted across a wide range of settings— including hospitals, GP practices, schools, and community organisations such as libraries and voluntary sector organisations. This is creating consistency across the region to embed carer awareness, but most importantly it is an “everybody’s business” approach to making every contact count.

Participants report greater confidence in identifying and engaging with unpaid carers, leading to earlier support and improved wellbeing. In the past year, the scheme has refreshed its standards, streamlined its processes, and enabled 666 unpaid carers to be referred to local support services via

GP practices. Currently, 171 settings are involved in the scheme, with a notable rise in bronze-level awards in 2024/25.

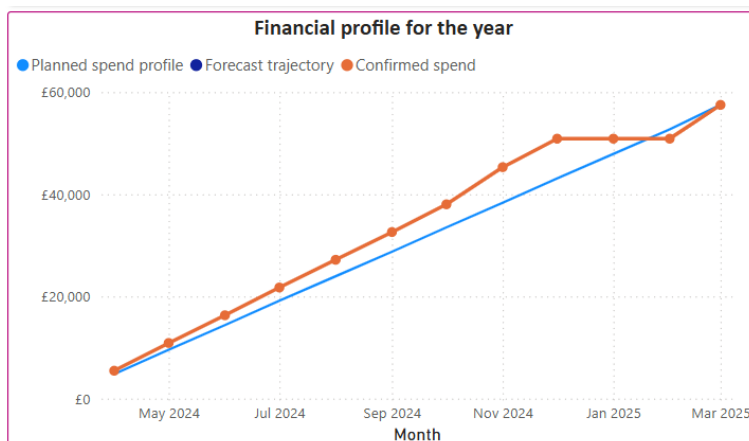
**Investment 2024-25**

**£57,500**  
Confirmed spend to date

**\*RIF funding**

**Awareness raising activities:**

During Carers Week and Carers Rights Day, a variety of awareness-raising events were held across Carmarthenshire, Ceredigion, and Pembrokeshire. Information stands in hospitals, led by the Health Board, engaged 341 individuals including; patients, unpaid carers, and staff providing one-to-one conversations and signposting to support.



Local Authorities and Carers Information Services also hosted wellbeing workshops, drop-in sessions, and community events across the region. All these events helped promote the importance of identifying unpaid carers and the available services for unpaid carers in hospitals and in the community.

**Carers Information and Support Services**

Carers Information and Support services have been jointly commissioned by the Health Board and the three Local Authorities ensuring a collaborative approach to the planning and delivery of services between statutory organisations. Below is an overview of the activity reporting, including a comparison with the previous year.

**Services jointly commissioned by the Health Board and Local Authority:**

**Adferiad Recovery** - Carmarthenshire Carers Information and Outreach Service

**Gofalwyr Ceredigion Carers** - Ceredigion Information, Outreach and Young Carers Service

**Action for Children** – Pembrokeshire Young Carers Service

**Carers Trust Crossroads West Wales** - Carers Support Pembrokeshire and Carmarthenshire Young Carers services

Key performance indicators	2023/24	2024/25
Number of new adult carer referrals	1189	2080
Number of adult carers who were supported	2218	2170
Number of new young carers referrals	261	341
Number of young carers who were supported	1586	2019

There has been a notable rise in referrals for both adult and young carers, with more young carers receiving support. Although a change in service provider temporarily reduced the number of adult carers supported, service activity is now increasing again.

**Carers Hospital Discharge Support Services**

The Health Board and local authority partners have implemented a whole-system approach to ensure unpaid carers are actively supported and involved in hospital discharge planning.

As part of this approach, the Health Board commissioned the voluntary sector to employ dedicated Carer Officers. These officers work closely with hospital and community staff to identify unpaid carers at the earliest opportunity, involve them in the discharge process of the person they care for, and provide appropriate information and support. This early identification ensures that carers are recognised as key partners in care planning.

The service also delivers training to hospital staff, helping them understand how to identify unpaid carers and make timely referrals to Carer Officers across both main and community hospitals. This has led to improved carer engagement and smoother discharge processes for patients.

In 2024/25, the service recorded a 15% increase in referrals to Carer Officers and a 32% rise in the number of unpaid carers supported, compared to 2023/24, demonstrating the growing impact and reach of the service across the region.

The table below provides an overview of the outputs from the service this financial year.

	2023/24	2024/25
Number of new referrals	488	560
Numbers of unpaid carers being supported	718	950
Number of staff training sessions	38	40
Number of staff attending training	197	100
Number of drop in sessions	224	207
Number attending the drop in sessions	1130	1560
Number of information packs given	1185	837



Carer Officers have adjusted their methods to raise awareness among staff about unpaid carers' needs. Although training attendance has decreased, drop-in session participation has risen. Similarly, fewer information packs are being distributed, as many unpaid carers now prefer accessing information digitally or through the Carers Support West Wales website.

**Investment 2024-25**

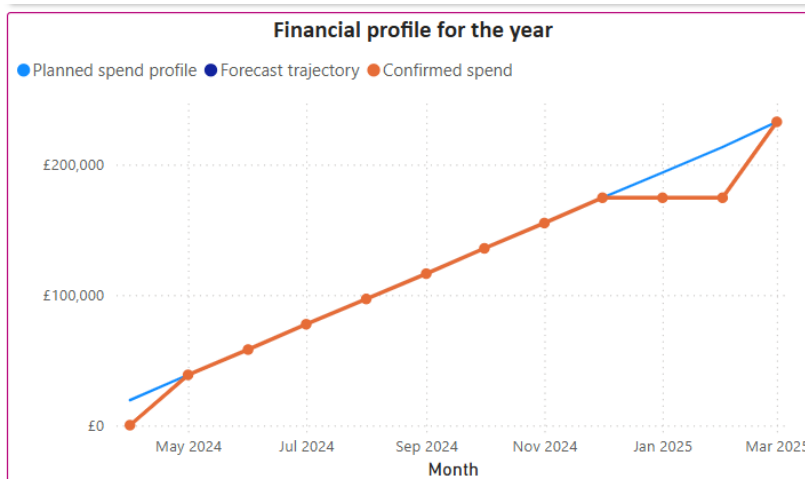
**£232,750**  
Confirmed spend to date

\*RIFfunding

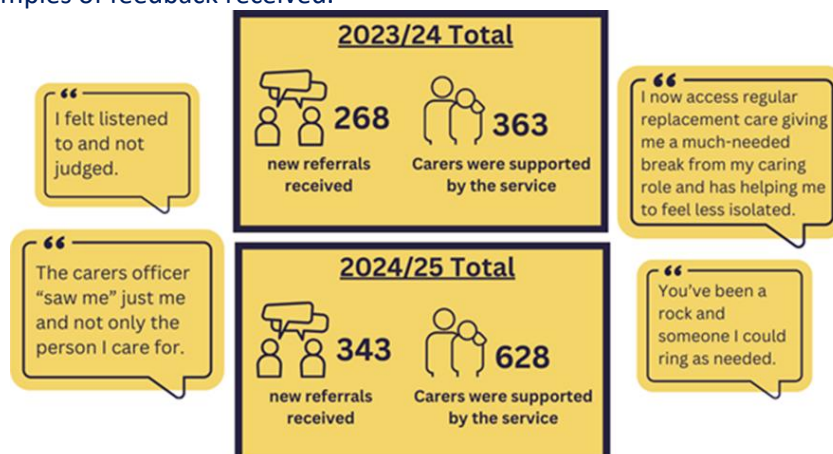
**Carers Community Outreach Discharge Service**

The Carers Community Outreach Discharge Support Service is a key part of the broader support system for unpaid carers, working alongside the Carers Hospital Discharge Support Service. It

plays a vital role in both hospital admissions and timely discharges by ensuring unpaid carers are supported and their needs are addressed. The service provides a crucial link between hospital and community care, ensuring that once carers are identified in a hospital setting, they continue to receive holistic support in the community to help them sustain their caring role.



Here is a summary of the support provided for 2024-25 with a comparison against the previous year, along with examples of feedback received.



Part of the monitoring of this service includes recording the outcomes and impact for unpaid carers. During their 'what matters to me' conversation unpaid carers are asked to rate their views and experiences. The service reported a significant improvement in unpaid carers' wellbeing in all five areas.

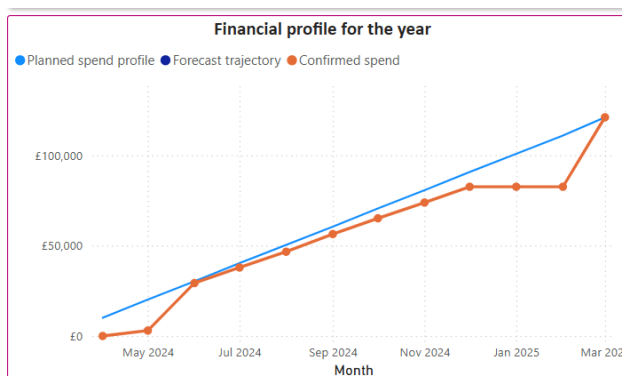
### Investment 2024-25

**£121,000**  
Confirmed spend to date

#### \*RIF funding

#### Carers Breaks

Much of the work relating to unpaid carers contributes to the Model of Care for Emotional Health and Wellbeing which is referenced earlier in this report.



Providing a variety of opportunities for unpaid carers to have a meaningful break from their caring role is a priority in West Wales, aligned to priority 2 of the regional Carers Strategy. This builds on the Rethinking Respite work previously undertaken by Swansea University (and commissioned by the West Wales Carers Development Group). Carers breaks activity across the region is being funded through Local Authority core budgets alongside Welsh Government Short Breaks funding (AMSER) and Regional Integration Fund (RIF) funding.

In 2024-25, 3965 individuals have accessed a short break opportunity. Evaluation undertaken by RIF, showed that 97.3% of those accessing short breaks reported that they have maintained or improved their emotional health and wellbeing, this demonstrates the huge impact of breaks on carers and their ability to continue in their caring role.

## Investment 2024-25

£291,513

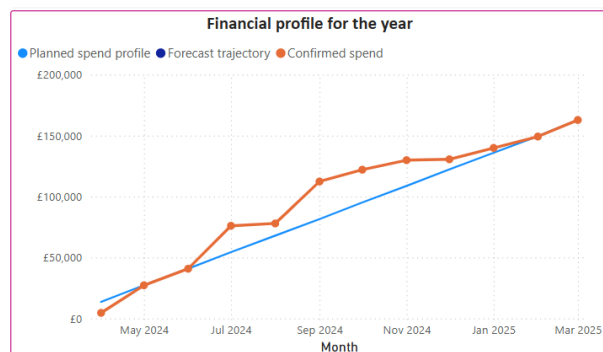
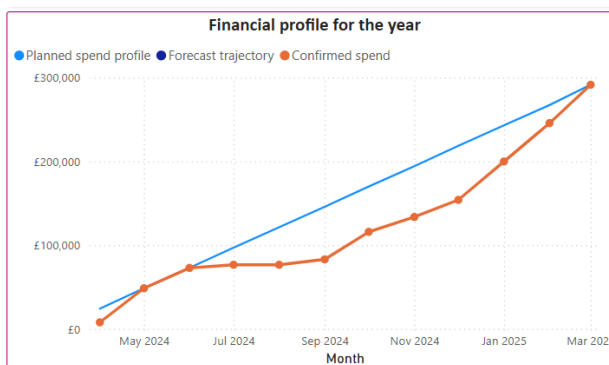
Confirmed spend to date

\*RIF funding

£162,807

Confirmed spend to date

\*AMSER funding



### Knowing your Rights & Carers Support West Wales

In response to the financial challenges faced by unpaid carers, the West Wales Carers Development Group launched the Income Maximisation programme in 2022/23. Now in its third year, the programme offers both emergency support and preventative advice through a holistic, carer-focused service model that complements existing welfare and benefits services.

The programme helps carers navigate complex benefits systems, access the right information at the right time, and connect with services that support their wellbeing. It also provides early intervention to help prevent crisis. In addition to direct support, the programme is promoted widely through campaigns such as Carers Rights Day, Carers Week, social media outreach, and online video content. All videos can be found on YouTube and have also been placed on the home page of Carers Support West Wales. <https://www.youtube.com/@CarersSupportWW/videos>

Unpaid carers have reported that the system is often difficult to navigate, especially during times of personal crisis. The programme's targeted guidance has had a direct, positive impact on carers' financial stability, emotional wellbeing, and overall health.

### Supporting unpaid carers to become digitally included

The Carers Support West Wales (CSWW) website ([Carers Support West Wales | Cymorth Gofalwyr Gorllewin Cymru](#)), now in its third year, continues to serve as a central, up-to-date information hub for unpaid carers of all ages. A steering group regularly reviews its content to ensure its relevance and usefulness.

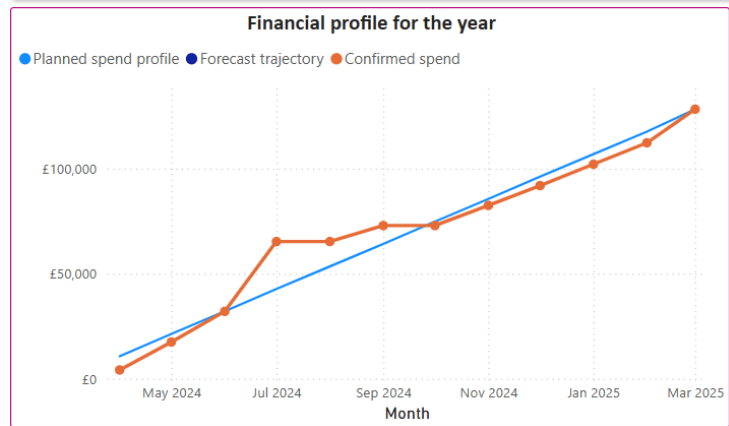
Between April 1, 2024, and March 31, 2025, the website received 187,687 visits. This is a 294% increase from the previous year, highlighting its growing recognition and effective promotion across the region.

A user survey with 321 participants showed that 100% were satisfied with the information, rated their experience as good or excellent, and found what they were looking for on the site.

**Investment 2024-25**

**£128,335**  
Confirmed spend to date

\*RIF funding



## Learning Disabilities & Neurodevelopmental Conditions

### Regional Improving Lives Partnership (RILP)

This partnership (RILP) continues to oversee the delivery of a range of initiatives and projects which support the aims within our Area Plan and those set out within the ground-breaking West Wales Learning Disability Charter. This Charter was developed by the 'Dream Team', a group of people with learning disabilities from across West Wales. It aims to increase visibility of issues faced by people with learning disabilities, promote their rights, improve access to services, business and leisure facilities and empower people to co-produce future solutions.

The projects include:

- Innovative and transformative day opportunities
- Pathways to employment
- Exercise buddies
- Positive behaviour support
- Progression to more independent living

### Autism

A Regional Strategic Group for Autism continued during 2024 – 25 with the overall purpose of the group being:

- To improve outcomes for autistic people, their families, and carers
- To ensure autistic people are engaged in the evaluation, development and delivery of services in West Wales
- To ensure that services are meeting their obligations under the Social Services and Wellbeing (Wales) Act 2014 and the NHS (Wales) Act 2006 and the Code of Practice for the delivery of Autism Services (2021)

### West Wales Neurodivergence Improvement Board (WWNIB)

In line with Welsh Government direction, the aims and objectives of the Regional Strategic Group for Autism have been integrated and as such, this group has been superseded by the West Wales Neurodivergence Improvement Board (WWNDIB). This new name reflects the group's expanded scope of responsibilities and diverse funding sources.

Work has been undertaken during the year to bring together senior representatives from the Local Authorities, Hywel Dda University Health Board and third sector to improve, integrate and transform health and social care services for neurodiverse children, young people, adults and their families in West Wales. Having conducted the foundation work on setting this up, the WWNIB meetings will commence during 2024-25 and will replace the Regional Strategic Group for Autism.

## Integrated Planning and Commissioning

### Commissioning Programme

Work of the Commissioning Board in 2024-25 has focused on delivering a programme of strategic priorities, including the response to the recommendations of the Market Stability Report (MSR).

In terms of the MSR, four priorities have been worked on during 2024-25:

1. Undertake options appraisal to assess and make recommendations on creating and enhancing regional strategic commissioning capacity. This led to agreement to increase strategic commissioning capacity from April 2025
2. Establish a regional specialist children's commissioning programme to meeting health and care needs of children and young people
3. Establish a regional specialist working age adults commissioning programme to secure local provision (focussing on transition from children's to adult services)
4. Undertake a feasibility study for the delivery of public sector nursing care homes provision in the region. This study is nearing completion and will provide an evidence base for possible future investment schemes

Other successes include:

- Development and agreement of a regional Quality Assurance framework, initially being implemented in older adult care homes, but with scope to cover other areas
- Light touch review of the Shared Lives adult placement service
- Preparatory work to develop a care and support data portal to support commissioning and the review of the Market Stability Report scheduled for completion by June 2025
- Improved arrangements for placements funded jointly by Health and local authorities
- The agreement of a dispute resolution policy
- Agreed regional definition of 'transitions'
- Work to align the delivery of community equipment across the three jointly funded services in the region
- Benefit realisation work underway to understand the economic impact of community equipment services

# West Wales Capital Programme

## Investment Schemes

### “Strategic Capital Plan” & Regional Programme

Key messages:

- Innovation / different types of schemes – Clynfyw / A4C / blueprint (lift from slides)
- Priorities 2025-2027

The West Wales RPB first submitted its “Strategic Capital Plan” (SCP) to Welsh Government in July 2023 which coincided with the creation of a new Capital Programme Management Office (PMO) within the wider WWRPB team. The SCP outlined the intention for West Wales to develop modern and accessible accommodation-based solutions and integrated health and social care hubs in support of government policy commitments, as well as priorities outlined in the Market Stability Report. Coupled with relevant priority population groups and cross-cutting themes outlined in the Population Needs Assessment, capital investment is a significant enabler for opportunities to develop models of care as part of the wider development of the ICCS. Strategic Capital Planning embedded within partnership and governance arrangements is key to ensure these opportunities are fulfilled.

One of the main developments during 2024/2025 has been the significant performance improvement of the delivery programme:

#### Housing with Care Fund (HCF)

- HCF Objective 1 - 18 schemes funded – totalling approximately £3.3m of investment for Approximately 40 units of accommodation will be delivered directly from these investments
- HCF Objective 2 – 4 children’s residential schemes funded – totalling approximately £1.6m. An additional 11 children’s places have been created directly from this investment

Other minor projects funded by HCF will mean that total investment in West Wales equates to £6.9m, 87% of our allocation. This is up from 54% in 2023/2024.

#### Integration and Rebalancing Capital Fund (IRCF)

The majority of the current IRCF programme is in support of Integrated Health and Social Care Hub developments. (IHSCs). Both Carmarthen Hwb and South Quay are on-site whereas other Priority 1 schemes are developing Outline Business Cases (OBC). Fees drawn down in 2024/2025 are included the table below

Scheme	Priority	County	Amount Claimed (£)
Carmarthen Hwb	1	Carmarthenshire	3,892,000
South Quay	1	Pembrokeshire	2,416,026
Plas Y Bryn	2	Carmarthenshire	86,432
Cross Hands	1	Carmarthenshire	208,000

Fishguard	1	Pembrokeshire	70,000
Cylch Caron	1	Ceredigion	-

Plas y Bryn is the only Priority 2 (in support of the rebalancing of Adult Social Care) scheme. This sees the acquisition of a former care home in Carmarthenshire. The Local Authority aims to create a new-build 60 bed home on the site, spread across five wings, which would be dual registered for residential and nursing care, with 3 of the 5 wings used for nursing care.

### IRCF Revenue

In addition to capital investment, the West Wales region has also benefitted from IRCF revenue investment. Funding has supported some of these priority capital investments. For instance, a feasibility study was performed in support of options for operating a public sector run nursing home. There is a clear case for Local Authorities operating their own homes to address regional care shortages effectively, ensuring quality, sustainability, and collaboration between public sector partners. Dialogue will now move forward between Carmarthenshire County Council and Hywel Dda UHB to determine which option is moved forward in relation to Plas Y Bryn, as the first example of a public sector led nursing home in the region.

### Eliminate

Another successful deployment of revenue has been to develop a Regional Design Blueprint for New Build Children’s Accommodation, for both single and two storey properties. This has helped the region come together to provide a solution to for all counties e.g. in absence of any Welsh Design Standards for Children’s Homes. The project yields numerous benefits as the package is designed up to RIBA Stage 2 (concept) and can now be taken forward by respective counties at a project level, saving them time, money and resource affiliated with this initial piece of design work. The outcome is a foundational guide that will assist with standardisation of children’s projects across the region, with approval in principle on the designs received from Care Inspectorate Wales (CIW).



To date, West Wales has completed 6 residential children’s accommodation projects, through the support of Housing with Care Fund (HCF) from Welsh Government, creating some 19 units and capital investment in the region of £4.7 million, utilising almost a quarter of the 24-25 HCF allocation to support the Eliminate agenda.

It is forecast that there are set to be up to another 6 children’s residential projects completed within the next 24 months.

## Capital Prioritisation

An important requirement of Strategic Capital Planning within the regional partnership is the need to prioritise capital investments, as outlined in IRCF. The Capital PMO has co-produced and introduced a new prioritisation process wired into governance arrangements led by the Strategic Capital (Programme) Board. The process provides a screening of a range of questions presented to project leads and directors in order to compare several projects presented by partner organisations. It aims to ensure that projects meet regional priorities and are a fit for the grant criteria. Much of the information shared and responded to via recommendations will enhance future WG applications and business cases.

## Strategic Capital Plan (SCP) Refresh

The prioritisation above has been a key aspect of a refresh of the SCP. A number of new schemes have been agreed by the Regional Strategic Capital Programme Board as a result of the prioritisation process. These combined schemes total over £180m in required investment, staggered over the medium and long-term. Over £8m is profiled as required in 2025/2026, mainly for fees to progress business-case developments. Plas y Bryn is the only scheme which is targeting the final investment decision from Welsh Government in that time (£2.584m)

Other aspects of the SCP refresh have included:

- A clearer, concise set of key principles for capital investment, including where these principles have then developed into a blueprint for IHSCH's
- Updated policy and strategic context as the landscape evolves around the ICCS
- A caveat on the PNA / MSR position which is due to be refreshed over the summer
- Clarity on the directive from WG on Integrated Health and Social Care Hubs and what this means for planning new schemes in West Wales
- Detail on the care campus model, aspects of which form the blueprint for priority rebalancing schemes
- Detail on the Eliminate portfolio, which has emerged as one of the policy areas of most significance enabled by capital investment
- The forward work programme of priority schemes that has been shared with WG
- PMO priorities for 2025-2026

## Capital Benefits Framework

A weakness of the West Wales regional programme during the first tranche has been the lack of a common benefits framework that specifically calls out the impact of capital investment in support of the wider ICCS development and accompanying RIF programme.

The West Wales RPB welcomes the requirement within the revised IRCF guidance for RPBs to align their benefits register to the RIF Outcomes Framework and the Model of Care high level outcomes that relate to, for example community-based care and accommodation-based solutions, and to the other Models of Care outcomes where there is interface and relevance to provide the story of intended change for the priority population groups.

It is a priority for the West Wales RPB Capital Programme to develop a Capital Benefits Framework

The main aim for the West Wales Capital Benefits Framework is to:

- Develop a set of common outcomes and benefits that all capital projects are synonymous with

The objectives for the West Wales Capital Benefits Framework are:

- To build the evidence based for further investment in the ten-year plan
- To understand the “difference made” from capital investment
- To develop a common understanding of the impact of capital investment
- For current and future projects to understand the need for benefits management and realisation
- To track data at a regional level that can act as key indicators for the impact of capital developments
- To link strategic objectives to achievement

## Innovation and Technology

### Overview

The West Wales Regional Innovation Coordination Hub (WWRIC) connected with industry, academia, local authorities, health boards, third sector, RPB and national agencies, to coordinate and facilitate innovation in health and social care across the West Wales region. Regular collaborators include:

- Social Care Wales
- Bevan Commission
- Life Sciences Hub Wales
- SBRI Centre of Excellence
- MediWales
- NHS Wales Collaborative
- University of Wales Trinity Saint David - Assistive Technologies Innovation Centre (ATiC)
- Swansea University
- Wales Intensive Learning Academies
- Health Technology Wales
- Rural Health and Care Wales
- Welsh Government Communities of Practice

It is acknowledged that areas of joint work which have the potential to benefit from ‘innovation support’ often require initial research, demonstrations and trialling. These are recognised as essential elements to help inform decisions and determine whether there is value in pursuing further development. It is also recognised that not all will proceed to the next phase, however it is vital that these are carried out to establish costs and benefits prior to investing further time and resource.

### Examples of work supported during 2024-25

- **Point of Care Testing trial – CATCH – Clinical assessment to care at home (Umbrella outreach team) POCT is one aspect of the work which is being undertaken within the CATCH team. The CATCH team will be equipped with POCT devices, associated consumables, and equipment, to test patient blood glucose and ketones, blood gases, renal profile and perform Urinalysis.**
- **Pre Hospital Video Triage – Stroke team in WGH and WAST utilising attend anyway to triage patients effectively ensuring right pathway for patients.**
- **Discovery – Patient discharge – Patient experience report completed and project to review how staff manage patient discharge is now underway.**

- **Bro Preseli – New innovative model to deliver day centre provision in Crymych.**
- **Bevan Exemplars – Continue to support many Bevan Exemplar projects, utilising a Dragons Den approach last year with great success. The region has a consistent track record in having the highest number of Bevan Exemplars year on year. Also, it provides a talent pipeline for Bevan Clinical fellow with 3 in last cohort and 3 in the existing cohort.**

With the proposed changes to RIC funding for 25-26, the staff moved on to alternative employment during the year, curtailing active delivery however, a recent funding bid submitted by HDdUHB on behalf of the region, was successful in securing funding to support activities for the next year.

## Workforce Development and Integration

### Approach

The Regional Workforce Board (RWB) has had a busy year. Following a period of uncertainty, a new Programme & Change Manager for Workforce commenced in September 2023, who has supported the RWB partners to come together to develop several workstreams that ensures the region develops the workforce it needs. These include the following:

- 1) Education and Development
- 2) Leadership and Talent Management
- 3) Workforce Data and Intelligence
- 4) Retention and Recruitment

#### 1) Education & Development Workstream

The Education & Development Workstream continues to make strides in developing a Support Worker (Band 2-4) Clinical Skills training programme. This will ensure skills such as; Oral Health, Effective Communication, Diabetes Care and Foot Care are governed and provided across the region by ratified matter experts. Since it's launch in January 2025, 546 health employees have accessed the Band 2-4 Support Worker training. Health and Local Authority partners are now exploring the possibility of making this accessible to Local Authority employees, with the Local Authority partners also providing training to support the programme.

#### 2) Leadership Workstream

The Leadership Workstream's focus this year has been to develop a Regional Coaching Network. This has allowed us to develop a large pool of Coaches to support the region's workforce, bringing Health and Social Care Coaches together to share expertise and knowledge in an integrated way. The Regional Coaching Festival took place in Pembrokeshire on the 24<sup>th</sup> October 2024, and the event was a great success with more than 70 of our Coaches in attendance. In addition to what will now be an annual Regional Coaching Festival event, Continued Professional Development (CPD) sessions have also taken place to further support, develop and appreciate our Coaches and the good work they do in addition to their day-to-day role. The Leadership Workstream has developed and designed a regional process to access Coaching, as well as regional paperwork to aid consistency. The Leadership Workstream will now focus on their long-term ambition of developing a Regional Integrated Leadership Pathway for all Health and Social Care employees.

#### 3) Workforce Data Intelligence

The Data & Intelligence workstream continues to work in partnership with Social Care Wales and HEIW to develop a shared space/repository of workforce related Data & Intelligence to inform Health & Social Care workforce planning and to share resources.

The workstream has begun a pilot in partnership with Health and Carmarthenshire County Council to develop a joint Health & Social Care workforce planning training resource. A shared interest in Children Services has been the focus of the pilot. The aim of the pilot is to develop a joint Health Board and Local Authority workforce plan to assist both partners.

The workstream has an ambition to facilitate a regional conference to inform thinking on the "Technological Supercycle" i.e. advances in AI, Bioscience and Smart Sensors.

#### 4) Recruitment & Retention Workstream

The Recruitment & Retention Workstream is early on in its journey, being established since October 2024. However, its main priority is to reinstate and develop work-based visits/placement opportunities for school aged children in the Health and Social Care sector. The Recruitment & Retention Workstream has secured £27,000 funding to support its ambition in developing Virtual Reality (VR) modules that will allowing children to be fully emersed into a 'day in the life' of a range of roles across Health and Social Care. The Recruitment & Retention Workstream's ambition is to develop a career pathway that will allow and support children to make informed decisions about the future careers in the field of Health and Social Care.

#### Registered Managers Forum

Due to the Covid-19 pandemic, the Registered Managers Forum was placed on hold. However, in December 2024 it was reinstated as a full day, face-to-face event. Over 30 Registered Managers from across the region from 3<sup>rd</sup> sector, independent sector and statutory sector came together to receive relevant updates, share good practice, learn in a safe and engaging environment and network with a range of colleagues. This event has set the future direction for the Registered Managers Forum for 2025/2026 which will include virtual sessions on a quarterly basis and continuing with the annual face-to-face event.



#### The WeCare Programme

This aims to raise the profile of careers in the care sector and supports the next generation of our social care and childcare workforce, highlighting routes into care, pathways and opportunities, ensuring there are enough people with the right values, qualities, and skills in the care workforce to meet the needs of the most vulnerable people in society.

Through this work, students are better informed about the routes into care, career pathways, current job vacancies and the opportunities available to them such as apprenticeships, training opportunities and placements. Through improved awareness of the Social Care, Childcare, Early Years and Play labour market and increased understanding of the workplace, they will have a greater understanding of the sector, the job roles available and the qualities, values and qualifications required to work within it.

Through discussions with teaching staff both in schools and colleges along with Careers Wales Education Business Advisers, students are educated about the different career options, job roles and career paths available through bespoke face to face sessions, online and interactive sessions, talks and workshops, to suit students' needs and support their Health and Social Care studies. Included in this is a 2-day free Introduction to Social Care course and a one-day Childcare presentation run by WeCare Wales training team. It is a programme specifically for students in year 12 and 13 and FE college students studying health and social care.

Furthermore, WeCare Ambassadors and champions who work in a variety of different care job roles within the Social Care, Childcare, Early Years and Play sector are also able to provide a real insight into their work through informal talks and discussions. This both enriches the school curriculum and learner experience of the world of work and provides real stories from real people working in the sector to inspire and share their passion for care.

Career information, advice and guidance is relayed onto students and parents through attendance and support at career related events such as festivals, carousels, job fairs, parents' evenings and mock interviews etc.

### **Achievements**

The WeCare Wales Programme has been successfully delivered during the year to continue to promote social care, childcare, early years and play career pathways with:

- 20 secondary schools and 2 colleges supported
- 65 sessions delivered
- 8,500 (approx.) students supported
- Continued Partnership working with WeCare Wales. Supporting WeCare Wales' national campaigns and initiatives e.g. raising awareness of training and jobs board, promoting campaigns at regional level
- Delivery of the Childcare Project
- Delivery of the WeCare Ambassador programme
- Providing expertise and knowledge of the profession to partners not directly working in the sector e.g. highlighting workforce opportunities to training providers
- WeCare West Wales Working Group – to drive collaborative working and respond to priorities

### **Outcomes**

- ✓ Outcome one: Improved perception and understanding of the early years / childcare / social care professions by: next generation of the workforce current job seekers key stakeholders and partners.
- ✓ Outcome two: Regional stakeholders are actively engaging with WeCare Wales.
- ✓ Outcome three: Improved coordination of recruitment and retention opportunities offered by regional partners.
- ✓ Outcome four: Regional intelligence is shared with WeCare Wales

## PART 3: REFERENCES & LINKS

WWRPB website	<a href="http://wwrpb.org.uk">West Wales – West Wales Regional Partnership Board (wwrpb.org.uk)</a>
WWRPB Agendas	<a href="#">WWRPB Agendas – West Wales Regional Partnership Board</a>
Area Plan	<a href="http://wwrpb.org.uk">Area Plan – West Wales Regional Partnership Board (wwrpb.org.uk)</a>
Conference & Awards	<a href="https://wwrpb.org.uk/wwrpb-conference-awards-2025-summary/">https://wwrpb.org.uk/wwrpb-conference-awards-2025-summary/</a>
WWRPB Newsletters	<a href="#">WWRPB Newsletters – West Wales Regional Partnership Board</a>
Programme for Government	<a href="#">(Welsh Government Programme for government: update [HTML]   GOV.WALES)</a>
Nyth / Nest Framework	<a href="#">NEST framework (mental health and wellbeing)   GOV.WALES</a>
No Wrong Door	<a href="#">NoWrongDoor_FINAL_EN230620.pdf (childcomwales.org.uk)</a>
Carers Support West Wales	<a href="#">Carers Support West Wales   Cymorth Gofalwyr Gorllewin Cymru</a>
Adult Advocacy Strategy	<a href="#">Adult Advocacy Strategy – West Wales Regional Partnership Board (wwrpb.org.uk)</a>
Adult Advocacy strategy Easy Read	<a href="#">Adult Advocacy Strategy Easy Read – West Wales Regional Partnership Board (wwrpb.org.uk)</a>
Capital Strategy	<a href="#">Capital Strategy – West Wales Regional Partnership Board (wwrpb.org.uk)</a>
Capital Strategy Easy Read	<a href="#">Capital Strategy Easy Read – West Wales Regional Partnership Board (wwrpb.org.uk)</a>
West Wales Dementia Strategy	<a href="#">Dementia Strategy – West Wales Regional Partnership Board (wwrpb.org.uk)</a>

# Appendix 1

## Membership of RPB (April 2025)

Name	Organisation	
<b>Hazel Lloyd Lubran (RPB chair)</b>	Ceredigion Association of Voluntary Organisations	Chief Officer
<b>Michael Gray</b>	Pembrokeshire County Council	Director of Social Services and Housing
<b>Estelle Hitchon</b>	Welsh Ambulance Service NHS	Director of Partnerships and Engagement
<b>Councillor Tessa Hodgson</b>	Pembrokeshire County Council	Cabinet Member for Social Services
<b>Audrey Somerton Edwards</b>	Ceredigion County Council	Statutory Director of Social Services & Corporate Lead Officer: Porth Cynnal
<b>Ardiana Gjini</b>	Hywel Dda University Health Board	Director of Public Health
<b>Vacant</b>	Hywel Dda University Health Board	Independent Member – Local Government
<b>Hilary Jones</b>	Bro Myrddin Housing Association	Chief Executive
<b>&lt; Name &gt;</b>	Carmarthenshire County Council	Director of Communities
<b>Jonathan Morgan</b>	Carmarthenshire County Council	Head of Homes and Safer Communities
<b>Gareth Morgans</b>	Carmarthenshire County Council	Director of Education and Children
<b>Jill Paterson</b>	Hywel Dda University Health Board	Director of Primary Care, Community and Long-Term Care
<b>Casey French</b>	Care Forum Wales	< Role >
<b>Donna Pritchard</b>	Ceredigion County Council	Deputy Director of Social Services & Corporate Lead Officer: Porth Gofal
<b>David Pritchard</b>	Social Care Wales	Assistant Director
<b>Gaynor Toft</b>	Pembrokeshire County Council	Chief Housing Officer
<b>Councillor Jane Tremlett</b>	Carmarthenshire County Council	Executive Board Member for Social Care and Health
<b>Councillor Alun Williams</b>	Ceredigion County Council	Cabinet Member for Adult Services
<b>James Tyler</b>		Service user representative
<b>Alan Thomas</b>		Service user representative
<b>Vacant</b>	< Organisation >	Carer representative