Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

PWYLLGOR ADNODDAU CYNALIADWY
SUSTAINABLE RESOURCES COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	22 August 2022
TEITL YR ADRODDIAD: TITLE OF REPORT:	Regional Integration Fund (RIF) Plans
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Jill Paterson, Director of Primary Care, Community and Long Term Care
SWYDDOG ADRODD: REPORTING OFFICER:	Kelvin Barlow, Regional Partnership Programme Manager, West Wales Care Partnership Elaine Lorton, County Director

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

This paper provides an overview of the Health and Social Care Regional Integration Fund (RIF) for the West Wales Region. Plans for this fund have been agreed by the Regional Partnership Board (RPB) for the 2022-23 transitional year. This paper provides assurance to the Committee and explains the key features of RIF, including the allocations, and summarises the approach taken to developing the investment proposals.

Cefndir / Background

The Health and Social Care RIF is a 5 year fund from April 2022 to March 2027 and will seek to create sustainable system change through the integration of health and social care services.

The aim of the RIF is to build upon the excellent work undertaken though the Integrated Care Fund (ICF) and the Transformation Fund (TF). It is not a continuation of those schemes. It is a new programme with distinctly different architecture and objectives. The fund brings together several existing funding streams to provide a renewed focus on community based care, emotional health and well-being, supporting families to stay together safely, care experienced children, home from hospital services and accommodation based solutions.

The expectation is that the utilisation of the RIF will closely align to other key strategic programmes in West Wales to help create a whole systems approach. In particular, the Accelerated Cluster Development and the Unscheduled and Emergency Care Policy Goals as well as our regional priorities.

The ICF and TF deliver a significant level of resource to health and social care in West Wales. Many projects have been in place a number of years and are integrated within the health and social care system. However, the grant funding has often been delivered on an annual basis, split by specific population groups or areas, making it difficult to plan, deliver and evaluate strategically. The move towards a 5 year programme of funding is welcome as it gives the

opportunity to move away from this approach and allows the Regional Partnership Board RPB to plan on a regional basis to meet the strategic priorities for West Wales.

Whilst RIF guidance was issued to RPBs on 21st January 2022, preparations began for the transition to RIF in West Wales in 2021.

Reviews of the projects funded under ICF and TF were undertaken by local partners with support from the West Wales Care Partnership (WWCP) team. This was done largely on a locality or population group basis to establish which projects had delivered good outcomes and may need to continue under the RIF. However, the ability of partners to undertake a comprehensive review on a regional basis, and in advance of the guidance being issued, was impacted as a result of COVID-19, severe operational pressures and staff changes during winter 2021.

The strategic priorities of the RPB do require further development. This will follow the publication of our Population Needs Assessment (PNA) and Market Stability Report (MSR). These will be published in 2022-2023 and will assist in identifying our shared strategic priorities and shaping our future investment plans, including RIF, which will be reflected in our West Wales Area Plan for 2023. In this context, 2022-23 will be a transitional year.

Asesiad / Assessment

Key features of the RIF
The Health Board will hold the RIF funding on behalf of the RPB but will not make decisions on behalf of the RPB. A Memorandum of Understanding will be developed for this purpose. The allocations in West Wales are:

Regional Infrastructure Fund 75% up to £750K	National Priorities 100% WG Funding				New Model Development 90% WG Funding	National Embedding Fund 70% WG Funding	Total WG Contribution
	IAS	Dementia	Memory Assessment	Carers Hospital Discharge			
£'000s							
750	398	1,249	384	121	4,732	11,041	18,675

There are 4 separate components to the RIF. These are set out below:

1. Regional Infrastructure Fund - It is essential that all RPBs have adequate resources and infrastructure arrangements to support delivery against the collective duties and expectations placed on them under the Part 9 duties of the Social Services and Well Being (Wales) Act 2014 (SS&WBA). Under this guidance, the RIF can fund up to £750,000 (at a maximum of 75% intervention rate) towards the costs of the RPB infrastructure with statutory partners needing to match this by investing £250,000 (at a minimum of 25% intervention rate.)

2. National Priorities Fund - Under this section of the fund, RPBs will be allocated 100% funding to deliver against national ministerial commitments with no match funding required. The allocations will be issued in year on receipt of, and subsequent approval of, investment proposals.

3. New Model Development Fund - This funding is to develop and test new models of care. It should be used for a new idea or a project that has not moved beyond initial concept phase, which needs further development and testing of proof of concept. This is not intended for any

models that have been developed and tested previously under the ICF, TF or any other funding stream. However, it is recognised that some projects may have started under previous funding streams and have not yet concluded their testing phase.

As a guide, no more than 30% of the RPB's overall allocation for the RIF should be allocated to models of care in this area. Projects funded under this part of the fund will receive a 90% intervention rate from Welsh Government with statutory partners being expected to match the remaining 10%.

4. National Embedding Fund - This section of the fund is for projects that have been tested and evaluated as having had good impact and are agreed by all partners as meeting regional needs and ready for embedding as key a service to support embedding the national models of care.

It is anticipated that several evaluated projects or services developed under the ICF and the TF will move directly into this fund from April 2022. As a guide, 70% of the RPBs overall allocation for the RIF should be allocated to models of care in this area. Projects funded under this part of the fund will receive a 70% intervention rate from Welsh Government with statutory partners being expected to match the remaining 30%.

Carers and Social Value Sector
RIF guidance states that RPBs will be expected to invest a minimum of 5% to provide direct support to carers and 20% into social value in 2022/23. Although social value is not clearly defined, it is anticipated that our continued investment into third sector provision will achieve this.

Match Funding
Match resources are a key principle of the RIF and are intended to assist with levering sustainable change across our health and social care system. Match resources can be made up of two key elements, monetary and wider resources. Monetary match funding consists of direct financial contributions from core funds or other non-Welsh Government grant sources. The wider resource contribution consists of staff time, volunteer time, and use of premises and / or facilities.

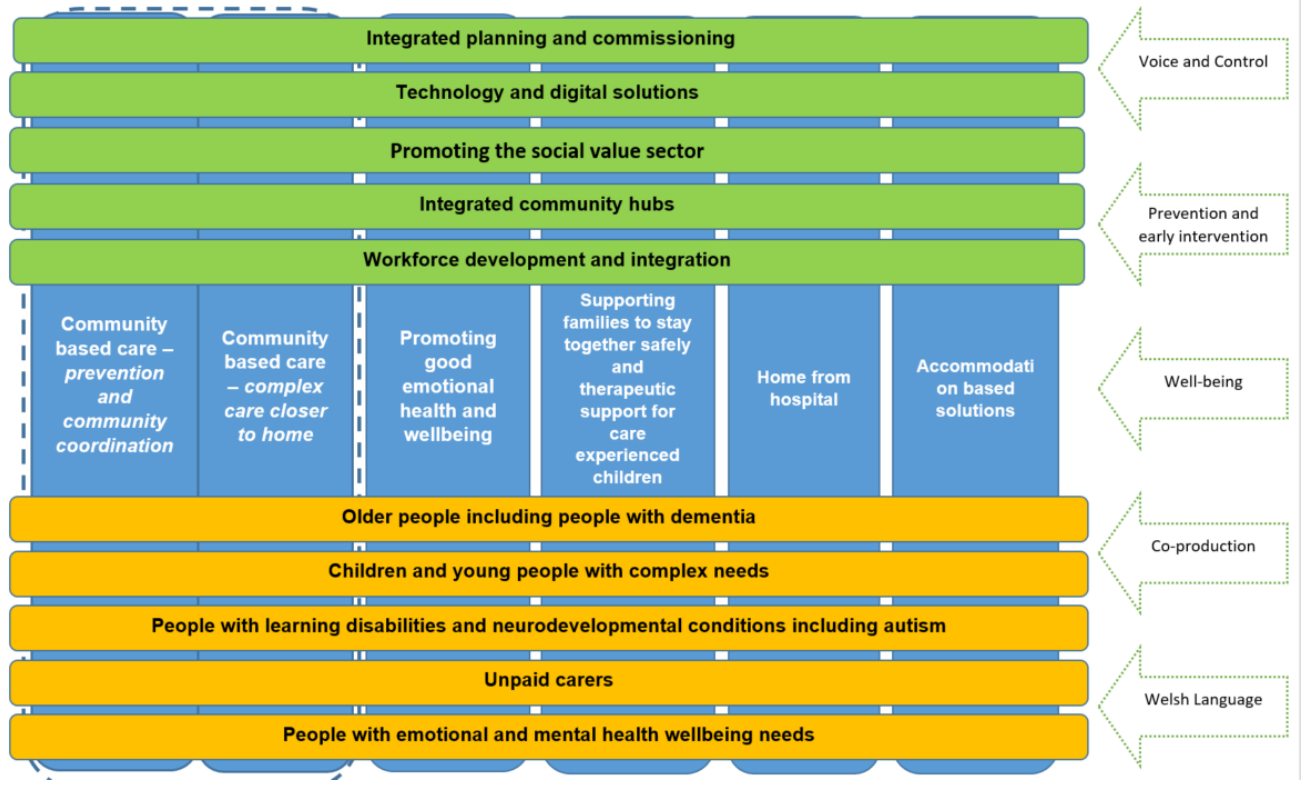
RIF is a tapered fund and partners must agree and commit resources to ensure that the project or model of care will be sustained long term. After the 5 years of the RIF, Welsh Government's vision is for an 'Integrated Mainstreaming Fund'; this fund will take the shape of a recurrent pooled fund with partners contributing 50% and Welsh Government contributing the remaining 50%.

All projects within our programmes are required to evidence match funding based on the intervention rate outlined above.

Models of Care
RIF has identified six models of care based on experiences and learning from the ICF and TF and through extensive engagement and co-design work with RPBs and key partners.

The 'models of care' are set out by Welsh Government in the six blue pillars in the diagram below:

Models of care, enablers and population groups



In designing each of the national models of integrated care, RPBs must consider how they will meet the specific needs of the above population groups. Some models of care will inevitably support some population groups more than others, however most of the model should be developed to meet the needs of all of these population groups.

All investment proposals under RIF must fit within one of the 6 models of care set out in the above framework. In West Wales, the approach taken is to develop programmes around each model of care and has been welcomed by Welsh Government.

This will be an opportunity to align the programmes of work that already deliver good outcomes in West Wales within a framework that maximises benefits across population groups.

Progress to date

In January 2022, a Funding Transformation Steering Group was established, comprising representation from all partner organisations, including third sector leads, to oversee the transition to and implementation of the RIF in West Wales. The group met weekly and aimed to deliver the key objectives including:

- Evaluate all projects funded via TF/ICF in West Wales.
- Identify the continuation or exit strategy for all projects funded via TF/ICF.
- Develop investment proposals in line with Welsh Government guidance for the RIF for 2022-2027.
- Identify or develop a Memorandum of Understanding and suitable governance arrangements to support the implementation of the new funding agreements.
- Secure match funding requirements from partners.
- Ensure there are robust business plans in place to support the development, implementation and review of new investment proposals.
- Identify new proposals for investment.

- Advise the Integrated Executive Group and RPB of risks and mitigating actions.

The group has acted as the regional coordination point for activities that have been undertaken on a county basis and those undertaken by the following regional groups:

- West Wales Carers Development Group
- Regional Improving Lives Partnership
- Children's Group
- Dementia Steering Group

Work has been undertaken to develop a 'Key Features' financial guide with the Health Board finance team and establish a schedule for reporting. A Memorandum of Understanding is also under development.

The group has coordinated the development of **6 programmes** comprising of existing projects, which have been remodelled to fit within RIF and new projects for investment. These are provided within the RIF Investment Proposal Document, attached at Appendix 1.

National Priorities
In addition to the 6 new programmes, Welsh Government has maintained investment in their national priorities, which are 'ringfenced' allocations. These are:

- **Carers -** RIF guidance states that RPBs will be expected to invest a minimum of 5% of the RIF into direct support for unpaid carers in 2022/23. In addition, a further £121,000 has been allocated as a ring-fenced National Priority to specifically fund activity to improve the involvement of unpaid carers in hospital discharge processes. In addition to the national priority funding, the West Wales Carers Development Group has developed the following RIF projects:
    - Carers breaks: Promoting good emotional health and wellbeing
    - Income Maximisation
    - Investors in carers
    - Discharge Support Service

  These are incorporated within the 6 programmes and reach the 5% target of £788,652 set within the guidance. The plan also supports the investment in services delivered via third sector partners. This approach will allow us to deliver on the priorities within the West Wales Carers Strategy and will ensure the needs of carers are considered across each of our programmes, avoid duplication and maximise the impact of RIF investment.

- **Dementia & Memory Assessment -** The Dementia Steering Group oversees an established programme of work. This has delivered a number of projects, including:

    - Expanding community-based memory assessment services
    - Establishing a team of Admiral Nurses
    - Establishing a regional community dementia well-being team
    - Developing a regional dementia strategy
    - Developing a regional dementia training framework
    - Co-designing a person centred community-based wrap around care and support pathway

  The West Wales Dementia Strategy is in the process of being approved by partners. The strategy will ensure that we focus on further refinement of integrated service model/ care

pathway delivering community-based person-centred, wrap-around, diagnosis, care and support, particularly post-diagnostic support and coordination for people living with dementia, their family and carers. There will also be a further refinement of initiatives to encourage early diagnosis and improve diagnosis rates by 3% per annum.

These projects will continue and be aligned and incorporated within our 6 programmes to avoid any duplication and maximise investment. The Dementia Programme will be overseen by a dedicated Programme and Change Manager who came into post in May 2022.

- **Integrated Autism Service -** The Integrated Autism Service (IAS) is a joint service delivered by the Health Board and the 3 Local Authorities. The service provides adult autism diagnostic assessment, support and advice for autistic adults, parents/ carers, and professionals. The delivery of the service is overseen by the West Wales Strategic Autism Group. The group also oversees the implementation of the Code of Practice for Autism in West Wales and provides a report to the RPB twice each year. The IAS will continue to be overseen and delivered in this way.

- **Project and Programme Management -** RIF recognises that it is essential that all RPBs have adequate resources and infrastructure arrangements to support delivery against the collective duties and expectations placed on them under the Part 9 duties of the SS&WBA.

  The West Wales Care Partnership Team has been funded originally via local authority Regional Collaboration Fund. In addition, a 'top slicing' of ICF and TF funds has been used to provide capacity to deliver new initiatives. This has established a core team of staff.

  In addition, the West Wales Transformation Programme developed the programme management capacity in establishing a Transformation lead role in each county. These posts have held a local lead role as well as having regional responsibility for particular aspects of the Transformation Programme. RIF also allows for Project Management costs, which can be supported from within RIF to be funded at 100%.

  In order to support the delivery of change, Transformation Lead posts have been extended initially until 31st March 2023. The Regional Partnership Programme Manager Post is a secondment for up to 12 months from December 2021. The WWCP Team continue to oversee and support Programme Management for some 'Enabling' workstreams including integrated commissioning, workforce and capital programmes. They will also provide Project Management capacity for a number of initiatives, including capital projects and the NEST Framework.

  WWCP has wider responsibilities beyond RIF to support the work of the RPB, including the commissioning and production of the Population Assessment and Market Stability Reports, the Annual Report and the West Wales Area Plan in March 2023. The focus of the Local Transformation Leads will be supporting the implementation of the RIF programmes and supporting other partnership activity as required. These details are set out below.

WWCP Team	**Local Transformation Leads**
1. Finance and Performance Management 2. Partnership Governance 3. Engagement	1. Local Implementation 2. Project Management and partner support 3. Financial Management

4. Programme Management and Project Support 5. Service Improvement	4. Alignment with local priorities developments

These arrangements will continue and fall within the available budget of RIF and LA contributions. A detailed review of the functions of the WWCP has been undertaken which will allow a permanent structure to be confirmed and agreed by partners.

Regional Allocations and next steps

The requirement for match funding from partners and the need to provide assurance to local partners that they are receiving a fair allocation for their population has driven the decision making at a county level.

As a guide, the county values agreed under ICF, and based on population, were used to determine a fair allocation:

- Ceredigion 20%
- Carmarthenshire 48%
- Pembrokeshire 32%

A level of over commitment for this year has been agreed. This will be covered via slippage as projects will not commence from April 1st. The level of over-commitment does need to be examined by each county and decisions made in respect of local priorities.

RIF Project	Allocation	Plan 100%	Plan 90%	Plan 75%	Plan 70%	Total Plan	Match / Over / Under Commitment *
National Ringfenced Fund	2,152,000.00	2,152,000.00	-	-	-	2,152,000.00	-
IAS	398,000.00	398,000.00				398,000.00	
Dementia	1,249,000.00	1,249,000.00				1,249,000.00	
Memory Assessment Services	384,000.00	384,000.00				384,000.00	
Unpaid Carers Hospital Discharge Engagement	121,000.00	121,000.00				121,000.00	
RegionalInfrastructure Fund	750,000.00	-	-	1,158,072.00	-	1,158,072.00	408,072.00
Regional Infrastructure Fund (75% up to £750,000)	750,000.00			1,158,072.00		1,158,072.00	
New model development and national embedding fund	15,773,040.00	599,634.02	4,666,965.40	-	13,322,593.48	18,589,192.90	2,816,152.90
1 Place based care – Prevention and community coordination			773,181.00		2,539,545.44	3,312,726.44	
2 Place based care – complex care closer to home			1,195,206.51		1,459,712.34	2,654,918.85	
3 Promoting good emotional health and wellbeing			1,054,535.00		320,071.76	1,374,606.76	
4 Preventing children entering care and supporting children to remain with their families			431,967.00		1,569,565.00	2,001,532.00	
5 Home from hospital			1,212,075.89		5,905,060.82	7,117,136.72	
6 Accommodation based solutions					1,528,638.12	1,528,638.12	
New Model Development 90% WG Funding	4,731,912.00						
National Embedding Fund 70% WG Funding	11,041,128.00						
Regional Project Management **		599,634.02				599,634.02	
Grand Total	18,675,040.00	2,751,634.02	4,666,965.40	1,158,072.00	13,322,593.48	21,899,264.90	3,224,224.90

* County Leads have been issued with the Accountibility letters and will prioritise approved schemes and provide detailed project information to ensure themes are within funding envelopes.

** RIF makes provision *for programme management costs associated with direct delivery to be 100% funded from the New Model and Embedding Fund. Within West Wales we have taken the approach of our Programme/Project Management officers being embedded within the Integrated Locality systems. Along with Transformation Leads they will support the implementation of our RIF programme across all population groups and each of our six programmes.*

Investment Proposals have been submitted to Welsh Government on 11th June 2022 for scrutiny and feedback. They will also be evaluated independently. The feedback will be considered by our Performance and Finance group, which will report directly to IEG/RPB.

Argymhelliad / Recommendation

The Committee is requested to take assurance from the plans for the Health and Social Care Regional Integration Fund (RIF) for the West Wales Region, as outlined in this paper.

Amcanion: (rhaid cwblhau)
Objectives: (must be completed)

Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	Sustainable Resources Committee
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	N/A
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	1. Staying Healthy 3. Effective Care 4. Dignified Care 5. Timely Care
Amcanion Strategol y BIP: UHB Strategic Objectives:	5. Safe sustainable, accessible and kind care 6. Sustainable use of resources 4. The best health and wellbeing for our individuals, families and communities
Amcanion Cynllunio Planning Objectives	4C Transformation fund schemes 4J Regional Well-being Plans 5H_22 Integrated locality plans 5J_22 24/7 emergency care model for Community and Primary Care
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2018-2019	8. Transform our communities through collaboration with people, communities and partners 4. Improve Population Health through prevention and early intervention, supporting people to live happy and healthy lives 2. Develop a skilled and flexible workforce to meet the changing needs of the modern NHS Choose an item.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Social Services and Wellbeing (Wales) Act
Rhestr Termau: Glossary of Terms:	Contained within the body of the report
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Adnoddau Cynaliadwy: Parties / Committees consulted prior to Sustainable Resources Committee:	N/A

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	The financial context is set out within the body of the report

Ansawdd / Gofal Claf: **Quality / Patient Care:**	The RIF aims to support and enhance community based care and the emotional health and well-being of our population. Further it supports families to stay together safely, care experienced children, home from hospital services and accommodation based solutions. The expectation is that the utilisation of the RIF will closely align to other key strategic programmes in West Wales to help create a whole systems approach. In particular, the Accelerated Cluster Development and the Unscheduled and Emergency Care Policy Goals as well as our regional priorities.
Gweithlu: **Workforce:**	The RIF supports the recruitment of workforce to deliver regional initiatives. Sustaining this workforce through core organisational funding will need to be aligned to their planning cycles.
Risg: **Risk:**	Partners must agree and commit resources to ensure that the project or model of care will be sustained long term.
Cyfreithiol: **Legal:**	As outlined in the report RIF requires administration and delivery against the collective duties and expectations placed on them under the Part 9 duties of the Social Services and Well Being (Wales) Act 2014 (SS&WBA).
Enw Da: **Reputational:**	Not Applicable
Gyfrinachedd: **Privacy:**	Not Applicable
Cydraddoldeb: **Equality:**	EqIA screening is undertaken with any new initiative or change in existing provision as routine.

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WEST WALES Regional Partnership Board

Regional Integration Fund (RIF) Investment Proposal 2022-23

Content

Health & Social Care Regional Integration Fund

Investment Proposals

West Wales Strategic Plan

Regional infrastructure

West Wales Care Partnership Team support the Regional Partnership Board in delivering their vision of integrated health and social care in West Wales.

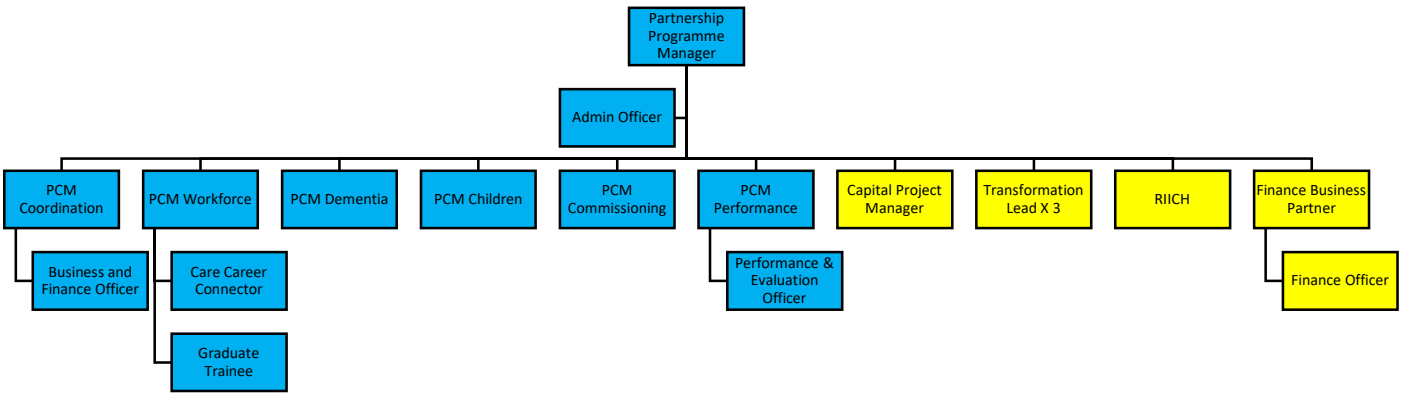
This includes the production of the Population Assessment, Market Stability Report and Area Plan. The team provide strategic programme and project management capacity in relation to grant funded initiatives which have included the Integrated Care Fund (ICF) and Transformation Fund (TF). The team also support and facilitate a range of local initiatives in West Wales and have a lead role in facilitating the work between partners.

The team has been funded through the Delivering Transformation Grant with additional capacity through the ICF & TF. The RIF now provides additional resource which will enable us to consolidate the existing team and create additional capacity to deliver the ambitions of the RPB.

The team is overseen by a dedicated Programme Manager. The team fulfil the business functions of managing finance, communications, and performance on behalf of the RPB, including the management of the RIF. The team are supported by a small business and admin resource with a dedicated budget for commissioning and supporting activities to promote the work of the RPB. The core team are hosted by Carmarthenshire County Council with finance officers employed by Hywel Dda University Health Board who act as bankers for the RIF.

The core team consists of Programme and Change Managers and Project Managers. These posts hold dedicated portfolios of work and will support the strategic programmes of change and delivery of the RPB. Each of our 6 RIF programmes will have dedicated programme management capacity.

In addition to the core team the Transformation Lead roles are a vital link to the county-based delivery of the regional programmes. They are hosted within each of our county integrated structures. They champion the transformation of services in their locality and ensure that each programme is delivering the expected outcomes set out within our investment proposals and embedded within local integrated networks of service delivery. The current team composition is set out below:



RIF will allow us to review and formalise the structure above for the next 5 years. This includes the capacity to create and recruit 2 additional Project Managers who will lead our implementation of key initiatives, including NYTH/NEST.

We will also this year develop our integrated Capital Programme Office to maximise the delivery of the Housing with Care Fund (HCF) and the opportunities through the Rebalancing agenda.

Direct Programme/Project Management Costs

RIF makes provision for programme management costs associated with direct delivery to be 100% funded from the New Model and Embedding Fund. Within West Wales we have taken the approach of our Programme/Project Management officers being embedded within the Integrated Locality systems. Along with Transformation Leads they will support the implementation of our RIF programme across all population groups and each of our six programmes.

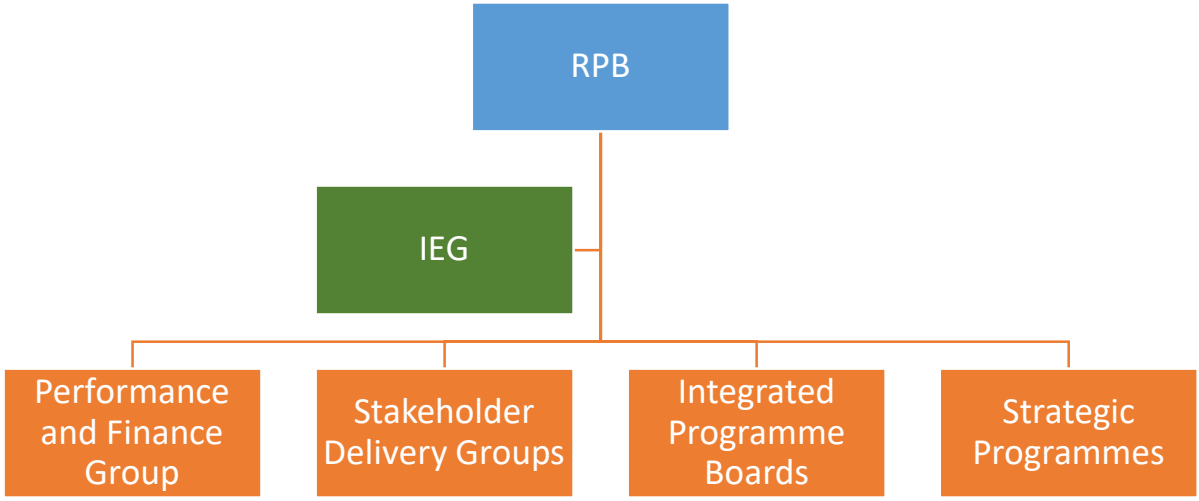
The summary of our resource is as follows:

Posts / type of roles	Estimated FTE	Sum of Total
Business Analyst	1	£44,858
Project Management	6	£361,531
Project Support	5	£193,245
Grand Total	**12**	**£599,635**

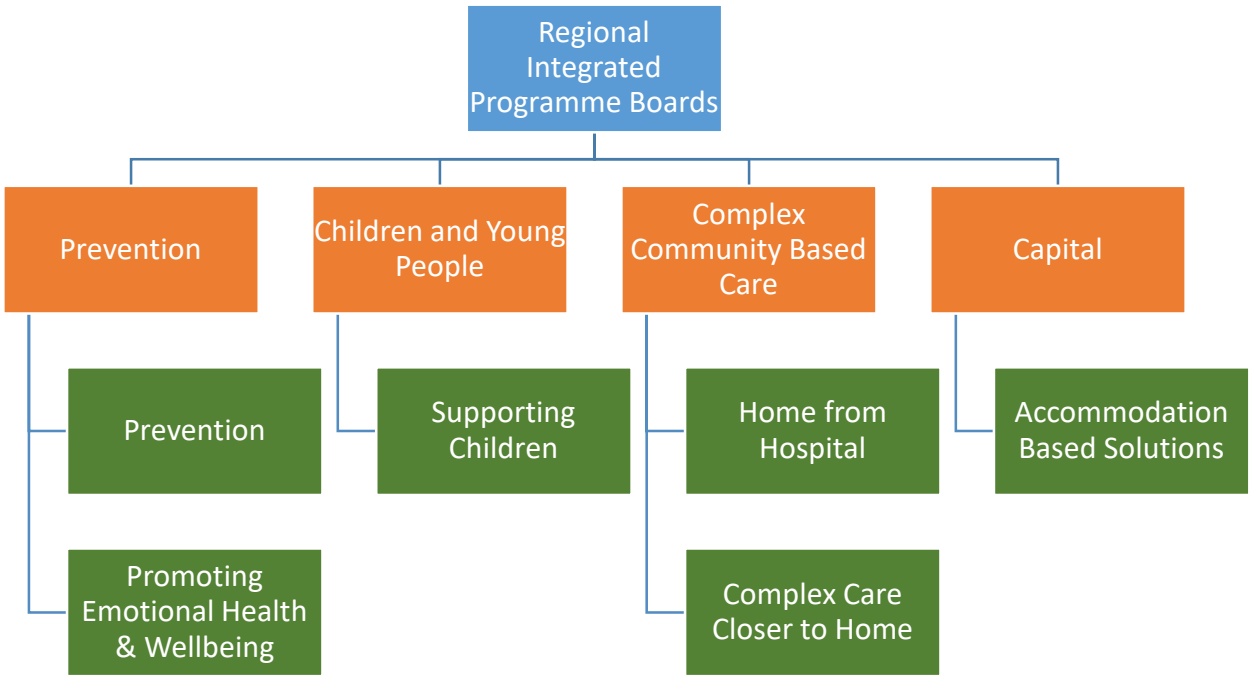
Governance

In West Wales we are reviewing our governance arrangements to oversee the work of the RPB. This will be aligned with our local arrangements for the delivery of our Healthier West Wales strategy, Accelerated Cluster Development & Unscheduled and Emergency Care Goals. Our aim is to streamline existing structures and move away from arrangements led by funding.

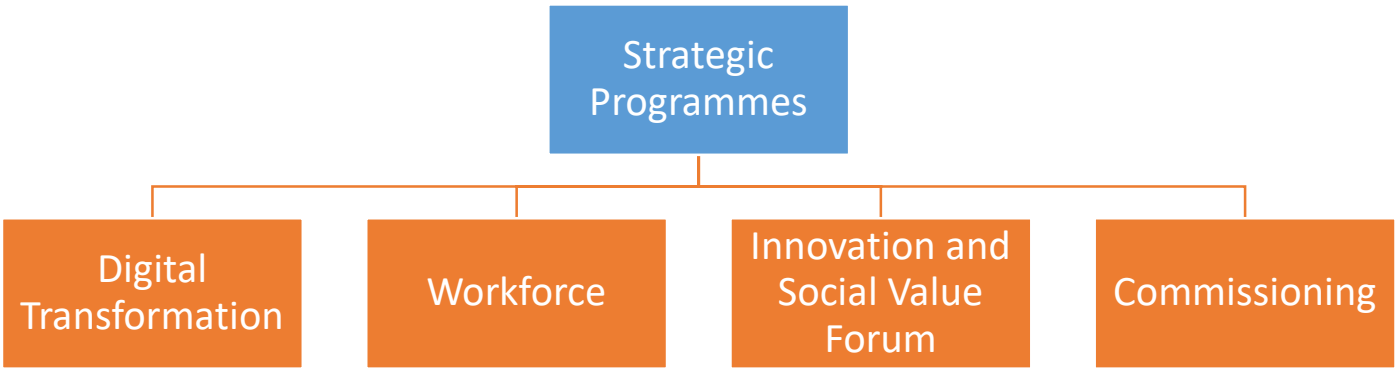
The below is a draft of the structure we plan to employ.



1. IEG our Integrated Executive Group oversees executive function of the performance, finance and commissioning, in order to provide assurance to RPB
2. Strategic **Enabling** Programmes support the transformation and implementation
3. Regional **Integrated Programme Boards** oversee the delivery of RIF Investment proposals and are integrated with other core programmes.
4. Stakeholder Delivery groups oversee delivery of area plan or strategies for specific population groups and ensures user voice heard at RPB and in the development and delivery of services.



Integrated Programme Boards will oversee the implementation of the RIF programmes and be chaired and led by IEG members/Exec Sponsor.



The strategic programmes will build on the work already underway in West Wales and cut across our delivery programmes. These will be supported by the partnership team.

Regional continuous engagement strategy

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APPENDIX TWO: THE WEST WALES CARE PARTNERSHIP CONTINUOUS ENGAGEMENT FRAMEWORK

The framework aims to support any community engagement with:

- Better dialogues and evaluation
- Enabling communities to lead
- Being more efficient and effective
- Reducing need for 'big bang' engagement
- Integrating consultations where needed

The Framework was developed by the West Wales Care Partnership with HICo. It sets out the stages needed to ensure ongoing dialogue between communities and

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The framework complements and integrates with formal consultations so that best practice is shared across all engagement and consultation.

There are a range of enablers needed to ensure the framework becomes common practice.

Enablers

Coordinating Groups

- Share reasons and plans much earlier
- Engagement Groups exist these can be used for coordinating and planning
- Embedding the groups in governance e.g. PSBs and RPBs
- Protocols if work is being duplicated – who will change their plans?

Senior leadership buy-in

- Continuous Engagement needs to support work, not create work
- Needs to ensure national policy requirements on involvement are met
- Make strategy development easier – wellbeing and population insights will already be already known, no new engagement

Commitment to joint working

- Flexibility and compromise in planning
- Sharing information routinely
- Acceptance of others' reports and findings
- Accountable in governance
- Evaluation of service change
- Monitoring and evaluation of the Continuous Engagement Framework

Inclusive for wider system partners

- Feedback gathered that is relevant to others is not routinely shared with relevant partners, e.g. health engagement that gathers feedback on housing and benefits is not shared with relevant departments
- Sharing information and resources helps efficiency and effectiveness

Repository for insight and reports

- Lots of reports and analysis exist, but not shared in a consistent way, sometimes not at all
- A searchable repository could mean Listen stage looks at what is already known – may not need to repeat the listening and go straight to analysis

Resources

- Most resources focussed on Reason, Listen and Analyse stages
- Could these be desktop exercises using what is already known?
- Resource can then be moved to Check Understanding, New Input and Options & Solutions stages
- A Regional Coordinating/signposting role, could help coordinate activity

Continuous Improvement Culture

- Adopt a Continuous Improvement approach rather than big service change
- Support for teams and communities to embed new ways of working
- Move away from gathering insight and build experience of techniques around dialogue and discussion
- New project management techniques
- Focus on evaluation and lessons learned
- Self-assessment process for partners to assess how much they already have in place to enable continuous engagement and what they need to do

Data permissions

- Engagement uses GDPR permissions that allow going back to the person about the same or new issues
- Partners build 'virtual citizen assembly' databases

Population Needs Assessments

Our Investment Proposals seek to address the recommendations from of our Population Assessment. These recommendations will be incorporated into our area plan for 2023 onwards. The executive summary and recommendations are as follows:

1. OLDER PEOPLE

   Overview and key messages

West Wales has a higher proportion of older people than average across Wales, with inward migration a major accelerating factor for the growth of the older population. Pembrokeshire has an older population than Carmarthenshire and Ceredigion, with a projected regional increase in those 85 and over of 28% by 2030, with variation as follows: Carmarthenshire=25%; Ceredigion=26% and Pembrokeshire=33%.

People are living longer with increasingly complex issues, whilst wanting to remain in their own homes as independently as possible for as long as possible. COVID-19 has had a significant impact on the physical and mental wellbeing of older people. This is as a result of long periods of social isolation, lack of access to health and care services as well as the direct impact of contracting COVID-19.

Care and support arrangements should be designed with older people, should be flexible and include a range of community, digital and technology-based solutions.

Gaps and areas for improvement

Include:

- Involving older people and their carers in assessment and care planning, including discharge planning
- Helping people to remain independent in their homes for longer through continuing development of digital and telehealth support particularly for those in very rural areas and where transport is an issue
- Providing additional support for carers managing multiple and complex conditions
- Continuing development of community connectivity, well-being and resilience services that address a range of needs including loneliness and isolation
- Increasing supply of alternative accommodation options such as extra-care schemes.
- Ensuring older people and their families can access services through their language of choice and the active offer through the medium of Welsh is available.

The impact of COVID -19:

The COVID-19 has led to widespread social isolation, with lasting implications on mental health of older people. People have delayed seeking help during the pandemic and now are presenting with much more complex health issues.

Due to the reported mortality rates in residential care older people are now far more reluctant to go into residential care creating a greater demand for alternative accommodation.

2. DEMENTIA

Overview and key messages

As life expectancy and inward migration of older people impacts on the percentage of older people in the region, the number of People Living with Dementia (PLwD) in West Wales is expected to increase in the coming decades.

The Dementia Action Plan for Wales (DAP) 2018 – 2022 sets out a clear vision for "Wales to be a dementia friendly nation that recognises the rights of people with dementia to feel valued and to live as independently as possible in their communities."

Our West Wales Regional dementia strategy is being produced and will inform the development of person-centred dementia pathways, co-produced with users and carers.
(*a link to which will be included once is has been approved*).

Key messages are as follows:

- The incidence of dementia on the Quality Assurance and Improvement Framework (QAIF) disease register in Hywel Dda in 2019-20 was 0.7%, in line with the Welsh national average of 0.7%
- In 2016-17 dementia diagnosis rates were one of the lowest in Wales at 45.6% indicating that prevalence rates are likely to be closer to 1.4% although, the number of those diagnosed has increased an average of 3% per annum to 2947 in 2020.
- Over thirty genetic, medical, lifestyle, cultural and societal factors have been identified, which impact the risk of cognitive decline differently depending on gender. Some of these factors increase risk more dramatically in women than in men.

Gaps and areas for improvement

Include:

- Continuing to improve awareness, identification, and diagnosis of dementia, including onset of dementia in younger people
- to ensure timely diagnosis and access to appropriate care and support
- Improving co-production of services by including PLwD
- Increasing diagnosis rates in non-specialist community settings by:
    - Improving training and awareness of new evidence-based best practice dementia models within primary care, based on the Good Work Framework
    - Supporting GPs, allied health professionals (AHPs) and nurses to make assessments
    - Improving quality of referrals into specialist care for those requiring it
- Developing more consistent rights-based person-centred care and support

- Continuing improvements in community support, training and help for PLwD to discuss their diagnosis, navigate/co-ordinate services, to build resilience and maintain balance across all aspects of their life
- Ensuring equal access to physical health services and treatment for PLwD
- Ensuring advance care planning and end of life care is fully embedded in wider inclusive, person-centred care and wellbeing planning
- Improving research into dementia by involving care homes in the region in current research opportunities
- Continuing the development of a "hub" or single point of contact approach for PLwD to access information and support.

The impact of COVID -19:

COVID-19 has had a disproportionately negative impact on PLwD, with dementia being shown as an age-independent risk factor for severity and death in COVID-19 patients.

Although the exact impact on the diagnosis and incidence rate of dementia is unclear, stakeholders have identified that COVID-19 has impacted timely diagnosis due to late presentations.

Full information on the impact of COVID-19 upon those with dementia and their carers is not yet available. However, there is some concern that it may cause damage to the brain in the longer term.

3. UNPAID CARERS

Overview and key messages

2011 ONS Census data indicates there are more than 47,000 known unpaid carers across West Wales, of which, 3,436 were Young Carers (defined as 5-17 years old), representing 12.5% of residents. It is recognised also that there is a considerable number of 'hidden' carers who do not define themselves as such.

Early identification and self-identification of unpaid carers is vital to ensure they access the right help and support at the right time, as well as maintain their own health, well-being and independence.

Support for unpaid carers in West Wales is driven through the West Wales Carers Development Group (WWCDG), a formal sub-group of the West Wales Regional Partnership Board (RPB) and a partnership between Hywel Dda University Health Board, the three Local Authorities of Carmarthenshire, Ceredigion and Pembrokeshire, Third and Voluntary sector organisations and representatives of service users and Carers in West Wales.

The Regional Partnership Board published their Carers Strategy in November 2020. WWCDG West Wales Carers Strategy 2020-2025 The West Wales Carers Development Group (WWCDG) are responsible for ensuring that an annual action plan is in place to respond to the key priority areas.

Gaps and areas for improvement

Highlighted during the engagement session include:

- Continuing improvements in the consistency of approach, information, advice and assistance provided across the region, within a more integrated system
- Reviewing information provided to carers to ensure it is current, relevant, more accessible and easier to find
- Extending use of social media and technology to identify and provide information to carers and maintain regular contact, particularly for young carers
- Developing a single point of contact to help people navigate the system
- Ensuring respite care fits the needs of both the carer and the cared for
- Addressing the challenges of accessing support in rural areas
- Improving the statutory carers assessment process, which can be challenging, often takes too long and may not always consider carers needs appropriately
- Improving delivery of the "active offer" through the medium of Welsh. Carers want to feel comfortable using their preferred language of choice, including languages other than English and Welsh

Young carers report:

- They struggle to have a break, are not seeing their friends and don't have their own space.
- They find it difficult to balance schoolwork, homework and their caring role and can feel stressed, worried and anxious at school, as they are away from the person that relies on them for care
- They may require extra support for their mental health and wellbeing.

The impact of COVID -19:

Caring is such an important part of life and the role of unpaid Carers has become increasingly prominent. A significant number of unpaid carers have sought support with their caring role and in an on-line survey circulated as part of the process to develop the PA, many carers reported:

- Feeling isolated during the pandemic
- Being cautious of people coming into their homes due to the risk in virus transmission, with many choosing to suspend domiciliary care, putting further strain on their wellbeing and mental health
- Experiencing financial pressure, as they have had to take more time off work to support the person they care for
- Concern over the adverse effect of limited social contact on the well-being of loved ones in hospitals and care homes, due to strict visiting restrictions
- Young carers missed the break from caring and social interaction with peers that schooling (suspended during lockdown) usually provides
- Improved access to support due to the increased availability of on-line services in response to the pandemic.

4. LEARNING DISABILITY

Overview and key messages

The population of People with a Learning Disability (PwLD) in West Wales is projected to remain relatively stable. However, projections suggest the number of people diagnosed with severe or profound and multiple learning disabilities (PMLD) is expected to grow by 1.8% each year. The number of older people with a learning disability is set to increase.

PwLD often have additional diagnoses and/or co-existing conditions such as: autism; physical disabilities; sensory and communication impairment. They are more likely to experience poorer physical and mental health and multiple morbidities, often linked to poor diet, low levels of physical activity, smoking, alcohol use and difficulties in accessing preventative health services.

Through the Regional Improving Lives Partnership, PwLD have worked together with partners to develop the West Wales Charter – a simple list of things they expect, and need, to live fulfilling lives, which is supported by the Welsh Government; County Councils of Carmarthenshire, Ceredigion and Pembrokeshire, Hywel Dda University Health Board and a range of community and 3rd sector organisations.

Gaps and areas for improvement

Include:

- Improving awareness of the needs of PwLD and through training and education of service providers, healthcare workers, families and carers
- Improving the quality of communication with and information for PwLD (easy read)
- Widening access to supported accommodation in a location of choice
- Strengthening access to education, volunteering and paid work opportunities in local communities
- Improving processes for managing transition between children's and adult services and specialist health services
- Supporting self-advocacy for PwLD
- Increasing planning and resources for PMLD and their carers.

The impact of COVID -19:

COVID-19 has had a particular effect on mental health, well-being, health and feeling of isolation for PwLD and their care and support network. There has been a significant impact upon services and care available, such as day opportunities and short breaks which has significantly impacted their health and wellbeing.

Many PwLD have been required to shield during the pandemic, limiting their opportunities to contribute to many of the consultations and planning events around services in LD, including the development of the PA.

5. AUTISM

Overview and key messages

Autism is a term used to describe people with a group of complex neuro developmental symptoms, of variable severity which affects how people communicate and interact with the world. Autism is generally described as a spectrum and can cover a wide range of behaviours and needs. Autism was covered under the Learning Disability chapter in the 2017 PA however, in response to the introduction of the Autism Code of Practice in 2021, a separate Autism chapter is being developed.

The term 'autistic people' rather than 'people with autism', reflects the language preferences expressed by autistic people. The term 'people' refers to children, young people and adults.

Estimates of the prevalence of autism spectrum disorders suggest rates of around 1% in the general population. This would suggest there are about 4000 autistic people living in West Wales. However, there is much debate and the suggestion that not all individuals are identified[1]

New services for adult diagnosis have been set up across Wales at a time of rising awareness of the spectrum of autism experiences; however, until recently no studies have examined adult autism prevalence in Wales

Increased rates of diagnosis and more prevalence of autism will require more specialist support in the community.

Feedback from engagement meetings across the region identified the following:

Gaps and areas for improvement:

- Improve waiting times for diagnosis and diagnosis rates for both children and adults
- Improve access to information and advice for Autistic people and their families, including the autism strategy and the associated support services available in West Wales.
- Improve awareness of Autism and the Autistic Spectrum Conditions across health, social care services, education and all public services.
- Greater emphasis on user engagement and coproduction in service development
- Improving the transition for Autistic Young people when they leave school
- Increasing opportunities for volunteering, work experience, employment opportunities and networking for autistic people.

The impact of COVID -19:

The pandemic has impacted on the care and support available for autistic people as many support services were paused. In addition, the uncertainty and frequent changes to routines and rules will, in some cases have had a significant impact upon people's mental-health and wellbeing. This has placed increased pressure on family members and carers.

For Autistic People the resumption of and reintegration to activities such as education following prolonged periods of lock down has also presented significant challenges.

6. CHILDREN AND YOUNG PEOPLE

Overview and key messages

[1] (Brugha et al., 2011, 2016; Chiarotti & Venerosi, 2020; Fombonne et al., 2021; Lyall et al., 2017).

There are over 82,000 children and young people in the region, approximately 22% of the total population. Although the population of children and young people up to the age of 25 will remain relatively stable, the number of children aged 10-15 in the region is expected to decline by 8% by 2031. It is estimated that 6,105 children and young people live with a long-term condition or disability.

Children and young people are considered under the following three groups:

- Up to the age of 18
- Up to the age of 21 if they've been in care
- Up the age of 25 if they've been in care and are still in education

The region has a lower number of looked After Children (LAC) than the national average. The Capped 9-point score (Year 11 pupils' best 9 results from qualifications available in Wales) is 361.7, above the Wales average of 353.8.

At 14%, the number of young people not in education, employment or training in West Wales is marginally lower than the Welsh average.

Gaps and areas for improvement:

Include:

- Further integration with early years services
- Involvement of children and young people, including care experienced young people and those with complex needs such as disability in the planning of services.
- Further development of preventative and early intervention services, building on established programmes such as Family Information Services, Families First and Team Around the Family and trauma informed models of support
- Considering the importance of physical, mental and emotional wellbeing of children and the key role of community services play in achieving this
- Enhancing partnership working to deliver a *'No Wrong Door'* approach to services so that children and young people receive the support they need regardless of where they enter the system.
- Developing resilience and wellbeing in families to enable children and young people to remain within their families and/ or communities so long as it is safe for them to do so
- Continuing development of multi-agency and individualised approach to supporting children with complex needs
- Developing a regional transition process for children and young people into adult services where appropriate.

The impact of COVID -19:

Children and Young People's Mental Health and Wellbeing has been significantly affected during the pandemic. School closures, quarantine periods, fear of becoming unwell and impact upon older relatives are factors that have contributed to a decline in their Mental Health and Wellbeing.

In addition, Children and Young People from areas of poverty were subject to increased risk of poor Mental Health and Wellbeing. Contributing factors included the increased worry of parent financial insecurity, lack of social support, housing quality and poor nutrition.

Children's Social Services have maintained face-to-face contact for children identified as at risk throughout the pandemic. However, enforced absences form school and time at home has presented significant challenges in identifying and responding to risk.

The region has experienced a rise Children and Young People seeking support with complex emotional and mental health difficulties, including behaviours that challenge.

7. MENTAL HEALTH

Overview and key messages

Our mental health affects how we think, feel and act. A healthy outlook can reduce both the intensity and duration of illnesses, whereas poor mental health can have the opposite effect. It has been shown that depression and its symptoms are major risk factors in the development of coronary heart disease and death after myocardial infarction. Stigma surrounding mental illness is common and can play a role in people potentially hiding issues surrounding their mental health rather than seeking help, which can be mitigated through increasing the information, education and public awareness.

According to the Welsh Government's Together for Mental Health Strategy:

- 1 in 4 adults experience mental health problems or illness at some point in their lifetime.
- 1 in 6 adults are experiencing symptoms at any one time.
- 1 in 10 children between the ages of 5 and 16 has a mental health problem, and many more have behavioural issues.
- Approximately 50% of people who go on to have serious mental health problems will have symptoms by the time they are 14 and many at a much younger age.

The Hywel Dda Mental Health Quality and Outcomes Framework (QOF) register records approximately 4,100 patients in 2019.

Through a range of facilitated engagement sessions we were able to identify:

Gaps and areas for improvement

- Improving integration and communication between services, so that patients with multiple issues have access to the range of support and care needed
- Improving processes for those experiencing crisis, to reduce instances where patients in crisis have difficulty accessing services
- Promoting and supporting self-management by educating people on how to manage their conditions, live more independently and make their own choices.
- Shifting the emphasis to community-based services

- Recognising the effect of COVID-19 and the resulting increased demand for mental health services.

The impact of COVID -19:

COVID-19 has led to increased isolation and a disruption of normal life, which could have short term effects on mental health. It is not clear what the long-term effects of COVID on mental health and wellbeing might be however, in the period immediately before the pandemic, it was reported that 11.7% of Welsh people suffered from severe mental health issues, which reportedly climbed to 28.1% in April 2020.

COVID-19 has also had a worse effect on particular on those groups who already experience poor mental health outcomes, including those from black and minority ethnic backgrounds, those with existing physical or learning disabilities and those in areas of high poverty.

8. HEALTH AND PHYSICAL DISABILITIES

Overview and key messages

Most people in the West Wales region between the age 18 to 64 will not access care and support for a specific need or protected characteristic. Instead, they are served by public health information and national and local programmes designed to encourage healthy lifestyles and practices. These programmes are aimed at reducing specific health risk factors such as cardiovascular disease, often achieved by strategies to reduce obesity and smoking and improve diets.

There are a proportion of people who have a range of specific needs because of physical disability or chronic health conditions that may require extra support to enable them to live as independently as possible.

Gaps and areas for improvement

identified through engagement include:

- Involving people with a range of disabilities at the planning and design phase of new developments and accommodation, to ensure they are easy to use and accessible.
- Improving early identification, treatment and management of preventable and chronic conditions including diabetes, heart disease and respiratory illness, to improve long term well-being and reduce complications.
- Improving appropriate access to a range of information, advice and assistance.
- Increasing use of assistive technology, such as telecare to transform domiciliary care and supported living services
- Improving access support for assisted living. Many of the current rules and regulations about supporting and helping people with disabilities are too rigid.
- Improving access to and communication of financial support such as personal independence payments, disabled facilities grant, direct payments
- Improving the process for home improvements and modifications.
- Increasing the flexibility of step up and down provision to respond to changing needs

- Improving access to transport.

The impact of COVID -19:

COVID-19 has led to widespread social isolation, with lasting impact on physical and mental health for those people having to shield during the pandemic.

People will struggled to access or delay seeking help during and are now presenting later, with much more complex health issues often resulting in worsening comorbidities and prolonged illness.

9. SENSORY IMPAIRMENT

Overview and key messages

Sensory impairment is inevitable with ageing. As sensory impairment can be a significant life-limiting condition, the challenges associated with the condition are likely to grow over the coming decades.

People with sensory impairment are more likely to feel lonely and isolated. Research by RNID in 2000 found that 66% of deaf and hard of hearing people feel isolated due to their condition excluding them from everyday activities.

Sensory impairment is something that cuts across system wide services; it is important that sensory impairment awareness and services are embedded in the whole system of provision.

The combination of two sensory impairments can mean that a deafblind person will have difficulty, or find it impossible, to utilise and benefit fully from services for deaf people or services for blind people. Meeting the needs of deafblind people therefore needs a different approach.

Apart from the day-to-day difficulties, people with sensory impairment also have poorer health outcomes, higher rates of poverty and lower educational achievements than people free from disability.

- Both visual and hearing impairment are projected to increase in West Wales over the coming years
- Accelerating factors for sight loss include diabetes and obesity
- Sensory impairment is associated with increased risk of falls and fear of falling has a major impact on people's ability to remain independent.

Gaps and areas for improvement

- Improving awareness and understanding of sensory impairment
- Improving the accessible implementation standard and developing a process to audit implementation
- Improving provision of accessible information e.g., braille letters
- Extending provision of the interpretation service outside 9-5 and increasing availability of interpreters

- Enhancing record systems such as Welsh Patient Administration System (WPAS) to be able to record more than one impairment

The impact of COVID -19:

The COVID pandemic has contributed to communication difficulties for both hearing and visually impaired people. Access to information has been more difficult to obtain for the visually impaired e.g., reduced access to braille in surgeries. Where services have shifted from face to face to video consultations, they don't work for sight impaired people, who prefer phone conversations.

The pandemic has also led to challenges for hearing impaired people around communication e.g., face masks make lip reading impossible. People with sensory impairment are more likely to suffer from isolation and loneliness, which has been exacerbated by the COVID pandemic.

Health & Social Care Regional Integration Fund

Investment Proposal

(West Wales)

Community based care – Prevention and community coordination

Place based care – Prevention and community coordination – West Wales Strategic vision

Provide a short, precise summary of the strategic vision for successfully achieving the regional aspirations for "*Community based care – Prevention and community coordination*". This should contribute to the wider delivery of A Healthier Wales.

Our Area Plan 'Delivering Change Together' sets out clear objectives for changing our approach. It introduces a pathway of care and support that focuses on personal and community assets to help people stay independent and healthier for longer whilst getting the support they need to recover quickly. Achieving this will require a fundamental rebalancing of resources as envisaged in A Healthier Wales.

This approach is supported by Hywel Dda UHB's review of its clinical services, and reflected in its strategy for health and care A Healthier Mid and West Wales: Our Future Generations Living Well.

Prevention is a theme that runs throughout our plans, but to deliver upon this commitment, this programme seeks to strengthen our links with, and support of, communities.

Our strategic vision is to create active, resourceful, connected, sustainable and kind communities where people can live interdependently, healthily and happily in their own homes and communities for as long as they choose to do so.

Our approach is evidence and asset-based, person-centred and builds a tailored package of support to meet the aspirations and needs of each individual identified through a "what matters" conversation covering the wider determinants of good health & wellbeing. People's contributions are valued, recognising opportunities to use their skills, knowledge, experience and ideas to help themselves and others.

Investing in this preventative programme will help us achieve our collective vision to create sustainable community-based care, support and wellbeing systems that will mobilise local assets to meet local needs and enable people to stay well for longer with the support of family, friends, neighbours, volunteers, voluntary groups, micro & social enterprises, and health & social care practitioners.

Dementia Action Plan (DAP) Summary

For funding that supports the Dementia Action Plan, this summary should outline how older people including people with dementia can be supported by *"Place based care – Prevention and community coordination"*.

Place based care – Prevention and community coordination – West Wales Business Case

The aim of this programme is to bring together initiatives which support our vision to create active, resourceful, connected, sustainable and kind communities across West Wales.

Baseline

The projects included within this model of care represent a step change in the work being undertaken in West Wales in relation to Prevention and Community Co-ordination, whilst delivering against objectives defined within 'A Healthier Wales' by –

- Transitioning services out of hospital and into communities, and providing more services closer to home
- Making it easier for people to remain active and independent in their homes and communities
- Supporting people to stay well, not just treating them when they become unwell

Some have been tested locally and will be scaled up and rolled out across the region with the RIF funding. Others are local initiatives which deliver against our agreed Regional aims, with clear plans for local delivery to reflect the assets, aspirations and needs of our local communities.

Over the last two years, we have seen communities mobilise to provide help and support at an unprecedented level, and this programme aims to build on and consolidate this. We have seen a change in practice, culture and relationships with a greater emphasis on the role and assets of communities to deliver local change, with partners putting the right support in place as and when needed. We seek to ensure that this momentum is not lost, but instead harnessed and further developed to ensure that the shift from a state-market paradigm to community-led power continues –

Evidence required by the state-market hybrid paradigm	Nature of community power
Guided by metrics	Guided by ethos
Quantitative	Qualitative
Immediate	Long-term
Large scale for efficiency	Small-scale for impact
Within a service silo	Embedded in the community
Related to a service output	Related to individual outcomes
Focused on proving	Focused on improving
Reporting data	Recalibrating relationships
Uniformity	Pluralism
Policy implementation	Human-centred design
Linear	Adaptive
Immediate cashable savings	Avoids costs occurring

New Local (2021) Community Power: the Evidence

It is recognised that it is within these communities that people spend the majority of their lives and that when enabled and supported to thrive, communities have an important role in supporting people to have active, interdependent and socially connected lives, remaining in their own homes and feeling valued for what they can contribute. However, it should

also be noted that even as people move and transition between the RIF Models of Care, people's wellbeing can be maximised if they remain connected to and supported by strong communities.

Likewise, people should not be confined to any one Model of Care at a single point in time, as these are descriptions of support and interventions, whereas people's lives are defined by their assets and strengths, which will differ at any one point across time, circumstances and environments. For example, during COVID, people with certain health conditions were advised to shield with additional support in place for them to do so yet many still had much to give e.g. relationships, work, volunteering etc.

The model, as described here, delivers towards Goal 1 of the 6 Goals for Urgent and Emergency Care – Co-ordination, planning and support for populations at greater risk of needing urgent or emergency Care. It delivers against this priority through the provision of community based services which help people stay well for longer and provides proactive support and preventative interventions.

Working with individuals, their families and carers to ensure that the care and support they receive is the best it can be, is at the heart of the Social Services and Wellbeing (Wales) Act 2014. This model of care, and the projects within it, are designed to ensure that there are opportunities for everyone to have a voice in the co-design and delivery of services within their communities, for themselves and their loved ones.

The Model includes actions to ensure that direct support is provided to unpaid carers, to assist them with their informal caring roles. This activity also links to actions being driven through other Models of Care, including work to identify and recognise carers.

The **Population Assessment** highlights the following areas for improvement in relation to preventions and community co-ordination:

- Future care and support should be co-designed to flex in response to changing demands and expectations and include a range of community, digital and technology-based solutions
- The further development of integrated, person centred, co-produced services was highlighted for every population group, and central to the delivery of this model of care
- Helping people to remain independent in their homes for longer through continuing development of digital and telehealth support including video consultations, monitoring and support for falls prevention, particularly for those in very rural areas and where transport is an issue
- Continuing development of community connectivity, well-being and resilience through community-based, user-led, co-produced services that address a range of needs including loneliness and isolation
- The COVID pandemic has led to widespread social isolation, with lasting implications on mental health across population groups.
- Strengthening access to education, volunteering and work opportunities in local communities for all population groups

- Developing a single point of contact to help people navigate the system. This was highlighted across a range of population groups, and is supported in this programme by the development of Community Hubs
- The pandemic has increased pressure on existing unpaid carers, as reflected in an increase of 2073 in the number of requests for support
- The number of unpaid carers known to health and care services is significantly less than existing Census data, therefore continued work on supporting the early identification and awareness of the needs of unpaid carers is required

Projects within the Model have been designed to address the identified needs and include:

Technology Enabled Working

This project will embed the Transformation funded 'Connect' programme locally and enhance the digital strategy further by developing a portfolio plan of digital health and social care applications and deploying two consumer technology-based applications which have been designed through coproduction across the region. This will ensure seamless and consistent local service delivery whilst still delivering against this key Regional priority.

Transformative Day Opportunities

This project proposal is for the development of an innovative new model for day opportunities, based on consultation and 'what matters' to individuals, giving them greater voice, choice, control, quality of life and independence.

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.

Our Resourceful Communities

This proposal brings together a series of initiatives which support ambitions to have Active, Connected, Resourceful, Sustainable and Kind Communities across West Wales. This includes initiatives which are in the early stages of development and evaluation, as well as building on the learning and success of the work undertaken through Transformation Programme 7 – Connecting People, Kind Communities.

To support this we will develop of Community Hubs and increase opportunities for building community connections and supporting people to help themselves.

The Dream Team & LD Charter

The Dream Team is about making sure citizens' voices are at the heart of all services – planning, doing, & reviewing. Currently it comprises a group of 35 people with additional needs – but the plan is to grow it, involve more people, cover more complex needs, and share more voices.

The LD Charter sits at the heart of this region's work – the project is about the resource needed to develop, advocate and manage the Charter and the Dream Team.

West Wales Catalysts for Care

West Wales Catalysts for Care is a new initiative that will develop and test a proof of concept designed to support the establishment of social and micro enterprises delivering a range of care, support and wellbeing

services. It will promote the diversification of community care & support markets to support local people to live good quality lives in their local communities, whilst also contributing to the development of strong local economies focused on creating social value.

Social Investment & Innovation Fund: Creating the Infrastructure to Deliver Differently

This proposal builds on the success of the innovation funds built into former funding programmes for people with learning disabilities, unpaid carers, and themes of work delivered across population groups. The project aims to transform health, care & wellbeing services by establishing an investment framework that will support and encourage third sector and community providers to co-design and co-deliver new models of care and support, and embed/scale up successful pilots. Following evaluation of outcomes, we will support projects to secure sustainable, longer-term funding to enable benefits to be maintained.

Steady On…Stay Safe Falls Prevention Programme

The Steady on Stay Safe project will trial establishing a co-ordinated approach to the prevention of falls in the community of Pembrokeshire, working in partnership with the local authority, 3rd sector, health staff and local residents. If successful, this can then be adapted and rolled out across West Wales.

Programme Outcomes

This programme delivers against the following identified **wider system outcomes and principles** -

- People are healthier and happier
- Health, care and wellbeing services are better and easier to access
- Health, care and wellbeing services are innovative and use the latest technology
- Principles of co-production are embedded in the design, delivery and evaluation of Models of Care
- Models of Care are preventative and provide early intervention solutions
- Care pathways are clear, equitable and accessible across the population groups
- Models of Care demonstrate the impact and benefits that they bring

The model also supports the following identified **person centred outcomes** –

- People feel more able to make their own decisions about what is important to and for them
- People have more voice in and control over their care and support needs
- People have greater awareness of what care and support services are available and local to them
- People have improved access to care and support at home or close to home

The programme also delivers against the identified **person centred Model of Care 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 crisis interventions

Projects have identified their own measures and outcomes. Specialist resources available in West Wales are engaged in producing an evaluation framework that will standardise the approach and measures used across the project, using an RBA approach to demonstrate –

- How much has been delivered (Quantity)
- How well it has been delivered (Quality)

- 'Is anyone better off?' (Impact)

Action research will be central to the adoption of an ongoing approach to evaluation. Qualitative and quantitative data will be collected to gauge success in relation to outputs, outcomes and impacts. We will build on the success of Most Significant Change Stories as a way of collecting the lived experience of people and using those experiences to instigate change.

Place based care – Prevention and community coordination - Key enablers

Select which of the key enablers will maximise the delivery of the programme, using the free text box to describe how this will be achieved.

Key Enablers	Select
Integrated planning and commissioning	x
Models provide an appropriate range of opportunities to ensure they connect with their target population groups. The establishment of the **Regional Innovations Forum** (potentially with County-based equivalents) will provide increased opportunities for commissioners and providers to plan and co-produce services with an emphasis on social value. A key element of the **Catalysts for Care** project is to develop the care & support market with an emphasis on local and person-centred delivery. Social enterprises will be supported to measure social return on investment and to use appropriate tools to articulate and measure social value created. The results of this work will feed into the development of a commissioning/procurement framework that takes social value into account when determining "best value". The approach described within **Transforming Day Opportunities** is underpinned by robust community mapping and gap analysis to inform community and commissioning plans The **Dream Team** is about making sure citizens' voices are at the heart of the commissioning cycle for all services – having a say in planning, doing, & reviewing.	
Technology enabled care	x
Models provide a choice of activities to support well-being both digitally and face-to-face through a 'single door' (e.g. integrated community hubs) County-based preventative models (including **Community Hubs**) will make use of the Connect platforms, developed through P7 of the Transformation Fund, which offer a range of facilities including community pages, community listings, ideas & polls, skills exchange (person-to-person time banking), campaigns, and group management tools. This technology platform is designed to improve digital and social connections.	

Community Hubs will be able to provide single points of access to schemes such as Pembrokeshire Digital Connections, which bring together a range of ICT support services including digital volunteers, loan-out of kit, digital coaching, training, etc. Through the Versatile Village Spaces work delivered within **Our Resourceful Communities**, Community Halls will be supported to make use of digital kit (purchased through P7) to link up with care homes, Attend Anywhere virtual GP appointments, training and events that are being delivered from a central point, etc. This Model includes the provision of digital support to staff and individuals in the community, as well as providing opportunity to further develop the roles of volunteers as Digital Champions through the **Community Hub** activities The Transformation funded 'Connect' programme clearly identified and developed 4 'service pillars' for TEC, and these projects will build on and embed these pillars locally. This will ensure seamless and consistent local service delivery whilst still delivering against this key Regional priority. The **'Assist my Life'** project builds on the development work already carried out to research, coproduce, model and develop a smartphone app which supports users to gain confidence and independence with accessing travel, healthcare, and communication services.	
Promoting the social value sector This Model is built upon the social capital of communities in West Wales, with the majority of the activities described being delivered through local social value organisations. The **Social Investment & Innovation Fund** will support the co-production of new activities and services that contribute to the development of active, resourceful, connected, sustainable and kind communities where people can live interdependently, healthily and happily in their own homes and communities for as long as they choose to do so. Projects will be supported based on evidence of good practice. If prior evidence is not available then these will be thoroughly evaluated to inform future developments. The choice of projects will be informed by the expresses needs of communities as identified by the many local, regional and national surveys undertaken in the past two years. Support for social enterprises under the **Catalysts for Care** proposal – social enterprises will be supported to co-produce services, work collaboratively, measure social value/impact, and develop an enterprising approach to sustainable service delivery The **Dream Team** and **Learning Disabilities Charter**, are supported and managed through local social value organisations. The CVCs in West Wales are integral partners in the work of the RPB and, through them, the social value (third) sector will be fully involved in the delivery of this programme, particularly through social value commissioning and the **Social Investment & Innovation Fund.** Within the **Transformative Day Opportunities** project, the primary focus will be on signposting and supporting access to existing community groups and activities. Support will also be provided to existing groups to enable them to become more inclusive, and sustainable.	**x**

Integrated community hubs	
Models provide a choice of activities to support well-being both digitally and face-to-face through a 'single door' (e.g. integrated community hubs) The approaches described within these projects provide opportunities for individuals to access services closer to where they live, in their own communities – we are taking the services closer to the people who need them. Each County will develop its **Community Hub** model making the most of local assets to address identified needs. In Pembrokeshire, there is a commitment to developing an integrated Hub team which will have a visible presence in communities through an outreach programme and a network of volunteer Hub Champions. Services will be accessible as locally as possible, with digital support provided, if this is needed. Community transport will also be explored as an option if people do need to travel to service centres. **Transformative Day Opportunities** will also provide integrated, local points of contact for a wide range of providers and resources from across all partners (private, voluntary & 'in-house'). This will then enable service users access to identify a bespoke package of day opportunities that will meet their social, aspirational, emotional and functional needs. These will work closely alongside the Community Hubs being developed to avoid duplication. In Pembrokeshire, once developed, the Bureau functions will be embedded within the Community Hub. **Community Hubs** will be able to provide single points of access to schemes such as Pembrokeshire Digital Connections, which bring together a range of ICT support services including digital volunteers, loan-out of kit, digital coaching, training, etc. Through the Versatile Village Spaces work delivered within **Our Resourceful Communities**, Community Halls will be supported to make use of digital kit (purchased through P7) to link up with care homes, Attend Anywhere virtual GP appointments, training and events that are being delivered from a central point, etc. The **Dream Team** provides a sounding board and engagement structure for community based solutions to be just that – accessible, centred around the community of interest, and developed with the citizen at the centre. More than this, the Dream Team will be involved in developing these solutions, not just commenting upon them.	**x**
Workforce development and integration	
Within the Model there is a focus on workforce development around the adoption of SROI and other tools to measure the social value and impact of service and activities and their use in driving social value commissioning and procurement. Many of the proposals include elements of staff training and awareness raising, which also support workforce development. The **Dream Team** champion the **Learning Disabilities Charter**, and deliver a range of awareness raising courses to all partners. They are also involved in recruitment processes for relevant statutory staffing positions.	**x**

The West Wales **Continuous Engagement Framework** will provide a mechanism for workforce development and integration, specifically around engagement techniques. Building research & evaluation capacity in partner organisations is also a priority, with a particular focus on linking qualitative data (based on narrative and lived experience) with quantitative data (statistical/needs assessments) to determine causal links and understand the conditions that need to be in place for successful scaling up/replication of community initiatives.	

Place based care – Prevention and community coordination - Priority population groups

Select both the primary and secondary beneficiaries of the programme by priority population group, using the free text box to describe the particular impacts this will have. Please also indicate if the beneficiaries are supported using DAP funding.

Priority population groups	Primary	Secondary	DAP
Older people including people with dementia	**x**		
This is the Primary population group for many of the Projects within this Model. Initiatives which will have significant impact on this group include – • Technology Enabled Care • Digital Support • Building social connections including - Community Connectors and social prescribing • Community Hubs • Social Investment and Innovations Fund • Transformative Day Opportunities • Building social connections			
Children and young people with complex needs		**x**	
Projects within this Model will provide benefits to children and young people with complex needs, but they are not the primary beneficiaries of these services. Proposals such as **Our Resourceful Communities**, **Transforming Day Opportunities** and the **Social Investment and Innovations Fund** will provide most benefit, but all projects will likely have an impact on this population group.			
People with learning disabilities and neurodevelopmental conditions including autism*	**x**		
The Model includes a range of projects which were developed to support people with Learning Disabilities. Learning from projects piloted through ICF and Transformation funding means that these projects can be rolled out across West Wales, and expanded to include a wider range of population groups. Specifically, these are -			

The Dream Team & LD Charter
The Dream Team is about making sure citizens' voices are at the heart of all services – planning, doing, & reviewing. Currently it comprises a group of 35 people with additional needs – but the plan is to grow it, involve more people, cover more complex needs, and share more voices, across population groups.
Assist my Life builds on the development work already carried out to research, coproduce, model and develop a smartphone app which supports users to gain confidence and independence with accessing travel, healthcare, and communication services. This was originally a project for people with Learning Disabilities, but through the development of the RIF will be able to support across population groups.
The **Social Investment and Innovations Fund** builds on learning from the delivery of the Regional LD Innovations Fund, which involved people with learning disabilities in the co-production of projects from design to delivery, the allocation of funds and the evaluation of the projects. This approach is being taken forward across population groups, as part of the wider proposal.

All other projects within this Model will also provide significant benefits to people with learning disabilities.

Unpaid carers*	**x**		

Unpaid Carers will be primary beneficiaries for the majority of projects within this model. They will benefit from access to –

- Technology Enabled Care
- Digital Support
- Building social connections including - Community Connectors and social prescribing
- Community Hubs
- Social Investment and Innovations Fund
- Transformative Day Opportunities
- Building social connections

Specifically within this Model, there is an initiative around **Digital Enablement** which focusses on improving access to online information & support for carers. This is the further development of an ICF funded-project, but links across other digital and technology components of this Model, providing opportunities to upscale and embed this work, and expand across population groups by integrating with other initiatives.

Co-production of services and improving sustainability of services for carers is also an important component of this Model, and there are opportunities for this work to continue described within the **Social Investment and Innovation Fund**.

People with emotional and mental health wellbeing needs		**x**	

People with emotional and mental health and wellbeing needs will benefit from many of these projects, although they are not the primary beneficiaries.

Proposals such as **Our Resourceful Communities**, **Transforming Day Opportunities** and the **Social Investment and Innovations Fund** will provide most benefit, but all projects will likely have an impact on this population group.

Other beneficiaries

If there are other stakeholders benefiting from the programme, please provide this detail below.

There are likely to be a wide range of beneficiaries for this Model because many of these projects are supporting access to services across the population of West Wales, rather than for specific population groups.

Total programme cost and match funding projection

Total cost of Programme	Welsh Government contribution	Partner match monetary	Partner match resource	% support for unpaid carers	% for social value sector delivery
£4,487,012	£3,312,726	£1,174,285.62	Volunteer hours Staff to support delivery of projects Access to Work funding	2.72%	79.10%

Programme resource and management details

Provide a summary of the planned resource and roles required to deliver this specific programme. These roles are 100% funded via the RIF and will accounted for within the allocated fund.

Posts / type of roles	Estimated FTE	Costs

Regional Integration Fund (RIF) Project plans

Title of your project

Technology enabled working

Any additional Models of Care the project will contribute towards

2. Community-based Care – complex care closer to home
3. Promoting good emotional health and well-being
5. Home from hospital

Project Summary

Purpose

This project will embed the Transformation funded 'Connect' programme locally and enhance the digital strategy further by developing a portfolio plan of digital health and social care applications and deploying two consumer technology-based applications which have been designed through coproduction across the region.

Programme alignment

The project supports outcomes in models of care 1, 2, 3 and 5. If project objectives are achieved, it should:

- Improve access to services and equity in service access between user groups
- Lead to a progressively more "joined-up" user experience
- Increase interoperability between counties or at least avoid divergence and improve tech-equity in the region.
- Individual self-sufficiency and community resilience should improve as advanced technology innovations are trialled and integrated into the system of work.
- Staff are expected to benefit from more ordered, planned work supported by planning systems that are integrated with technological innovations.

Background

The region has used Transformation Funds to install in people's homes assistive devices such as alarms, sensors and wearables backed up by a centralised monitoring centre. The region has trialled a self-funding payment scheme, centralised urgent response and centrally coordinated, though locally deployed, wellbeing assessments.

Digital inclusion and online access to services has been identified as a key priority for vulnerable groups to offset rural isolation and limited public transport networks and this has included using Integrated Care funding to work on a smartphone app for people with learning disabilities and a regional carers' website.

However, there is a desire evaluate more advanced technology and the systems which integrate the technology into the working day of health and social care staff. There is also a desire to join up separate responses to specific needs into a coordinated response to all digital opportunities at a regional level.

The vision, therefore, is to create a landscape of interoperable technology which supports service provision across all service providers. This will complement the existing assistive device monitoring service, integrate with other local authority and health board services and provide a technology-friendly environment for all new developments to thrive.

Approach

This approach is made up of 3 parts:

1. Optimise regional CONNECT telecare monitoring service
2. Develop a portfolio plan of digital health and social care applications
3. Identify and develop consumer technology-based applications
    a. Digital enablement for carers

b. “Assist My Life” app. for people with Learning disabilities

1. Optimise the regional CONNECT telecare monitoring service (Att 3)

It is expected that telecare services will continue to be developed for the foreseeable future.

Current arrangements will continue for at least the first 6 months of year during which there shall be a review and decision made about how the provision can be improved.

As a part of the review, a future scope and solution design will be agreed and in so much as this represents change, a transition plan will be implemented.

The region remains committed to the regional telecare concept and expects to the improved approach to include broadly the same scope as the current provision.

2. Explore a portfolio strategy of digital health and care applications

Research and investigate advanced care technology and staff work-enabling applications which can be integrated to increase productivity, enable “at home” care and enhance the user/patient experience.

Ceredigion to take the lead, liaise with the Health Board’s digital vision initiative, existing services and other RIF sponsored projects to assess new solutions and develop a portfolio strategy and test plan for approaches including but not limited to:

- Digital care management systems
- Electronic medication administration records (eMAR)
- Rostering, case management and work management software
- Innovative advances in single handed care, complex care/manual handling kit.
- Emerging through-age equipment and robotics to assist in sensory augmentation, dementia, autism, mental health and anxiety management.
- Link up self-assessment, technology/equipment demonstration and frictionless equipment ordering.

3. Identify and develop consumer technology-based applications

Incorporate into the portfolio strategy technology-based solutions which are built on existing widely available consumer technology such as smartphones, tablets, smart watches, smart speakers/virtual assistants, and virtual reality applications.

In the first year, deliver the following specific solutions

3a Supporting Carers to become digitally included (Att 1)

This regional proposal will deliver a portal for easily accessible and up to date information and advice to support unpaid carers, regardless of where they live in West Wales. This includes maintenance, hosting and further development.

It will also scope a regional digital tablet loan scheme for Carers which includes outreach support, based on learning from a GP Cluster funded Connect IT project in Pembrokeshire.

Include research other digital solutions that could support carers in recognising their own well-being needs.

3b “Assist My Life” app. for people with learning disabilities (Att 2)

This regional proposal will deliver a smartphone app that enables independent access to travel healthcare and communication for people with learning disabilities.

The project team comprises

- 6 part time team members WTE 2.5
- Admin and management WTE .5 of existing post

The app itself, together with a feedback tool, will be built by the Barod Research team whose work provides the match funding

Expected outputs

- Existing Teletec Care service supplied by the current provider, Delta Wellbeing
- A report regarding the Teletec Care services together with a future plan
- Future Teletec Care provision implemented
- Portfolio strategy of digital health and social care work integration applications
- Carer portal
- Assist my Life app for people with learning disabilities

Benefits Measurements (user groups)

- Self-reported outcomes for Teletec Care users
- Improve access to and take up of resources by unpaid carers measured through traffic through website
- Self-reported benefits of the "AssistMyLife" app built into app will be available after app launch.

Exit Plan

Exiting from Teletec Care provision would entail moderately high exit costs because staff working for our current provider would be affected. There would also be an impact on current clients which are at present in the region of 3000, for whom a mitigation plan would be required.

There is provision for mainstreaming the Teletec Care project which relies up take up of the self-funded subscriptions and the volume of work that can be leveraged across current resources.

Ceasing to maintain the Carers platform could affect single point access of services for carers which is difficult to quantify and effects would depend upon how access could otherwise be provided. The exit cost is not significant amounting to 1 WTE on a fixed term contract.

The AssistMy Life App exit cost is not significant as it is a one time development cost. However, consideration would have to be given to the qualitative impact on the lives of people who may come to rely on the app.

Priority population group(s)

- Older people including people with dementia
- People with learning disabilities, neurodiverse and neurodevelopmental conditions including autism
- Unpaid carers

Key enablers

- Technology and digital solutions
- Promoting the social value sector

New or existing investment

- New and existing investment

Estimated Total Cost (Att 4)

The total estimated cost is £2,275,623

Start date	Estimated completion date
1 April 2022	31 March 2025

Regional investment model

Select the funding element which the project will be set against. Repeat the table and rationale below for each project.

Title of project to support Model of Care (programme)	
Technology enabled working	
Funding elements	**Select**
Element 1 - Acceleration funding year 1	**X**
Element 1 - Acceleration funding year 2	**X**
Element 2 - Embedding fund year 1	**X**
Element 2 - Embedding fund year 2	**X**
Element 2 - Embedding fund year 3	**X**
Element 3 - Legacy integrated pooled fund	
Element 4 – National priorities (Dementia and Memory Assessment Services/ Diagnostic Support)	

Provide the rationale for the element selected.

The CONNECT monitoring model has been set up and run for over 2 years with transformation funding. It is now entering its embedding phase which will be informed by the proposed evaluation review.

The carer project is in the 1st year of developmental stage endeavouring to build on the research and coproduction work already carried out to bring the build, development, deployment

The "AssistMyLife" project was funded to develop and prove the concept of a smartphone app as a tool for independence, this next stage is the natural development to establish the app and kitemark across the region. This will mean reflecting on the work to date, developing the region wide model based on this experience and establishing a team of self-advocates and others drawn from the apps community and user base.

We will also establish a model to measure the impact of the work , gather stories and share them regionally and for other communities that will benefit from this model.

Delivery partners

Title of project to support Model of Care (programme)

Technology enabled working				
Delivery Partners	**Welsh Government contribution**	**Partner match monetary**	**Partner match resource**	**Total funding required**
Local Authority	£72,833	£31,214	**Staffing / Buildings / Income**	**£2,275,623**
Social Value Sector	£1,530,103	£641,473	**Staffing / Buildings / Income**	
Health Board				

Regional Integration Fund (RIF) Project plans

Title of your project
Transformative Day Opportunities
Any additional Models of Care the project will contribute towards
2. Community Based Care - Complex care closer to home. 3. Promoting good emotional health & wellbeing 4. Supporting families to stay together
Project Summary

Purpose

This project proposal is for the development of an innovative new model for day opportunities, based on consultation and 'what matters' to individuals, giving them greater choice, control, quality of life and independence.

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.

Background

The following provide the specific context for this work;

- The ALN bill
- The West Wales Care Partnership "My Charter" highlighting the wishes of individuals living with a Learning Disability
- The Ceredigion, Carmarthenshire and Pembrokeshire LD Strategies
- The need to develop local employability pathways, networks and opportunities within the service user's community
- The need to align with wider opportunities e.g. DWP

The model as was, prior to COVID does not meet the changing needs of the population, along with providing a progression and person-centred outcome model supporting required for individuals.

COVID has obviously had a huge impact on day services, with many building-based services being very restricted in what they could offer. Despite the barriers COVID introduced, it also gave the opportunity to trial small scale changes, feeding into the strategic vision of how we will deliver on the outcomes of the consultation.

Prior to the pandemic, Pembrokeshire carried out a wide-ranging consultation on the future of day services, and the feedback was that although building based day care was still essential to some, there were a large percentage of service users who wanted a more community-based, individualised service with access to a wide range of activities and opportunities.

Partners in West Wales are now in a position to carry out the comprehensive review and development of their Day Opportunities offers.

Approach

This proposal has two elements –

1. The comprehensive review and development of the range of services offered for individuals with an assessed need/s, using co-productive approaches
2. Establishment of 'single points of contact' for individuals and referrers across each locality in Carmarthenshire, & a Day Opportunities Bureau in Pembrokeshire

Central to the review of services will be the development and delivery of an engagement and consultation plan to ensure that the voices of service users and carers are heard. There will also be a need to develop specialist communicative tools, engagement opportunities and advocacy, as required, to support with ensuring the voice of the individual is heard as part of the process.

The co-productive service review completed in Pembrokeshire, proposed the establishment of a 'day opportunities bureau' to act as a central point for a wide range of providers and resources from across all partners (private, voluntary & 'in-house'). This will enable service users then access to identify a bespoke package of day opportunities that will meet their social, aspirational, emotional and functional needs. The Bureau will be open to all adult service users- older people, people with a learning disability and young adults transitioning from childcare.

Learning from the delivery of the Bureau can then be shared with partners across West Wales to support the next phase of their delivery.

Outcomes

Success will be evidenced by the numbers of people engaged in the activity – either as part of the engagement processes, or accessing the bureau, and reported outcomes for individuals.

Most Significant Change stories will be gathered to provide the service user's perspective on these processes.

Benefits

It will link to other community projects, particularly social prescribing and the over-arching preventions agenda, and will improve access to community activities, and green and blue environments.

There will be a clear pathway of inclusive opportunities for individuals, following a strengths based approach.

Having services in communities and closer to their home will also improve access for service users, reducing their need to travel, and therefore also reducing risks for the service users.

Exit Plan

Once the project is established, the 'exit' strategy is that this becomes part of 'core' services.

Priority population group(s)
This project supports all age-groups

Key enablers	
All 5 RIF enablers will contribute to the successful delivery of this project.	
New or existing investment	
New investment	
Estimated Total Cost	
295,505	
Start date	**Estimated completion date**
1st April 2022	**31st March 2024**

Regional investment model

Title of project to support Model of Care 1	
Transformative Day Opportunities	
Funding elements	**Select**
Element 1 - Acceleration funding year 1	**X**
Element 1 - Acceleration funding year 2	**X**
Element 2 - Embedding fund year 1	
Element 2 - Embedding fund year 2	
Element 2 - Embedding fund year 3	
Element 3 - Legacy integrated pooled fund	
Element 4 – National priorities (Dementia and Memory Assessment Services/ Diagnostic Support)	

Provide the rationale for the element selected.

This project is for an innovative new model, based on direct consultation and 'what matters' to individuals, giving them greater choice, control, quality of life and independence. It crosses population groups and is being scaled across the region.

Delivery partners

Transformative Day Opportunities				
Delivery Partners	**Welsh Government contribution**	**Partner match monetary**	**Partner match resource**	**Total funding required**
Local Authority	£229,757	£65,748	**Staffing / Buildings / Income**	**£295,505**
Social Value Sector				
Health Board				

Regional Integration Fund (RIF) Project plan

Title of project to support Model of Care 1
Our Resourceful Communities
Any additional Models of Care the project will contribute towards
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
Project Summary
Purpose This proposal brings together a series of initiatives which support ambitions to have Active, Connected, Resourceful, Sustainable and Kind Communities across West Wales. This includes initiatives which are either in the early stages of development or testing, as well as building on the learning and success of the work undertaken through Transformation Programme 7 – Connecting People, Kind Communities. **Background** Connecting People, Kind Communities provided resource to develop a number of projects including – • Development of Connect platforms • Development of the Connect to Kindness programme • Community Connector Plus role • Community Volunteer Development Officer roles

- A range of community grants schemes
- Participatory budgeting pilot schemes

Through the delivery of Transformation Programme 7, a strong partnership has developed. The 3 Local Authorities, CVCs, Hywel Dda, Public Health Wales, and other community partners have worked together to develop and deliver the programme and through this work, have built a strong and constructive approach to partnership working.

This next phase will further develop the following elements of work to support the West Wales ambition

- Increased focus on community engagement and co-production
- Development of community volunteering opportunities
- Establishment of the Community Hubs
- A community skills development programme

Approach

Community Engagement and Co-production
This element of the proposal will provide resource to work with communities and third sector groups to co-produce future services to tackle key areas to improve integrated packages of support, including the provision of day services, low level domiciliary care and support at home and within the community, respite for carers, access to services and the design and implementation of social and green solutions for health.
This will include working with existing and new community groups, town and community councils to mobilise support on a 'hyper-local' basis, providing practical and emotional support, reducing loneliness and isolation, and building on the work of initiatives such as the Cardi Care project and 'Solva Care'.

Community Volunteering Development
Resource is provided here to work alongside community volunteer involving organisations to further develop the support available, including –

- Creating or developing a peer learning and support networks for patch based service providers/organisers
- Shared approaches to volunteer recruitment, and training
- Development of pools of volunteers to support community service delivery
- Development of opportunities for community volunteers, services and third sector support into care home settings
- Use of the Connect platforms to enable co-production and encourage provision of voluntary support in communities
- Development of a work-force passport scheme, to 'fast-track' individuals who volunteer in care to access paid work opportunities in the sector

Establishment of Community Hubs
Carmarthenshire – CUSP project
The focus of the CUSP Project is to develop Wellbeing Community Hubs which will be aligned to the 5 geographical areas within the new Community Support Model for Carmarthenshire. Each Hub will be set up to accommodate all client groups and will offer a wellbeing conversation and personal development plan to those who require one.

Each Hub will provide:

- Information –to enable people to understand what support is available to them, provide assistance to navigate the system, signposting to relevant organisations, condition specific information and self-help guides. Each Hub will be supported by a digital project to help with the digital skills to enable engagement online.
- Opportunities – access to meaningful opportunities including training and work experience, befriending and peer support, wellbeing and health promoting activities and development of life skills in accordance with their personal development plan.
- Support – low level support (not domiciliary care or regular community support) to respond to short term issues that impact on health and wellbeing. The level of support will differ for each situation, the key aspect being that the Hub has the mechanism to respond quickly, particularly in a crisis situation and that individuals are supported to find the right solution for them.
- Creative pathways of support for Individuals to access the right support for them

Pembrokeshire Community Hub

The Pembrokeshire Community Hub will provide a "one stop shop" for:

- People looking for support within the community (who don't know where to start)
- People wanting to volunteer or contribute to their community (who don't know where to start)
- Communities and professionals who need advice when supporting individuals

Unlike more traditional hubs that are located within a single building, the Pembrokeshire Community Hub will be visible and present in community settings across the county, in places that are familiar and comfortable to local people, as well as being accessible by phone, email, social media etc.

The Hub will consolidate and re-focus a number of existing projects including:- the **Community Connectors** whose team will expand and include working to a new social prescribing framework; the **Connect Pembrokeshire** platform, which will become a fundamental part of the Hub offer to communities; and the **Digital Connections** collaboration. It will also implement a number of new developments that have been identified as gaps or areas for improvement such as creating a pool of Hub volunteers and providing resources for community skills development.

Community Skills Development Programme

A responsive and flexible programme/offer of skills development for community leaders/members which will support the movement towards community-led power.

This will also include a shared skills programme for volunteers, with partners providing training in areas such as safeguarding, first aid, and health and safety.

We will also create links between informal community support providers and the more formal expertise offered by third sector groups and encourage collaboration.

Outcomes

This proposal meets the following outcomes identified for Model 1 -

People's wellbeing needs are improved through accessing co-ordinated community-based solutions

Local prevention and early intervention solutions support people to avoid escalation and crisis interventions

Benefits

Improved quality of life
More services available in communities
More services co-produced by communities and service users
People are better supported in their own communities

Exit Plan
A robust evaluation framework will underpin this work and provide the necessary data on which to base future investment of core funding by partners. Partners will also work together to identify other mechanisms of funding such as creating community funds, investment of precepts, community contributions/shares, etc.

Priority population group

- Older people including people with dementia
- Children and young people with complex needs
- People with learning disabilities and neurodevelopmental conditions including autism
- Unpaid carers
- People with emotional and mental health wellbeing needs

Key enablers

- Integrated planning and commissioning
- Technology and digital solutions – This proposal includes the provision of digital support to staff and individuals in the community, as well as providing opportunity to further develop the roles of volunteers as Digital Champions
- Promoting the social value sector – specifically this proposal utilises social capital in communities and draws upon local social value organisations
- Integrated community hubs – models provide a choice of activities to support well-being both digitally and face-to-face through a 'single door' – the proposal includes the establishment and embedding of the Pembrokeshire (Integrated) Community Hub, and Community Hubs in Carmarthenshire
- Workforce development and integration

New or existing investment

New

Estimated total cost

£1,217,227

Start date	**Estimated completion date**
1st April 2022	31st March 2027

Regional investment model

Title of project to support Model of Care 1	
Our Resourceful Communities	
Funding elements	**Select**
Element 1 - Acceleration funding year 1	x
Element 1 - Acceleration funding year 2	x
Element 2 - Embedding fund year 1	x
Element 2 - Embedding fund year 2	x
Element 2 - Embedding fund year 3	x
Element 3 - Legacy integrated pooled fund	
Element 4 – National priorities (Dementia and Memory Assessment Services/ Diagnostic Support)	

Provide the rationale for the element selected.

Element 1 has been selected as the funding requested will support the development and testing of a new collaboration of initiatives that will primarily support the Community Care – Prevention and Community Coordination model of care, but also the other 5 RIF models of care. Whilst some elements of the proposal have been running in West Wales, this is a new model of support that redefines and re-structures the work in relation to prevention and early intervention in the county. Many initiatives have not moved beyond initial concept phase due to COVID and the wider pressures on the care sector and they need further development and testing of proof of concept. Other elements of this proposal will be completely new and will cover the entire proof of concept phase.

Delivery partners

Title of project to support Model of Care 1				
Our Resourceful Communities				
Delivery Partners	**Welsh Government contribution**	**Partner match monetary**	**Partner match resource**	**Total funding required**
Local Authority	£327,191	£140,225	**Staffing / Buildings / Income**	**£1,217,227**
Social Value Sector	£521,893	£169,841	**Staffing / Buildings / Income**	

Health Board	£40,654	£17,423	**Staffing / Buildings / Income**	

Regional Integration Fund (RIF) Project plan

Title of project to support Model of Care 1
The Dream Team and the LD Charter
Any additional Models of Care the project will contribute towards
Promoting good emotional health and wellbeing
Project Summary

The Dream Team is about making sure citizens' voices are at the heart of all services – planning, doing, & reviewing. Currently it comprises a group of 35 people with additional needs – but the plan is to grow it, involve more people, cover more complex needs, and share more voices.

The LD Charter sits at the heart of this region's work – the project is about the resource needed to develop, advocate and manage the Charter and the Dream Team.

The Dream Team is a growing group of people with learning disabilities and neurodevelopmental conditions, who model meaningful engagement of People with a Learning Disability (PwLD) from all counties of our region in decision-making, specifically in boards, groups and bodies with decision making powers. "Nothing about us, without us".
The Dream Team has been instrumental in developing the LD Charter, which frames all our region's work.
The Dream Team monitors ICF projects, and would take a role in monitoring RIF funded projects.
The Dream Team provides the panel for the regional LD Innovation Fund.
The Dream Team provides the Ambassadors who promote the LD Charter alongside the AssistMyLife project.
Additionally, the facilitator of the Dream Team provides project management support to RILP, to ensure the work is led by the wishes and imperatives of the Dream Team and that all materials are easy read.
The Dream Team has a development plan for 2022-2024 which includes:

- More publicity for the LD Charter, and audits of organisations signing up
- Developing its work on sex and relationships, and parents with learning disabilities
- Developing wider engagement, particularly with people with PMLD/ communication needs
- Developing more training and skills for Dream Team members
- Looking at ways to engage more widely

What difference is it going to make?
To Dream Team members:

- Skills development
- A meaningful voice
- Being respected, valued, included
- Meaningful pay for work rather than an assumption of volunteering

To people with additional needs across our region:

- "Nothing about us, without us" made a reality
- A consistent, strong voice taking every project back to those it affects

To professionals:

- A unique opportunity to engage with people with additional needs, and put their imperatives at the centre of planning
- A framework to check projects against – too often services become mired in structures. The Dream Team strips this back to "what difference does it make?"

To communities:

- The chance to see engaged, involved and inspirational people with additional needs living full, meaningful lives
- Building communities' capacity and resilience

Key Outcomes

1. People's well-being needs are improved through accessing co-ordinated community-based solutions
The Dream Team provides a sounding board and engagement structure for community based solutions to be just that – accessible, centred around the community of interest, and developed with the citizen at the centre. More than this, the Dream Team will be involved in developing these solutions, not just commenting upon them.
The LD Charter provides a simple, powerful "aide memoire" for the needs, wants and rights of people with learning disabilities. The project will, as we come out of the pandemic, re-double efforts to improve its reach.

2. Local prevention and early intervention solutions support people to avoid escalation and crisis interventions
This project is all about prevention. By involving, and listening to, people with learning disabilities at every stage, and ensuring people feel included and valued, resilience is built, emotional and mental health is protected, and the wider community of people with learning disabilities benefits.

Sustainability
As funding tapers, the Dream Team plans to develop training and audit streams which will generate an income.
As skills grow, support needs will lessen, so facilitation/support costs from the Third Sector will taper.

The Dream Team and Charter work across health and social care, and sit squarely as a preventative project – their focus is on ensuring citizens' voices have a meaningful say in designing services that promote wellbeing, develop engagement, and prevent the need for citizens to access crisis services – as in the Social Services and Wellbeing Act, its focus is on empowering individuals to take control of their lives.

Priority population group
People with learning disabilities and neurodevelopmental conditions including autism People with emotional and mental health wellbeing needs
Key enablers
Integrated planning and commissioning

Promoting the social value sector Integrated community hubs
New or existing investment
Existing project to be further developed Robust monitoring throughout the project's life is available to evidence its effectiveness, and future plans build on this.
Estimated total cost
Total project costs per year = £358,736 Match is provided by partners through their work around developing Easy Read information, and staff time to support the members of the Dream Team. Access to work funding will also provide match for the funding. Match value = £224,000 RIF funding requested = £134,736

Start date	Estimated completion date
1/4/22	**31/3/27**

Regional investment model

Title of project to support Model of Care (programme)	
The Dream Team and LD Charter	
Funding elements	**Select**
Element 1 - Acceleration funding year 1	
Element 1 - Acceleration funding year 2	
Element 2 - Embedding fund year 1	**x**
Element 2 - Embedding fund year 2	
Element 2 - Embedding fund year 3	
Element 3 - Legacy integrated pooled fund	
Element 4 – National priorities (Dementia and Memory Assessment Services/ Diagnostic Support)	

Provide the rationale for the element selected.

Although the Dream Team is established, this next phase of its work will focus on widening engagement and representation, which is a new and complicated departure.

Delivery partners

Title of project to support Model of Care (programme)				
The Dream Team and LD Charter				
Delivery Partners	**Welsh Government contribution**	**Partner match monetary**	**Partner match resource**	**Total funding required**
Local Authority				**£192,480**
Social Value Sector	£134,736	£57,744	**Staffing / Buildings / Income**	
Health Board				

Regional Integration Fund (RIF) Project plans

Title of project to support Model of Care 1
West Wales Catalysts for Care
Any additional Models of Care the project will contribute towards
• Community based care – *prevention and community coordination* • Community based care – *complex care closer to home* • Promoting good emotional health and well-being • Home from hospital services • Accommodation-based solutions
Project Summary

West Wales Catalysts for Care is a new initiative that will develop and test a proof of concept that would support the establishment of social and micro enterprises delivering a range of care, support and wellbeing services. It would promote the diversification of community and care & support markets to support local people to live good quality lives in their local community.
 	
The rationale and value of the project sits firmly within the Welsh legislative and policy frameworks, as well as the current environment across health and social care:
• Social Services & Wellbeing (Wales) Act 2014
  ○ Fundamental principles - Voice & Control; Prevention and early intervention; Well-being; and Co-production
  ○ Part 2 - Promote social enterprises, co-operatives, user-led services and the third sector
• Prosperity for All: Economic Action Plan – 4 foundation sectors include Care
• West Wales Population Needs Assessment

- Market Stability Report
- Local care and support market
    - Limited capacity with significant pressures upon existing providers and workforce
    - Traditional models of care in relation to support at home i.e. domiciliary care
    - Limited small business support following wind-up of Pembrokeshire Business Initiative
    - Need to develop more creative and personalised opportunities for people using direct payments

As well as supporting the development of new enterprises, the project will work with embryonic or established micro and social enterprises, who want to improve their governance and business practices and/or develop new services to meet identified needs. In addition, the project will help service commissioners and practitioners to understand what needs to change (culture, systems and pathways) and will then help them to implement those changes to bring about a transformation in the way domiciliary care and support services are provided across West Wales.

Within Pembrokeshire, a pilot Catalysts for Care project has commenced and whilst it would appear to have potential, it has yet to move beyond initial proof of concept stage due to the pandemic and requires further development before decisions can be taken to embed in to local infrastructures and practice. Furthermore, there is a need to further explore the scope of micro-enterprises in terms of developing opportunities not only for support at home, but also carer's breaks, day opportunities and the pooling of direct payments. This has been increasingly important as a result of the pandemic which has seen more traditional services being limited in their ability to fully meet people's needs due to infection & prevention control measures. Alongside this, there is opportunity to consider how social enterprises can be supported to further develop their business models and diversity income streams.

Alongside Pembrokeshire's need to progress the project through the 'proof of concept stage', there is a regional ambition across Carmarthenshire County Council, Ceredigion County Council and Hywel Dda University Health Board to expand and test the feasibility and fit of the Catalysts for Care model across the region. At present, there are no development programmes in relation to this part of the sector or model of care in Carmarthenshire or Ceredigion. This regional approach would ensure that the differences in county infrastructures, strengths, assets and communities are identified and responded to in ways that are appropriate to each County, within an agreed regional vision, set of objectives, and evaluation/impact framework.

To this end, the project would be formed of two elements, micro-enterprises and social enterprises. These which would run alongside each other with touchpoints where there are similarities and crossovers in the work, such as quality assurance, workforce development, creative options and choice & control for people who use direct payments and most importantly a cohesive offer from the perspective of the general public. Likewise, there will also be some areas of divergence, such as supporting organisations with constitutional arrangements and the types of service being delivered.

The project would be managed and delivered by a partnership involving the three local authorities and health board as statutory partners; PLANED, Community Catalysts and other local partners to deliver the micro-enterprise element; and the three local CVCs to deliver the social enterprise element. A Change Group would provide the governance arrangements in relation to setting the strategic direction, overseeing implementation, delivery of objectives and evaluation of impact and outcomes.

Priority population group

- Older people including people with dementia
- Children and young people with complex needs

• People with learning disabilities and neurodevelopmental conditions including autism • Unpaid carers • People with emotional and mental health wellbeing needs
Key enablers
• Integrated planning and commissioning • Technology and digital solutions • Promoting the social value sector • Integrated community hubs • Workforce development and integration
New or existing investment
New
Estimated total cost
314,998

Start date	**Estimated completion date**
1st April 2022	31st March 2027

Regional investment model

Title of project to support Model of Care 1	
West Wales Catalysts for Care	
Funding elements	**Select**
Element 1 - Acceleration funding year 1	**x**
Element 1 - Acceleration funding year 2	**x**
Element 2 - Embedding fund year 1	**x**
Element 2 - Embedding fund year 2	**x**
Element 2 - Embedding fund year 3	**x**
Element 3 - Legacy integrated pooled fund	
Element 4 – National priorities (Dementia and Memory Assessment Services/ Diagnostic Support)	

Provide the rationale for the element selected.

Element 1 has been selected as the funding requested will support the development and testing of a new model of care to the region through the West Wales Catalysts for Care project. Whilst a small scale Catalysts for Care project has been running in Pembrokeshire, this has not moved beyond initial concept phase due to COVID and the wider pressures on the care sector and needs further development and

testing of proof of concept. Furthermore, the concept has not been introduced at any level to Ceredigion or Carmarthenshire, and so the project will test out this new model of care on a regional footprint.

Within Year 1 & 2, resource has been built in to the funding schedule to ensure that there are clear governance arrangements in place and that there is capacity to undertake robust evaluation to measure impact and evidence the delivery of outcomes. Should this evaluation demonstrate that the proof of concept has been successful in delivering the project objectives, then it would be requested that the model of care be considered to move in to the embedding change fund.

It is anticipated that during Year 1 and 2 there will be opportunity to explore reducing some regional costs once the project has been established, although at this stage the level of reductions possible is unknown.

As outlined below under Delivery Partners, match funding has been identified across Element 1 to the level of 10% and should the project move in to Element 2, then match funding / resources to the value of 30% will be allocated to project.

Delivery partners

Title of project to support Model of Care (programme)				
West Wales Catalysts for Care				
Delivery Partners	**Welsh Government contribution**	**Partner match monetary**	**Partner match resource**	**Total funding required**
Local Authority				**£314,998**
Social Value Sector	£283,498	£31,500	**Staffing / Buildings / Income**	
Health Board				

Regional Integration Fund (RIF) Project plans

Title of your project
Social Investment & Innovation Fund: Creating the Infrastructure to Deliver Differently
Main Model of Care[1] (programme) that the project supports
Model 1: Community Based Care – Prevention & Community Co-ordination
Any additional Models of Care[1] the project will contribute towards

Model 2: Place-based care- complex care closer to home

Model 3: Promoting good emotional health & wellbeing

Model 4: Preventing children entering care & supporting children to remain with their families

Model 5: Home from Hospital

Model 6: Accommodation based solutions

The **Social Investment & Innovation Fund** will support the co-production of new activities and services that contribute to the development of active, resourceful, connected, sustainable and kind communities where people can live interdependently, healthily and happily in their own homes and communities for as long as they choose to do so.

The **Social Investment & Innovation Fund** will be themed across **all priority models of care**, population groups and enablers.

Project Summary

This proposal builds on the success of the innovation funds built into former funding programmes for people with learning disabilities, unpaid carers, and themes of work delivered across population groups. The project aims to transform health, care & wellbeing services by establishing an investment framework that will support and encourage third sector and community providers to co-design and co-deliver new models of care and support.

The **Social Investment & Innovation Fund** framework will offer:

- **Micro grants** – to support the development of small-scale, hyperlocal activity based on identified need and approved by CVCs, Community Connectors and Social Prescribers

- **Small grants** – County-based grant schemes with funding themes and criteria established by appropriate preventions partnerships (or equivalent) - administered by CVCs with decisions taken by a multi-agency and cross-sector panel. These grants could be targeted at particular population groups and/or enablers, as well as encouraging intergenerational working, social/green prescriptions, arts & nature based solutions, testing new ideas, etc.
- **Social Innovation & Collaboration Fund** – larger grants to support service transformation with a view to co-producing collaborative solutions to regional priorities identified through Market Stability Reports and the Population Needs Assessment. It is proposed to distribute these funds in a way that truly involves service users based on the way that the Learning Disabilities Innovation Fund was administered by the Dream Team (supported by Pembrokeshire People First with all guidance and applications being produced in Easy Read/short films) and the participatory budgeting pilots under Programme 7 of the Transformation Fund.

The **Social Investment & Innovation Fund** will support the following interconnected workstreams:

- Support for social enterprises under the *Catalysts for Care* proposal – social enterprises will be supported to co-produce services, work collaboratively, measure social value/impact, and develop an enterprising approach to sustainable service delivery
- Establishing the Regional Innovations Forum (potentially with County-based equivalents) for commissioners and providers to plan and co-produce services with an emphasis on social value
- Workforce development around adopting SROI and other tools to measure the social value and impact of service and activities and use this to drive social value commissioning and procurement

The **Social Investment & Innovation Fund** will deliver the following benefits:

Micro grants will support the development of volunteer-led and community-based activities that can be used by Community Connectors, Social Prescribers, Dementia Connectors and other link workers for signposting to clients. These activities will also build social connectedness, help combat loneliness and social isolation, and strengthen community resourcefulness and resilience.

Small grants enable commissioners to drive innovative practice to meet needs identified in market stability reports, etc. Groups are supported to test out different ways of doing things, piloting and evaluating new ideas and approaches. Successful pilots can then be scaled up, either with RIF funding (through the Accelerated Revenue Fund element) or through other funding sources, such as the Lottery or Trusts & Foundations – we have seen this happen in the past through the Caring Communities Innovation Fund. Small grants can also be used to encourage good practice, such as intergenerational working.

Social Innovation & Collaboration Fund – this element of the **Innovation Fund** will provide longer term and higher level funds to support the commissioning of co-produced and collaborative services to meet care, support and wellbeing needs. It will help to bring social enterprises fully into the care market, including domiciliary and residential care services. There is a link here to the Housing with Care capital fund to test new approaches to care at home, community land trusts offering sheltered or multi-generational communal living arrangements, care farms, nature-based care facilities, etc. Ultimately it is envisaged that these services will be directly commissioned and/or will be marketed to self-funders, people in receipt of direct payments, linked into day opportunities, etc.

A single **Social Investment & Innovation Fund** built into the RIF will provide the flexibility that is needed to support community investment and continuous improvement/innovation and will enable us to manage a pipeline of new projects coming into the Accelerated Revenue Fund. The Fund could also provide a vehicle for managing slippage in a more strategic way than is currently possible.
The **Social Investment & Innovation Fund** can be administered by the CVCs and overseen by a multi-agency and cross-sector steering group. However, every effort will be made to follow the best practice demonstrated by the Learning Disabilities Innovation Fund, where people with learning disabilities have been supported to be in the lead throughout the funding process. Participatory budgeting and other inclusive practices for grant distribution will also be used, where appropriate. In this way, the **Social Investment & Innovation Fund** will support service user voice, choice and control, involvement & engagement, service co-production and strengthening the role of the social value sector all of which is in line with the Social Services & Wellbeing Act and Welsh Government policy.

Priority population group(s)[2]

The **Social Investment & Innovation Fund** will support all the priority population groups

Key enablers[3]

The **Social Investment & Innovation Fund** can be used to strengthen all the key enablers identified in the RIF programme, particularly digital inclusion/technology enabled care and maximising the capacity of the social value sector in delivery care, support and wellbeing services.
This will enable regional innovation funds to be established for the priority population groups, as well as County-based micro and small grants schemes.

New or existing investment

The ICF/Transformation programmes have supported regional innovation funds for people with learning disabilities and unpaid carers, as well as County-based micro and small grants schemes eg the Pembrokeshire Supporting Community Action Fund (previously the Caring Communities Innovation Grant).
Estimated Total Cost
For Year 1, funds are requested to develop the framework for this funding, to enable the move from open grants schemes and towards a truly co-productive approach. £150,000 is requested for this work and an initial round of funding, working closely with commissioners to target the scheme towards priority areas. This figure is indicative only. To some extent, the value of the Innovation Fund can be established year on year by the Regional Partnership Board. As previously mentioned, the Innovation Fund could also be used as a vehicle for the strategic management of in-programme slippage. It is important to provide some consistency across the years of the RIF programme so that we move away from short-term grant funding based on slippage (often only allowing 3 months for delivery) and give groups sufficient time to set up, deliver and evaluate services, as well as building sustainable delivery models for the future.

Start date	**Estimated completion date**
1st April 2022	**31st March 2027**

Regional investment model

Title of project to support Model of Care 1	
Social Investment & Innovation Fund: Creating the Infrastructure to Deliver Differently	
Funding elements	**Select**
Element 1 - Acceleration funding year 1	**x**
Element 1 - Acceleration funding year 2	**x**
Element 2 - Embedding fund year 1	
Element 2 - Embedding fund year 2	
Element 2 - Embedding fund year 3	
Element 3 - Legacy integrated pooled fund	
Element 4 – National priorities (Dementia and Memory Assessment Services/ Diagnostic Support)	

Provide the rationale for the element selected.

We have run a number of grants schemes using funding and slippage from ICF, Transformation and other funding sources, to enable access to these funding streams for the wider partnership. We now need to move towards a more sustainable and targeted approach, clearly meeting the needs of commissioners, and citizens, and across population groups. This proposal sets out the approach to developing this Innovations approach, and since all projects supported through the Fund will be new, they sit clearly within Element 1 of the RIF funding.

Delivery partners

Title of project to support Model of Care (programme)				
Social Investment & Innovation Fund: Creating the Infrastructure to Deliver Differently				
Delivery Partners	**Welsh Government contribution**	**Partner match monetary**	**Partner match resource**	**Total funding required**
Local Authority				**£166,667**
Social Value Sector	£150,000	£16,667	**Staffing / Buildings / Income**	
Health Board				

Regional Integration Fund (RIF) Project plans

Title of project to support Model of Care 1
"Steady on… Stay Safe" (1. Community-based Care – prevention and community coordination)
Any additional Models of Care the project will contribute towards
3. Promoting good emotional health & wellbeing The emotional impact of falls effects the individual, their partners and family. It can contribute to increased isolation and low mood. The follow-up telephone calls will specifically question people about the emotional changes of the last 6 weeks or months for the individual and their family.

Project Summary

Purpose

The purpose of the Falls Service is to establish a co-ordinated approach to the prevention, assessment and management of falls in the community of Pembrokeshire, working in partnership with the local authority, 3rd sector, health staff and local residents.

Background

Falls and fall-related injuries are a common problem, but particularly for older people. Adults aged 65 and older have the highest risk of falling, with 30% of people over the age of 65 and 50% of people older than 80 falling at least once a year leading to distress, pain, injury, loss of confidence, loss of independence and mortality. Falling also affects the family members and carers of people who fall.

A Pembrokeshire Community Falls Prevention and Management Service was established in 2020 with an aim to reduce the incidence of falls and associated injuries in Pembrokeshire residents over the age of 65 years.

During this time the service has responded to an increasing number of referrals from a range of sources and existing staff have had to prioritise referrals from the Ambulance Service (WAST) and people who are judged to be at a greater risk of falls, injuries and admission to hospital.

Consequently, preventative and proactive interventions have taken a back seat. So, it has been recommended to separate these interventions from the response elements of the service.

The Approach

The project has four components:

1. **Education sessions** to Community Groups in Pembrokeshire.
    - To improve awareness of factors that increase risk of falls and to assist individuals to respond to their risk factors.
    - These sessions will be based on the “Steady on... Stay SAFE/ Sadiwch i... Gadw’n SAFF” leaflet (Note a).

2. **“Making Every Contact Count”** (Note b)
    - Education sessions to Staff and volunteers in 3rd Sector and Community Organisations in Pembrokeshire.
    - This session also is based around the “Steady on... Stay SAFE/ Sadiwch i... Gadw’n SAFF” resource.

3. **Home Assessments** (Note c)
    - Staff of 3rd Sector organisations, Community Groups, Delta Wellbeing and Housing organisations (including local authority) will be encouraged to refer people who have experienced two or more falls in the last 12 months.

4. **Data Collection** at 6 weeks and 6 months
    - Each individual attending education or being seen for an assessment will be offered a 6 week and 6 month telephone follow-up.
    - The aim of the call is to increase adherence to any behaviour change targets e.g. social prescribing or home changes.

- It also will help produce outcome data and show effect of the Steady On... Stay Safe intervention by way of outcome data (falls, injuries, presentations at GP/Minor Injuries or Emergency Department) as well as collection Patient Experience information as Patient Stories and Most Significant Change stories.

The proposal is for an initial 21 months of funding for one member of staff to deliver the 'Steady On … Stay Safe' initiative in Pembrokeshire.

This member of staff would join the two existing Clinical Falls Practitioners in the Pembrokeshire Community Falls Service.

As appropriate, this role will link with the ARMED initiative to incorporate the facility into pathways and make use of any learnings.

The project will be delivered by 1 WTE Band 4 Falls Assistant Practitioner.

Expected Outputs

At least 75 education sessions to public groups in Pembrokeshire.

At least 150 home assessments to individuals referred to the Falls Team, in addition to the current rate of 300 referrals to the Falls Service in the last calendar year.

The home assessments and telephone calls will produce over 150 social prescriptions in Pembrokeshire with telephone follow up to evidence take-up.

The two existing Clinical Falls Practitioners will carry out at least 6 'train-the-trainer' sessions to increase the number of people able to present information to their colleagues in Pembrokeshire community groups, 3rd Sector organisations and Local Authority teams.

Benefits (for users/patients)

It is anticipated that 75% of individuals will show evidence of greater physical ability (using the Rockwood Clinical Frailty Scale) or sustained activity after a social, prescription.

The activity of education sessions and home assessments will continue to raise the topic of Falls and self-management amongst people in Pembrokeshire. It will support people remaining independent at home with their families and will contribute towards making communities more resilient.

We anticipate that the individuals being follow-up at 6 months will show a reduced presentation at Emergency Department following a fall.

We anticipate that over 30 Patient Stories, using the Most Significant Change methodology will be produced within the 18 months, showing individual benefits and impacts.

There are also expected synergies with other projects and services

- The Steady On… Stay Safe project will link with the Pembrokeshire Falls Service. This will strengthen the Pembrokeshire response to the Future Generations Act and specifically the well-being goals
- The Pembrokeshire Falls Service is a small team that provides quick responses to referrals. The Steady On… Stay Safe project will assist the service to see more people, be responsible for more preventative interventions and conversely be better placed to respond to referrals for frailer individuals, through its exiting clinicians.
- The project will also help strengthen the crisis response of PCFS by supporting existing staff.
- Likewise it will strengthen the coordination and responses available through the Pembrokeshire Co-ordination Centre and Community Hubs.

Exit Plan

Direct, attributable savings off operating costs cannot be calculated because it is a proactive preventative initiative. Measuring either a reduction in falls or a reduction in hospital admissions or WASP attendances or GP visits directly attributable to any reduction in falls is not currently practical.

Therefore, the project will attempt to measure both its reach (number of people impacted) and the quality of its impact to demonstrate value. The exit plan must then consist of a discretionary assessment of value within which the whole system the service operates.

Priority population group(s)
The target population will be over-65 but 75% of referrals are likely to be over 70 years old with or without a diagnosis of dementia.

Key enablers
Support from the Co-ordination Centre and from two Clinical Falls Practitioners is essential to support a person into a new post and to deliver the new initiatives of this project. This project will be delivered through the Intermediate Care Team, which is planned and commissioned by Health and Social Care in partnership. This bid and this project have been discussed and is supported by the Clinical Lead Nurse in Urgent Care and Coordination. Support in social prescribing is also expected of the Community Connector project. The proposal is to trial the approach in Pembrokeshire, working closely with colleagues across West Wales to share learning and further develop into a regional initiative, building on experiences in Pembrokeshire.

New or existing investment
This is a new project, so the funding request is new.

Estimated Total Cost
£24,512

Start date	**Estimated completion date**
01/07/2022	**31/03/2024**

Notes

a) “Steady on... Stay SAFE:

This resource/leaflet has been developed by Age Cymru / Care and Repair and Age Connects Wales and we would establish a resource on Connect Pembrokeshire Web-site to promote this project and make this resource available electronically. Every participant in Education session would also be offered a physical copy of the leaflet, printed by Care and repair.

b) Making every contact count

to improve their confidence in talking with individuals about falls and risks of falls. These sessions will be based on the brief intervention package produced by Public Health Wales which is designed to help staff/people to feel more comfortable discussing falls and falls risk. The Clinical Falls Practitioners are trained to train others and would train and check competency of staff to deliver this session.

c) Home Assessments

These referrals will be triaged by Clinical Falls Practitioner and the Falls Assistant Practitioner would offer a Home-based assessment. The aim of the home based Multifactorial Falls Risk Assessment is to refer or signpost services to help the individual to lead to improved resilience and reduced frailty. The assessment will also follow current NHS advice for members of the public to prevent future falls https://www.nhs.uk/conditions/falls/prevention/

If medical illness is suspected to be the cause of falls such as cardiac or neurological cause then the Clinical Falls Practitioner will carry out the home based assessment or refer on to a more appropriate NHS professional. The individual will remain part of the Steady on… Stay Safe initiative and will still be counted in the follow up figures.

Social Prescribing will expected to be a frequent outcome of the assessment.

Regional investment model

Title of project to support Model of Care (programme)	
"Steady on… Stay Safe" (1. Community-based Care – prevention and community coordination)	
Funding elements	**Select**
Element 1 - Acceleration funding year 1	**X**
Element 1 - Acceleration funding year 2	**X**
Element 2 - Embedding fund year 1	
Element 2 - Embedding fund year 2	
Element 2 - Embedding fund year 3	
Element 3 - Legacy integrated pooled fund	
Element 4 – National priorities (Dementia and Memory Assessment Services/ Diagnostic Support)	

Provide the rationale for the element selected.

New proposal based on falls prevention, initially trialling in Pembrokeshire, but anticipate that the project can be scaled and replicated across the region in following years.

Delivery partners

Title of project to support Model of Care 1				
"Steady on… Stay Safe"				
Delivery Partners	**Welsh Government contribution**	**Partner match monetary**	**Partner match resource**	**Total funding required**
Local Authority				**£24,512**
Social Value Sector				
Health Board	£22,061	£2,451	**Staffing / Buildings / Income**	

Health & Social Care Regional Integration Fund

Investment Proposal

(West Wales)

Place based care – Complex Care Closer to Home

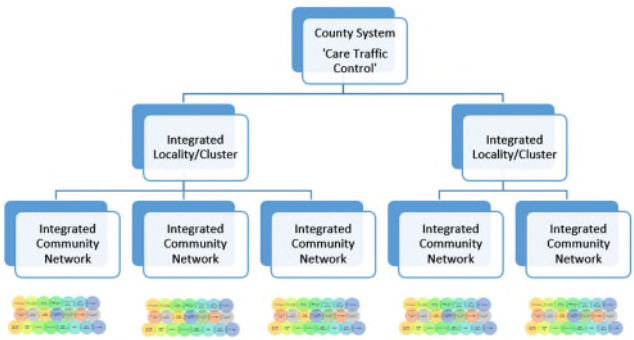
Place Based Care - Complex care closer to home – Strategic vision

> "To ensure every child, young person and adult in West Wales will be able to reach their full potential. To ensure fair access for all to excellent universal and targeted services that supports the health and wellbeing of all people. To develop skills and resilience that will last a lifetime and enable individuals to cope well with the challenges and pressures that they may face"

'Complex care closer to home' model should support implementation of the 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. This may include the following:

- Models of care that maximise recovery following a period of ill health or other life events, and reduce reliance on long-term care, through enablement and community rehabilitation, to maximise independence, reduce admission and long-term care dependence.
- Models of care that provide integrated coordinated care and support at home for individuals with more complex care and support needs for examples integrated Community Response Teams.
- Models of care that provide effect support for multiple health conditions and frailty within the community.

West Wales is moving away from a complex system of care centred upon layers of teams and criteria led services to one that uses the 'wrap around' concept with a 'patch based' approach. Developing integrated community networks to support strong communities will bring together multi-disciplinary teams to support GPs in delivering patch based, person centred care. 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, third sector, the health board, local authority, private sector, primary care and most importantly communities themselves. This programme will use the intelligence and relationships developed through *'Community Based Care- Prevention and Co-Ordination'* to move into a more co-productive culture. This is in the alignment with the strategic aim of the Urgent and Emergency Care strategy, which aims to prevent unnecessary escalation of care where possible, by providing proactive support, and to enable access to the right care, first time for people who have a need for urgent or emergency care.



Dementia Action Plan (DAP) Summary

For funding that supports the Dementia Action Plan, this summary should outline how older people including people with dementia can be supported by *"Place based care – Prevention and community coordination"*.

Model of Care (2 – complex care closer to home) Business case

Programme aims and objectives

The Quadruple Aim of *A Healthier Wales*[1] is used as a reference for setting the **aims and objectives** of this Programme. The four aims below, with associated SMART objectives listed below each:

Improved population health and well-being

- ✓ People will be equipped with the capability (knowledge, skills and motivation) to support their emotional health and wellbeing ('stay well')
- ✓ People will take greater responsibility for their emotional health and wellbeing
- ✓ People will take part in activity that promotes good emotional health and wellbeing

Better quality and more accessible health and social care services

- ✓ Providers deliver services that are aligned, accessible and fit for purpose
- ✓ People will understand what services are available
- ✓ People will appropriately judge which Health and Social Care services are most likely to meet their needs

Higher value health and social care

- ✓ Projects will be evaluated to understand the impact on demand reduction (statutory services)
- ✓ Projects will be evaluated to understand the extent to which they create system value

A motivated and sustainable health and social care workforce

[1] A Healthier Wales (gov.wales)

- ✓ Health and social care employers will promote the emotional health and wellbeing of their workforce

Each objective is *specific*. It will be necessary to define appropriate measures. An RBA approach will be taken to reflect: how much has been delivered (quantity); how well (quality); and 'is anyone better off?' (impact). It is a (Regional) condition of funding that monitoring and evaluation arrangements – as set out in the Regional RIF Evaluation Framework – are put in place for all supported projects at project inception.

Aims and Objectives in the wider context

Strategic Programme for Primary Care[2]:

'Deliverables' are varied and could result in:

- the launch of new or improved resources (e.g. service guidelines, new toolkits)
- changes to processes and systems to enable more effective and efficient ways of working.
    - shifting the focus to a 'social model of care'
    - ensuring timely access to primary care services across Wales
    - working closely with partners to strengthen services and achieve seamless working across the whole system
    - working on a 'once for Wales' basis. For example, this could be either:
        - championing and 'scaling up' of local initiatives across Wales
        - identifying solutions and enabling functions at a national level
        - A framework to support a coordinated approach to prevention in clinical settings.

[2] Strategic Programme for Primary Care v9.pdf (wales.nhs.uk)

Urgent and Emergency Care Goals[3]

Sets out expectations for health, social care, independent and third sector partners for the delivery of the right care, in the right place, first time for physical and mental health. This will be achieved through consistent and integrated delivery of six goals for urgent and emergency care to help achieve the best possible clinical outcomes, value and experience for patients and staff involved in the delivery of care.

An urgent or emergency need for advice, care or treatment is not predictable for the majority of people. However, some people are at greater risk of needing urgent or emergency care because of risk factors such as their age, frailty, a long-term condition(s), or other vulnerability; or as a consequence of health inequalities.

'Emergency' and 'urgent care' are frequently used interchangeably, with different perceptions in meaning and a sense of confidence that others have the same understanding. This can cause confusion with both care providers and the public, and can be detrimental because users of services want a clearer sense of service priorities and clarity in the purpose of different services to ensure they access the right service, first time. Therefore, we have determined that:

> • Urgent care: means health and wellbeing issues that may result in significant or permanent harm if not dealt with within the next 8 hours.
>
> • Emergency care: means health and wellbeing issues that may result in significant or permanent harm or death if not dealt with immediately.

West Wales Specific:

- Strengthen local collaboration in both the planning and delivery of services
- To agree what an Integrated Community Network model will look like in West Wales; how many, where and who
- To improve access to services (especially for our primary care colleagues)
- To build upon existing working relationships and promoting a culture of integration
- To improve our ability to share information appropriately
- To build processes that are streamlined that ensure value added at each step
- To develop our integrated intake hubs into a single 'front door' in each county

Programme outcomes:

- ✓ People are more involved in deciding where they live while receiving care and support

[3] Right care, right place, first time: Six Goals for Urgent and Emergency Care - A policy handbook 2021-2026 (gov.wales)

- ✓ Complex care and support packages are better at meeting the needs of people and delivered at home or close to home

Population Groups

The projects that are within this programme are primarily focused on meeting the needs of people who are:

- ➢ Older people including people with dementia
- ➢ People with learning disabilities and neurodevelopmental conditions including autism
- ➢ Unpaid carers

A future aspiration is that projects within this Model of Care will also support other priority population groups such as

- ➢ Children and young people with complex needs
- ➢ People with emotional and mental health wellbeing needs

Baseline

General

According to the Office for National Statistics (ONS), by 2025the population of the West Wales region is estimated at 389,719, an increase of 1.34% since the 2017 population assessment.

- 48.8% of the population in the region live in Carmarthenshire, 18.7% in Ceredigion and 32.5% live in Pembrokeshire.
- 40% of adults in Carmarthenshire; 49% of adults in Ceredigion and 22% of adults in Pembrokeshire speak Welsh.
- Current population projections by Welsh Government predict the total population of West Wales will increase to 396,000 by 2043, with a rise in those aged over 65 from 94,336 in 2018 to 124,587 by 2043.
- 2021 estimates from ONS indicate that people over 65 make up 24.1% of the population in Carmarthenshire, 26.2% in Ceredigion and 26.7% in Pembrokeshire and as large parts of West Wales are both rural and coastal, the area attracts high levels of inward migration of people over 65.

Children and Young People

According to Stats Wales, there are over 82,000 children and young people in the region, approximately 22% of the total population. The number of children and young people in the region is expected to stay relatively stable over the next 15 years, an estimated 6,105 of whom live with a long-term condition or disability. The pandemic presents new challenges to identifying risk. Children's Social Services have maintained face-to-face contact for children identified as at risk throughout the pandemic, however, most children not already identified as at risk will have only had virtual contact via video, telephone or online with services from their home with family members present. This is likely to have impacted on the opportunities for practitioners to identify abuse and for children to disclose harm.

The region has a lower number of looked After Children (LAC) than the national average. The Capped 9 point score (Year 11 pupils' best 9 results from qualifications available in Wales) is 361.7, above the Wales average of 353.8.

At 14%, the number of young people not in education, employment or training in West Wales is marginally lower than the Welsh average.

Gaps and areas for continuing improvement:

- Developing a pathway for services reflecting evidence-based best practice
- Further integration with early years services
- Further development of preventative and early intervention services, building on established programmes such as Family Information Services, Families First and Team Around the Family and trauma informed models of support
- Refocusing managed care and support to promote independence and wellbeing
- Considering the importance of physical, mental and emotional wellbeing of children and the key role of universal services in achieving this
- Enhancing partnership working, for example between social services, youth services, youth prevention services and other organisations to ensure that young people have access to social activities
- Developing community resilience and resilience and wellbeing in families and focus wherever possible on promoting family life and enabling children and young people to remain within their families and/ or communities so long as it is safe for them to do so
- Continuing development of multi-agency and individualised approach to supporting children with complex needs
- Developing a regional transition process for children and young people into adult services where appropriate.

Carers

The pandemic has increased pressure on existing unpaid carers, as reflected in an increase of 2073 in the number of requests for support.

The number of unpaid carers known to health and care services is significantly less than existing Census data, therefore continued work on supporting the early identification and awareness of the needs of unpaid carers is required.

Reluctance to place people in care homes (and, for many, the expanded opportunities to work from home) has expanded the number engaged in unpaid care. The trend is likely to continue in line with projections for older people making up a greater proportion of the population.

The emotional health and wellbeing of carers (including young carers) is likely to have been adversely affected and ensuring their needs are considered and providing timely support will play an important part of maintaining informal caring roles.

Learning Disability

COVID-19 has had a particular effect on mental health, well-being, health and feeling of isolation for individuals with LD and their care and support network. Furthermore, significant delays have been introduced in the services and care that people with LD access which has also significantly impacted their health and wellbeing. Many PMLD have been required to shield during the pandemic, limiting their opportunities to contribute to many of the consultations and planning events around services in LD, including the development of the PA which, as they are more likely to suffer the most health inequalities, needs to be mitigated once circumstances allow.

The population of people with a Learning Disability in west Wales is projected to remain relatively stable overall however, due to improved practice, projections suggest the number of people diagnosed with severe or profound and multiple learning disabilities (PMLD)is expected to grow by 1.8% each year. A diagnosis of PMLD is often combined with a complex range of health conditions.

Gaps and areas for improvement

- Re-establishing momentum in the development of integrated, person centred, co-produced services impacted by COVID-19
- Improving awareness of the needs of PwLD and through training and education of service providers, healthcare workers, families and carers
- Improving the quality of communication with and information for PwLD (easy read)
- Widening access to supported accommodation in a location of choice
- Strengthening access to education, volunteering and work opportunities in local communities
- Improving processes for managing transition between children's and adult services and specialist health services
- Supporting self-advocacy for PwLD
- Increasing planning and resources for PMLD and their carers.

Older People

West Wales has a higher proportion of older people than average across Wales, with inward migration a major accelerating factor for the growth of the older population. Pembrokeshire has an older population than Carmarthenshire and Ceredigion, with a predicted 93% increase in those over 85 by 2043.

People are living longer with increasingly complex issues, whilst wanting to remain in their own homes as independently as possible for as long as possible. Additional exacerbating factors of the pandemic on the older population include the negative effect on mental health that come with the social isolation caused by lockdown and potential increased care needs due to the longer-term impact on the health of those who contract COVID.

The COVID pandemic has led to widespread social isolation, with lasting implications on mental health in the older population group. Also, they have tended to delay seeking help during the pandemic and now are presenting later, with much more complex health issues often resulting in prolonged illness, that previously may have been prevented or treated more effectively. Due to the reported mortality rates in residential care due to COVID, older people are now far more resistant to go into residential care settings, resulting in a much greater demand for alternatives.

Future care and support should be co-designed to flex in response to changing demands and expectations and include a range of community, digital and technology-based solutions.

Gaps and areas for improvement

- Involving older people and their carers in assessment and care planning, including discharge planning
- Helping people to remain independent in their homes for longer through continuing development of digital and telehealth support including video consultations, monitoring and support for falls prevention, particularly for those in very rural areas and where transport is an issue
- Providing additional support for carers managing multiple and complex conditions
- Continuing development of community connectivity, well-being and resilience through community-based, user-led, co-produced services that address a range of needs including loneliness and isolation
- Addressing reduced demand for residential care by increasing supply of alternative accommodation options such as extra-care schemes.
- Ensuring older people and their families can access services through their language of choice and the active offer through the medium of Welsh is available

Dementia

In a review of expert consensus, it is concluded that the COVID-19 pandemic has had a disproportionately negative impact on PLwD, with dementia being shown as an age-independent risk factor for severity and death in COVID-19 patients. Although the exact impact of COVID on the diagnosis and incidence rate of dementia is unclear, stakeholders have identified that COVID has impacted timely diagnosis due to late presentations. There is also some concern that in some cases, COVID causes damage to the brain and long-term, this could lead to increased risk of developing dementia However, full information on the impact of COVID upon those with dementia and their carers is not yet available.

As life expectancy and inward migration of older people impacts on the percentage of older people in the region, the number of people living with dementia (PLwD) in west Wales is expected to increase in the coming decades. The Dementia Action Plan for Wales (DAP) 2018 – 2022 sets out a clear vision for "Wales to be a dementia friendly nation that recognises the rights of people with dementia to feel valued and to live as independently as possible in their communities."

Evidence, key messages and areas of improvement sourced from stakeholders and the regional dementia strategy have informed this new dementia section as follows:

- The incidence of dementia on the Quality Assurance and Improvement Framework (QAIF) disease register in Hywel Dda in 2019-20 was 0.7%, congruent with the Welsh national average of 0.7%
- In 2016-17 dementia diagnosis rates were one of the lowest in Wales at 45.6% indicating that prevalence rates are likely to be closer to 1.4% although, the number of those diagnosed has increased an average of 3% per annum to 2947 in 2020.
- Over thirty genetic, medical, lifestyle, cultural and societal factors have been identified, which impact the risk of cognitive decline differently depending on gender. Because of the unique aspect of the female brain, some of these factors increase risk more dramatically in women than in men.

Importantly, hormonal changes in the years leading up to and after the menopause have been shown to act as key underlying mechanism that can activate these risks as well as existing predispositions.

Gaps and areas for improvement

Summarised below, these were identified through co-production and engagement of the strategy although, it is expected that as the strategy and new pathways are developed, alternative gaps and areas for improvement may be identified:

- Continuing to improve awareness, identification, and diagnosis of dementia, including young onset dementia, to ensure timely diagnosis and access to appropriate care and support and long-term care as required
- Improving co-production of services by including PLwD in service design.
- Building on the dementia training framework, develop evidence-based best-practice workforce learning and development strategies
- Increasing diagnosis rates in non-specialist community settings by:
- Improving training and awareness of new evidence-based best practice dementia models within primary care, based on the Good Work Framework
- Supporting GPs, allied health professionals (AHPs) and nurses to make assessments
- Improving quality of referrals into specialist care for those requiring it
- Developing more consistent rights-based person-centred care and support
- Continuing improvements in community support, training and help for PLwD to discuss their diagnosis, navigate/co-ordinate services, to build resilience and maintain balance across all aspects of their life
- Ensuring equal access to physical health services and treatment for PLwD, as poor physical health is an inevitable consequence of dementia
- Ensuring advance care planning and end of life care is fully embedded in wider inclusive, person-centred care and wellbeing planning, which also considers general health issues, so that PLwD die with dignity in a place of their choosing
- Improving research into dementia by involving care homes in the region in current research opportunities
- Building on emerging data and intelligence to inform future evidence-based best practice and service development
- Continuing the development of a “hub” or single point of contact approach for PLwD to access information and support.

Carers

- The pandemic has increased pressure on existing unpaid carers, as reflected in an increase of 2073 in the number of requests for support.
- The number of unpaid carers known to health and care services is significantly less than existing Census data, therefore continued work on supporting the early identification and awareness of the needs of unpaid carers is required.
- Reluctance to place people in care homes (and, for many, the expanded opportunities to work from home) has expanded the number engaged in unpaid care. The trend is likely to continue in line with projections for older people making up a greater proportion of the population.

- Providing timely support and access to benefits advice will play an important part of maintaining informal caring roles.

Description of projects

Integrated Community Networks

West Wales has been on its *'integration'* journey for a number of years, the experience of COVID has brought the benefits of working together centre stage. Integration needs to be a default position, but to gain the most from working together, integration needs to be an organic process that reflects real people and real communities and must be supported by rather than defined by regional structures and requirements.

West Wales is well on the way to delivering the community infrastructure required to support the shift left and already has high quality Integrated Care Centres in the region with plans being advanced for other sites in partnership with the local authorities alongside a network of wellbeing hubs.

Moving forward, there are a number of areas in which we will focus our efforts to ensure meaningful integration, our intention is to develop Integrated Community Networks that will;

- Enable early recognition of higher risk people and their families ***(UEC Goal 1 and 6).*** Integration will enable this, as we will increase the networking opportunities across both professional and geographical boundaries.
- Work collaboratively and use a solution focussed approach to ensuring people remain in the most appropriate environment for them according to their needs and ***'What Matters'***[4] to them ***(UEC Goal 3 and 6)***
- Create integrated Teams: To deliver anticipatory and reactive care when required by an appropriately skilled individual or team ***(UEC Goal 4)***
- Enable integrated Decision Making and shared risk management- the evolution of county *'care control/ co-ordination hubs'*.
- Develop integrated Spaces: Physical and virtual spaces to facilitate team development across traditional boundaries and barriers.
- Enable integrated Rehabilitation/Re-enablement: To support people to remain or to return home.
- Produce integrated Information: To support appropriate decision-making and resource allocation and to evidence service delivery and outcomes.
- Integrate Budgets: To support local decision making to maximise the ease and impact of working together.

Forging Collaboratives with the Care Sector

This project sits firmly alongside the regional aspiration to develop local integrated community networks, which sees all assets within the patch working collaboratively ensuring resources are deployed efficiently as a ***whole system***. To deliver improved population health and wellbeing, better quality and more

[4] Direct payments and why "what matters" conversations and assessment are important. Resources for Wales | Social Care Wales

accessible health and social care services; higher value health and social care; and a motivated and sustainable health and social care workforce across public, private, independent and third sector. It is an extension of work commenced in response to the pandemic although there is evidence within the region of piloting this exact approach back in 2003- there is now the shared vision (and resource) required to deliver on this project.

The teams working in collaboration will be creative and innovative with their finite resource looking for ways that promotes efficiency and improves the experience of those we support. One way that teams have identified to do this is to conduct a review of manual handling services to encourage and embed single-handed care principles across all care sectors. In doing so this will encourage;

- Facilitating change to moving and handling practices and culture.
- Engagement of key enablers and champions across services/ sectors.
- Delivery of training.
- Risk assessment – embracing risk and enabling choice.
- Identification and provision of specialist equipment.
- More rapid stop and start of care packages as teams have an overarching view of the need within their *'patch'*

Accessible Health Checks

The project aims to promote the delivery of annual health checks by GP's in line with WG requirements and build and sustain relationships between primary care and LD service.

This will improve health outcomes for people with Learning Disabilities and brings together GP clusters, third sector support and LD secondary health care to improve uptake..

The project provides Learning Disability nurses and 3rd sector health check champions to link directly with GP's to improve uptake and involves people with learning disabilities to help improve services.

The project aims to improve the

- Quality
- Quantity
- Outcome

Of the annual health check and in so doing improve the overall health of people with a learning disability.

Knowing Your Rights - Income Maximisation

It is widely acknowledged that unpaid carers experience greater financial hardship than people without caring responsibilities do and that this can have a significant impact on their quality of life, overall wellbeing and future life opportunities.

Findings from research undertaken by Carers UK in November 2021 reported that:

- One in five unpaid carers are worried they may not cope financially over the next 12 months
- One in four carers (23%) may not have enough money to cover their monthly expenses

- Carers spend an estimated £1,370 a year on average on services or equipment for the person they care for
- Over half of carers (52%) feel anxious or stressed about their finances

Since this report was released, further pressures on the cost of living have been announced which will disproportionately impact many unpaid carers. These include rising fuel and household utility costs, inflation and National Insurance contributions.

The West Wales Carers Strategy 2020 – 2025 recognises the financial hardships that many carers face and in a survey of 558 carers from across West Wales in 2019/2020, it was identified that being a carer, particularly for those aged 35-44 years, impacted negatively on finances. A Regional Forward Planning Event in January 2020 also highlighted the importance of support to 'navigate the system', particularly in relation to financial benefit advice and accessing Carers Allowance. To this end, this project aligns with the following West Wales Carers Strategy priorities:

Priority 2: Ensure a range of services is available to support the well-being of Carers of all ages, in their life alongside caring

Priority 3: support Carers to access and maintain education, training and employment opportunities

Workforce Development

Provide a regional, integrated, work-based learning route for young people to enter the health and social care professions allowing young people to experience options across the health board and local authorities and seeing the work within a wider context of opportunity.

All three local authorities support the development and design of the programme and it has been agreed that Pembrokeshire will host the pilot administered by the LHB in partnership with the LA. Having one pilot will provide learning to perfect a model that can be replicated across all counties.

This application concerns the pilot which is expected to include 15 apprentices, all additional to the planned intake and address the following:

- Allow apprentices to try several aspects of Health and Social Care, before choosing a career to suit their career aspirations
- Contain Welsh language skills development
- Rotational placements that allow apprentices to experience various areas within community and social care
- Weekly attendance at college, working towards qualifications relevant to Health and Social Care
- Employability skills development workshops & support resources to support independence and increased autonomy within their role
- Quarterly skills development workshops, including team building skills
- Shadow opportunities with community, domiciliary and third sector organisations to broaden their understanding of multi-disciplinary working and how to make every contact count
- Bespoke training courses (e.g. sign-language, learning needs, mental health)

- Access to additional units to support multi-disciplinary working (OT, Physio, Speech & Language, Dietetics, Rehabilitation)
- Reverse mentoring to shape the future of Health and Social Care
- Bi-monthly site visits to be agreed to support their career aspirations (conferences, exemplar health and care providers, educational visits)
- Pastoral support
- Monthly action learning sets
- Well-being programme built into the programme

Integrated Community Continence and Physiotherapy pelvic health service

The project will develop a multi-disciplinary, integrated programme of pelvic health care with a strong focus on prevention and early intervention combining therapies and mental health provision into medical, social, and nursing pathways, delivering community-based care, close to home. Early intervention through MDT assessment within the community will prevent and avoid admissions to health and social care.

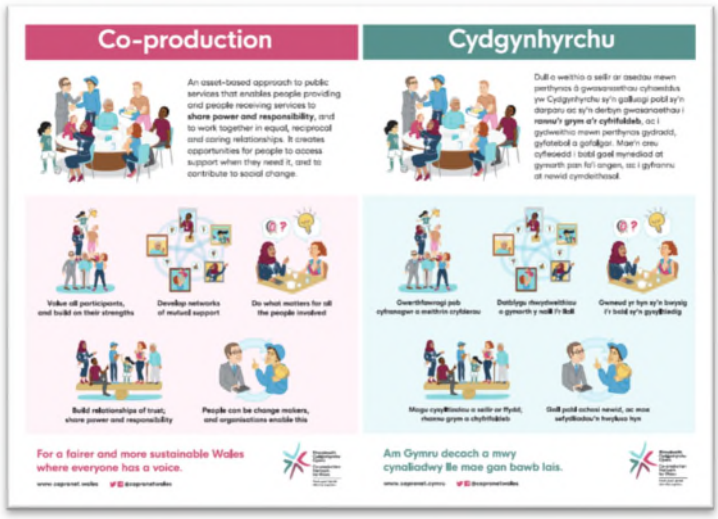
The development of a Pelvic Health Service MDT will enhance its pathways, creating holistic, person centred and biopsychosocial model of care. The project will enable the development of the following:

- Enable development of a new model of psychological care within pelvic health pathways by training and upskilling MDT in psychological interventions, “right time, right place” and providing access to specialist psychological treatments within a stepped care approach.
- Enhance existing community continence services by embedding expert physiotherapy pelvic health and specialist health psychology skills to ensure a cultural shift to proactive prevention and early intervention for patients presenting with continence problems. Ensure easy and local access for help and support that is imbedded within the community, shifting away from secondary care.
- Development of evidence-based MDT interventions e.g Pelvic Health Pain Management Group, Pelvic Floor MDT Programme across the region.
- Replicate and test remote service delivery utilising developments in digital technology to enhance breadth

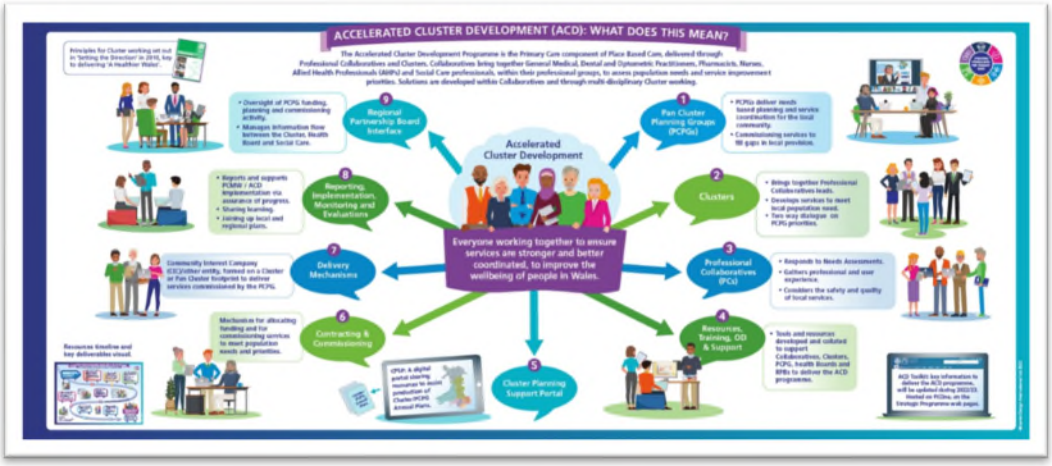
Model of Care (2- complex care closer to home) - Key enablers

Key Enablers	Select
Integrated planning and commissioning	X

The introduction of Pan Cluster Planning Groups [5] (PCPGs) is to deliver the aims of the Social Services & Well-being Act 2014 (the Act), The Wellbeing of Future Generations Act (2015) and A Healthier Wales. This builds upon current innovative practice and seeks to increase alignment and engagement between the Regional Partnership Board, Innovation Forum and Cluster arrangements bringing services together at a local level. PCPGs will be established as sub-groups of Health Boards and will operate under the auspices of the Regional Partnership Board (RPB) giving a direct route for information sharing and decision making between frontline services and strategic leadership.



A Healthier Wales remains the overarching policy context for health and social care and drives our commitments to deliver seamless care. Integrated plans must focus on improving population health as the mechanism to deliver health equity, learning from the pandemic and address the impact of issues such as obesity and smoking on people's outcomes.[6]To plan future IMTPs effectively and efficiently, organisations need to commit to simplify and



streamline the existing planning landscape creating a culture of inclusivity to support the development of co-produced, collaborative, *integrated* plans for the future population- requires alignment with the Accelerated Cluster Development work to deliver pan cluster/locality planning.

[5] 4 – Pan-cluster planning groups (PCPGs) - Primary Care One (nhs.wales)
[6] NHS Wales Planning Framework 2022-2025 (gov.wales)

Commissioning is a vital part of system change that needs to align with the changes in moving towards the Integrated Community Networks' culture of asset based and joined up practice. There is a need to move away from the 'Time and task' approach to one based on person-centred outcomes. Significant decisions about the provision of care is dictated by the budget from which the care is commissioned- a shift towards a *'funding fed'* approach as opposed to '*funding led'*. Commissioning should be undertaken on the basis of agreed principles:- • Understanding the needs of users and communities by undertaking effective and comprehensive engagement; • Consulting potential and existing provider organisations, including those from the third sector, and local experts well in advance of commissioning new services, working with them to set priority outcomes for that service; • Putting outcomes for users at the heart of the strategic planning process; • Mapping the fullest possible range of providers with a view to understanding the contribution they could make to delivering those outcomes; • Investing in the development of the provider base, • Ensuring contracting processes are transparent and fair, facilitating the involvement of the broadest range of suppliers • Ensuring long term contracts and risk sharing, wherever appropriate, as ways of achieving efficiency and effectiveness; and • Seeking feedback from service users, communities and providers in order to review the effectiveness of the commissioning process in meeting local needs.[7] NHS Wales Planning Framework 2022-2025 (gov.wales) Link to Innovations Forum (SV Forum)	
Technology enabled care	X
Digital technology plays a key role in making patient care more efficient and safe- this is especially true when co-ordinating and delivering complex care in the community. Digital technology allows professionals to easily record and share information centred on the person receiving support. Achieving our goal may require close partnership working with other suppliers or ongoing projects such as; • Delta TEC • Digital solutions • Connect platforms • Assist my Life It has the potential to make care seamless and improve communications between services and organisations. It also has a huge potential to free up staff time to focus on patient care. • Our key focus areas will be: • Integration with the partners to take forward the digital programmes and related population health initiatives	

[7] 4 – Pan-cluster planning groups (PCPGs) - Primary Care One (nhs.wales)

• Unlocking the power of information to improve decision making at the point of care • Exploiting digital technologies to deliver patient centred solutions in neighbourhoods and communities • Keeping patient and service user's information safe, secure, and up to date, and only used with appropriate governance and controls • Improving organisational digital maturity, and user digital literacy to maximise the benefits of digital technologies • Delivering digital services, paper-free at the point-of-care	
Promoting the social value sector	X
The Innovation Fund will support the co-production of new activities and services that contribute to the development of active, resourceful, connected, sustainable and kind communities where people can live interdependently, healthily and happily in their own homes and communities for as long as they choose to do so. Developing solutions based on the needs that are identified, working with other – citizens and service users	
Integrated community hubs	?
This will require significant development and redesign of community space and our key principles for design will be: • Services which have to be delivered within a building to be co-located to best suit multi-professional and one stop models • Teams who would benefit from being co-located to be so • Delivery of services as close to the population as possible • Community/Wellbeing hubs in partnership will all stakeholders around the wider network of mobile teams, community assets that can be connected • Ensure that the estate supports the sustainability of all primary and community services • There will be sufficient space configured to enable multi-disciplinary working, large training, and group use • Sufficient space for safe storage and these will be located to enable mobile workers to have easy access to equipment and supplies Transforming Day Opps – provide links across the whole community for people accessing day services	
Workforce development and integration	X
Our starting position is significantly challenged by: • High levels of staff sickness absence- particularly in relation to stress, anxiety and depression • High levels of anticipated retirement in the next 5 years • Challenges in recruiting to specialised roles- team leadership, specialist nurses and advance practitioners, social workers • Temporarily funded posts through ICF,TF, and cluster funding which will require substantive commitment where there is evidence of delivery and impact	

Workforce development is a key tenet in the delivery of community based complex care. This will require • Workforce analysis • Remodelling and therefore repurposing of roles • An innovative approach to consider the possibility of cross boundary (in every sense) working	

Priority population groups

Priority population groups	Primary	Secondary	DAP
Older people including people with dementia	**X**		
Children and young people with complex needs			
People with learning disabilities and neurodevelopmental conditions including autism*		**X**	
Unpaid carers*	**X**		
People with emotional and mental health wellbeing needs	**X**		

Other beneficiaries

If there are other stakeholders benefiting from the programme, please provide this detail below.

Total programme cost and match funding projection

Provide a breakdown of the total programme cost, Welsh Government contribution, partner monetary and resource match including costs attributed to support unpaid carers and / or social value sector delivery. You can find more information on match funding in the guidance notes.

Total cost of Programme	Welsh Government contribution	Partner match monetary	Partner match resource	% support for unpaid carers	% for social value sector delivery
£3,413,311	£2,654,919	£758,392		3.12%	1.15%

Programme resource and management details

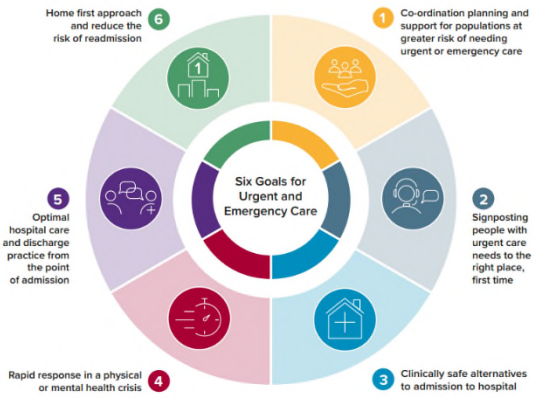
Provide a summary of the planned resource and roles required to deliver this specific programme. These roles are 100% funded via the RIF and will accounted for within the allocated fund.

Posts / type of roles	Estimated FTE	Costs

Project Plan - Integrated Community Networks

Title of project
Integrated Community Networks
Any additional Models of Care the project will contribute towards
• Community based care – prevention and community coordination • Promoting Good Emotional Health and Wellbeing • Supporting families to stay together safely, and therapeutic support for care experienced children • Home from Hospital • Accommodation based solutions
Project Summary

Although West Wales has been on its *'integration'* journey for a number of years, the experience of COVID has brought the benefits of working together centre stage. Integration needs to be a default position, but to gain the most from working together, integration needs to be an organic process that reflects real people and real communities and must be supported by rather than defined by regional structures and requirements.

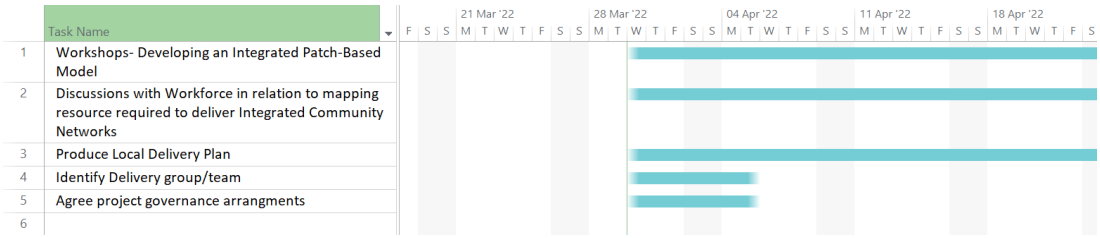


West Wales is well on the way to delivering the community infrastructure required to support the shift left and already has high quality Integrated Care Centres in the region with plans being advanced for other sites in partnership with the local authorities alongside a network of wellbeing hubs.

Moving forward, there are a number of areas in which we will focus our efforts to ensure meaningful integration, our intention is to develop Integrated Community Networks that will;

- Enable early recognition of higher risk people and their families ***(UEC Goal 1 and 6).*** Integration will enable this, as we will increase the networking opportunities across both professional and geographical boundaries.
- Work collaboratively and use a solution focussed approach to ensuring people remain in the most appropriate environment for them according to their needs and ***'What Matters'*** to them ***(UEC Goal 3 and 6)***
- Create integrated Teams: To deliver anticipatory and reactive care when required by an appropriately skilled individual or team ***(UEC Goal 4)***
- Enable integrated Decision Making and shared risk management- the evolution of county *'care control hubs'*.
- Develop integrated Spaces: Physical and virtual spaces to facilitate team development across traditional boundaries and barriers.
- Enable integrated Rehabilitation/Re-enablement: To support people to remain or to return home.
- Produce integrated Information: To support appropriate decision-making and resource allocation and to evidence service delivery and outcomes.

- Integrate Budgets: To support local decision making to maximise the ease and impact of working together.



Priority population group(s)

The development of the Integrated Community Networks will have an impact across all of the priority population groups. However, 'Older People' will be the main beneficiaries due to the complex nature of the care often provided.

- Older people including people with dementia
- Unpaid carers

Key enablers

Integrated planning and commissioning

Integrated Community Networks are expected to be fully engaged with and form part of the membership of pan-cluster planning groups as part of the *'Accelerated Cluster Development Fund'.* To plan future IMTPs effectively and efficiently, organisations need to commit to simplify and streamline the existing planning landscape creating a culture of inclusivity to support the development of co-produced, collaborative, *integrated* plans for the future population.

Commissioning is a vital part of system change that needs to align with the changes in moving towards the Integrated Community Network's culture of asset based and joined up practice. There is a need to move away from the 'Time and task' approach to one based on person-centred outcomes. Significant decisions about the provision of care is dictated by the budget from which the care is commissioned.

Technology and digital solutions

Digital technology plays a key role in making patient care more efficient and safe. Digital technology allows clinicians to easily record and share information centred on the patient. It has the potential to make care seamless and improve communications between services and organisations. It also has a huge potential to free up clinician / staff time to focus on patient care.

Our key focus areas will be:

- Integration with the partners to take forward the digital programmes and related population health initiatives
- Unlocking the power of information to improve decision making at the point of care
- Exploiting digital technologies to deliver patient centred solutions in neighbourhoods and communities
- Keeping patient and service user's information safe, secure, and up to date, and only used with appropriate governance and controls
- Improving organisational digital maturity, and user digital literacy to maximise the benefits of digital technologies
- Delivering digital services, paper-free at the point-of-care

Integrated community hubs

This will require significant development and redesign of community space and our key principles for design will be:

- Services which have to be delivered within a building to be co-located to best suit multi-professional and one stop models
- Teams who would benefit from being co-located to be so
- Delivery of services as close to the population as possible
- Community/Wellbeing hubs in partnership with Local Authorities around the wider network of mobile teams, community assets that can be connected
- Through the use of technology we will network premises within each ICN and network the hubs across the County and Regional centres
- Ensure that the estate supports the sustainability of all primary and community services
- There will be sufficient space configured to enable multi-disciplinary working, large training, and group use
- Sufficient space for safe storage and these will be located to enable mobile workers to have easy access to equipment and supplies

Workforce development and integration Our starting position is significantly challenged by: • High levels of staff sickness absence- particularly in relation to stress, anxiety and depression • High levels of anticipated retirement in the next 5 years • Challenges in recruiting to specialised roles- team leadership, specialist nurses and advance practitioners • Temporarily funded posts through ICF,TF, and cluster funding which will require substantive commitment where there is evidence of delivery and impact
New or existing investment
New investment
Estimated Total Cost
£1,882,827

Start date	**Estimated completion date**
1st April 2022	**31st March 2024**

Regional investment model

Select the funding element which the project will be set against. Repeat the table and rationale below for each project.

Funding elements	**Select**
Element 1 - Acceleration funding year 1	**X**
Element 1 - Acceleration funding year 2	**X**
Element 2 - Embedding fund year 1	**X**
Element 2 - Embedding fund year 2	**X**
Element 2 - Embedding fund year 3	**X**
Element 3 - Legacy integrated pooled fund	
Element 4 – National priorities (Dementia and Memory Assessment Services/ Diagnostic Support)	

Provide the rationale for the element selected.

This will support the development and testing of a new collaboration of initiatives that will primarily support this model of care, but also the other 5 RIF models of care.

Whilst some elements of the proposal are using existing resources in West Wales, this is a new model of support that redefines and re-structures the work

A number of these initiatives need further development and testing of proof of concept. Other elements of this proposal will be completely new and will cover the entire proof of concept phase.

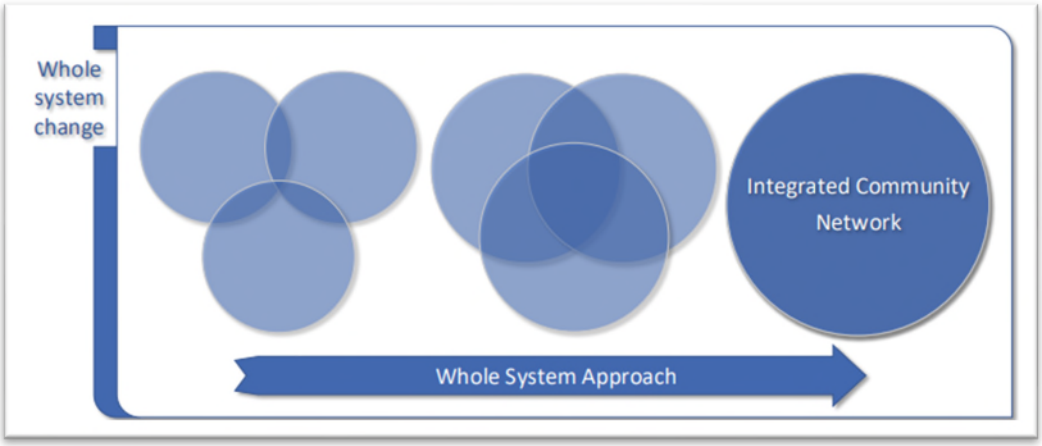
Delivery partners

Include details of local LHBs, local authorities, third sector and other providers that will support in the delivery of the projects. In this section you will also need to explain what they bring to the project by means of match contribution. This can be evidenced by either monetary or resource match. Repeat the table below for the number of projects being put forward.

RPBs will be expected to invest a **minimum of 20%** of their RIF allocation in delivery through social value sector organisations. RPBs should be connecting closely with their social value forums to ensure the wider sector can be engaged in the planning, design and delivery of these Models of Care. The information provided below will help aggregate the social value sector involvement at programme level.

Delivery Partners	Welsh Government contribution	Partner match monetary	Partner match resource	Total funding required
Local Authority	£610,138	£130,437	**Staffing / Buildings / Income**	**£1,882,827**
Social Value Sector				
Health Board	£835,131	£307,122	**Staffing / Buildings / Income**	

Project Plan - Forging Collaboratives within the Care Sector

Title of project
Forging Collaboratives within the Care Sector
Any additional Models of Care the project will contribute towards
• Community based care – prevention and community coordination • Promoting Good Emotional Health and Wellbeing • Supporting families to stay together safely, and therapeutic support for care experienced children • Home from Hospital • Accommodation based solutions
Project Summary
Ever-increasing demands on wider NHS and Social Care services, an aging population and increased public expectations places increased pressure on an already fraught service. Current models of health and a separate system of social care is not a fit model for the future of our population in West Wales. There are strong, foundations within the region upon which to build and deliver a bespoke, innovative and improved service to our population- together! The current structure of the social care market for adults is a monopsony. Local authorities are the main buyer of the social care market; in the context of austerity, this market structure and pressurised budgets has caused a driving down of fees and costs. Care providers are often competing within the same local area by minimising costs to win contracts. With the main costs for providers being labour, pay, terms and conditions are a cost to be minimised to ensure providers can win contracts. This has led to downward pressure on pay and on terms and conditions. The vision is to deliver improved outcomes, as well as better value for money and an environment of partnership with the independent sector to commission new sustainable care models.    Whilst there are nuances in each county and indeed each cluster or community, the local issues are broadly the same. The proportion of older people is greater than the national average, further exacerbating the need for change. Services in Wales have evolved over time to reflect the need of the population often leading to several ‘add-on’ roles or services, often funded temporarily. We plan services

based on the funding offered leading to a 'funding led service as opposed to being funding fed'. This has led to duplication of services, complex care and referral pathways, layers of eligibility criteria that then leads services to attempt to 'hand-off' to others instead of developing a culture of shared responsibility when people needing support slip through the gaps.

This project sits firmly alongside the regional aspiration to develop local integrated community networks, which sees all assets within the patch working collaboratively ensuring resources are deployed efficiently as a ***whole system.*** To deliver improved population health and wellbeing, better quality and more accessible health and social care services; higher value health and social care; and a motivated and sustainable health and social care workforce across public, private, independent and third sector. It is an extension of work commenced in response to the pandemic although there is evidence within the region of piloting this exact approach back in 2003- there is now the shared vision (and resource) required to deliver on this project.

The teams working in collaboration will be creative and innovative with their finite resource looking for ways that promotes efficiency and improves the experience of those we support. One way that teams have identified to do this is to conduct a review of manual handling services to encourage and embed single-handed care principles across all care sectors. In doing so this will encourage;

- Facilitating change to moving and handling practices and culture.
- Engagement of key enablers and champions across services/ sectors.
- Delivery of training.
- Risk assessment – embracing risk and enabling choice.
- Identification and provision of specialist equipment.
- More rapid stop and start of care packages as teams have an overarching view of the need within their 'patch'

In order to achieve the strategic aims we must focus on;

Partnership working

- Facilitates collaboration between Health, Social Care and Care providers in order to achieve the desired outcome of increasing individual's independence and reducing the need for formal care.

Prevention

- Prevents unnecessary hospital admission, inappropriate admission to residential care, and delayed discharges from hospital.
- Enables individuals to live independently at home by identifying appropriate equipment/ adaptations.
- Early intervention to make services sustainable into the future.

Innovation

- Supports reductions in packages of care/ preventing the need for a second carer to release the capacity of care providers. This enables care services to improve the way we meet demand by freeing capacity within the system.
- Using new equipment and moving and handling techniques facilitates a change in thinking (and culture) which in turn supports the delivery of sustainable care services to the local population.

National Outcomes Framework

- Improves the outcomes and well-being of people with care and support needs, and their carers through improving independence and reliance on formal care.
- The cost of care can be significantly and safely reduced by changing existing working practices in relation to manual handling.

- The end user experience is also significantly enhanced when a single carer is present when compared to 2 carers with evidence showing that people have more meaningful interactions and better satisfaction rates.

Challenges

- The domiciliary care market is fragile, recruitment and retention is increasingly difficult, the sector has an older workforce and is struggling to attract and retain the younger generation in a sustainable career path
- Providers operate in isolation not collaboration, seeing competition rather than opportunity
- Increased acuity, complexity of care delivered in the home, discharge to recover and assess, stress and anxiety in the workforce, behaviour management, health and safety issues, risks of handbacks from frontline staff feeling unsupported when faced with unresolved

Priority population group(s)

The development of the Integrated Community Networks will have an impact across all of the priority population groups. However, 'Older People' will be the main beneficiaries due to the complex nature of the care often provided.

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Key enablers

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Technology and Digital Solutions
Digital technology plays a key role in making patient care more efficient and safe. Digital technology allows care providers across all sectors to easily record and share information centred on the patient. It has the potential to make care seamless and improve communications between services and organisations. It also has a huge potential to free up staff time to focus on patient care.

Our key focus areas will be:
- Integration with the partners to take forward the digital programmes and related population health and well-being initiatives
- Unlocking the power of information to improve decision making at the point of care
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New or existing investment
New investment
Estimated Total Cost
£1,001,597

Start date	**Estimated completion date**
1st April 2022	**31st March 2024**

Regional investment model

Select the funding element which the project will be set against. Repeat the table and rationale below for each project.

Funding elements	**Select**
Element 1 - Acceleration funding year 1	**X**
Element 1 - Acceleration funding year 2	**X**
Element 2 - Embedding fund year 1	**X**
Element 2 - Embedding fund year 2	**X**
Element 2 - Embedding fund year 3	**X**
Element 3 - Legacy integrated pooled fund	
Element 4 – National priorities (Dementia and Memory Assessment Services/ Diagnostic Support)	

Provide the rationale for the element selected.

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Delivery Partners	Welsh Government contribution	Partner match monetary	Partner match resource	Total funding required
Local Authority	£423,225	£153,012	**Staffing / Buildings / Income**	**£1,001,597**
Social Value Sector				
Health Board	£349,318	£76,043	**Staffing / Buildings / Income**	

Project Plan - Knowing your rights

Title of project
Knowing your rights
Any additional Models of Care the project will contribute towards
• Community based care – prevention and community coordination • Promoting Good Emotional Health and Wellbeing • Supporting families to stay together safely, and therapeutic support for care experienced children • Home from Hospital • Accommodation based solutions
Project Summary
It is widely acknowledged that unpaid carers experience greater financial hardship than people without caring responsibilities do and that this can have a significant impact on their quality of life, overall wellbeing and future life opportunities. The West Wales Carers Strategy 2020 – 2025 recognises the financial hardships that many carers face and in a survey of 558 carers from across West Wales in 2019/2020, it was identified that being a carer, particularly for those aged 35-44 years, impacted negatively on finances. A Regional Forward Planning Event in January 2020 also highlighted the importance of support to 'navigate the system', particularly in relation to financial benefit advice and accessing Carers Allowance. To this end, this project aligns with the following West Wales Carers Strategy priorities: **Priority 2**: Ensure a range of services is available to support the well-being of Carers of all ages, in their life alongside caring **Priority 3**: support Carers to access and maintain education, training and employment opportunities Further support for this project is outlined in the findings of Carers UK who in November 2021 reported that: • One in five unpaid carers are worried they may not cope financially over the next 12 months • One in four carers (23%) may not have enough money to cover their monthly expenses • Carers spend an estimated £1,370 a year on average on services or equipment for the person they care for • Over half of carers (52%) feel anxious or stressed about their finances[8] Since this report was released, further pressures on the cost of living have been announced which will disproportionately impact many unpaid carers. These include rising fuel and household utility costs, inflation and National Insurance contributions. Within West Wales there have been two small scale and time-limited projects undertaken to support carers to maximise their incomes through bespoke information and advice, supporting them to navigate the numerous benefits and entitlements systems and pathways. However, there has not yet been evaluation of the outcomes of these exercises or of best practice from across Wales and the UK in terms

[8] Carers-Strategy-Final-20.10.20-Eng.pdf (wwcp.org.uk)

of the most effective model of support to ensure that carers are provided with specialist information and advice to maximise their incomes. The project would therefore consist of three parts: • Research to review the impact of West Wales pilot projects, as well as best practice models in providing specialist information and advice to carers to maximise their incomes • Scope a regional project for specialist information and advice for carers with respect to income maximisation that can be developed and tested • Initiate testing of proof of concept through delivery of the scoped project as described in (2), in a manner that delivers against regional objectives as outlined in the West Wales Carers Strategy, as well as reflecting local differences in service delivery and infrastructures
Priority population group(s)
• Unpaid carers
Key enablers
• Integrated planning and commissioning • Promoting the social value sector • Integrated community hubs • Workforce development and integration
New or existing investment
New investment
Estimated Total Cost
£92,149

Start date	**Estimated completion date**
1st April 2022	**31st March 2024**

Regional investment model

Select the funding element which the project will be set against. Repeat the table and rationale below for each project.

Funding elements	**Select**
Element 1 - Acceleration funding year 1	X
Element 1 - Acceleration funding year 2	**X**

Element 2 - Embedding fund year 1	
Element 2 - Embedding fund year 2	
Element 2 - Embedding fund year 3	
Element 3 - Legacy integrated pooled fund	
Element 4 – National priorities (Dementia and Memory Assessment Services/ Diagnostic Support)	

Provide the rationale for the element selected.

As outlined above in the project summary, there is work to be undertaken to develop and test a 'proof of concept' for this project on a regional footprint. All work undertaken to date has been very small scale, not progressed beyond initial concept phase and has not been yet evaluated. Element 1 is therefore being selected in order to ensure that due resource and consideration is given to this project, as well as consideration of how, should it be funded beyond Element 1, it could be embedded within existing and developing models of care.

It is anticipated that should positive outcomes be delivered in Year 1, then Year 2 of Element 1 would also be requested.

Delivery partners

Include details of local LHBs, local authorities, third sector and other providers that will support in the delivery of the projects. In this section you will also need to explain what they bring to the project by means of match contribution. This can be evidenced by either monetary or resource match. Repeat the table below for the number of projects being put forward.

RPBs will be expected to invest a **minimum of 20%** of their RIF allocation in delivery through social value sector organisations. RPBs should be connecting closely with their social value forums to ensure the wider sector can be engaged in the planning, design and delivery of these Models of Care. The information provided below will help aggregate the social value sector involvement at programme level.

Delivery Partners	Welsh Government contribution	Partner match monetary	Partner match resource	Total funding required
Local Authority	£82,934	£9,215	**Staffing / Buildings / Income**	**£92,149**
Social Value Sector				
Health Board				

Project Plan - Annual Health Checks

Title of project
Annual Health Checks
Any additional Models of Care the project will contribute towards
• Promoting good emotional health and wellbeing
Project Summary
The project aims to promote the delivery of annual health checks by GP's in line with WG requirements and build and sustain relationships between primary care and LD service. This will improve health outcomes for people with Learning Disabilities and brings together GP clusters, third sector support and LD secondary health care to improve uptake.. The project provides Learning Disability nurses and 3rd sector health check champions to link directly with GP's to improve uptake and involves people with learning disabilities to help improve services. The project aims to improve the: • Quality • Quantity • Outcome Of the annual health check and in so doing improve the overall health of people with a learning disability. Key outcomes: • People's well-being needs are improved through accessing co-ordinated community-based solutions • Attendance at an effective Annual Health Check will ensure that any physical health issues are identified at an early stage when treatment options are more readily available. • The number of Annual Health Checks completed are available on a monthly basis as GP surgeries are paid to complete the checks. • Local prevention and early intervention solutions support people to avoid escalation and crisis interventions Discussion via a questionnaire with people with a learning disability and their carers will identify the individual's experience of the annual health check and ensure that a health action plan is developed as a result of the check. The team have collected baseline information on the amount of AHC carried out over the past 3 years as the pandemic had had a negative effect on the quantity of checks carried out. Initial data suggests that there has been a substantial increase in AHC completed when compared to pre-pandemic levels e.g. • LD Activity December 2019 (Based on ES Claims) • Carmarthenshire (13 Reviews) • Ceredigion (1 Review) • Pembs (1 Review) • TOTAL 15 reviews • LD Activity December 2021 (Based on ES Claims) • Carmarthenshire (35 reviews)

- Ceredigion (5 Reviews)
- Pembs (7 Reviews)
- TOTAL 47 reviews

A questionnaire has been developed to ask individuals and/or their carers about their experience of the AHC this information is based on a previous questionnaire used in a research project which will allow for comparison of data.
The team have also developed a simple health action plan which will allow data to be analysed with improved healthcare at the next AHC the key outcome.

Future Plans

- Embed team further and look at how work with new primary care liaison service will develop.
- To take an active role in the health liaison community of practice set up by Improvement Cymru
- Launch the new health profile across the HB
- Ensure the pre health check questionnaire and easy read invite letters are used consistently

The project aligns with a number of key local & national priorities but primarily the Learning Disability – Improving Lives Programme[9]

The annual health check (AHC) is one of the key drivers of the Improving Lives programme. The project team have worked closely with representatives from Welsh Govt to ensure that the project is in line with national strategies.

Improving Lives Recommendation:
Primary Health Care: Improve the take up and quality of annual health checks to monitor and identify health needs (target: 75% of all individuals registered with their GP practise who have a diagnosed learning disability are to have an annual health check).
Key Action: (1) Review the role of community learning disability teams to support delivery of the annual health checks (primary care cluster level), supporting step-down and children and young people's services. (2) Establish a community learning disability link nurse for every primary care cluster.
The West Wales Learning Disability Charter leads work undertaken by the Health Action Team. The health check champions report to the '*Dream Team'* and this ensures that all work of the team is informed by the people the service is intended to serve and meets the requirements of '*my health'* and the health actions contained within '*Improving Lives'.*

Priority population group(s)

- People with a learning disability

Key enablers

All 5 RIF enablers will contribute to the successful delivery of this project.

Technology and Digital solutions

[9] Learning disability: improving lives programme | GOV.WALES

Promoting social value sector
Workforce development and integration

New or existing investment	
New investment	
Estimated Total Cost	
£194,451	
Start date	**Estimated completion date**
1st April 2022	**31st March 2024**

Regional investment model

Select the funding element which the project will be set against. Repeat the table and rationale below for each project.

Funding elements	**Select**
Element 1 - Acceleration funding year 1	
Element 1 - Acceleration funding year 2	
Element 2 - Embedding fund year 1	**X**
Element 2 - Embedding fund year 2	**X**
Element 2 - Embedding fund year 3	
Element 3 - Legacy integrated pooled fund	
Element 4 – National priorities (Dementia and Memory Assessment Services/ Diagnostic Support)	

Provide the rationale for the element selected.

This is an existing established ICF project and the model has already been developed in part.

The project has reported to the Regional Improving Lives Partnership board (West Wales) and the Dream Team on progress made and outcomes delivered. Quarterly monitoring reports and case studies are available.

The project has potential to provide significant health benefits for the LD population and a business case will be developed to mainstream the provision to deliver WG expectations.

Match funding will be provided by equivalent staff resources employed by each partner. There is a focus on the healthcare needs of people with a learning disability from Welsh Government and an expectation to expand Annual Health Checks.

Delivery partners

Include details of local LHBs, local authorities, third sector and other providers that will support in the delivery of the projects. In this section you will also need to explain what they bring to the project by means of match contribution. This can be evidenced by either monetary or resource match. Repeat the table below for the number of projects being put forward.

RPBs will be expected to invest a **minimum of 20%** of their RIF allocation in delivery through social value sector organisations. RPBs should be connecting closely with their social value forums to ensure the wider sector can be engaged in the planning, design and delivery of these Models of Care. The information provided below will help aggregate the social value sector involvement at programme level.

Delivery Partners	Welsh Government contribution	Partner match monetary	Partner match resource	Total funding required
Local Authority				**£194,451**
Social Value Sector	£30,536	£13,087	**Staffing / Buildings / Income**	
Health Board	£105,580	£45,249	**Staffing / Buildings / Income**	

Project Plan - Workforce Development- Joint Integrated Apprentice Programme Pilot

Title of project
Workforce Development- Joint Integrated Apprentice Programme Pilot
Any additional Models of Care the project will contribute towards
• Community-based Care – complex care closer to home • Home from hospital • Accommodation-based solutions
Project Summary
<u>Purpose</u> Provide a regional, integrated, work-based learning route for young people to enter the health and social care professions allowing young people to experience options across the health board and local authorities and seeing the work within a wider context of opportunity. <u>Background</u> Overall, the attraction of applicants into qualified roles is regarded as difficult throughout the region leading to long recruitment times, some vacant posts and limited choice of candidates during selection. Generally speaking, the HB experiences far more applications for apprenticeships than it has posts while the LAs struggle to attract as many applications in the care worker sector. Though there is overlap in some areas, young people are asked to choose at early stage without good information with which organisation they should pursue employment and once qualified LHBs and LAs compete for each other's professionals from the same pool. Exploratory work has been undertaken in consultation with the Regional Workforce Programme Board (RWPB) involving HDUHB and the Pembrokeshire, Ceredigion and Carmarthenshire LAs to develop synergies in workforce development across the region. As a result of this, attracting local young people into the sector was identified as a priority. <u>Approach</u> It is proposed to develop an integrated apprenticeship programme for the region over 3 years, consisting of a pilot year in 22/23 followed by an evaluation and, if successful, the rollout of an improved design in year in 23/24 and an embedding and consolidation year in 24/25, ending in August 2025. Therefore, although a 3 year programme, the tail end of the 3rd year will extend into the second quarter of the 4th financial year. All three local authorities support the development and design of the programme and it has been agreed that Pembrokeshire will host the pilot administered by the LHB in partnership with the LA. Having one pilot will provide learning to perfect a model that can be replicated across all counties. This application concerns the pilot which is expected to include 15 apprentices, all additional to the planned intake and address the following: • Allow apprentices to try several aspects of Health and Social Care, before choosing a career to suit their career aspirations

- Contain Welsh language skills development
- Rotational placements that allow apprentices to experience various areas within community and social care
- Weekly attendance at college, working towards qualifications relevant to Health and Social Care
- Employability skills development workshops & support resources to support independence and increased autonomy within their role
- Quarterly skills development workshops, including team building skills
- Shadow opportunities with community, domiciliary and third sector organisations to broaden their understanding of multi-disciplinary working and how to make every contact count
- Bespoke training courses (e.g. sign-language, learning needs, mental health)
- Access to additional units to support multi-disciplinary working (OT, Physio, Speech & Language, Dietetics, Rehabilitation)
- Reverse mentoring to shape the future of Health and Social Care
- Bi-monthly site visits to be agreed to support their career aspirations (conferences, exemplar health and care providers, educational visits)
- Pastoral support
- Monthly action learning sets
- Well-being programme built into the programme

Expected outputs

- Integrated professional brand for health and social care workers that is attractive for young people.
- A sustainable pipeline of local young people entering the sector
- 100% attraction rate into pilot
- 86% retention rate of candidates after year 1
- Targeted 33.33% and 66.66% spilt joining LHB and LA respectively in line with vacancy projection
- Enhancement of number and quality of new entrants into health and social care support worker roles
- Joint proposal for regional year 2 rollout based on learnings of year 1 pilot in Pembs

Benefits (user groups)

- Employment opportunities for young people in the local population for work-based learning.
- Lift in status and esteem associated with care support work
- Increased capacity from regular supply of workers should improve responsiveness and coverage in sector

Exit Plan

As year one 22/23 is a pilot, there is an exit possibility in summer 2023 if the pilot is unsuccessful.
If the regional rollout proceeds and is embedded, then it is expected that the costs could be folded into current programmes at a level proportion to the projected intake and it would no longer be “additional”.

Priority population group(s)

All client groups who benefit from health and social care in the home should benefit, especially: • Older people including people with dementia • People with learning disabilities, neurodiverse and neurodevelopmental conditions including autism • Unpaid carers •
Key enablers
All 5 RIF enablers will contribute to the successful delivery of this project. **Integrated planning and commissioning** **Workforce development and integration**
New or existing investment
New investment
Estimated Total Cost
£144,508

Start date	**Estimated completion date**
1st April 2022	**31st March 2024**

Regional investment model

Select the funding element which the project will be set against. Repeat the table and rationale below for each project.

Funding elements	**Select**
Element 1 - Acceleration funding year 1	**X**
Element 1 - Acceleration funding year 2	**X**
Element 2 - Embedding fund year 1	**X**
Element 2 - Embedding fund year 2	**X**

Element 2 - Embedding fund year 3	
Element 3 - Legacy integrated pooled fund	
Element 4 – National priorities (Dementia and Memory Assessment Services/ Diagnostic Support)	

Provide the rationale for the element selected.

This is a new integrated concept for apprenticeships spanning health and social care which is agreed regionally and is targeted for regional deployment. It is planned to have a county pilot in year one and a regional development in year 2 followed by stabilisation and embedding in year 3.

Delivery partners

Delivery Partners	Welsh Government contribution	Partner match monetary	Partner match resource	Total funding required
Local Authority	£86,705	£9,634	**Staffing / Buildings / Income**	**£144,508**
Social Value Sector				
Health Board	£43,352	£4,817	**Staffing / Buildings / Income**	

Project Plan - Integrated Multi-Disciplinary Pelvic Health Service

Title of project
Integrated Multi-Disciplinary Pelvic Health Service
Any additional Models of Care the project will contribute towards
The development of a Pelvic Health Service MDT will enhance its pathways, creating holistic, person centred and biopsychosocial model of care. Its addition will ensure a cultural shift towards more proactive prevention and early intervention. This project will be the catalyst for further integration and will influence new and existing intermediate care models through. • Community based care – prevention and community coordination • Community based care – complex care closer to home • Promoting good emotional health and well-being • Support Home from hospital services • Providing Accommodation solutions
Project Summary
The project will develop a multi-disciplinary, integrated programme of pelvic health care with a strong focus on prevention and early intervention combining therapies and mental health provision into medical, social, and nursing pathways, delivering community-based care, close to home. Early intervention through MDT assessment within the community will prevent and avoid admissions to health and social care. The prevalence of Pelvic Health Disorders is high and increases with age, affecting more than 40% of women from 60 to 79 years of age, and about **50%** of women 80 and older. Urinary incontinence affects 10% to 58% of community-dwelling women and up to 50% of nursing home residents. Prevalence of incontinence gradually increases during young adult life, has a broad peak around middle age, and then a steady increase in the elderly. A significant proportion of disease severity is preventable or reversable if individuals are supported earlier in their life journey. It is acknowledged that an equitable service will also be delivered for men within the region. Pelvic Health covers a wide range of disorders such as Endometriosis, Bowel and Bladder Incontinence, Chronic Pelvic Pain, mesh complications and menopause to name the most common. All commonly result in significant medical, social, psychological, interpersonal, and functional difficulties. With the growing elderly population, the proportion of people with pelvic health disorders is expected to grow substantially during the coming decades yet, many are preventable or progression may be decelerated. Pelvic floor disorders such as urinary incontinence, faecal incontinence, and pelvic organ prolapse affect older women disproportionately, it is estimated that the growth in demand for services to care for female pelvic floor disorders will increase at twice the rate of growth of the population over the next 30 years. Approximately 10% of women have surgery for pelvic organ prolapse or urinary incontinence in

their lifetime and nearly 30% of these operations are for recurrent disease. Urinary and faecal incontinence substantially impacts upon physical health and is associated with significant psychological distress and reduced quality of life. Due to stigma and embarrassment, many patients do not present for management of their incontinence. Psychological factors may either contribute to or arise from Incontinence and should be addressed as part of the overall MDT management plan. Replicating MDT evidence-based interventions, the project will aim to deliver treatment approaches accessible to working age as well as the elderly to prevent and avoid further deterioration, reducing need for incontinence management and prolapse surgery.
Endometriosis is a chronic condition and often requires long-term management when surgery is contraindicated, inappropriate or has failed to resolve symptoms. Welsh Government guidelines indicate it is essential to manage patient expectations and provide access to non-surgical services in these cases including specialist physiotherapy and specialist psychological support.
Anxiety, Depression and Post Traumatic Stress Disorder are mental health disorders that often accompany pelvic health disorders. Enduring pain, sexual difficulties, infertility, work loss, repeated investigations, despair, and uncertainty can aggravate or induce mental health and psychological difficulties. In many, repeated intrusive examinations trigger previous sexual abuse events, resulting in perpetuating traumatic memories and reliving of adverse experiences.

The project will enable the development of the following:

- Enable development of a new model of psychological care within pelvic health pathways by training and upskilling MDT in psychological interventions, “right time, right place” and providing access to specialist psychological treatments within a stepped care approach.
- Enhance existing community continence services by embedding expert physiotherapy pelvic health and specialist health psychology skills to ensure a cultural shift to proactive prevention and early intervention for patients presenting with continence problems. Ensure easy and local access for help and support that is imbedded within the community, shifting away from secondary care.
- Development of evidence-based MDT interventions e.g Pelvic Health Pain Management Group, Pelvic Floor MDT Programme across the region.
- Replicate and test remote service delivery utilising developments in digital technology to enhance breadth

The project will also continue to reduce the socio-economic burden to both health and social care through optimising physical and functional capability and maximising health and wellbeing. Wider benefits are to be expected in:-

- Reduction in risk of falls and hip fractures relating to incontinence.
- Delaying the requirement for social care assessments and statutory support.
- Reduction in pharmacy costs.
- Reduction in containment product costs.
- Improvement in Health and Wellbeing.
- Reduction of surgical interventions.
- Provide expert advice and personal support to families and carers in reducing carer burden for family members with incontinence. Provide person centred care plans; facilitate practical help and expert interventions and treatment to reduce the impact of incontinence thus avoiding the need for statutory carers or admission to care homes. The model will continue to keep families living together in their own home especially those with complex care needs. We will continue to support unpaid carer resilience and confidence.

- Provide advice to care homes and domiciliary care staff and champion awareness of the management of continence. Develop education and training packages for families, voluntary sector organisations and professionals in the recognition of pelvic health disorders. The service will be delivered utilising both traditional models and innovative technology solutions in order to reach all patients.
- Build clinical capacity and awareness with core members of the existing community MDT to undertake pelvic health assessments and screening as part of a frailty assessment as a proactive model of care. Reduce the risk of secondary complications e.g. falls, infections, depression and loss of function / social isolation or hospitalisation.
- Review and modify existing gynae, medical, and surgical pathways to maximise the opportunity for early intervention and prevention models in the pre – frailty population. Support hospital to home and early supported discharge models to enable care closer to home.
- Contribute to the existing services in community focussing on reducing catheter use and the resulting care needs.
- Pelvic Health experts to upskill and collaborate with core community services e.g.
    - Physiotherapy to reduce hip fractures and non-bony injury falls
    - Dietetic colleagues to promote good hydration and reduce risk of infections.
    - Medical and pharmacy colleagues to reduce pharmaceutical costs
    - Nurses to reduce containment costs
    - Social workers to reduce need for packages of care

- Share all evidence-based practice within the community teams and support networking in pelvic health forums.
- Establish professional career rotations, and develop core skills within the core workforce for the assurance of versatile and skilled rural health practitioners.
- Ensure an MDT approach is embedded in the design and evaluation of service delivery. Ensure care planning is patient centred through service evaluation, and appreciating the patient voice through stories and feedback.

Priority population group(s)

Primary:

- Pre frailty population with preventable and reversible pelvic health disorders, to prevent and reduce burden of chronic presentation
- Older people including those with dementia and frail adults presenting with complex care needs.

Secondary:

- Unpaid carers and family members
- Health and Social care professionals and voluntary sector organisations
-

Key enablers

All 5 RIF enablers will contribute to the successful delivery of this project.

Integrated planning and commissioning

Technology enabled care

Promoting the social value sector
Integrated community hubs / triage and response
Workforce development and integration of skills within the community

New or existing investment
This is new investment for a new model of care across the MDT in the region of Hywel Dda. Building on the evidence collated via exploratory pilot studies across the UK and mapping evidence-based practice, the development of an integrated community based pelvic health model has been recognised as essential for building community resilience. This bid adds additional expertise to the existing community MDT, including the Bowel and Bladder Assessment Service (specialist nursing, district nursing, social care,) to maximise the opportunity for sustainable services moving forward. The additional expertise will enable workforce redesign, support families to stay together for longer and lessen the demand on both health and social care resources. It strongly supports the prevention agenda and focuses around supporting individuals to live well.

Estimated Total Cost
£97,778

Start date	**Estimated completion date**
1st April 2022	**31st March 2024**

Regional investment model

Select the funding element which the project will be set against. Repeat the table and rationale below for each project.

Funding elements	**Select**
Element 1 - Acceleration funding year 1	**X**
Element 1 - Acceleration funding year 2	
Element 2 - Embedding fund year 1	**X**

Element 2 - Embedding fund year 2	**X**
Element 2 - Embedding fund year 3	
Element 3 - Legacy integrated pooled fund	
Element 4 – National priorities (Dementia and Memory Assessment Services/ Diagnostic Support)	

Provide the rationale for the element selected.

There is a strong evidence base that demonstrate the benefits of preventative and early condition management interventions for people with pelvic health conditions. There is currently a significant paucity of community infrastructure within HDUHB to deliver these services. This investment model would support the development of new services delivered by physiotherapy and psychology professionals that would work with existing integrated MDT structures and support pathway transformation.

National evidence based standards that specifically endorse this approach include the following publication :- Urinary incontinence and pelvic organ prolapse in women: management. NICE 2019.

Urinary incontinence and pelvic organ prolapse in women: management. NICE guideline 2019. Offer a trial of supervised pelvic floor muscle training of at least 3 months duration as first-line treatment to women with stress or mixed urinary incontinence.
Specialist physiotherapists should be included in both local and regional multidisciplinary teams for women with urinary incontinence and primary prolapse. NICE, NG 123 (2019) Welsh Assembly Government (2018) Report of the Welsh Task and Finish Mesh Review. Enhanced physiotherapy service is required as part of an agreed Pelvic Health and Wellbeing Pathway in Wales, making it more robust, accessible and sustainable.

Delivery partners

Include details of local LHBs, local authorities, third sector and other providers that will support in the delivery of the projects. In this section you will also need to explain what they bring to the project by means of match contribution. This can be evidenced by either monetary or resource match. Repeat the table below for the number of projects being put forward.

RPBs will be expected to invest a **minimum of 20%** of their RIF allocation in delivery through social value sector organisations. RPBs should be connecting closely with their social value forums to ensure the wider sector can be engaged in the planning, design and delivery of these Models of Care. The information provided below will help aggregate the social value sector involvement at programme level.

Delivery Partners	Welsh Government contribution	Partner match monetary	Partner match resource	Total funding required
Local Authority				**£97,778**
Social Value Sector				
Health Board	£88,000	£9,778	**Staffing / Buildings / Income**	

Health & Social Care Regional Integration Fund

Investment Proposal

(West Wales)

Promoting good emotional health and wellbeing

Model of Care (Programme) – Strategic vision

Provide a short, precise summary of the strategic vision for successfully achieving the regional aspirations for *"Promoting good emotional health and wellbeing"*. This should contribute to the wider delivery of A Healthier Wales.

Successful implementation of the 'promoting good emotional health and wellbeing (EH&WB)' Programme will help meet the Quadruple Aim of *A Healthier Wales* – in particular, the first aim: 'improved population health and well-being'. The programme will act at this foundational level – and may help reduce demand for acute mental health services, including for children and adolescents. The programme will contribute to the regional Area Plan: *Delivering Change Together*, and health and care strategies in the Region, by:

- Supporting individuals to take more responsibility for their own EH&WB
- Enabling organisations to support individuals or groups with EH&WB needs
- Supporting communications and engagement around good EH&WB
- Supporting the implementation of the NYTH/NEST framework for children and young people

Our vision is of a West Wales where people are equipped to be resilient, positive and in charge of their own emotional health and wellbeing.

Dementia Action Plan (DAP) Summary

For funding that supports the Dementia Action Plan, this summary should outline how older people including people with dementia can be supported by *"Promoting good emotional health and wellbeing"*.

Model of Care (Programme) - Business case

In this section you should set out how your programme is going to clearly support the delivery of the national Models of Care.

A robust case for change should include but is not limited to:

- The programme aims and objectives to deliver "*Promoting good emotional health and wellbeing*."
- A summary of the baseline position of the programme including population needs, service and community assets and capability.
- What regions are seeking to achieve using RBA methodology, incorporating a consistent set of indicators and measures.
- Initial plans for sustainability and wider scale up and exit planning following the end of the investment through the RIF.

A population with good emotional health and wellbeing means:

- Greater capacity for self-help and peer support
- Less demand on statutory services
- More people participating in education, training and the labour market (including health, social care, preventative and wellbeing services)
- Less staff absence, including within critical services

The Health Wellbeing Framework for Hywel Dda recognises that 'Healthcare services working alone can have as little as 10% influence on our health'. This programme will support wellbeing – one of the most important of the wider determinants of good health – and thus contribute to relevant respective Hywel Dda, Local Authority and PSB plans in the Region.

Programme aims and objectives

Our vision is of a West Wales where people are equipped to be resilient, positive and in charge of their own emotional health and wellbeing. The Quadruple Aim of *A Healthier Wales* is used a reference for setting the **aims and objectives** of this Programme. The four aims are numbered below, with associated SMART objectives listed below each:

1. **Improved population health and well-being**
    - People will be equipped with the capability (knowledge, skills and motivation) to support their emotional health and wellbeing ('stay well')
    - People will take greater responsibility for their emotional health and wellbeing
    - People will take part in activity that promotes good emotional health and wellbeing

2. **Better quality and more accessible health and social care services**
    - Providers deliver services that are aligned, accessible and fit for purpose
    - People will understand what services are available
    - People will appropriately judge which Health and Social Care services are most likely to meet their needs

3. **Higher value health and social care**
    - Projects will be evaluated to understand the impact on demand reduction (statutory services)

- Projects will be evaluated to understand the extent to which they create system value

4. **A motivated and sustainable health and social care workforce**
    - Health and social care employers will promote the emotional health and wellbeing of their workforce

Each objective is *specific*. It will be necessary to define appropriate measures. Projects will use the RBA approach to reflect: how much has been delivered (quantity); how well (quality); and 'is anyone better off?' (impact). It is a (Regional) condition of funding that monitoring and evaluation arrangements – as set out in the Regional RIF Evaluation Framework – are put in place for all supported projects at project inception and maintained throughout project duration.

Programme outcomes[1]

Welsh Government guidance highlights the following Programme outcomes:

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

The projects that are within this programme are primarily designed to meet the needs of people who are ***Children and Young People***, ***Carers***, ***People with a Learning Disability and people with Mental Health needs.*** Where appropriate and possible, projects will also address the needs of other priority population groups.

Baseline

The Population Assessment highlights the following in relation to *promoting good emotional health and wellbeing*:

General

- Access to services and opportunities is geographically uneven, generally as a function of population density
- People welcome a well-connected, integrated approach to the services they need to access
- The COVID-19 lockdowns necessarily led to social isolation with (likely) lasting impacts on mental health. Opportunities to take part in activities that promote good emotional health and wellbeing were severely curtailed
- There is a projected increase in single older people, some of whom may lack local social connections. This may lead to increases in loneliness
- Freedom from abuse is a precondition for positive emotional health and wellbeing
- Dementia prevalence is projected to rise significantly in line with projected increases for people 85 and over. The condition presents specific challenges in maintaining positive emotional health and wellbeing
- People in most population groups prefer to have their needs met within accommodation that maximises their choice and control, but some will need support to promote their emotional health and wellbeing

[1] Taken from the WG funding guidance document.

Children and Young People

- The number of children 0-15 is expected to decline 8% over the next decade (to 2031). There are likely to be sufficient universal services, but demand for specialist support and services such as CAMHs and residential care (already hard to source locally) may increase
- The number of Looked After Children is increasing in Ceredigion and Pembrokeshire (recent reductions in Carmarthenshire)
- 1 in 10 children between the ages of 5 and 16 has a mental health problem, and many more have behavioural issues.
- Approximately 50% of people who go on to have serious mental health problems will have symptoms by the time they are 14 and many at a much younger age

Carers

- The pandemic has increased pressure on existing unpaid carers, as reflected in an increase of 2073 in the number of requests for support.
- Reluctance to place people in care homes (and, for many, the expanded opportunities to work from home) has expanded the number engaged in unpaid care. The trend is likely to continue in line with projections for older people making up a greater proportion of the population.
- The emotional health and wellbeing of carers (including young carers) is likely to have been adversely affected and opportunities for breaks will be beneficial.
- The following apply to many young carers:
    - They struggle to have a break, are not seeing their friends and don't have their own space.
    - They find it difficult to balance schoolwork, homework and their caring role and can feel stressed, worried and anxious at school, as they are away from the person that relies on them for care.
    - They may require extra support for their mental health and wellbeing.

Learning Disability

- Rights-based person-centred planning foster independence and often lead to reduced dependence on Statutory Services. This is supported by ensuring effective communication and self-advocacy.
- Life expectancy for people with a learning disability is increasing, with implications for accommodation choices and support arrangements

Mental Health

- Mental health affects how people think, feel and act. A healthy outlook can reduce both the intensity and duration of illnesses, whereas poor mental health can have the opposite effect.
- Promoting and supporting self-management can have a demonstrable impact on living independently.
- The COVID pandemic has negatively impacted upon mental health. The extent to which this is a lasting effect is unclear.
- 1 in 4 adults experience mental health problems or illness at some point in their lifetime.
- 1 in 6 adults are experiencing symptoms at any one time.

Description of projects

Children and Young People

NEST Framework
Embedding the approach is a key Welsh Government priority which is fully embraced by the West Wales Care Partnership. It is proposed that core project support capacity will be utilised to plan Regional action to ensure services incorporate NEST principles across relevant service delivery. NEST is therefore referenced here, but there is no specific plan within this Programme Investment Proposal, as it is resourced elsewhere.

Carers

Carer Breaks
The contribution of unpaid carers is very significant, and the demands of the role are considerable. For informal caring to be sustainable, and burnout avoided, support is critical. This project is focused on the development of a new vision for respite and short breaks, co-produced with unpaid carers. A range of opportunities will be developed to ensure unpaid carers have access to meaningful breaks, which may include discounted or free access to services and activities, and bespoke arrangements that meet need. The project will focus on testing new ideas and concepts, and assessing impact in order to inform future support interventions.
Investors in Carers (IiC)
The crucial contribution of unpaid carers is increasingly recognised. This project works with a wide range of settings (including health, social care, and public, private and 3rd 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

Learning Disability

Exercise Buddies
This regional project aims to increase the amount of physical activity that people with disabilities engage in. They frequently only access services during the day and many of them do not access mainstream leisure activities that involve physical exercise. As a result, they do not gain the physical and mental health benefits of regular exercise. This 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. 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 will roll out the current Carmarthenshire-based 0-2 tier service across the Region, though the employment of a co-ordinator and support workers, who will work collaboratively with existing Psychology, CTLD and PIBS services. Applying ‘through age’, the approach will provide support in line with co-produced Positive Behaviour Plans (PBSs) which harness individual skills and talents and set out strategies to avert crisis. The service provides prevention and early intervention - reducing or delaying the need for PBIS intervention.
Pathways to employment
Building on existing Pembrokeshire activity, this regional project will support employability and progression pathways for individuals living with disabilities. There are three key elements.

Firstly, the development of a regional Employability Plan, which will involve co-productively establishing progression pathways with close links to further education and local ALN provision. Secondly, existing supported employment will be embedded in Pembrokeshire – forging closer links to supported living and wider skills development. Thirdly, the focus in Carmarthenshire and Ceredigion will be to establish a supported employment programme, including work experience, volunteering and paid work opportunities.
Citizen Champions
Building on the successful regional LD Campions initiative, this project will help ensure citizens from all priority population groups have a voice in services that then meet their needs. Champions will be employed and supported, and will be active in areas including service co-production, peer support (e.g., keeping fit and healthy), Easy Read information provision and citizen-led awareness training.

Mental Health

Partners for the Journey
This project supports GP and other Primary Health Care service users, who have underlying non-medical needs and/or low level mental ill health, to deal with a range of issues such as loneliness and isolation, housing, welfare benefits, and debt, thereby ensuring that Health Care staff can concentrate on relevant health issues. The project commenced in December 2020, with funding support including from the North and South Pembrokeshire GP Clusters. Although delivery will be Pembrokeshire-specific during 2022-23, plans will be developed to support regional roll out from 2023-24.
'Grow Our Own' Social Workers and Approved Mental Health Practitioners
The project aims to meet skills shortage and recruitment issues in relation to social worker and Approved Mental Health Practitioners practitioners by developing and upskilling social work assistants.

Model of Care (Programme) - Key enablers

Select which of the key enablers will maximise the delivery of the programme, using the free text box to describe how this will be achieved.

Key Enablers	Select
Integrated planning and commissioning	
There is a wide range of factors that affect good emotional health and wellbeing – many lying outside of the Health and Social Care system. Strengthened integrated planning and commissioning will be needed, based around 'what matters' to population groups - and individuals within them - to ensure interventions to support good emotional health and wellbeing integrate effectively with other support that is put in place 'around the person'. Establishing the Regional Innovation Forum (the Regional Social Value Forum) will help enable commissioners and providers to plan and co-produce services with an emphasis on social value. It is proposed that the Innovation Forum will work closely with the Regional Commissioning Programme Group, as part of the Regional governance infrastructure. The Citizens Champion project will involve people from relevant population groups being involved in the co-productive enhancement of service development and commissioning. Wider stakeholder engagement and co-production will support effective delivery of projects within the Programme.	**X**
Technology enabled care	
Technology can support good emotional health and wellbeing in a number of ways: • Entertainment • The development and maintenance of relationships through social media • Self-help apps • The Internet as a source of useful information • The possibilities of virtual interaction via the Metaverse (particularly where physical interaction is constrained) Opportunities to utilise technology to maximise programme impact will be explored as part of programme roll out, particularly in the context of ensuring equitable access across geography and population groups.	**X**
Promoting the social value sector	
The promotion of good emotional health and wellbeing is 'foundational' activity that typically happens outside traditional health and social care provision. Social Value organisations are well-placed to continue taking a leading role in this area of support.	**X**

The projects within the Programme all have a focus on delivering wider Social Value benefits – over and above core outcomes. As noted above, a key priority for 2022-23 is enhancing the mobilisation of Social Value through establishing the Innovation Forum, with a clear link to the Regional Commissioning Programme Group and firmly embedded within Regional planning structures. Links to National initiatives and the work of the Wales Co-op Centre will be maintained to ensure good practice is embedded within the Programme.	
Integrated community hubs	
While some hubs are in place, wider establishment is an emerging WG ambition. It is important that hub development encompasses the broader council and PSB input to help ensure these meet whole needs, and are sustainable into the future. Where in place, hubs could support several projects, including Exercise Buddies, Citizens Campions and Partners for the Journey.	**X**
Workforce development and integration	
Promoting good emotional health and wellbeing will help ensure maximum participation in the labour market. Effective in-work initiatives that support good emotional health and wellbeing will assist staff commitment. Positive emotional health can encourage employees to adopt a growth mindset where challenges of self-development and working in multi-disciplinary way are actively embraced. Some of the projects have strong connections to employability or direct employment – including Pathways to Employment, Citizens Champions. Others support the ability of people to maintain employment – including Investors in Carers and the Positive Behavioural Support projects. Wider Health and Social Care initiatives to develop and integrate workforces will enhance the impact of the Programme.	**X**

Model of Care (Programme) - Priority population groups

Select both the primary and secondary beneficiaries of the programme by priority population group, using the free text box to describe the particular impacts this will have. Please also indicate if the beneficiaries are supported using DAP funding.

Priority population groups	Primary	Secondary	DAP
Older people including people with dementia		X	
Partners for the Journey			
Children and young people with complex needs	X		
NEST			
People with learning disabilities and neurodevelopmental conditions including autism*	X		
Positive Behaviour Service (PBS) Exercise Buddies Employability Pathway Citizen Champions			
Unpaid carers*	X		
Carers breaks Investors in Carers			
People with emotional and mental health wellbeing needs	X		
Partners for the Journey			

Total programme cost and match funding projection

Provide a breakdown of the total programme cost, Welsh Government contribution, partner monetary and resource match including costs attributed to support unpaid carers and / or social

Total cost of Programme	Welsh Government contribution	Partner match monetary	Partner match resource	% support for unpaid carers	% for social value sector delivery
£1,628,951	£1,374,607	£254,344		27.39%	11.02%

Programme resource and management details

Provide a summary of the planned resource and roles required to deliver this specific programme. These roles are 100% funded via the RIF and will accounted for within the allocated fund.

Posts / type of roles	Estimated FTE	Costs

Project plans

Title of project to support Model of Care (programme)
Carers Breaks
Any additional Models of Care the project will contribute towards
• Community based care – prevention and community coordination • Community based care – complex care closer to home • Supporting families to stay together safely, and therapeutic support for care experienced children • Home from hospital
Project Summary

Purpose

Without the right support, unpaid Carers are more likely to experience burnout and be unable to provide care, which in turn will affect health and social care systems and increases the likelihood of hospital admissions or other forms of nursing care. This project is focused on the development of a regional short breaks statement as recommended in the 2021 Carers Trust Wales report. The project seeks to develop a new vision for respite and short breaks in West Wales and it will be co-produced with unpaid carers.

Background

A recent report published by Carers UK (2020) stated that unpaid Carers across the UK have provided an incredible £135 billion of care, and in Wales, it is estimated that unpaid Carers have provided £8.4 billion of care since the beginning of the pandemic in March 2020. The figures clearly show the importance and economic value that family members and friends provide through the provision of unpaid care.

Recent research into Carers' experiences during the pandemic found that 78% of unpaid Carers reported that the needs of the person they care for have increased. Unsurprisingly, the caring role during the pandemic has had an impact on the Carers physical health and 64% of Carers said that their mental health has worsened.

Approach

The project will work across the region to establish a variety of opportunities for carers to have a meaningful break from their caring role. This may include initiatives such as:

- Developing discounted/free access to a range of services and facilities enabling carers to have a break from their caring role with or without their families.
- Work with businesses to consider how they can contribute to meet unpaid Carers needs to be supported to have a life alongside caring
- Exploring and developing new and alternative ways of delivering bespoke breaks to carers to improve their wellbeing, including work with the leisure and hospitality sector.

This project will work toward meeting the priorities of the WWCDG strategy

Outcomes

The project will meet the *primary* Programme outcomes as follows:

People are better supported to take control over their own lives and well-being	• Carers have an improved life balance • Carers will have greater opportunity to take care of their mental health and wellbeing
People have improved skills, knowledge, and confidence to be independent in recognising their own well-being needs	• Carers will have time away to reflect on their own wellbeing needs

Benefits

These include:

- Reduced chance of carer burnout
- Enhanced personal wellbeing
- Reduced demand for health and care services from carers and cared for

Exit plan

Assuming the Project delivers the required outcomes, it will be put forward for Acceleration funding, (year 2). Thereafter, core funding is anticipated.

Priority population group	
• Unpaid carers	
Key enablers	
• Integrated planning and commissioning • Technology enabled care • Promoting the social value sector • Integrated community hubs • Workforce development and integration	
New or existing investment	
New	
Estimated total cost	
£333,000 / yr	
Start date	**Estimated completion date**
1st April 2022	31st March 2024

Title of project to support Model of Care (programme)	
Carers Breaks	
Funding elements	**Select**
Element 1 - Acceleration funding year 1	x
Element 1 - Acceleration funding year 2	x
Element 2 - Embedding fund year 1	
Element 2 - Embedding fund year 2	
Element 2 - Embedding fund year 3	
Element 3 - Legacy integrated pooled fund	
Element 4 – National priorities (Dementia and Memory Assessment Services/ Diagnostic Support)	

Provide the rationale for the element selected.

Element 1 is being selected as it is testing new ideas developing new initiatives to inform future work and new model of bespoke carers breaks to meet the ends that carers themselves have identified.

Title of project to support Model of Care (programme)				
Carers Breaks - Promoting good emotional health and wellbeing				
Delivery Partners	**Welsh Government contribution**	**Partner match monetary**	**Partner match resource**	**Total funding required**
Local Authority	£300,000	£33,000	**Staffing / Buildings / Income**	**£333,000**
Social Value Sector				
Health Board				

Title of project to support Model of Care (programme)
Investors in Carers scheme
Any additional Models of Care the project will contribute towards
• Community based care – prevention and community coordination • Community-based care – complex care closer to home • Supporting families to stay together safely, and therapeutic support for care experienced children • Home from Hospital
Project Summary

Purpose

The Investors in Carers (IiC) scheme is a quality assurance scheme which has themed standards, an audit and certification processes and rewards, which recognises best practice. It has been designed for use across a generic range of settings; health, social services, community teams, public, private and third sector organisations and promotes a whole-system approach and responsibility for the early identification of unpaid carers and proactive signposting for additional early help and support.

Background

Census data from 2011 estimates that there are over 47,000 unpaid Carers in the Hywel Dda area, however these numbers are likely to increase when the most recent census reports are released in 2022/23. This is in part due to the experiences of the pandemic, which has amplified the role that families play in supporting those who could not otherwise manage without their help.

The West Wales Carers Strategy – sets out 4 priority areas on of which is to "Improve the early identification and self-identification of Carers including Young Carers and Young Adult Carers". The Investors in Carers scheme delivers direct outcomes for unpaid carers and plays a vital role in the identification and support for unpaid carers to ensure their health and wellbeing is also supported.

Approach

This project works with a wide range of settings (including health, social care, and public, private and 3rd 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.

Outcomes

The project will meet the *primary* Programme outcomes as follows:

People are better supported to take control over their own lives and well-being	• Increased numbers of unpaid carers being referred to the local Carers Information Support services for outreach support.

People have improved skills, knowledge, and confidence to be independent in recognising their own well-being needs	• Unpaid carers (of all ages) to organisations recognise themselves as carers. • Increase in the number of carers seeking help with training, education, and employment opportunities.

Benefits

These include:

- Organisations are better able to support unpaid carers – as users and as employees
- Staff are more carer aware enabling earlier identification signposting and support.
- Unpaid carers are supported to access community-based services, that help them better negotiate the challenges of caring alongside other aspects of their lives

Exit plan

It is proposed that the project will be mainstreamed from year 4 onwards.

Priority population group	
Unpaid carers across all population groups.	
Key enablers	
• Integrated planning and commissioning • Promoting the social value sector • Workforce development and integration	
New or existing investment	
Existing	
Estimated total cost	
£109,286	
Start date	**Estimated completion date**
1st April 2022	To move to mainstream funding from year 4 (2026)

Title of project to support Model of Care (programme)	
Investors in Carers scheme	
Funding elements	**Select**
Element 1 - Acceleration funding year 1	
Element 1 - Acceleration funding year 2	
Element 2 - Embedding fund year 1	**X**
Element 2 - Embedding fund year 2	
Element 2 - Embedding fund year 3	
Element 3 - Legacy integrated pooled fund	
Element 4 – National priorities (Dementia and Memory Assessment Services/ Diagnostic Support)	

Provide the rationale for the element selected.

The IiC scheme has been in existence for many years and has been held up as a best practice example by the Welsh Government Carers Team. The challenge is to ensure the scheme is embedded as good practice.

Title of project to support Model of Care (programme)				
Investors in Carers scheme				
Delivery Partners	**Welsh Government contribution**	**Partner match monetary**	**Partner match resource**	**Total funding required**
Local Authority				**£109,286**
Social Value Sector	£76,500	£32,786	**Staffing / Buildings / Income**	
Health Board				

Title of project to support Model of Care (programme)
Exercise Buddies
Any additional Models of Care the project will contribute towards
Place based care – Prevention and community coordination
Project Summary

Purpose

The Exercise Buddies project is a regional project that aims to increase the amount of physical activity that people with disabilities engage in. There is significant research that demonstrates that many people with a learning disability have significant health issues as they age, and this can result in a reduced life expectancy. They frequently only access services during the day and many of them do not access mainstream leisure activities that involve physical exercise. As a result, they do not gain the physical and mental health benefits of regular exercise.

Background

The Exercise Buddies Project addresses a gap in provision and is aligned to numerous priorities locally, regionally, and nationally. It contributes to the Learning Disability – Improving Lives Programme (Welsh Government, 2018a), and is in line with the principles of the Social Services and Wellbeing Act and the UK Equality Act 2010.

Regionally, the Project supports the West Wales Learning Disability Charter, as it ensures that people are supported to take control of their health and well-being within their communities. The activities support the development of relationships with other people who have similar interests and provides opportunities for people to develop their skills and confidence. The Project also supports the aims of the Regional Population Assessment and the most recent Area Plan.

Approach

This regional Project ensures that many more people who have disabilities can try different activities and build up their confidence to participate in physical activities outside of services. This is having a positive effect on people's overall well-being (improved physical and mental health).

Unfortunately, the current projects have been limited due to the pandemic where large group activities have been curtailed and leisure facilities closed but where activities have taken place they have been very successful with a number of people increasing skills and confidence.
The project is to also increase the amount of physical activity that parents/carers (paid and unpaid) undertake.

There will also be an element of recruiting volunteers to support people to access physical activities in their local communities. This will ensure that people are able to access local facilities with people who are interested in the same things.

Outcomes

The project will meet the *primary* Programme outcomes as follows:

People are better supported to take control over their own lives and well-being	• The project will offer a range of physical activities within a local area. • People will be enabled to try out local activities and to develop relationships with other people. • This increases confidence and skills as well as improving physical and mental well-being.
People have improved skills, knowledge, and confidence to be independent in recognising their own well-being needs	• The physical activity undertaken supports people to see how activities can improve their physical and mental well-being. • People are supported to set their own goals and are supported to achieve these within a local community setting.

Benefits

These include:

- People have improved physical and mental health across the region.
- People develop networks of people to support them therefore less reliance on health and social care services across the region.
- People become more integrated into their own communities.
- People become more independent across the region.

Exit plan

The Project will be delivered using core funding from 2025-26

Priority population group	
• Disability – all age	
Key enablers	
Promoting the social value sector	
New or existing investment	
The investment extends existing funding to ensure that the activities become a normal part of people's lives	
Estimated total cost	
£151,596	
Start date	**Estimated completion date**
01/04/2022	31/03/2025

Title of project to support Model of Care (programme)	
Exercise Buddies	
Funding elements	**Select**
Element 1 - Acceleration funding year 1	
Element 1 - Acceleration funding year 2	
Element 2 - Embedding fund year 1	**X**
Element 2 - Embedding fund year 2	
Element 2 - Embedding fund year 3	
Element 3 - Legacy integrated pooled fund	
Element 4 – National priorities (Dementia and Memory Assessment Services/ Diagnostic Support)	

Provide the rationale for the element selected.

The Exercise Buddies project has been able to provide opportunities for many people to try out different physical activities but due to the pandemic this has not been as extensive as it could be. Use of Embedding funding will help ensure the aims of the Project are fully realised.

Title of project to support Model of Care (programme)				
Exercise Buddies				
Delivery Partners	**Welsh Government contribution**	**Partner match monetary**	**Partner match resource**	**Total funding required**
Local Authority	£106,117	£45,479	**Staffing / Buildings / Income**	**£151,596**
Social Value Sector				
Health Board				

Title of project to support Model of Care (programme)
Positive Behaviour Support (PBS) Service
Any additional Models of Care the project will contribute towards
• Place based care – Prevention and community coordination • Place based care – Complex care closer to home • Preventing children entering care and supporting children to remain with their families • Home from hospital • Accommodation based solutions
Project Summary

Purpose

The Positive Behaviour Support (PBS) Service is designed to improve the quality of a person's life and that of the people around them. This includes children, young people, adults as well as older people. PBS provides the right support for a person, their family, and friends to help people lead a meaningful life and learn new skills without unnecessary restrictions. With the right support at the right time the likelihood of behaviour that challenges are reduced.

The PBS service provides support to individuals, families, and staff at tiers 0- 2. Good links with CTLD nursing, PIBS and psychology mean there will be a fluidity of support which ensures individuals can access support at the right level and intensity, when they need it and can move between the tiers of provision seamlessly, ensuring good outcomes for them and efficient use of resources.
Thus, promoting independence, personal growth, and quality of life, preventing placement breakdowns, and supporting repatriation from out of county provision where applicable.

Background

The PBS project is aligned to numerous priorities locally, regionally, and nationally.
In line with the Social Services and Wellbeing Act, the service puts people at the centre of their care, to help prevent, delay, or reduce the need for more restrictive care and support by holistic working and collaboration across agencies.
The Project also helps meet the requirements of the Learning Disability – Improving Lives Programme (Welsh Government, 2018a), through meeting specialist health care needs throughout the lifespan to ensure a good quality of life. The PBS service ensures that people with complex needs have timely and easy access to LD specialist services.

The Project also supports the successful implementation of a wide range of of acts and policies, including the UK Equality Act 2010, the Regulation and Inspection of Social Care (Wales) Act 2016, the Reducing Restrictive Practices Framework 2021 and the Regional West Wales Learning Disability Charter, Population Assessment and Area Plan.

Approach

The current Carmarthenshire based PBS project (ICF) will be regionalised and embedded to ensure a consistent, integrated approach to Positive Behavioural Support across the region. The project will employ a coordinator and support workers in each county. By having dedicated PBS officers working in collaboration with existing Psychology services in each county, the project

will provide a regional framework for positive behavioural support across West Wales. New elements are likely to include:

- Integrated pathways of delivery
- Regional training programme
- Development of a regional PBS competency framework
- Implementation of the Reducing Restrictive Practices Framework

Outcomes

The project will meet the *primary* Programme outcomes as follows:

People are better supported to take control over their own lives and well-being	• Individuals will understand what is important to them and how best to support them to achieve their aspirations and utilise their skills. • Advice, guidance and training will be provided to individuals, families, support services, employers, the community and primary health care to promote the understanding of PBS, including alternative communication methods, environmental adaptations and preventative strategies.
People have improved skills, knowledge, and confidence to be independent in recognising their own well-being needs	• Individualised support plans will be used with the option to share with family, friends, employers, and support services to help facilitate access to opportunities, including housing, jobs, education, leisure, or access to health care. • Support plans will ensure the person is supported to become independent and self-reliant.

Benefits

These include:

- Individuals have the right support at the right time as staff are more informed and pathways for support are clear
- Reduction in restrictive practice
- Increased independence
- People can live within their own community, developing their own networks and resilience as support is provided closer to home, with a reduced reliance of out of area specialist support services.

Exit plan

Assuming the Project delivers the required outcomes, it will be put forward for Acceleration funding, (year 2). Thereafter, core funding is anticipated.

Priority population group
People with Learning Disabilities and neurodevelopment conditions including autism.

People with emotional and mental health wellbeing needs. Children and young people with complex needs.
Key enablers
Integrated planning and commissioning Technology enabled care Integrated community hubs Workforce development and integration
New or existing investment
New investment on top of existing investment to regionalise approach
Estimated total cost
£358,728

Start date	**Estimated completion date**
01/04/2022	31/03/2025

Title of project to support Model of Care (programme)	
Positive Behaviour Support Service	
Funding elements	**Select**
Element 1 - Acceleration funding year 1	
Element 1 - Acceleration funding year 2	**x**
Element 2 - Embedding fund year 1	
Element 2 - Embedding fund year 2	
Element 2 - Embedding fund year 3	
Element 3 - Legacy integrated pooled fund	
Element 4 – National priorities (Dementia and Memory Assessment Services/ Diagnostic Support)	

Provide the rationale for the element selected.

So far, the Project has been proven in Carmarthenshire, working with adults, and based solely on social care delivery and improving links with health colleagues. The extension to the project will include a regional, integrated and through age approach.

Title of project to support Model of Care (programme)				
Delivery Partners	**Welsh Government contribution**	**Partner match monetary**	**Partner match resource**	**Total funding required**
Local Authority	£280,535	£31,171	**Staffing / Buildings / Income**	**£311,706**
Social Value Sector				
Health Board				

Title of project to support Model of Care (programme)
Regional Employability Plan
Any additional Models of Care the project will contribute towards
• Community based care – prevention and community co-ordination
Project Summary

Purpose

The project helps working aged disabled people to enter supported paid employment or a work-based day opportunities – key to the maintenance of good emotional health and wellbeing. The project will provide holistic support which enable people to take control of their lives and wellbeing and gives them the skills, knowledge and confidence to live and work independently.

Background

Currently each county (Pembrokeshire, Ceredigion & Carmarthenshire) has progressed at a difference pace in relation to employability and progression pathways for individuals living with disabilities. The project is made up of 3 work streams recognising this position: the development of a regional employability plan; work in Pembrokeshire to embed work from the last 3 years with people with learning disabilities into a wider age group and other population groups; and, work across Carmarthenshire and Ceredigion to establish the programme across all population groups.

Approach

Regional Employability Plan: this will set out a framework for supporting working age individuals to acquire employability skills and enter paid supported employment. Work will include engaging with young people from age 14 to develop aspirations for employment post education. The pathway will include supported paid employment (Pembs), employability at transition to adulthood (Ceredigion) and positive behavioural management (Carmarthenshire – linked to separate project). The plan will create a community of practice in West Wales to support the employability of disabled people.

Pembrokeshire: over the past 3 years Pembrokeshire has developed its supported employment programme for people with learning disabilities. The focus of support over the next 3 years will be on developing a supported employment programme linked to transitions which will provide holistic support for developing employability alongside the development of independent living and wide skills development. The project will also work with employers and organisations to develop and provide opportunities for training, volunteering, internships, work experience, work placement, supported paid work and progression into open employment.

Carmarthenshire and Ceredigion: Carmarthenshire and will establish a supported employment programme which takes good practice from Pembrokeshire. The project will support the development of work experience, volunteering and paid work opportunities. Funding will in the first year will pay for project leadership and support workers to develop the specific support skills associated with the programme and people gaining employability

promoting learning that enhances skills. In future years funding will support disabled people to gain paid work as per the Pembrokeshire model.

Outcomes

The project will meet the *primary* Programme outcomes as follows:

People are better supported to take control over their own lives and well-being	• The project will often be the first point of contact for crisis intervention. • people have been able to reduce care and support needs from other places, move into independent living and take control of their disability.
People have improved skills, knowledge, and confidence to be independent in recognising their own well-being needs	• the project promotes financial independence, positive physical and wellbeing by encouraging people to engage in work-based activities and employment. • Isolation is reduced whilst support networks that enable people to be in control of their support needs are enhanced

Benefits

These include:

- People will be better able to support themselves financially through paid work
- Reduced demand for statutory services from this population group

Exit plan

Assuming the Project delivers the required outcomes, funding is sought through to 2026. Thereafter, core funding is anticipated.

Priority population group

- People with Learning Disabilities and neurodevelopment conditions including autism
- People with emotional and mental health wellbeing needs
- Children and young people with complex needs.

Key enablers

Integrated planning and commissioning -
Technology and digital solutions – information
Promoting the social value sector – the Pembrokeshire project is based in a series of social enterprise style settings which combine supported employment with community provision.
Workforce development and integration – people within the project work across settings improving inclusion, diversity and integration.

New or existing investment

Existing – remodelled and extended

Estimated total cost	
Total Project	£406,508
Start date	**Estimated completion date**
1/4/2022	**31/3/2026**

Title of project to support Model of Care (programme)	
Regional Employability Plan	
Funding elements	**Select**
Element 1 - Acceleration funding year 1	
Element 1 - Acceleration funding year 2	**x**
Element 2 - Embedding fund year 1	
Element 2 - Embedding fund year 2	
Element 2 - Embedding fund year 3	
Element 3 - Legacy integrated pooled fund	
Element 4 – National priorities (Dementia and Memory Assessment Services/ Diagnostic Support)	

Provide the rationale for the element selected.

Elements of the project are established in each county. The project has been established in Pembrokeshire and will now be rolled out across the region. The Pembrokeshire project will develop to include additional population priority groups and to include work at transitions to ensure young people have aspirations for employability rather than other support pathways.

Title of project to support Model of Care (programme)				
Pathways to Employment				
Local Authority	£343,000	£63,508	**Staffing / Buildings / Income**	**£406,508**
Social Value Sector				
Health Board				

Title of project to support Model of Care (programme)
Citizen Champions
Any additional Models of Care the project will contribute towards
• Community based care – prevention and community coordination • Accommodation based solutions
Project Summary

Purpose

Building on the successful regional LD Campions initiative, this project will help ensure citizens from all priority population groups have a voice in services that then meet their needs. Champions will be employed and supported, and will be active in areas including service co-production, peer support (e.g., keeping fit and healthy), Easy Read information provision and citizen-led awareness training.

Background

The Project addresses a gap in use voice and is aligned to numerous priorities locally, regionally, and nationally. It contributes to the Learning Disability – Improving Lives Programme (Welsh Government, 2018a), and is in line with the principles of the Social Services and Wellbeing Act and the UK Equality Act 2010.

Regionally, the Project supports the West Wales Learning Disability Charter, as it ensures that people are supported to take control of their health and well-being within their communities. The activities support the development of relationships with other people who have similar interests and provides opportunities for people to develop their skills and confidence. The Project also supports the aims of the Regional Population Assessment and the most recent Area Plan.

The intention is to broaden the successful LD Champions approach to encompass other population groups.

Approach

The project will employ a coordinator (1FTE), a group of citizen champions (5FTE) and their support staff (estimated 2FTE but dependent on support needs and funded through Access to Work (match). Other volunteer champions (for example older people who do not want employment) will also be supported through the project. The champions will be employed or supported by a range of organisations across the region to ensure that they engage widely with people from all counties to tell them about projects that affect them and to support people to engage with services in their communities.

Key areas will include:

- Community Engagement
- Keeping fit and healthy
- Employment
- Digital information
- Easy Read information

- Transport
- Housing

The champions will also be members of and chair key project boards and partnerships, to ensure that planning and commissioning takes into account the views of citizens and delivers a meaningful change in the way services are designed and delivered. The champions will report their work to project and programme boards across the region.

Outcomes

The project will meet the *primary* Programme outcomes as follows:

People are better supported to take control over their own lives and well-being	• the champions will provide peer support to help people to know what support is available, to access services and support independently and to take control over their support package.
People have improved skills, knowledge, and confidence to be independent in recognising their own well-being needs	• the champions will provide peer support to help people to recognise their support needs and to have the confidence to choose and access support and services that are meet their needs

Benefits

These include:
- The contribution of people is recognised financially
- The initiative supports positive self-esteem
- Participants will act as role models, encouraging others to join the programme

Exit plan

Assuming the Project delivers the required outcomes, it will be put forward for Acceleration funding, (year 2). Thereafter, core funding is anticipated.

Priority population group

- People with learning disabilities and neurodevelopmental conditions including autism
- People with emotional and mental health wellbeing needs
- Older people including people with dementia
- Unpaid carers
- Children and young people with complex needs.

Key enablers

Integrated planning and commissioning – champions will sit on or chair key local and regional planning boards to ensure citizen voice is heard.

Technology and digital solutions – champions will develop and use digital solutions to support their work.

Promoting the social value sector – champions will promote and support people to engage in a wide range of activities including those delivered by the third sector. Third sector organisations will host and support champions. Integrated community hubs – champions will support the development and delivery of coordinated services in the community. Workforce development and integration – champions will be employed within social care and third sector and will provide awareness training (both informally through their employment and directly via training)
New or existing investment
The Project is a remodelling of part of the ICF LD Employment and Training project which has employed LD champions for the last 3 years in Pembrokeshire. The project is being expanded to include other citizen groups.
Estimated total cost
Cost per annum (full year fully staffed) Total £151,111

Start date	**Estimated completion date**
1/4/22	**31/3/27**

Title of project to support Model of Care (programme)	
Citizen Champions	
Funding elements	**Select**
Element 1 - Acceleration funding year 1	**x**
Element 1 - Acceleration funding year 2	
Element 2 - Embedding fund year 1	
Element 2 - Embedding fund year 2	
Element 2 - Embedding fund year 3	
Element 3 - Legacy integrated pooled fund	
Element 4 – National priorities (Dementia and Memory Assessment Services/ Diagnostic Support)	

Provide the rationale for the element selected.

The project has been included in ACF for the following reasons. This project was part of a larger project and is now being recognised as an area of work in its own right. It is also being re-modelled.

Title of project to support Model of Care (programme)				
Citizen Champions				
Delivery Partners	**Welsh Government contribution**	**Partner match monetary**	**Partner match resource**	**Total funding required**
Local Authority	£136,000	£15,111	**Staffing / Buildings / Income**	**£151,111**
Social Value Sector				
Health Board				

The split between organisations will be determined based on the needs of the citizen champions and the areas of work that are prioritised. It is estimated that over 50% of the project will be led by the social value sector.

Title of project to support Model of Care (programme)
Partners for the Journey
Any additional Models of Care the project will contribute towards
• Community Based Care - Prevention & Community Co-ordination • Supporting families to stay together
Project Summary

Purpose

This project aims to support GP and other Primary Health Care service users, who have underlying non-medical needs and/or low level mental ill health, to deal with a range of issues such as loneliness and isolation, housing, welfare benefits, and debt, thereby ensuring that Health Care staff can concentrate on relevant health issues.

Background

The project commenced in December 2020 funded by both North & South Pembrokeshire Clusters and has established an innovative referral and ongoing support system for patients/clients with low-level mental health needs on a wider multi-agency basis.

Support is provided to the patient/client from the point of seeking support through to having their issues addressed and has shown significant impacts both for patients and for Practices.

Approach

The service is delivered both remotely and face to face by Citizens Advice Bureau Pembrokeshire & MIND Pembrokeshire and facilitates seamless multi-agency responses between Citizens Advice Pembrokeshire (CAP), Mind Pembrokeshire, specific GPs and other Primary Health Care teams.

The project requires close collaboration between partner teams in order to provide the 'joined up' approach with 'Referral and Support Coordinator' posts employed by both CAP and Mind Pembrokeshire, whose key functions are to:

- Ensure each patient/client's journey is person-centred and encapsulates a seamless and integrated response to their issues.
- Monitor all referrals to and from their organisation and problem-solve, where necessary, in collaboration with all involved agencies, with the aim to secure timely and effective solutions for each client.
- Establish new, and strengthen existing, links between professionals in all relevant organisations within Pembrokeshire and beyond.
- Organise the delivery of multi-agency training to establish person-centred and solutions-focused working practices, as well as any other training required.

- Oversee the monitoring and evaluation of the project, reporting on lessons learned and leading on an improvement action plan.
- Deliver Advice as required and/or ensure other members of the CAP and Mind Pembrokeshire teams provide support

The project also includes a dedicated 'Partners for the Journey Advisor', employed by CAP, and a Mind Support Practitioner.

Within the Cluster there is an appetite to continue to deliver and funding is sought to embed and expand this service within the County, working towards developing this as a *Once for Wales* model.

As part of the year 1 activity, comprehensive plans for Regional roll-out will be developed, with delivery beginning in year 2.

Outcomes

The project will meet the *primary* Programme outcomes as follows:

People are better supported to take control over their own lives and well-being	• Number of patients on active monitoring pathways • Practical support provided to individuals
People have improved skills, knowledge, and confidence to be independent in recognising their own well-being needs	• % Improvement in wellbeing of people supported • Reduction in GP visits for low level mental health issues

Benefits (user groups)

- Improved experience for individuals and the patient/client journey
- Improved partnership/cross agency working
- Practical support to address needs
- Reduced demand on Primary Care services

Exit Plan

It is anticipated that this project will demonstrate clear value and impact on Primary Care and Mental Health service pathways, sufficient to embed this service within core funding.

Priority population group(s)

This project primarily supports people with emotional health and mental well-being needs, but will also contribute towards:

- Older people including people with dementia
- People with learning disabilities, neurodiverse and neurodevelopmental conditions including autism

• Unpaid carers
Key enablers
All 5 of the key enablers will support the delivery of this project: • Integrated planning and commissioning • Technology and digital solutions • Promoting the social value sector • Integrated community hubs • Workforce development and integration
New or existing investment
This project is seeking new investment
Estimated Total Cost
£83,333

Start date	**Estimated completion date**
1st April 2022	**31st March 2027**

Title of project to support Model of Care (programme)	
Partners for the Journey	
Funding elements	**Select**
Element 1 - Acceleration funding year 1	
Element 1 - Acceleration funding year 2	
Element 2 - Embedding fund year 1	**X**
Element 2 - Embedding fund year 2	
Element 2 - Embedding fund year 3	
Element 3 - Legacy integrated pooled fund	
Element 4 – National priorities (Dementia and Memory Assessment Services/ Diagnostic Support)	

Provide the rationale for the element selected.

The project seeks to join up support across services. It was completed as a cluster project and the embedding of the approach which includes several targeted population groups requires expansion for which a RIF contribution is appropriate.

Delivery partners

Title of project to support Model of Care (programme)				
Partners for the Journey				
Delivery Partners	**Welsh Government contribution**	**Partner match monetary**	**Partner match resource**	**Total funding required**
Local Authority				**£83,333**
Social Value Sector	£75,000	£8,333	**Staffing / Buildings / Income**	
Health Board				

Title of project to support Model of Care (programme)
'Grow Our Own' Social Workers and Approved Mental Health Practitioners
Any additional Models of Care the project will contribute towards
Complex Care Closer to Home
Project Summary

Purpose

To meet skills shortage and recruitment issues in relation to the above practitioners by developing and upskilling social wok assistants.

Background

Recruitment and retention of social workers and approved mental health practitioners (AMHPs) is a key issue facing local authorities. This is particularly challenging in mental health services. Local evidence has clearly demonstrated that investing in the development of our existing workforce improves staff satisfaction, loyalty, and retention.

Approach

We therefore intend to apply this approach, alongside other workforce strategies, to help us meet the skills gap in the workforce for AHMPs and experienced social workers.

At the point of recruitment, Social Work assistants will be encouraged to progress their career by applying for the Social Work degree with the Open University. The cost of the course is £2616 per annum (120 credits) per student and takes 3 years part-time, commencing October 2023.

A further 2 years post-qualification will be required before the Division will expect identified staff to put themselves forward for AMHP training where they are based within Mental Health Teams. AMHPs can only be recruited from the following professions (Social Work, Registered Mental Nurses, Occupational Therapists, Chartered Psychologists).

The AMHP course at Swansea University lasts for an academic year, is a Masters level course and is part practice and part academic. Costs for the course in 2021 are in the region of £5000 per candidate. Essentially, we are looking at a 7-year timescale to train a newly recruited Social Work assistant to progress to qualified Social Worker and then train as an AMHP.

Outcomes

The project will meet the *primary* Programme outcomes as follows:

People are better supported to take control over their own lives and well-being	• The AMHP role offers an alternative perspective to a medical model • In relation to care and treatment the use of the least restrictive options will be promoted

People have improved skills, knowledge, and confidence to be independent in recognising their own well-being needs	• The AMHP role promotes the service users right to self determination • The AMHP role will keep the welfare of the individual at the centre of their consideration • The trainee scheme to AMHP will be Social Work Assistant- Social Worker- AMHP The SW and SWA role will focus on "what matters to the person" and the promotion of greater independence etc

Benefits

These include:

- The AMHP role is to make decisions around the use of compulsory powers that promote the autonomy of the individual while safeguarding the person, the family and the wider public.
- The recruitment and retention of AMHPs is critical to enable the LA to fulfil its statutory obligations.
- Additional resource in mental health social work will provide the capacity to align with the health board to improve early intervention and crisis response.

Exit plan

It is proposed that the project will be mainstreamed from year 4 onwards.

Priority population group	
People with Mental Health issues	
Key enablers	
Workforce development and integration	
New or existing investment	
New	
Estimated total cost	
£82,078	
Start date	**Estimated completion date**
1st April 2022	31st March 2027

Title of project to support Model of Care (programme)	
'Grow Our Own' Social Workers and Approved Mental Health Practitioners	
Funding elements	**Select**
Element 1 - Acceleration funding year 1	**X**
Element 1 - Acceleration funding year 2	

Element 2 - Embedding fund year 1	
Element 2 - Embedding fund year 2	
Element 2 - Embedding fund year 3	
Element 3 - Legacy integrated pooled fund	
Element 4 – National priorities (Dementia and Memory Assessment Services/ Diagnostic Support)	

Provide the rationale for the element selected.

This is a new project to scale up the approach of investing in the existing workforce.

Delivery partners

Title of project to support Model of Care (programme)				
'Grow Our Own' Social Workers and Approved Mental Health Practitioners				
Delivery Partners	**Welsh Government contribution**	**Partner match monetary**	**Partner match resource**	**Total funding required**
Local Authority	£57,455	£24,623	**Staffing / Buildings / Income**	**£82,078**
Social Value Sector				
Health Board				

Health & Social Care Regional Integration Fund

Investment Proposal

West Wales

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

Model of Care (Supporting families to stay together safely and therapeutic support for care experienced children) – Strategic vision

The *Supporting families to stay together safely and therapeutic support for care experienced children* programme brings together partners from Health, Social Care, Education, Third Sector to take forward effective delivery of integrated/preventative services in West Wales. In line with White Paper on Rebalancing Care and Support the projects aim to strengthen partnership arrangements, transform services, and deliver projects that encourage positive work with families to help them stay together safely and prevent the need for children to enter care.

The Social Services and Well-being Act (Wales) emphasises supporting families to stay together, where it is safe and in the best of interests of the child. The programme will deliver projects that help families to use their strengths and resources in their communities for support.

The programme will deliver support as early as possible to prevent serious problems developing as suggested in the Children's Commissioner for Wales 'No Wrong Door' report.

The programme is developed based on the recommendations within West Wales Population Assessment:

- Further development of preventative and early intervention services.
- Considering the importance of physical, mental, and emotional wellbeing of children and key role in universal services in achieving this.
- Enhancing partnership working.
- Developing community resilience and resilience and wellbeing in families and focus on wherever possible on promoting family life and enabling children and young people to remain with their families and/or communities so as it is safe for them to do so.

In addition, the West Wales Market Stability Report identified that whilst the number of children aged 0-15 is expected to decline 8% over the next decade (to 2031), demand for specialist support and services such as CAMHS and residential care which is already difficult to source locally may increase. Areas for development include more seamless transition to adult services, user voice, co – production and integration.

Model of Care (Supporting families stay together safely, and therapeutic support for care experienced children) - Business case

In this section you should set out how your programme is going to clearly support the delivery of the national Models of Care.

A robust case for change should include but is not limited to:

- The programme aims and objectives to deliver *Place based care – Prevention and community coordination*.
- A summary of the baseline position of the programme including population needs, service and community assets and capability.

- What regions are seeking to achieve using RBA methodology, incorporating a consistent set of indicators and measures.
- Initial plans for sustainability and wider scale up and exit planning following the end of the investment through the RIF.

Programme Aims and Objectives

- To develop models of care that work positively with families to help them stay safely together and prevent the need for children to enter care.
- To ensure the response to children and young people's needs is integrated with health care and education for care experienced children with complex emotional and behavioural needs.
- Reduce the numbers of LAC children across the region by delivering a range of preventative services and build stronger and more resilient families and communities.
- To strengthen therapeutic support, improving and enhancing the well-being of care experienced children.

The programme will deliver the following projects:

Edge of Care Project

The Population Needs Assessment suggests the need to:

- Develop community resilience and resilience and well-being in families and focus wherever possible on promoting family life and enabling children and young people to remain within their families and/or communities so long as it safe for them to do so.

Purpose of the project:

A Regional Edge of Care project will fund Teams to provide a range of early intervention methods including direct work, monitoring, and practical support for families to support children and young people remain at home with their families where it is safe to do so. The aim is to identify and assess as early as possible those children who need care and support (including help to achieve emotional and well-being resilience). Ensure intervention is at the right stage which prevents a crisis and result in entry to care. The project will see the development of discrete and dedicated support services for Special Guardians within the region. Historically those carers/family members who become special guardians by virtue of a court order have not had access to structured, responsive, and consistent support.

Outcomes and Key Measures

- The project will build community resilience with by supporting families stay together.
- Investment at an early stage will help reduce the numbers of children in care and free resource up in statutory services.
- Provide therapeutic support, to enhance the well-being of care experienced children
- Assess capacity/improving parenting skills for parents in/edge of care and provide intensive support.
- Special Guardians are training and offered support groups.
- Support plans are reviewed and amended to identify needs.
- Improved access to information and advice

Step Up Step Down Project

Purpose of the project:

The purpose of the Step Up Step Down project is to support children and families as they move between statutory and non-statutory services, ensuring they do not fall between the gaps.

Outcomes and Key Measures

- Step Up Step Down will ensure that children received consistent and seamless support at the right time from a range of professionals promoting positive health and well-being.
- Support children and families who have received support from the statutory service and have progressed positively by ensuring progress continues and is sustained and complies with the whole system approach to delivery (not being passed from one service to another).
- Reduce numbers of children and young people requiring statutory services or entering care
- Address key themes such as substance misuse, mental health, isolation, domestic abuse, poor physical health, neglect of children and poverty.

School Safeguarding and Assessment Team

Purpose of the project:

To improve the outcomes for children through engagement in education and to ensure that all learners are safeguarded (including those who are electively home educated) and that the needs of vulnerable learners are met, in line with the ACEs and wellbeing agenda.

Outcomes and Key Measures

- Children and families are included to work collaboratively with professionals agreeing support plans and systemic approaches.
- School attendance will improve and actively reduce persistent absenteeism.

Grow Your Own

Purpose of the project:

To provide a regional integrated work-based learning route for people to enter the qualified social work profession through a trainee scheme, allowing students to experience placements in social care and health and seeing the work within a wider context of opportunity.

Outcomes and Key Measures:

- Increased number of social workers in workforce
- Integrated opportunities for succession planning between Health and Social Care
- Increased likelihood of staff retention
- Career progression pathway
- Increased capacity

Complex Needs Project

Purpose of the project:

Occupational Therapy works with children, young people and their families to reduce the impact of ill health or disabilities and help children & young people to do the everyday activities they need or want to do.

This includes.

- Eating & drinking, washing, dressing and toileting
- Developing foundation skills for everyday life
- Environmental safety and adaptations in home, school and other settings
- Strategies to aid participation and engagement in activities, including play.
- Reducing the risk of developing deformities and debilitating movement patterns
- Rehabilitation and recovery
- Supporting transition into adulthood and developing independent living skills

Outcomes and Key Measures

- People reporting easier access to a range of information, advice and support from the service
- Outcomes of intervention will enable people to be healthier and happier
- Service innovation and utilisation of technology will be key to transform service provision on a regional footprint
- Better and timely support for families to help them stay together
- Therapeutic support that helps to improve and enhance the well-being of children, including those who have experienced care

Children and Young People Emotional Health and Wellbeing Service

Purpose of the project:

To provide a preventative service and offer early intervention to Children and Young People with emotional health and wellbeing issues.

Outcomes and Key Measures

- Prevent referrals to SCAMHS
- Advice and Guidance is provided early
- Support children and young people who are on the edge of care
- Provide psychological support in Education Settings

Model of Care (Supporting families stay together safely, and therapeutic support for care experienced children) - Key enablers

Select which of the key enablers will maximise the delivery of the programme, using the free text box to describe how this will be achieved.

Key Enablers	Select
Integrated planning and commissioning	
Technology enabled care	
Promoting the social value sector	
Integrated community hubs	
Workforce development and integration	
A resilient, skilled and integrated health and social care workforce is critical to the success of this programme. Projects will support the development the social care workforce and build on partnership relationships and strengthen the delivery of services.	**x**

Model of Care (Supporting families stay together safely, and therapeutic support for care experienced children) - Priority population groups

Select both the primary and secondary beneficiaries of the programme by priority population group, using the free text box to describe the particular impacts this will have. Please also indicate if the beneficiaries are supported using DAP funding.

Priority population groups	Primary	Secondary	DAP
Older people including people with dementia			
Children and young people with complex needs	X		
People with learning disabilities and neurodevelopmental conditions including autism*			
Unpaid carers*			
People with emotional and mental health wellbeing needs		X	

Other beneficiaries

If there are other stakeholders benefiting from the programme, please provide this detail below.

The programme supports families will include parents and carers including young carers.

Total programme cost and match funding projection

Provide a breakdown of the total programme cost, Welsh Government contribution, partner monetary and resource match including costs attributed to support unpaid carers and / or social value sector delivery. You can find more information on match funding in the guidance notes.

Total cost of Programme	Welsh Government contribution	Partner match monetary	Partner match resource	% support for unpaid carers	% for social value sector delivery
£2,722,199	£2,001,532	£720,667		0.00%	0.00%

Programme resource and management details

Provide a summary of the planned resource and roles required to deliver this specific programme. These roles are 100% funded via the RIF and will accounted for within the allocated fund.

Posts / type of roles	Estimated FTE	Costs

Project plans - Complex Needs Project

In this section, outline each project that will contribute towards the successful delivery of *"Supporting families to stay together safely and therapeutic support for care experienced children"*
For the purposes of the investment proposal you will need to provide:

- Information on all sections within the table below.
- Repeat the table for each project being put forward.
- Indicate if the project will be delivered using DAP funding in the summary.
- For Dementia project, outline which strand the project relates to DAP or Memory Assessment Services/Diagnostic Support in the summary.

Title of project to support Model of Care (programme)
Children with Complex Needs
Any additional models of care the project will contribute towards
Emotional Health & Wellbeing
Project Summary
Children with complex needs need something "different" and provision for them is usually agreed by formal processes in each local authority and in the local health board, such as inclusion panels in education, service and package advisory meetings in children's services and continuing health care assessment in health services. (People and Work Unit 2017) We have seen an increasing demand for children whose needs exceed our existing provision following the pandemic. This has required the development of bespoke solutions delivered by each local authority and health board. This also includes an increased reliance on services purchased from the independent sector such as domiciliary care and residential provision, which are often out of area. The needs vary from county to county. **The Complex Needs Project seeks to address these gaps by delivering bespoke projects that can be evaluated and 'scaled up,' if they are effective. The project will also establish a regional approach to commissioning and procurement.** • OT Project *continuation of CCC post 1 year then upscale building on the current occupational therapy provision for children and young people in our Region to shift the service towards a preventative and proactive model of care and drive integration of service provision across health & social care. • Occupational Therapists are currently employed across our region by the Health Board and the local authorities, to provide a service for children and young people. The current service is based on historic funding levels, with separate routes of access based on organisational statutory duties. Children are currently waiting too long to receive the service that can help them to live well and safely at home. On 31st January 2022, there were 148 children waiting over 14 weeks for an Health Board occupational therapy assessment. The longest wait on

24/02/22 was 62 weeks. Whilst there is a plan in place to address the current backlog, there is also an opportunity to utilise RIF to transform the service towards a sustainable, integrated, proactive and preventative way of working where children and their families have easy and earlier access to information, advice and occupational therapy assessment and intervention that is proportionate to their needs.

- For children, their families and carers it doesn't matter who employs the occupational therapist. They need the right service, that can help them, at the right time.

- ICF has funded one post in Carmarthenshire to work as part of the Health Board Occupational therapy team and to start to develop an integrated service model. All children's referrals for occupational therapy in the County are received and seen by the same team. Evaluation has demonstrated the effectiveness of this approach, but also the capacity gap. This proposal seeks to continue with this post and start to spread an integrated approach to occupational therapy for children & young people across the region.

- An integrated approach for occupational therapy has many benefits for the population, professionals and organisations.
- Opportunities to develop integrated and easier direct access routes for children and families to access help when they need it.
- Consistent approach across region and organisations to information & advice to support self-management.
- Efficient and prudent use of small and specialist workforce across large geographical region
- Building a more robust and sustainable workforce model for future generations
- Consistent approach across the region to support C&YP transitioning into adult services
- The proposal builds on existing teams, as illustrated below, and includes additional leadership and coordination across the region to support co-production and deliver the improvements.

Priority population group

Children are those age 17 and an under and who's needs can be:

- Complex due to chronic health conditions (including life-limiting conditions)
- Complex due to sensory impairment (e.g. blind, deaf)
- Complex due to physical disability and associated conditions such as learning disability and / or autism
- Complex due to the display of risky, challenging and or harmful behaviours
- Complex due to mental ill health
- Complex due to learning disability and/or autism
- Complex due to context (e.g. abuse, neglect, growing up with domestic violence, growing up as a refugee/asylum seeker). The circumstances of some young people will become complex because in addition to their original needs they have also become involved in the youth justice system.

Key enablers	
Integrated planning and commissioning	
New or existing investment	
New	
Estimated total cost	
£28,557	
Start date	**Estimated completion date**
1st April 2022	31st March 2023

Regional Investment Model

Select the funding element which the project will be set against. Repeat the table and rationale below for each project.

Title of project to support Model of Care (programme)	
Complex Needs Project	
Funding elements	**Select**
Element 1 - Acceleration funding year 1	x
Element 1 - Acceleration funding year 2	
Element 2 - Embedding fund year 1	
Element 2 - Embedding fund year 2	
Element 2 - Embedding fund year 3	
Element 3 - Legacy integrated pooled fund	
Element 4 – National priorities (Dementia and Memory Assessment Services/ Diagnostic Support)	

Provide the rationale for the element selected.

The complex needs project has been remodelled on a regional basis.

Delivery partners

Include details of local LHBs, local authorities, third sector and other providers that will support in the delivery of the projects. In this section you will also need to explain what they bring to the project by means of match contribution. This can be evidenced by either monetary or resource match. Repeat the table below for the number of projects being put forward.

RPBs will be expected to invest a **minimum of 20%** of their RIF allocation in delivery through social value sector organisations. RPBs should be connecting closely with their social value forums to ensure the wider sector can be engaged in the planning, design and delivery of these Models of Care. The information provided below will help aggregate the social value sector involvement at programme level.

Title of project to support Model of Care (programme)				
Complex Needs Project				
Delivery Partners	**Welsh Government contribution**	**Partner match monetary**	**Partner match resource**	**Total funding required**
Local Authority	£19,990	£8,567	**Staffing / Buildings / Income**	**£28,557**
Social Value Sector				
Health Board				

Regional Integration Fund (RIF) Project plans – Edge of Care Project

Title of project to support Model of Care (programme)
Edge of Care
Any additional Models of Care the project will contribute towards
Promoting good emotional health and wellbeing
Project Summary

Wales has a higher rate of looked after children than other areas of the UK. The 2022 Population Needs Assessment identified that West Wales has a lower number of children looked after than the national average. However, there are significant variations between counties. Recent trends have shown that numbers are increasing in Ceredigion and Pembrokeshire but declining in Carmarthenshire.

The 2022 Population Needs Assessment has also highlighted the impact of the COVID 19 pandemic on children and families. The increased pressure within families because of school closures, the impact on adult and children's mental health and reduced availability of universal and non-statutory support services has led to an escalation in need and increase in demand as restrictions have eased.

The 2022 Market Stability Report also recognises this difference in provision between counties and the pressure the increasing demand places on regulated provision, including foster care and specialist residential care homes.

Edge of Care Project aims to provide targeted and intensive support to children and families who will have had an assessment from our statutory children's teams. The aim is to improve outcomes for those families and reducing the number of families requiring protective interventions and children entering the care system.

This will be achieved by recognising the need to deliver evidence-based solutions which will enhance the existing arrangements in each county. The project will also allow effective solutions to be 'scaled up' to delivered consistent outcomes for children and families across West Wales.

Teams have been established to strengthen families and improve relationships and deescalate situations whereby children may become looked after. A range early intervention method consisting of direct work, monitoring and practical support for families will be provided, to enable children to remain at home.

Carmarthenshire

In Carmarthenshire the Edge of care team has been developed to embed the agenda of early intervention into social care across the service to improve the lives of children and young people by working collaboratively to raise aspirations, build on achievements and protect the most vulnerable in our communities. The Edge of care team provide a bespoke intensive package of intervention tailored to meet individual needs commensurate with the child's care plan.

Primary activities include:

1. Support carers in their caring role and enable them to maintain their own wellbeing.
2. Enable families to meet their children's needs and help them to stay together, by investment in preventative services.
3. Enable swift rehabilitation home where children have had to come into care
4. Provide engagement and support to families to avoid proceedings and removal at birth
5. Support mother and baby placements to increase the prospect of successful return of parents and child to the community
6. Intensive relationship work with older children and families to repair damaged relationships

The Edge of care team will provide short term, structured evidenced based interventions that enables families to develop problem solving skills, build resilience and achieve or modify positive and sustainable behaviour change.

Ceredigion

In Ceredigion the Edge of care team has been developed alongside the iFSS team to improve the lives of children and young people by working collaboratively to raise aspirations, build on achievements and protect the most vulnerable in our communities. The Edge of care workers provide a bespoke intensive package of intervention tailored to meet individual needs commensurate with the child's care plan.

The Edge of care Mental Health and Wellbeing Support Worker for Children and Young Adults offers a holistic approach with child and their family providing emotional and wellbeing support to strengthen their family unit directing to additional support services and feeding back to statutory services. The post works within local authority staff and Local Health Board, alongside Children and family Assessment Teams, safeguarding, Education, Community Mental Health Team, Child & Adolescent Mental Health Service.

Support relating to mental health and wellbeing support to all ages. A person-centred approach to promote and sustain the mental wellbeing needs of the child/young person. Monitor current mental health and to promote positive coping strategies within the recovery model.

Develop and maintaining wellbeing by giving guidance support to access the needs and objectives of the individual through education, social groups, support network, housing, employment, and general lifestyle.

Parent & Baby Support

A parenting assessment and support service is to be developed for parent and babies will also sit under the Edge of Care projects to help assess capacity/improving parenting skills for those parents with children in care or on the edge of care, by replicating a day-time home environment where monitoring and guidance can be offered, whilst providing drop-in checking and more intensive support on demand. The aim, to improve independence and wellbeing outcomes for children and families, reduce numbers of looked after children in the county and avoiding the need for high levels of out of region and residential placements as well as reducing the amount of parenting assessments needing to be outsourced.

The workers will work alongside and add to the preventative work of the IFSS/Edge of Care team and the care and support team in Planned Care.

Pembrokeshire

An Edge of Care posts will focus on supporting parents of young children accessing our support and assessment facility for Parents and Children in Haverfordwest. Currently being designed as a day contact/support and assessment facility, the longer-term plan will be to evolve the service into one that can offer residential provision, to reduce the need for parents and children to either be separated or to avoid placing such families away from Pembrokeshire in specialist and externally sourced placements.

An Edge of Care Support worker will assist with the planning, running and administration of Family Group meetings within the Edge of Care service, in order to provide opportunity from within families, to care for or support their relative children as an alternative to local authority intervention and in particular to avoid those children either coming into foster care, or remaining looked after in the longer term

Special Guardian Support Service (Supporting Families to Stay Together)

The project will see the development of discrete and dedicated support service for Special Guardians within the region. Historically those carers/family members who become special guardians by virtue of a court order have not had access to structured, responsive, and consistent support. Recent research has found that a lack of support services and contact with other SGs, along with properly managed and reviewed support plans, are key factors in the ongoing stability of the placement of the children subject to these orders. There is currently a large amount of attention being paid to the issue nationally with Welsh Government having commissioned work to understand the issues across Wales, issuing new formats for support plans and sharing research carried out independently. The drive to reduce the numbers of children in state care is inextricably linked with the making of SGOs as the children who are subject to these orders would otherwise have remained within the care of the local authority. This project would see the establishment of a small professional team in each LA area who would support fieldwork teams with development of support plans; provide direct support to SGs in the region inc via support groups; carry out review of support (inc financial support) periodically and in line with guidance and regs; and overall aim to enhance the attractiveness of SGOs as a viable alternative to children remaining subject to care orders.

A small research study carried out in Wales in 2020 made the following key recommendations in its bid to see the disruptions of SGO placements reduce:

Access to timely information on the full range of issues relevant to special guardianship arrangements.

Proper consideration is given to the special guardianship support plan, which will include a plan for contact with the local authority during the first year, including visits for face-to-face discussion and support, contingency plans and the plan for a review. The support plan will include provision for ongoing contact with the local authority after the first year, and information on how the special guardian can access information, advice and support.

Special guardians have access to a named person or team for information, advice and support. That person or team has experience in special guardianship arrangements/kinship care. Mechanisms are devised to keep special guardians informed and updated about the support available and how it can be accessed.
The annual review will take account of the reality of the experience of the past year, from both the child and the special guardian's perspective. Where there have been challenges, these are properly addressed, and a fresh plan developed where it is in the child's best interests.

Each local authority makes available to special guardians a clearly identified pathway to information, assistance, and advice, to include education, health and housing where appropriate.

Key Functions

1. Support the development of individual SGO support plans with social work teams.
2. Deliver training to SGs.
3. Convene and run support groups for SGs.
4. Review and amend support plans depending on identified need following assessment.
5. In carrying out assessments consider the ongoing and changing needs of the children, the SGs and the wider family, to include considerations therapeutic intervention, support with supervised or managed contact, and developing costs related to the care and support of the children concerned.

Outcomes of Edge of Care Project • Families get better support to help them stay together • Therapeutic support improves and enhances the well-being of care experienced children • Early intensive intervention to reduce cyclical events • Identify support services in local community to promote mental, emotional, and physical well-being and resilience. • Reduced number of children entering care • People feel they are involved in decisions about their care and support
Priority population group
People with emotional and mental health wellbeing needs. Children and young people with complex needs.
Key enablers
Integrated planning and commissioning Integrated community hubs Workforce development and integration
New or existing investment
Existing investment – Embedded fund for 3 years.
Estimated total cost
£1,011,597

Start date	**Estimated completion date**
1st April 2022	31st March 2023

Regional investment model

Select the funding element which the project will be set against. Repeat the table and rationale below for each project.

Title of project to support Model of Care (programme)	
Edge of Care Project	
Funding elements	**Select**
Element 1 - Acceleration funding year 1	
Element 1 - Acceleration funding year 2	
Element 2 - Embedding fund year 1	**x**
Element 2 - Embedding fund year 2	
Element 2 - Embedding fund year 3	
Element 3 - Legacy integrated pooled fund	

Element 4 – National priorities (Dementia and Memory Assessment Services/ Diagnostic Support)	

Provide the rationale for the element selected.

Existing project that has been evaluated and continued under RIF.

Title of project to support Model of Care (programme)
Edge of Care

Delivery Partners	Welsh Government contribution	Partner match monetary	Partner match resource	Total funding required
Local Authority	£718,118	£293,479	**Staffing / Buildings / Income**	**£1,011,597**
Social Value Sector				
Health Board				

Regional Integration Fund (RIF) Project plans - Grow Your Own Social Workers

Title of your project
Joint Integrated Grow Your Own Social Workers (Children's Services)
Main Model of Care (programme) that the project supports
4. Supporting families to stay together
Any additional Models of Care[1] the project will contribute towards
1 Community based care – prevention and community co-ordination 3 Promoting good emotional health and well being 6 Accommodation based solutions
Project Summary

The Grow Your Own Social Worker project aims to provide a regional integrated work-based learning route for people to enter the qualified social work profession through a trainee route, allowing students to experience placements in social care and health and seeing the work within a wider context of opportunity.

Overall, the attraction of applicants into social worker roles is regarded as challenging throughout the region leading to long recruitment times, vacant posts and limited choice of candidates during selection. Turnover and vacancy rates are high and retention is challenging.

Exploratory work has been undertaken in consultation with the Regional Workforce Programme Board (RWPB) involving HDUHB and the Pembrokeshire, Ceredigion and Carmarthenshire LAs to develop synergies in workforce development across the region. As a result of this, attracting more people to train as social workers across social care and health was identified as a priority.

Pembrokeshire and Ceredigion will host the pilot during the first year and following evaluation it is envisaged that the programme will also be upscaled to include Carmarthenshire and will become regional across all three counties.

This application concerns the pilot which is expected to include 11 social work trainees in total (5 Pembs and 6 Ceredigion):

- Allow TSW to try several aspects of social work in Health and Social Care, before choosing a career to suit their career aspirations
- Contain Welsh language skills development
- Rotational placements that allow trainees to experience various areas within community and social care
- Modular attendance at university, working towards a degree in social work
- Reverse mentoring to shape the future of Health and Social Care
- Pastoral support
- Monthly action learning sets

Expected outputs

Growing our own Social Workers via a Grow your own Social Workers programme would offer:

- Ability to increase the number of social workers in workforce; The number qualifying in 2025 (possibly 2024 if already hold Cert He)
- Future proof/succession planning for SW role & LA ability to cover statutory duties
- A combination of placements within health, social care and third sector to enable students to gain experience and insight across the whole sector
- High quality employment opportunities and alternative to University/ 'earn as you learn' for citizens of Ceredigion and Pembrokeshire
- Potential to increase number of Welsh speaking SWs through local recruitment
- Increased likelihood of retention
- A career progression pathway

Benefits (user groups)

- Employment opportunities for people in the local population for work-based learning.
- Increased capacity from regular supply of workers should improve responsiveness and coverage in sector
- Ensuring that we have a continued flow of new SWs means we can better guarantee a level of intervention that extends beyond the urgent and responsive approach that arises when SW vacancies are an issue, to a more truly, consistent preventative approach which is much improved for citizens and services

Exit Plan

By developing an annual cycle of TSW over 3 years, acquiring a larger cohort every year core funding can be used due to reduced spend on agency workers, reduced reliance on alternative care as the regional approach to preventions will be improved, and a reduction in retention/recruitment/relocation costs as there will be an increase in the regional workforce

Priority population group(s)

All children, young people and their families who benefit from working with social work teams should benefit, especially:

- Children and young people with complex needs
- People with learning disabilities and neurodevelopmental conditions including autism
- Unpaid carers
- People with emotional and mental health wellbeing needs

Key enablers

- Integrated planning and commissioning
- Technology and digital solutions
- Promoting the social value sector
- Integrated community hubs
- Workforce development and integration

New or existing investment

New Funding Proposal	
Estimated Total Cost	
£366,630	
Start date	**Estimated completion date**
1st April 2022	31st March 2023

Title of project to support Model of Care (programme)	
Element 1 - Acceleration funding year 1	**x**
Element 1 - Acceleration funding year 2	
Element 2 - Embedding fund year 1	
Element 2 - Embedding fund year 2	
Element 2 - Embedding fund year 3	
Element 3 - Legacy integrated pooled fund	
Element 4 – National priorities (Dementia and Memory Assessment Services/ Diagnostic Support)	

Provide the rationale for the element selected.

The new project will address the workforce staffing crisis at present. And provide opportunity to upscale the project across the region.

Title of project to support Model of Care (programme)				
Grow Your Own Social Workers				
Delivery Partners	**Welsh Government contribution**	**Partner match monetary**	**Partner match resource**	**Total funding required**
Local Authority	£329,967	£36,663	**Staffing / Buildings / Income**	**£366,630**
Social Value Sector				
Health Board				

Regional Integration Fund (RIF) Project plans – School Safeguarding and Attendance Project

Title of project to support Model of Care (programme)
School Safeguarding and Attendance Project
Any additional Models of Care the project will contribute towards
Promoting engagement in education Promoting good emotional health and wellbeing Supporting families to stay together safely Place based care – Prevention and community coordination
Project Summary

The school safeguarding and attendance project aims improve outcomes for children through engagement in education and to ensure that all learners are safeguarded (including those who are electively home educated) and the needs of vulnerable learners are met, in line with the ACEs and wellbeing agenda.

The project works to improve school attendance and actively reduce persistent absenteeism.

Covid 19 has adversely affected the mental health of children and young people and school attendance figures across Wales have been significantly impacted. There has also been a steep increase in the number of children becoming electively home educated during the pandemic.

The most common reason for families choosing to home educate their children has been due to Covid 19 and anxieties about this. Research has identified that risk factors for children having greater difficulties during the pandemic include poverty, pre-existing mental health difficulties, additional needs and children from lower socio-economic backgrounds seem to be at greater risk of falling behind in their education compared to peers. Therefore, there is an increased demand for the support of the team.
Additionally, the pandemic has resulted in increased levels of need in families and there has been an increase in the number of families referred to statutory services. Families referred to the School Safeguarding and Attendance Project have also presented with more complex support needs and higher levels of disengagement from education than pre-covid.

Carmarthenshire

The social workers and Family engagement workers under the school safeguarding and attendance project are able to undertake bespoke interventions and direct work with young people and families. They use a range of person centred, solution focused and systemic approaches to agree support plans with families and other professionals, working collaboratively with school based, preventative and statutory services (including health and social care).

Social workers and family engagement workers work with families and provide a range early intervention method consisting of direct work, linking families in with community resources. Practical support for families will also be provided, to minimise the risk of family breakdown.

EHE figures have increased exponentially during the pandemic. This group is, as we know, particularly vulnerable. Short term funding from WG has assisted but this work needs to be ongoing and sustainable.

Ceredigion The schools safeguarding officer liaises closely between schools the safeguarding team and families in order to ensure co-ordinated and effective support to reduce the risk of harm and promote well-being. The officer will work alongside social workers school staff carers and parents using a range of methods linking families with agencies and community resources.
Priority population group
Vulnerable learners and their families (both in school and those who are electively home educated) Children who are at risk of disengagement from education and persistent absenteeism .
Key enablers
Integrated planning and commissioning Integrated community hubs Workforce development and integration
New or existing investment
Existing investment – Embedded fund for 3 years.
Estimated total cost
£548,300

Start date	**Estimated completion date**
1st April 2022	31st March 2023

Regional investment model

Select the funding element which the project will be set against. Repeat the table and rationale below for each project.

Title of project to support Model of Care (programme)	
School Safeguarding and Attendance Project	
Funding elements	**Select**
Element 1 - Acceleration funding year 1	
Element 1 - Acceleration funding year 2	
Element 2 - Embedding fund year 1	**x**
Element 2 - Embedding fund year 2	
Element 2 - Embedding fund year 3	
Element 3 - Legacy integrated pooled fund	
Element 4 – National priorities (Dementia and Memory Assessment Services/ Diagnostic Support)	

Provide the rationale for the element selected.

The project is effective and has reported both quarterly and annually to DMT, CLOG and the Audit and Evaluation group on progress made and outcomes delivered. Quarterly monitoring reports and case studies are available. This is new project that has been re modelled on a regional basis.

Title of project to support Model of Care (programme)
School safeguarding and attendance Project

Delivery Partners	Welsh Government contribution	Partner match monetary	Partner match resource	Total funding required
Local Authority	£383,810	£164,490	**Staffing / Buildings / Income**	**£548,300**
Social Value Sector				
Health Board				

Regional Integration Fund (RIF) Project plans - Emotional Health & Wellbeing Project

Title of project to support Model of Care (programme)
Children and Young People Emotional Health and Wellbeing Project
Any additional Models of Care the project will contribute towards
Promoting good emotional health and wellbeing
Project Summary

The Children and Young Peoples Emotional Health and Wellbeing Project aims to provide early preventative support for Children and Young People with emotional health and wellbeing issues.

Since the COVID pandemic the region has seen a significant increase of referrals to statutory teams from children and families in need of support. This project will ensure the right help and support is provided at the right time.

The Children and Young People's Emotional Health and Wellbeing project sits within the targeted support area of our 'Right Help at the Right time' and provides bespoke solutions in each locality, addressing gaps in provision.

The Children and Young Peoples Emotional Health and Wellbeing Project will address a range of issues Children and Young People are experiencing such as mental health, emotional wellbeing, and behavioural issues. The project seeks to address issues highlighted within the Children's Commissioner for Wales 'No Wrong Door' report, whereby support moves towards a 'no wrong door approach' in responding to children and young people's emotional wellbeing and mental health needs. Meaning, they should not be told they're knocking on the wrong door when they're trying to access help.

The Children and Young Peoples Emotional Health and Wellbeing Project works in partnership across organisations providing techniques to cope, providing preventative support relating to suicide and harm.

Since the pandemic the region recognise the need to enhance and develop areas further to support children and young people's emotional health and wellbeing.
The project will link with development relating to the NEST framework, where in is envisaged work will continue evolve and strengthen West Wales' approach to supporting children with emotional health and wellbeing needs.

Carmarthenshire

In Carmarthenshire the role of Psychologists with pod teams alongside social workers supports an approach integrating both systemic practice and elements of the signs of safety model. This integrated approach is used as it provides a more robust approach to facilitating discussion, deepening understanding, and planning interventions for families.

Support provided by Psychologists use questioning techniques and reflection to enable families understand what needs to change so that a child will be safe and well but also use resources in their own network to make sure the change is lasting.

Psychologists sit within the pods and provide specialist help and formulate plans specifically relating to the Child's emotional health and wellbeing.

The psychologists also work across the region adopters and foster carers helping to provide post adoption and placement support. This is critical in the success of placements both in terms of stability but also in terms of developmental progress of the child using an evidence based PACE model.

Priority population group	
People with emotional and mental health wellbeing needs. Children and young people with complex needs. People with learning disabilities and neurodevelopmental conditions including autism Unpaid Carers	
Key enablers	
Workforce development and integration	
New or existing investment	
Existing investment – Embedded fund for 3 years.	
Estimated total cost	
£263,299	
Start date	**Estimated completion date**
01.04.22	31.03.23

Regional investment model

Select the funding element which the project will be set against. Repeat the table and rationale below for each project.

Title of project to support Model of Care (programme)	
Children and Young People Emotional Health and Wellbeing	
Funding elements	**Select**
Element 1 - Acceleration funding year 1	
Element 1 - Acceleration funding year 2	
Element 2 - Embedding fund year 1	**x**
Element 2 - Embedding fund year 2	
Element 2 - Embedding fund year 3	
Element 3 - Legacy integrated pooled fund	
Element 4 – National priorities (Dementia and Memory Assessment Services/ Diagnostic Support)	

Provide the rationale for the element selected.

Existing project that will be further evaluated within year 1

Title of project to support Model of Care (programme)				
Children and Young People Mental Health and Emotional Wellbeing Project				
Delivery Partners	**Welsh Government contribution**	**Partner match monetary**	**Partner match resource**	**Total funding required**
Delivery Partners	**Welsh Government contribution**	**Partner match monetary**	**Partner match resource**	**Total funding required**
Local Authority	£184,309	£78,990	**Staffing / Buildings / Income**	**£263,299**
Social Value Sector				
Health Board				

Health & Social Care Regional Integration Fund

Investment Proposal

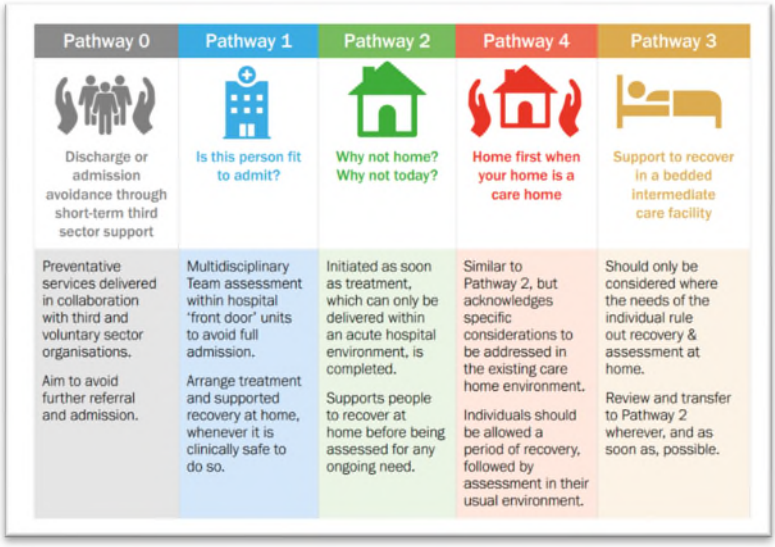
(West Wales) Home from Hospital

Home from Hospital West Wales Strategic vision

'Home from Hospital' model should ensure 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 '*Community Based Care'* 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*[1] 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. Home from hospital aims to develop;

- Models of care that provide integrated responses and pathways to allow people to return home from hospital swiftly and safely and avoid readmission.
- Models of care that maximise recovery following a hospital admission, and reduce reliance on long-term care, through reablement and community rehabilitation, to reduce admission and long term care dependence.
- The contribution, views and needs of unpaid carers is acknowledged and considered as part of the discharge planning process and direct support is provided to support them in their informal caring role.
-
-

The Welsh Discharge to Recover then Assess (D2RA) model, which has been supported by the ICF and the TF, has developed to be a key framework to enable integrated planning and delivery of community and hospital services across Wales. It was designed with stakeholders and RPBs to be adaptable, and as such it has been implemented by all RPBs across Wales. The pathways 0-4 set out in the model below range from community prevention activity through to integrated assessments and support to ensure people can return home a quickly and safely as possible.



Our vision: "To ensure every child, young person and adult in West Wales will be able to reach their full potential. To ensure fair access for all to excellent universal and targeted services that supports the health and wellbeing of all people. To develop skills and resilience that will last a lifetime and enable individuals to cope well with the challenges and pressures that they may face"

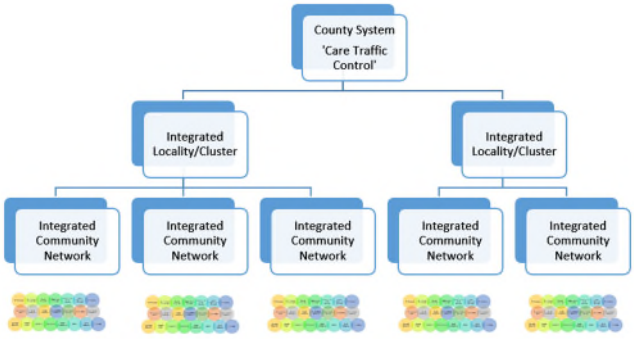
[1] Right care, right place, first time: Six Goals for Urgent and Emergency Care - A policy handbook 2021-2026 (gov.wales)

Dementia Action Plan (DAP) Summary

- For funding that supports the Dementia Action Plan, this summary should outline how older people including people with dementia can be supported by *"Place based care – Prevention and community coordination"*.

Business Case

West Wales is moving away from a complex system of care centred upon layers of teams and criteria led services to one that uses the 'wrap around' or 'patch based' approach. Developing integrated community networks to support strong communities will bring together multi-disciplinary teams to support GPs in delivering patch based, person centred care. 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- therefore it is imperative that Model of Care 1,2 and 5 are delivered hand in hand. Delivery depends upon excellent partnership working between, third sector, the health board, local authority, private sector, primary care and most importantly communities themselves. This programme will use the collaboration and partnerships achieved through Model of Care 2 to enable and facilitate timely discharges from acute sites in the same way that patch- based integrated teams will strive to avoid in-appropriate admissions. This is in the alignment with the strategic aim of the Urgent and Emergency Care strategy, which aims to prevent unnecessary escalation of care where possible, by providing proactive support, and to enable access to the right care, first time for people who have a need for urgent or emergency care. The vital role of unpaid carers in supporting care at home and timely hospital discharge is also acknowledged. This proposal includes action to ensure direct support is provided to unpaid carers to assist them with their informal caring roles. Our work to identify and recognise carers also links to actions being driven through Model of Care 3



Programme aims and objectives

The Quadruple Aim of *A Healthier Wales*[2] is used as a reference for setting the **aims and objectives** of this Programme. The four aims are numbered below, with associated SMART objectives listed below each:

Improved population health and well-being

- ✓ People who do not need to be in hospital will be cared for in a clinically safe alternative (UEC Goal 3)
- ✓ People will take greater responsibility for their emotional health and wellbeing resulting in fewer people requiring acute admission in the long term
- ✓ People will form part of more resilient communities enabling an asset based approach to care in the community that relies less upon statutory services (UEC Goal 6)

Better quality and more accessible health and social care services

- ✓ Hospital services will be designed to reduce the time spent in hospital and to speed up recovery.
- ✓ The shift in resources to the community will mean that when hospital based care is needed, it can be accessed more quickly.
- ✓ Providers deliver services that are aligned, accessible and fit for purpose (UEC Goal 3)
- ✓ People will understand what services are available (UEC Goal 2)
- ✓ People will appropriately judge which Health and Social Care services are most likely to meet their needs (UEC Goal 2)
- ✓

Higher value health and social care

- ✓ Projects will be evaluated to understand the impact on demand reduction (statutory services)
- ✓ Projects will be evaluated to understand the extent to which they create system value
- ✓ New models of care will involve a broad multi-disciplinary team approach where well-trained people work effectively together to meet the needs and preferences of individuals.
- ✓ The role of unpaid carers will be valued by multi-disciplinary teams and early identification and support will be provided to facilitate unpaid carers to continue their informal care in the community
-

A motivated and sustainable health and social care workforce

- ✓ Health and social care employers will promote the emotional health and wellbeing of their workforce
- ✓ Joint workforce planning will be in place with an emphasis on staff expanding generalist skills and working across professional boundaries.

Each objective is *specific*. It will be necessary to define appropriate measures. An RBA approach will be taken to reflect: how much has been delivered (quantity); how well (quality); and 'is anyone better off?' (impact). It is a (Regional) condition of funding that monitoring and evaluation arrangements – as set out in the Regional RIF Evaluation Framework – are put in place for all supported projects at project inception.

[2] A Healthier Wales (gov.wales)

Strategic Programme for Primary Care[3]:

- shifting the focus to a 'social model of care'
- ensuring timely access to primary care services across Wales
- working closely with partners to strengthen services and achieve seamless working across the whole system
- working on a 'once for Wales' basis. For example, this could be either:
- championing and 'scaling up' of local initiatives across Wales
- identifying solutions and enabling functions at a national level

Scope

- 111 Roll out
- Out of hours (OOH) Peer Reviews
- Winter Planning Initiatives
- OOH Pathways
- Escalation Processes
- Availability of services within the community
- Telephone first / Sign-posting / Triage Urgent Care.

Outputs

- OOH Peer Review National action plans
- Winter planning framework and a robust evaluation process
- Clear and consistent All-Wales OOH pathways to support:
  1. Urgent dental
  2. Mental health crisis
  3. Palliative care
  4. Care homes
  5. Paediatric services
  6. Urgent dental
  7. Mental health crisis
  8. Palliative care
  9. Care homes
  10. Paediatric services
-
- A once-for-Wales approach to escalation processes, defined levels of pressure and standardised responses to support 'in-hours' general practice services
- Mapping of all Independent Contract services available in a locality
- A clinical triage toolkit for general practice that includes a 'how to', the environment required and the expected benefits.

[3] Strategic Programme for Primary Care v9.pdf (wales.nhs.uk)

Urgent and Emergency Care Goals

Sets out expectations for health, social care, independent and third sector partners for the delivery of the right care, in the right place, first time for physical and mental health. This will be achieved through consistent and integrated delivery of six goals for urgent and emergency care to help achieve the best possible clinical outcomes, value and experience for patients and staff involved in the delivery of care.

An urgent or emergency need for advice, care or treatment is not predictable for the majority of people. However, some people are at greater risk of needing urgent or emergency care because of risk factors such as their age, frailty, a long-term condition(s), or other vulnerability; or as a consequence of health inequalities.

West Wales Specific Aims and Objectives:

- Strengthen local collaboration in both the planning and delivery of services
- To agree what an Integrated Community Network model will look like in West Wales; how many, where and who and agreed pathways or processes between the ICNs and the acute hospitals
- To improve access to services
- To build upon existing working relationships and promoting a culture of integration
- To improve our ability to share information appropriately
- To build processes that are streamlined that ensure value added at each step
- To develop our integrated intake hubs into a co-ordination hub/ care traffic control function for each county

Programme outcomes

- People are more involved in deciding where they wish to be cared for following discharge from hospital (What Matter conversations[4])
- Complex care and support packages are better at meeting the needs of people and delivered at home or close to home

Population Groups

The projects that are within this programme are primarily focused on meeting the needs of people who are:

- Older people including people with dementia
- People with learning disabilities and neurodevelopmental conditions including autism
- Unpaid carers
- People with emotional and mental health wellbeing needs

A future aspiration is that projects within this Model of Care will also support other priority population groups such as

[4] Direct payments and why "what matters" conversations and assessment are important. Resources for Wales | Social Care Wales

- Children and young people with complex needs

Baseline

The Population Assessment highlights the following in relation to Community Based Care – Complex Care Closer to Home:

General

According to the Office for National Statistics (ONS), by 2025the population of the West Wales region is estimated at 389,719, an increase of 1.34% since the 2017 population assessment.

- 48.8% of the population in the region live in Carmarthenshire, 18.7% in Ceredigion and 32.5% live in Pembrokeshire.
- 40% of adults in Carmarthenshire; 49% of adults in Ceredigion and 22% of adults in Pembrokeshire speak Welsh.
- Current population projections by Welsh Government predict the total population of West Wales will increase to 396,000 by 2043, with a rise in those aged over 65 from 94,336 in 2018 to 124,587 by 2043.
- 2021 estimates from ONS indicate that people over 65 make up 24.1% of the population in Carmarthenshire, 26.2% in Ceredigion and 26.7% in Pembrokeshire and as large parts of West Wales are both rural and coastal, the area attracts high levels of inward migration of people over 65.

Children and Young People

According to Stats Wales, there are over 82,000 children and young people in the region, approximately 22% of the total population. The number of children and young people in the region is expected to stay relatively stable over the next 15 years, an estimated 6,105 of whom live with a long-term condition or disability. The pandemic presents new challenges to identifying risk. Children's Social Services have maintained face-to-face contact for children identified as at risk throughout the pandemic, however, most children not already identified as at risk will have only had virtual contact via video, telephone or online with services from their home with family members present. This is likely to have impacted on the opportunities for practitioners to identify abuse and for children to disclose harm.

The region has a lower number of looked After Children (LAC) than the national average. The Capped 9 point score (Year 11 pupils' best 9 results from qualifications available in Wales) is 361.7, above the Wales average of 353.8.

At 14%, the number of young people not in education, employment or training in West Wales is marginally lower than the Welsh average.

Gaps and areas for continuing improvement:

- Developing a pathway for services reflecting evidence-based best practice
- Further integration with early years services
- Further development of preventative and early intervention services, building on established programmes such as Family Information Services, Families First and Team Around the Family and trauma informed models of support
- Refocusing managed care and support to promote independence and wellbeing
- Considering the importance of physical, mental and emotional wellbeing of children and the key role of universal services in achieving this
- Enhancing partnership working, for example between social services, youth services, youth prevention services and other organisations to ensure that young people have access to social activities

- Developing community resilience and resilience and wellbeing in families and focus wherever possible on promoting family life and enabling children and young people to remain within their families and/ or communities so long as it is safe for them to do so
- Continuing development of multi-agency and individualised approach to supporting children with complex needs
- Developing a regional transition process for children and young people into adult services where appropriate.

Carers

The pandemic has increased pressure on existing unpaid carers, as reflected in an increase of 2073 in the number of requests for support.

The number of unpaid carers known to health and care services is significantly less than existing Census data, therefore continued work on supporting the early identification and awareness of the needs of unpaid carers is required.

Reluctance to place people in care homes (and, for many, the expanded opportunities to work from home) has expanded the number engaged in unpaid care. The trend is likely to continue in line with projections for older people making up a greater proportion of the population.

The emotional health and wellbeing of carers (including young carers) is likely to have been adversely affected and ensuring their needs are considered and providing timely support will play an important part of maintaining informal caring roles.

Learning Disability

COVID-19 has had a particular effect on mental health, well-being, health and feeling of isolation for individuals with LD and their care and support network. Furthermore, significant delays have been introduced in the services and care that people with LD access which has also significantly impacted their health and wellbeing. Many PMLD have been required to shield during the pandemic, limiting their opportunities to contribute to many of the consultations and planning events around services in LD, including the development of the PA which, as they are more likely to suffer the most health inequalities, needs to be mitigated once circumstances allow.

The population of people with a Learning Disability in west Wales is projected to remain relatively stable overall however, due to improved practice, projections suggest the number of people diagnosed with severe or profound and multiple learning disabilities (PMLD)is expected to grow by 1.8% each year. A diagnosis of PMLD is often combined with a complex range of health conditions.

Gaps and areas for improvement

- Re-establishing momentum in the development of integrated, person centred, co-produced services impacted by COVID-19
- Improving awareness of the needs of PwLD and through training and education of service providers, healthcare workers, families and carers
- Improving the quality of communication with and information for PwLD (easy read)
- Widening access to supported accommodation in a location of choice
- Strengthening access to education, volunteering and work opportunities in local communities
- Improving processes for managing transition between children's and adult services and specialist health services
- Supporting self-advocacy for PwLD
- Increasing planning and resources for PMLD and their carers.

Older People

West Wales has a higher proportion of older people than average across Wales, with inward migration a major accelerating factor for the growth of the older population. Pembrokeshire has an older population than Carmarthenshire and Ceredigion, with a predicted 93% increase in those over 85 by 2043.

People are living longer with increasingly complex issues, whilst wanting to remain in their own homes as independently as possible for as long as possible. Additional exacerbating factors of the pandemic on the older population include the negative effect on mental health that come with the social isolation caused by lockdown and potential increased care needs due to the longer-term impact on the health of those who contract COVID.

The COVID pandemic has led to widespread social isolation, with lasting implications on mental health in the older population group. Also, they have tended to delay seeking help during the pandemic and now are presenting later, with much more complex health issues often resulting in prolonged illness, that previously may have been prevented or treated more effectively. Due to the reported mortality rates in residential care due to COVID, older people are now far more resistant to go into residential care settings, resulting in a much greater demand for alternatives.

Future care and support should be co-designed to flex in response to changing demands and expectations and include a range of community, digital and technology-based solutions.

Gaps and areas for improvement

- Involving older people and their carers in assessment and care planning, including discharge planning
- Helping people to remain independent in their homes for longer through continuing development of digital and telehealth support including video consultations, monitoring and support for falls prevention, particularly for those in very rural areas and where transport is an issue
- Providing additional support for carers managing multiple and complex conditions
- Continuing development of community connectivity, well-being and resilience through community-based, user-led, co-produced services that address a range of needs including loneliness and isolation
- Addressing reduced demand for residential care by increasing supply of alternative accommodation options such as extra-care schemes.
- Ensuring older people and their families can access services through their language of choice and the active offer through the medium of Welsh is available

Dementia

In a review of expert consensus, it is concluded that the COVID-19 pandemic has had a disproportionately negative impact on PLwD, with dementia being shown as an age-independent risk factor for severity and death in COVID-19 patients. Although the exact impact of COVID on the diagnosis and incidence rate of dementia is unclear, stakeholders have identified that COVID has impacted timely diagnosis due to late presentations. There is also some concern that in some cases, COVID causes damage to the brain and long-term, this could lead to increased risk of developing dementia However, full information on the impact of COVID upon those with dementia and their carers is not yet available.

As life expectancy and inward migration of older people impacts on the percentage of older people in the region, the number of people living with dementia (PLwD) in west Wales is expected to increase in the coming decades. The Dementia Action Plan for Wales (DAP) 2018 – 2022 sets out a clear vision for “Wales to be a dementia friendly nation that recognises the rights of people with dementia to feel valued and to live as independently as possible in their communities.”

Evidence, key messages and areas of improvement sourced from stakeholders and the regional dementia strategy have informed this new dementia section as follows:

- The incidence of dementia on the Quality Assurance and Improvement Framework (QAIF) disease register in Hywel Dda in 2019-20 was 0.7%, congruent with the Welsh national average of 0.7%
- In 2016-17 dementia diagnosis rates were one of the lowest in Wales at 45.6% indicating that prevalence rates are likely to be closer to 1.4% although, the number of those diagnosed has increased an average of 3% per annum to 2947 in 2020.
- Over thirty genetic, medical, lifestyle, cultural and societal factors have been identified, which impact the risk of cognitive decline differently depending on gender. Because of the unique aspect of the female brain, some of these factors increase risk more dramatically in women than in men. Importantly, hormonal changes in the years leading up to and after the menopause have been shown to act as key underlying mechanism that can activate these risks as well as existing predispositions.

Gaps and areas for improvement

Summarised below, these were identified through co-production and engagement of the strategy although, it is expected that as the strategy and new pathways are developed, alternative gaps and areas for improvement may be identified:

- Continuing to improve awareness, identification, and diagnosis of dementia, including young onset dementia, to ensure timely diagnosis and access to appropriate care and support and long-term care as required
- Improving co-production of services by including PLwD in service design.
- Building on the dementia training framework, develop evidence-based best-practice workforce learning and development strategies
- Increasing diagnosis rates in non-specialist community settings by:
- Improving training and awareness of new evidence-based best practice dementia models within primary care, based on the Good Work Framework
- Supporting GPs, allied health professionals (AHPs) and nurses to make assessments
- Improving quality of referrals into specialist care for those requiring it
- Developing more consistent rights-based person-centred care and support
- Continuing improvements in community support, training and help for PLwD to discuss their diagnosis, navigate/co-ordinate services, to build resilience and maintain balance across all aspects of their life
- Ensuring equal access to physical health services and treatment for PLwD, as poor physical health is an inevitable consequence of dementia
- Ensuring advance care planning and end of life care is fully embedded in wider inclusive, person-centred care and wellbeing planning, which also considers general health issues, so that PLwD die with dignity in a place of their choosing
- Improving research into dementia by involving care homes in the region in current research opportunities
- Building on emerging data and intelligence to inform future evidence-based best practice and service development
- Continuing the development of a “hub” or single point of contact approach for PLwD to access information and support.

Description of projects

Carers Discharge Support Service

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

provided £8.4 billion of care since the beginning of the pandemic in March 2020. The figures clearly show the importance and economic value that family members and friends provide through the provision of unpaid care.

There is no doubt that the NHS and social care system would struggle without this support which enables people to be cared for in their own homes and communities wherever possible. The pandemic has had an impact on the Carers physical health and a significant number of Carers have reported that their mental health has worsened. Without the right support, unpaid Carers are more likely to experience burnout and be unable to provide care in the community, which in turn will affect the health and social care systems and increases the likelihood of hospital admissions or other forms of nursing care.

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

Community Based Support

West Wales serves a growing ageing population and a range of services across health and social care have developed over time to meet their ever increasing needs. The majority of older people have multiple co-morbidities as well as physical and mental health needs that require timely and integrated multi-agency support from primary, secondary and social care settings. The challenges associated with this are further exacerbated across West Wales due to the rurality of much of the region and the potential for increased social isolation. Enabling people to be cared for in their own community, thereby reducing hospital admission and supporting timely transfer home through an integrated, responsive service & coordinated intermediate care pathway.

The project provides the opportunity to build upon and further develop the concept of integrated triage and assessment. Urgent MDT response to assessed need and is rooted in ‘what matters to the individual’. Advocating independence personalised care delivery through deployment of the right team member at the right time, preventing escalation of care needs (health or social care) and de-escalating a crisis, improve communication and prevent duplication, as well as forming the basis of the Urgent Primary Care pathway. Co-ordination Centres will provide a single place for the co-ordination and triage of referrals and enquiries regarding routine/planned, urgent and intermediate care needs for the population.

Community led 3rd sector support

There is a need to develop interim services which are person centric as the traditional model has a large divide between those clients who do not need statutory support and those requiring long term care support.

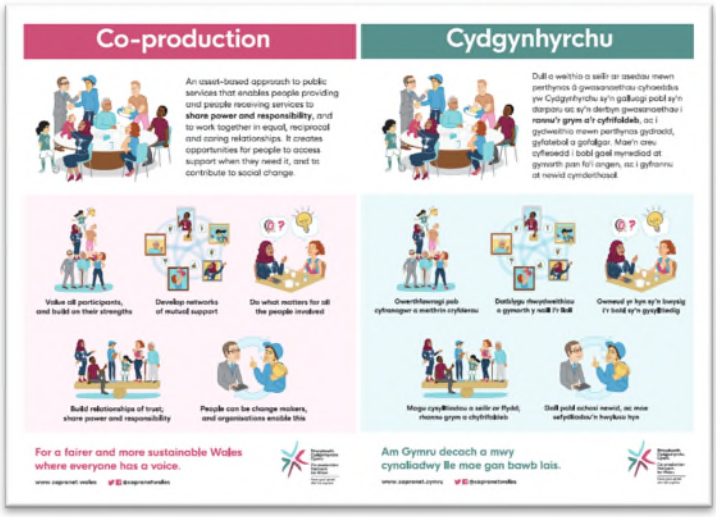
Within the intermediate care provision there is a spectrum between those requiring low level intervention and those requiring intense support. This service addresses the former by working with the client to understand where confidence is lacking and determining the best approach to work with the client to meet that need; mitigating the risk for assessment for statutory provision and enabling co-design of the service offered.

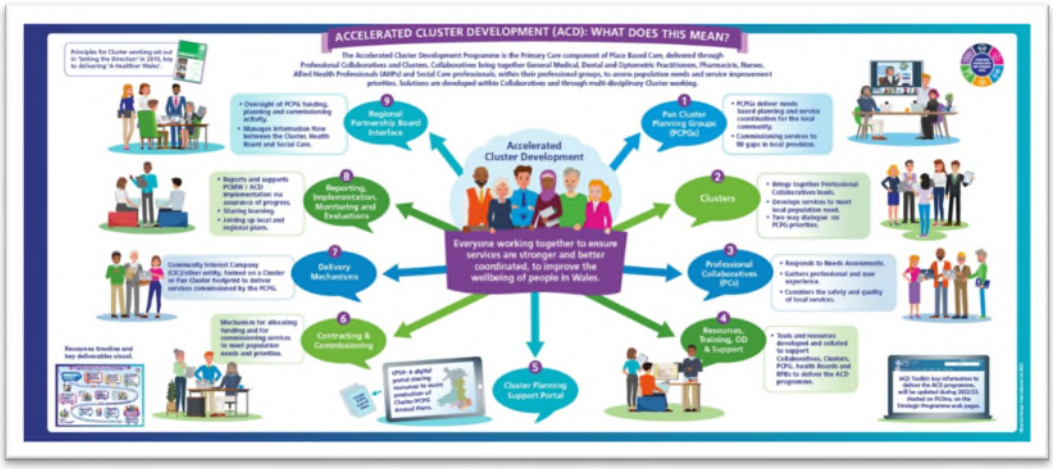
This low level provision can enable people to maximize their independence away from statutory provision as well as signposting into alternative non-statutory services and play a key role in the early identification of unpaid Carers.

The service delivers a clear shift left by supporting people to maintain their independence by delivering a low level flexible service at the right time to delay or reduce the risk of requiring long term statutory service provision. Good outcomes associated with individual's confidence to maintain their own independence.

Model of Care 5 - Home From Hospital - Key enablers

• Key Enablers	• Select
Integrated planning and commissioning	
The introduction of Pan Cluster Planning Groups [5] (PCPGs) is to deliver the aims of the Social Services & Well-being Act 2014 (the Act), The Wellbeing of Future Generations Act (2015) and A Healthier Wales. This builds upon current innovative practice and seeks to increase alignment and engagement between the Regional Partnership Board, Innovation Forum and Cluster arrangements bringing services together at a local level. PCPGs will be established as sub-groups of Health Boards and will operate under the auspices of the Regional Partnership Board (RPB) giving a direct route for information sharing and decision making between frontline services and strategic leadership. A Healthier Wales remains the overarching policy context for health and social care and drives our commitments to deliver seamless care. Integrated plans must focus on improving population health as the mechanism to deliver health equity, learning from the pandemic and address the impact of issues such as obesity and smoking on people's outcomes.[6]To plan future IMTPs effectively and efficiently, organisations need to commit to simplify and streamline the existing planning landscape creating a culture of inclusivity to support the development of co-produced, collaborative, *integrated* plans for the future population-	• x





[5] 4 – Pan-cluster planning groups (PCPGs) - Primary Care One (nhs.wales)

[6] NHS Wales Planning Framework 2022-2025 (gov.wales)

requires alignment with the Accelerated Cluster Development work to deliver pan cluster/locality planning. Commissioning is a vital part of system change that needs to align with the changes in moving towards the Integrated Community Networks' culture of asset based and joined up practice. There is a need to move away from the 'Time and task' approach to one based on person-centred outcomes. Significant decisions about the provision of care is dictated by the budget from which the care is commissioned- a shift towards a *'funding fed'* approach as opposed to '*funding led'*. Commissioning should be undertaken on the basis of agreed principles:- • Understanding the needs of users and communities by undertaking effective and comprehensive engagement; • Consulting potential and existing provider organisations, including those from the third sector, and local experts well in advance of commissioning new services, working with them to set priority outcomes for that service; • Putting outcomes for users at the heart of the strategic planning process; • Mapping the fullest possible range of providers with a view to understanding the contribution they could make to delivering those outcomes; • Investing in the development of the provider base, • Ensuring contracting processes are transparent and fair, facilitating the involvement of the broadest range of suppliers • Ensuring long term contracts and risk sharing, wherever appropriate, as ways of achieving efficiency and effectiveness; and • Seeking feedback from service users, communities and providers in order to review the effectiveness of the commissioning process in meeting local needs.[7] NHS Wales Planning Framework 2022-2025 (gov.wales) Link to Innovations Forum (SV Forum)	
Technology enabled care Digital technology plays a key role in making patient care more efficient and safe- this is especially true when co-ordinating and delivering complex care in the community. Digital technology allows professionals to easily record and share information centred on the person receiving support. Achieving our goal may require close partnership working with other suppliers or ongoing projects such as; • Delta TEC • Digital solutions • Connect platforms • Assist my Life It has the potential to make care seamless and improve communications between services and organisations. It also has a huge potential to free up staff time to focus on patient care. • Our key focus areas will be: • Integration with the partners to take forward the digital programmes and related population health initiatives • Unlocking the power of information to improve decision making at the point of care	• X

[7] 4 – Pan-cluster planning groups (PCPGs) - Primary Care One (nhs.wales)

• Exploiting digital technologies to deliver patient centred solutions in neighbourhoods and communities • Keeping patient and service user's information safe, secure, and up to date, and only used with appropriate governance and controls • Improving organisational digital maturity, and user digital literacy to maximise the benefits of digital technologies • Delivering digital services, paper-free at the point-of-care •	
Promoting the social value sector	• X
The Innovation Fund will support the co-production of new activities and services that contribute to the development of active, resourceful, connected, sustainable and kind communities where people can live interdependently, healthily and happily in their own homes and communities for as long as they choose to do so. Developing solutions based on the needs that are identified, working with other – citizens and service users	
Integrated community hubs	• X
This will require significant development and redesign of community space and our key principles for design will be: • Services which have to be delivered within a building to be co-located to best suit multi-professional and one stop models • Teams who would benefit from being co-located to be so • Delivery of services as close to the population as possible • Community/Wellbeing hubs in partnership will all stakeholders around the wider network of mobile teams, community assets that can be connected • Ensure that the estate supports the sustainability of all primary and community services • There will be sufficient space configured to enable multi-disciplinary working, large training, and group use • Sufficient space for safe storage and these will be located to enable mobile workers to have easy access to equipment and supplies Transforming Day Opps – provide links across the whole community for people accessing day services	
Workforce development and integration	• X
Our starting position is significantly challenged by: • High levels of staff sickness absence- particularly in relation to stress, anxiety and depression • High levels of anticipated retirement in the next 5 years • Challenges in recruiting to specialised roles- team leadership, specialist nurses and advance practitioners, social workers • Temporarily funded posts through ICF,TF, and cluster funding which will require substantive commitment where there is evidence of delivery and impact Workforce development is a key tenet in the delivery of community based complex care. This will require • Workforce analysis • Remodelling and therefore repurposing of roles	

• An innovative approach to consider the possibility of cross boundary (in every sense) working	

Priority population groups

Priority population groups	Primary	Secondary	DAP
Older people including people with dementia	**X**		
Children and young people with complex needs			
People with learning disabilities and neurodevelopmental conditions including autism*	**X**		
Unpaid carers*		**X**	
People with emotional and mental health wellbeing needs	**X**		

Total programme cost and match funding projection

Provide a breakdown of the total programme cost, Welsh Government contribution, partner monetary and resource match including costs attributed to support unpaid carers and / or social value sector delivery. You can find more information on match funding in the guidance notes.

Total cost of Programme	Welsh Government contribution	Partner match monetary	Partner match resource	% support for unpaid carers	% for social value sector delivery
£9,782,552	£7,117,137	£2,665,415.45		0.00%	14.61%

Programme resource and management details

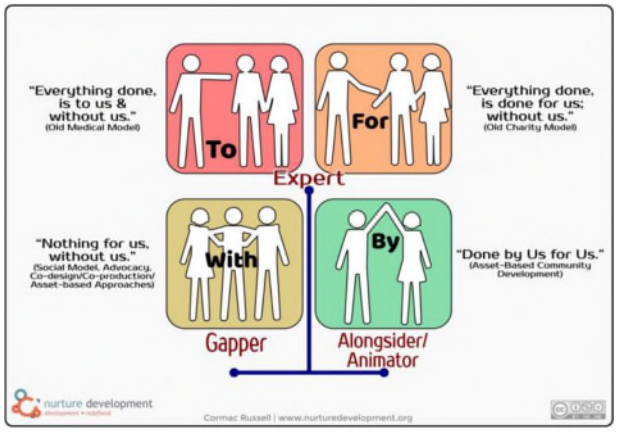
Provide a summary of the planned resource and roles required to deliver this specific programme. These roles are 100% funded via the RIF and will accounted for within the allocated fund.

Posts / type of roles	Estimated FTE	Costs

Project Plan - Community Led 3rd Sector Support

Title of project to support Model of Care (Home from Hospital)
Community Led 3rd Sector Support
Any additional Models of Care the project will contribute towards
• Community based care – prevention and community coordination • Community based care – complex care closer to home • Promoting Good Emotional Health and Wellbeing • Supporting families to stay together safely, and therapeutic support for care experienced children • Accommodation based solutions
Project Summary

There is a need to develop interim services, which are person centric as the traditional model has a large divide between those clients who do not need statutory support and those requiring long term care support. Within the intermediate care provision, there is a spectrum between those requiring low-level intervention and those requiring intense support. This service addresses the former by working with the client to understand where confidence is lacking and determining the best approach to work with the client to meet that need; mitigating the risk for assessment for statutory provision and enabling co-design of the service offered. This low-level provision can enable people to maximize their independence away from statutory provision as well as signposting into alternative non-statutory services and identifying Carers.



The service delivers a clear shift left by supporting people to maintain their independence by delivering a low-level flexible service at the right time to delay or reduce the risk of requiring long-term statutory service provision. Good outcomes associated with individual's confidence to maintain their own independence.

A whole system approach to health and social care; services which are seamless, delivered as close to home as possible.

The approach meets the following Health Board Priorities:

- Propose new planning objectives for the following year to pilot and test innovate approaches to offering people with complex and/or rising health and care needs greater control over the choice of care and support they need.
- Fully implement the Bronglais Hospital strategy
- By September 2021 propose new Planning Objectives to establish locality resource allocations covering the whole health budget (and social care where agreed with partners) and test innovative approaches to driving the shift of activity from secondary care settings to primary and community care.

The project priorities are:

- People feel more connected and supported within their communities
- People lead healthier lives for longer
- People take responsibility for their own health and wellbeing
- People with care and support needs are helped in their homes or close by
- People feel they are involved in decisions about their care and support
- People receive care and support through the medium of Welsh if they want it

The concept behind this service is that a mutual agreement exists between the supplier and the person, therefore ensuring that the service remains 'low level' and is not dictated by the referrer.

Urgent and Emergency Care Goals alignment

Goal 6: Home first approach and reduce risk of readmission

People will return home following a hospital stay – or to their local community with additional support if required – at the earliest and safest opportunity to improve their outcomes and experience, and to avoid deconditioning.

As a priority:

• Health and social care organisations will work together to increase the number of people transferred to the right place following admission to hospital, preferably their usual place of residence, within 48 hours of the decision about the next stage of their care being made.

• The proportion of people leaving hospital on a discharge to recover then assess pathway and with a co-produced personal recovery plan will also increase to help prevent readmission

A key component of the service is to assist in proactive discharge arrangements from the wards and to prevent unnecessary admission to hospital from the Emergency Department – individuals are supported to return home safely through the offer of transport, adaptations, ongoing caseworker and volunteer support. The service aims to prevent unnecessary admission to hospital and facilitate early discharge from hospital and is a critical component of demand management from the perspective of the hospital and social care teams. It also supports people to either remain in or return to their own homes where evidence shows they are most likely to make the best recovery and retain their independence for longer

It is recognised that demand for the third sector service is likely to significantly increase in the coming months for the following reasons:

- Planned elective surgery will start to pick up again as the hospital works through the backlog that has built up during COVID – facilitating early discharge will be critical to ensuring a smooth flow of patients through the system
- More referrals are likely to come through primary care as more consistent links are established between MDTs and third sector workers – this element of work is likely to focus on preventing unnecessary hospital admission
- Caseworker support will move from being delivered remotely (via phone or online) to being delivered face-to-face in a person's home – this means that more time will be spent with each person delivering hands-on support and the volunteer service will be critical in these circumstances so that caseworkers can manage demand

Priority population group

- Older people including people with dementia
- Unpaid carers

Key enablers	
Technology and digital solutions Partners are keen to explore the potential to use assistive technologies and digital equipment/applications to enhance the support that can be provided to individuals. Particular interest in this development as part of their "healthier homes" work and is contributing to a separate proposal around Technology Enabled Care. Digital Volunteers could facilitate digital inclusion. **Promoting the social value sector** Third sector-led service and would count towards the 20% minimum investment in the social value sector required under the RIF programme. **Integrated community hubs** Benefits from being part of the Care Co-ordination Centres having the opportunity to work closely with multi professionals making joint around care provision as well as opportunities to utilise skills and expertise of the MDT **Workforce development and integration** Delivery partner organisations would benefit from having access to a regional workforce development programme around measuring social value/impact/return on investment in order to better demonstrate the value added created through volunteer involvement	
New or existing investment	
New	
Estimated total cost	
£1,157,283	
Start date	**Estimated completion date**
2022	2025

Regional investment model

Select the funding element which the project will be set against. Repeat the table and rationale below for each project.

Funding elements	Select
Element 1 - Acceleration funding year 1	X
Element 1 - Acceleration funding year 2	X
Element 2 - Embedding fund year 1	X
Element 2 - Embedding fund year 2	X
Element 2 - Embedding fund year 3	X
Element 3 - Legacy integrated pooled fund	

Element 4 – National priorities (Dementia and Memory Assessment Services/ Diagnostic Support)	

Provide the rationale for the element selected.

This will support the development and testing of a new collaboration of initiatives that will primarily support this model of care, but also the other 5 RIF models of care.

Whilst some elements of the proposal are using existing resources in West Wales, this is a new model of support that redefines and re-structures the work

A number of these initiatives need further development and testing of proof of concept. Other elements of this proposal will be completely new and will cover the entire proof of concept phase.

Delivery partners

Include details of local LHBs, local authorities, third sector and other providers that will support in the delivery of the projects. In this section you will also need to explain what they bring to the project by means of match contribution. This can be evidenced by either monetary or resource match. Repeat the table below for the number of projects being put forward.

RPBs will be expected to invest a **minimum of 20%** of their RIF allocation in delivery through social value sector organisations. RPBs should be connecting closely with their social value forums to ensure the wider sector can be engaged in the planning, design and delivery of these Models of Care. The information provided below will help aggregate the social value sector involvement at programme level.

Delivery Partners	Welsh Government contribution	Partner match monetary	Partner match resource	Total funding required
Local Authority				**£1,157,283**
Social Value Sector	£810,098	£347,185	**Staffing / Buildings / Income**	
Health Board				

Project Plan - Community Based Support

Title of project
Community Based Support

Any additional Models of Care the project will contribute towards

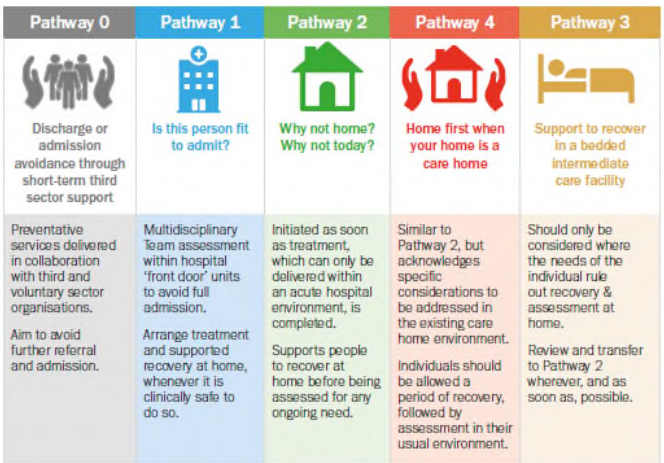
- Community based care – prevention and community coordination
- Community based care – complex care closer to home
- Promoting Good Emotional Health and Wellbeing
- Supporting families to stay together safely, and therapeutic support for care experienced children
- Accommodation based solutions

Project Summary

West Wales serves a growing ageing population and a range of services across health and social care have developed over time to meet their ever increasing needs. The majority of older people have multiple co-morbidities as well as physical and mental health needs that require timely and integrated multi-agency support from primary, secondary and social care settings. The challenges associated with this are further exacerbated across West Wales due to the rurality of much of the region and the potential for increased social isolation. Enabling people to be cared for in their own community, thereby reducing hospital admission and supporting timely transfer home through an integrated, responsive service & coordinated intermediate care pathway.
The project provides the opportunity to build upon and further develop the concept of integrated triage and assessment. Urgent MDT response to assessed need and is rooted in 'what matters to the individual'. Advocating independence, personalised care delivery through deployment of the right team member at the right time, preventing escalation of care needs (health or social care) and de-escalating a crisis, improve communication and prevent duplication, as well as forming the basis of the Urgent Primary Care pathway. Co-ordination Centres will provide a single place for the co-ordination and triage of referrals and enquiries regarding routine/planned, urgent and intermediate care needs for the population.

Supporting discharge to recover and assess (pathway 2) and medicines review at the front door with a focus on addressing polypharmacy in frailty.
Secondary prevention of problems through expert clinical assessment, providing an expert resource / safety net for third sector and voluntary sector services, supporting an effective and timely multi-agency response. Providing specialist MDT advice in key areas including Falls and Frailty prevention and secondary prevention. Working prudently to fully utilise the skills of the multi-agency and multi-professional team.

An Integrated Urgent and Intermediate Care Service, supported by the Co-ordination Centre (as a single point of referral triage), will provide co-ordinated urgent care/rapid response to avoid un-necessary admissions, step-up, step-down care and reablement services, enabling flow through acute services for our population, so that people can recover, rehabilitate and re-able in their own home environment.
This way of working has proven to aid in team building, problem solving, improving processes, and communication across the



range of teams and staff resulting in better care for our population and reducing duplication.

Current operating hours will be extended as well as providing a 7 day a week service, this will be a phased approach, the central point of contact will:

- Triaging the patient's needs using the information provided by the referrer
- Providing multi professional review and explore community-based options to manage individuals in their place of residence
- A co-ordinated response for patients needing urgent interventions but who Provide assessment for the provision of urgent equipment to avoid acute hospital admission
- Link with provider services to discuss the referral and an appropriate action plan
- Liaise with the referrer to agree the action plan, when appropriate
- Hold the role of "care co-ordinator" until all referrals have been made and the action plan completed
- Admission to community bed-based services where appropriate
- Close working with Integrated Community Teams, Primary Care and the wider health and care system to effectively manage clinical care at home
- The management of community clinic bookings including leg ulcer, catheter, TWOC and ear wax
- Information/advice/problem solving, linking closely with the Community Hub to identify additional community support mechanisms
- can remain at home

Expected outputs

- Single point of referral
- Improved communication and timely and effective feedback to referrers
- Reduction in duplication of processes
- Improved use of resources

Developing this new model also identifies further opportunities for integration and partnership working, which will be addressed with further embedding.
This model will ensure service delivery stability while we to align the pillars of intermediate care more closely across the system whilst ensuring flexibility and agility in the workforce underneath those pillars. The proposal is to embed the Integrated Urgent and Intermediate Care Service for Pembrokeshire, align this service with other community services in providing seamless care and integrate with the new Co-ordination Centre (as a single point of referral and triage). The service will also provide co-ordinated step-up, step-down care and flow through acute services for our population further joining up delivery across a range

It will enable rapid care response to enable people to be cared for within their own homes and contribute to a reduced in length of stay in an acute hospital bed so that people can recover, rehabilitate and re-able in their own home environment. This proposal will also improve and further develop the support offered through Discharge to Recover and Assess pathway 2 &3, with a particular focus on supporting more complex discharges. Information regarding capacity and availability for community teams (both Health and Social Care) and has the ability to delegate care provision in a collaborative approach and following the All Wales Delegation Framework, enable patient flow and timely assessment, facilitating a shift left from acute and bedded facilities to care in the community (Social Services and Well-being (Wales) Act 2014; The Wellbeing of Future Generations (Wales) Act 2015); and is a key element to support the National objective to deliver Same Day Emergency Care. The service not only supports admission avoidance but also timely discharge from bedded facilities.

Expected outputs

During 22/23, we will enhance and develop the Urgent and Intermediate Care model to support a reduction in hospital conveyance and timely discharge home. This includes –

- Streaming referrals through the Co-ordination centre to keep people at home with the right care
- Embedding Home First principles and Discharge to Recover and Assess pathways

• Development of robust pathways to and from SDEC/WGH to the Co-ordination Centre • Embedding daily urgent and Intermediate Care MDTs to proactively review patients in the acute care environment • Development of the Enhanced Bridging service to support D2RA principles • Development of the Virtual Ward model within U/ICT, providing a comprehensive, systematic approach to meeting the urgent needs of patients • Further development of our Reablement Service into a true Therapy–led provision • Embedding of the Discharge to Recover and Assess offer, to provide improved pathways for people with complex needs/cognitive issues
Priority population group
• Older people including people with dementia • Unpaid carers
Key enablers
Digital technology and the ability to share timely and appropriate information regarding care records would have a significant impact on the successful functioning of this team, as well as reducing duplication of activity.
New or existing investment
Both
Estimated total cost
£8,296,698

Start date	Estimated completion date
2022	**2025**

Regional investment model

Select the funding element which the project will be set against. Repeat the table and rationale below for each project.

Funding Elements	Select
Element 1 - Acceleration Funding Year 1	X
Element 1 - Acceleration Funding Year 2	X
Element 2 - Embedding Fund Year 1	X
Element 2 - Embedding Fund Year 2	X
Element 2 - Embedding Fund Year 3	X
Element 3 - Legacy Integrated Pooled Fund	
Element 4 – National Priorities (Dementia And Memory Assessment Services/ Diagnostic Support)	

Provide the rationale for the element selected.

This will support the development and testing of a new collaboration of initiatives that will primarily support this model of care, but also the other 5 RIF models of care. Whilst some elements of the proposal are using existing resources in West Wales, this is a new model of support that redefines and re-structures the work A number of these initiatives need further development and testing of proof of concept. Other elements of this proposal will be completely new and will cover the entire proof of concept phase.

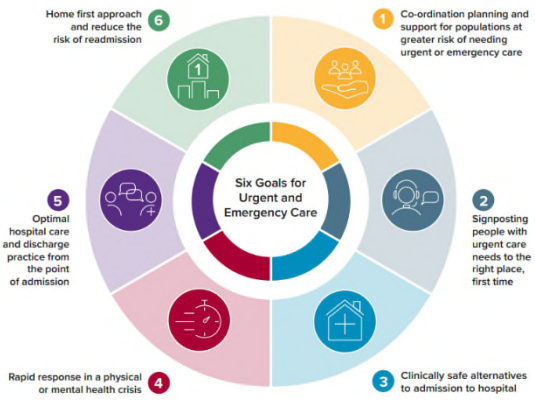
Delivery partners

Include details of local LHBs, local authorities, third sector and other providers that will support in the delivery of the projects. In this section you will also need to explain what they bring to the project by means of match contribution. This can be evidenced by either monetary or resource match. Repeat the table below for the number of projects being put forward.

RPBs will be expected to invest a **minimum of 20%** of their RIF allocation in delivery through social value sector organisations. RPBs should be connecting closely with their social value forums to ensure the wider sector can be engaged in the planning, design and delivery of these Models of Care. The information provided below will help aggregate the social value sector involvement at programme level.

Delivery Partners	Welsh Government contribution	Partner match monetary	Partner match resource	Total funding required
Local Authority	£2,040,467	£625,028	**Staffing / Buildings / Income**	**£8,296,698**
Social Value Sector				
Health Board	£4,036,572	£1,594,631	**Staffing / Buildings / Income**	

Project Plan - Carers Discharge Support Service

Title of project to support Model of Care (programme)
Carers Discharge Support Service
Any additional Models of Care the project will contribute towards
• Supporting families to stay together safely, and therapeutic support for care experienced children • Promoting good emotional health and wellbeing. • Community based care – prevention and community coordination • Community-based care – complex care closer to home
Project Summary
The Carers Discharge Support Service delivers a continuum of support for unpaid carers to aid the timely discharge of patient from hospital by supporting and involving unpaid carer the discharge process for the person they care for. It is estimated that unpaid Carers have provided £8.4 billion of care since the beginning of the pandemic in March 2020. The figures clearly show the importance and economic value that family members and friends provide through the provision of unpaid care. There is no doubt that the NHS and social care system would struggle without this support which enables people to be cared for in their own homes and communities wherever possible. The pandemic has had an impact on the Carers physical health and a significant number of Carers have reported that their mental health has worsened. Without the right support, unpaid Carers are more likely to experience burnout and be unable to provide care which in turn will impact on the health and social care systems and increases the likelihood of hospital admissions or other forms of nursing care. Ensuring timely discharge of patients from acute and community hospital settings not only impacts on patient care and treatment outcomes, but contributes to value based healthcare and better use of financial and staff resources by increasing patient flow. The Carers Discharge Support Service deliver direct outcomes for individuals as illustrated below, and the continuum of support for unpaid carers will deliver seamless and integrated support pre-admission, on admission and post discharge. **Goal 1: Co-ordination, planning and support for populations at greater risk of needing 18 urgent or emergency care** Health and social care organisations should work in collaboration with public service and third sector partners to deliver a coordinated, integrated, responsive health and care service, helping people to stay well longer and receive proactive support, preventative interventions or primary treatment before it becomes urgent or an emergency.      **Goal 5: Optimal hospital care and discharge practice from the point of admission** Optimal hospital based care provided for people who need short term, or ongoing, assessment or treatment for as long as it adds benefit to outcome, with a relentless focus on good discharge practice

Goal 6: Home first approach and reduce risk of readmission
People will return home following a hospital stay – or to their local community with additional support if required – at the earliest and safest opportunity to improve their outcomes and experience, and to avoid deconditioning

Alignment of National and local guidance will ensure the following has the best opportunity of being achieved.

People go home from hospital in a more timely manner with the necessary support in place at discharge, this will ensure:

- Carers are recognised early in their caring journey and can keep their caring role manageable and sustainable.
- Unpaid Carers have the support they need in place before the person they care for is discharged.
- People are cared for successfully reducing avoidable hospital admissions, readmissions, and discharge delays.

CDSS will deliver:

- Training to ward staff so they can identify family carers at the earliest opportunity on admission.
- Support the unpaid carer in discharge planning arrangements attending MDT meetings as required.
- An individual holistic 'what matters' assessment for the unpaid carer to ensure that support for their own health and wellbeing is in place to enable them to continue their caring role.
- Signpost unpaid carers to additional sources of information, advice and support to help them with their caring needs.

People have a better understanding of the discharge process and are more involved in pre and post discharge planning ensuring:

- The unpaid carer is supported to plan for a hospital admission and discharge to ensure arrangements are in place for the person that they are caring for.
- The unpaid carer feels informed about what to expect when the person they care for is admitted to hospital.
- Staff involved in discharge arrangements value the role and input of unpaid carers.
- Prevent unpaid carers in reaching breaking point and being unable to continue their caring role.

CDSS will deliver:

- Provide individual support for unpaid carers in the community and help them to consider their own needs and wishes in relation to their new or changing caring role and plan for their own hospital stay or that of the person they are caring for.
- Help unpaid carers build on their strengths and community assets to increase their resilience.
- Empower unpaid carers to communicate their needs and wishes with hospital teams during admission and discharge.
- Provide training to staff to raise awareness and understanding of the important role of unpaid carers.
- Advocate for and support the unpaid carers to be involved in hospital discharge planning meetings.
- Be a point of contact for any queries or difficulties unpaid carers may have pre and post discharge.

People are better supported to take control over their own lives and well-being therefore:

- Increasing numbers of unpaid carers being referred to the local Carers Information Support services for community outreach support.

CDSS will deliver:

- Provide individual support for unpaid carers in the community and help them to consider their own needs and wishes in relation to their new or changing caring role.

Support unpaid carers to plan for emergency situations

People have improved skills, knowledge, and confidence to be independent in recognising their own well-being needs

- Unpaid carers (of all ages) recognise their own well-being needs and are able to articulate these to access the support they require.

CDSS will deliver:

- Empowers unpaid carers to take their own decisions for themselves and the person they care for.

Families get better support to help them stay together

- People are cared for successfully in the community reducing avoidable hospital admissions, readmissions, and discharge delays.
- Reduction in breakdown of informal caring arrangements as unpaid carers feel supported and able to maintain their own health and well-being alongside their caring role.

CDSS will deliver:

- Provide training to staff to raise awareness and understanding of the important role of unpaid carers.
- Unpaid carers are signposted to specialist information, advice and support to help them in their caring role.

Given the ever-increasing fragility of the care sector, it is imperative we care for our carers ensuring they have the support and reliance they need to continue to provide the care and support required by some of our most vulnerable in our community**.** It has become evident that the need to integrate carers needs into healthcare planning and delivery is essential.

Priority population group	
Unpaid Carers	
Key enablers	
New or existing investment	
Existing investments scaled up based on evidence during the pilot phase	
Estimated total cost	
£328,571	
Start date	**Estimated completion date**
1st April 2022	To move into main streaming fund in year four.

Regional investment model

- Select the funding element which the project will be set against. Repeat the table and rationale below for each project.

Funding Elements	Select
Element 1 - Acceleration Funding Year 1	
Element 1 - Acceleration Funding Year 2	
Element 2 - Embedding Fund Year 1	X
Element 2 - Embedding Fund Year 2	X
Element 2 - Embedding Fund Year 3	X
Element 3 - Legacy Integrated Pooled Fund	
Element 4 – National Priorities (Dementia And Memory Assessment Services/ Diagnostic Support)	

Provide the rationale for the element selected.

This service was piloted from January 2020 using ICF funding. Despite the challenges of the pandemic, it has delivered significant outcomes and provided direct support for unpaid carers which would not otherwise be available. Evidence of impact of the initial pilot is illustrated in the infographic below.

The West Wales Carers Strategy – sets out 4 priority areas to set a clear vision for how agencies will work together to plan, develop and deliver services that will improve outcomes for Carers and their families. The priorities are based on the principal of equality and fair access for all and have a clear synergy with the national Carers Strategy. The four regional priorities are:

- 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 well-being of Carers of all ages, in their life alongside caring;
- Support Carers to access and maintain education, training and employment opportunities; and
- Support Carers to become digitally included.

The Carers Discharge Support Service will contribute to all four of the regional priorities, but particularly, early identification and ensuring that support is available to unpaid carers in their life alongside caring.

Delivery partners

Include details of local LHBs, local authorities, third sector and other providers that will support in the delivery of the projects. In this section you will also need to explain what they bring to the project by means of match contribution. This can be evidenced by either monetary or resource match. Repeat the table below for the number of projects being put forward.

RPBs will be expected to invest a **minimum of 20%** of their RIF allocation in delivery through social value sector organisations. RPBs should be connecting closely with their social value forums to ensure the wider sector can be engaged in the planning, design and delivery of these Models of Care. The information provided below will help aggregate the social value sector involvement at programme level.

Delivery Partners	Welsh Government contribution	Partner match monetary	Partner match resource	Total funding required
Local Authority				**£328,571**
Social Value Sector	£230,000	£98,571	**Staffing / Buildings / Income**	
Health Board				

Health & Social Care Regional Integration Fund

Investment Proposal

(West Wales)

Accommodation based solutions

Model of Care Accommodation Based Solutions – Strategic vision

The Accommodation based solutions program has been developed with a focus on prevention, early intervention and improving well-being. These key elements support the national vision documented in A Healthier Wales.

The programme is initially targeted at older people and those with mental health and learning disabilities. The programme aims to provide access to accommodation which promotes independent living.

A key aim of the program is that targeted groups and individuals have an input and are actively involved in deciding on their future services and accommodation options.

The staffing resources outlined in the project present a focus on engaging those people with accommodation needs in respect of where they want to live and with whom. This reflects the strategic intent across the region to give targeted groups a voice and a say in service provision and accommodation options. A good example in West Wales is the Dream Team Project. This involves a panel of people with learning disabilities who contribute to service development and provision across the region.

The regional strategic direction of travel comes from a range of assessment. Specifically:

- West Wales Population Needs Assessment, February 2022.
- West Wales Market Stability Report, February 2022.
- Housing and Accommodation Needs Assessment for people with learning disabilities and people with mental needs in West Wales, November 2021(Housing Lin).
- Assessment of Specialist Housing and Accommodation Needs for Older people in West Wales, November 2018 (Housing Lin).

Some general themes that have emerged from these assessments which are relevant and inform this programme.

- There is an increased demand for a range of accommodation with care across all the targeted groups.
- People are living longer and are experiencing increasingly complex issues but want to remain independent in their own home.
- There is scope to increase the development of ‘step-down’ housing-based models of care as part of a wider reablement strategy to ensure timely discharge from hospital and/or prevent unnecessary readmissions
- The need for people to be involved and have more choice in relation to their accommodation options.
- There is the need to help older people to remain independent through the development of digital and telecare.
- There is the need to develop preventative, early intervention, and multi-disciplinary services for children with complex needs.

Business case

Program Aims and Objectives

- To develop accommodation solutions that can support people's independent living.
- To ensure target groups care and support needs in both home and residential settings are met.
- To ensure people are actively involved in accommodation options and have opportunity to choose where they live.
- To link accommodation solutions to existing and new capital funding
- To promote and develop integrated long term regional working.

The program involves the following projects:

Progression to More Independent Living

Why is this project needed?

The West Wales Population Needs Assessment suggests the need:

- To improve access and availability of appropriate, suitable local housing and accommodation to enable people with a learning disability to live as independently as possible, in a place of their choice.
- To review existing packages of care to ensure they meet current needs, facilitate personal development, increase independence, and deliver cost-effective services that ensure best outcomes for service users.
- To maximise opportunities from regional collaboration, partnership, and integrated working to deliver high-quality, cost-effective services

Purpose

The project involves funding a team who undertake assessments across the region of people with mental health and learning disabilities to determine if individuals are ready to move to more independent living. The aim is to work with those individuals to get accommodation nearer their family, in their community and in line with their personal wishes.

Outcomes and Key Measures

- The project will deliver cost efficiencies by ensuring that existing placements are appropriate to current needs and maximising the use of supporting living options.
- The work will increase choice and control for service users through progression to more independent living options and reduce the current over reliance on residential care.
- People have more choice about where they live and with whom. The progression reviews will work with individuals to assess their needs, understand what is important to them and their future aspirations to establish their specific accommodation and support requirements.

B

Housing Development for Independence

Purpose

The project involves the maintenance of small team (1 officer in each local authority) to develop a supply of supported housing designed to provide independence and complex care closer to home.

Outcomes and Key Measures

- Increased numbers of appropriate accommodation which is currently in short supply
- People are more involved in the design of accommodation to meet their needs.
- People have more choice about where they live and with whom.

Intermediate and Step-Down Accommodation

Why is the project needed?

Assessment of Specialist Housing and Accommodation Needs for Older people in West Wales, November 2018. West Wales Population Needs Assessment, February 2022 makes it clear that people are living longer and are experiencing increasingly complex issues but want to remain independent in their own home.

In addition, the research identifies clear scope to increase the development of 'step-down' housing-based models of care as part of a wider reablement strategy to ensure timely discharge from hospital and/or prevent unnecessary readmissions. There is also the need to help older people to remain independent through the development of digital and telecare.

Purpose

The project involves providing staffing to support 26 bed spaces identified in, or close to residential or extra care settings across 4 sites. The purpose is to provide care and support to both prevent hospital admission and assist in discharge. In addition, individuals the service will be focussed on reablement, and technology supporting people to develop the skills and build confidence to enable them to return home and live independently.

Outcomes and Key Measures

- The accommodation will enable people to be supported within the community as an alternative to hospital admission.
- The average length of stay in hospital will be reduced and patient flow in hospitals will be improved.
- More people will be able to live independently resulting in more people who can return to their own home
- Reduced level of ongoing domiciliary support

Programs Future Sustainability

The program has potential to provide significant cost efficiencies for example through:

- Reduced use of residential care across key targeted groups
- Reduced homecare particularly through the use digital technology
- Reduced out of County placements in relation to children
- Reduced time in hospital
- Pooled staffing through development of regional collaborative teams

The projects need further development to continue the move to a more integrated and regional collaboration. The intention is that some resources are utilised on a spend to save so that it becomes a core funded mainstream service over time.

B

Key Enablers

Key Enablers	Select
Integrated planning and commissioning	
The West Wales Regional Partnership has commissioned several pieces of work which has informed the development of the programme. The Regional Partnership Board will be the focus to ensure the programme is delivered	X
Technology enabled care	
The West Wales Population Needs Assessment makes it clear that there is need to help older people to remain independent through the development of digital and telecare. The Step-Down project gives the opportunity for older people to use the technology with the view using it when they have returned home.	X
Promoting the social value sector	
Integrated community hubs	
Workforce development and integration	

B

Priority population groups

Priority population groups	Primary	Secondary	DAP
Older people including people with dementia	X		
• The programme through the Step-Down Intermediate Care project will benefit older people to live independently. • Older people can return to their own home to be supported within the community as an alternative to hospital admission.More people will be able to live. independently resulting in more people who can return to their own home. • It is anticipated this will result in reduced level of ongoing domiciliary support. • This also could help reduce the burden on unpaid carers			
Children and young people with complex needs			
People with learning disabilities and neurodevelopmental conditions including autism*	X		
• Both Housing for Independence and Progression projects will increase choice and lead to more independence • Similarly, they will reduce burdens on residential care			
Unpaid carers*			
People with emotional and mental health wellbeing needs	X	X	
• Both Housing for Independence and Progression projects will increase choice and lead to more independence • Similarly, they will reduce burdens on residential care			

Other beneficiaries

If there are other stakeholders benefiting from the programme, please provide this detail below.

B

Total programme cost and match funding projection

Provide a breakdown of the total programme cost, Welsh Government contribution, partner monetary and resource match including costs attributed to support unpaid carers and / or social value sector delivery. You can find more information on match funding in the guidance notes.

Total cost of Programme	Welsh Government contribution	Partner match monetary	Partner match resource	% support for unpaid carers	% for social value sector delivery
£2,183,769	£1,528,638	£655,131		0.00%	0.00%

Programme resource and management details

Provide a summary of the planned resource and roles required to deliver this specific programme. These roles are 100% funded via the RIF and will accounted for within the allocated fund.

Project Details -Are Attached

Regional Integration Fund (RIF) Project plans

Title of project to support Model of Care (programme)
Housing Development for Independence
Any additional Models of Care the project will contribute towards
Community based care – complex care closer to home (secondary people outcomes) **Community based care – prevention and community coordination** (Dream Team and Citizen champion links) **Promoting good emotional health and wellbeing** (PBS project)
Project Summary

Purpose

The purpose of the project is to provide dedicated officer resources (1 to cover each local authority area) to focus on sourcing accommodation for people with disability and mental health needs.

Context

Specific research involves Housing and Accommodation Needs Assessment for people with learning disabilities and people with mental needs in West Wales, November 2021(Housing Lin).It identifies considerable need for accommodation in West Wales. (565 units of housing and accommodation will be needed for people with a learning disability/autism in total across the West Wales Care Partnership area)

A Healthier Wales is Welsh Government's long-term plan for Health and Social Care clearly sets out greater independence for targeted groups. In addition, it specifies people having an input into their future accommodation and care needs.

The development officers will engage with people who use or expect to use the housing to ensure that the proposals meet a wide range of needs and to ensure that housing is both safe and appropriate and that the principals of "support for a good life" are met.

There is an increasing need for supported housing options as the Social Care and Wellbeing Act requires the local authorities provide more choice and control to citizens around housing options. Supported housing uses an integrated planning and commissioning approach via the Housing LIN Report to establish availability and need. The project supports an increase in the number and type of properties to provide this choice and control.

The project links with Community based – complex care closer to home.
People are more involved in deciding where they live while receiving care and support: the project will develop choice within the supported housing stock to enable people to have more choice about living in the community while receiving more complex care and support packages.

Summary

The project involves the maintenance of small team (1 officer in each local authority) to develop a supply of supported housing designed to provide independence and complex care closer to

home. The development officers will access capital resources to purchase and adapt properties to increase the stock of suitable housing across the region.

The team will:

- Engage with people with disability or mental health problems to better understanding their needs and ensure that their voice is heard in capital proposals
- Identify a pipeline of suitable properties/developments that could be purchased or development.
- Support the capital programme including HCF to purchase new houses that are suitable for supported living arrangements
- Support the capital programme to adapt housing to meet people's needs.
- Work with local authority housing department to identify and recommend suitable adaption to housing stock
- Work with local authority housing department to support the purchase or repurposing of housing to meet specific needs.
- Work with planning to ensure that supported housing options are included in new developments
- Create a community of practice that will enable officers to share good practice and learning

The HCF provides additional capital resources to purchase and adapt properties to increase the stock of suitable housing alongside existing housing capital grants operated by each local authority.

The programme is, however, opportunistic, looking at properties and developments as they come onto the market or are presented to planning. Currently HCF bids are being discussed and the amount of funding that will be available through that route is uncertain although it is expected to be substantial.

The project is based on an existing model (ICF and ICF Capital programmes) which has supported the development and purchase of property over the last 2 years. Given current market conditions, purchase of suitable properties is challenging and there are a limited number of suitable properties available.

Regional commissioning of need has provided opportunities for further regional working including development of regional coordination, good practice, cross local boarder authority referrals .

Outcomes

The main outcomes are:

- Increased numbers of appropriate accommodation which is currently in short supply
- People are more involved in the design of accommodation to meet their needs.
- People have more choice about where they live and with whom.

Impact

Monitoring progress is undertaken via the Dream Team project and the Citizen Champion Project (both Community based care – prevention and community coordination) and the PBS Project (Promoting good emotional health and wellbeing).

25 units of accommodation have been developed so far with another 9 in the pipeline.
Priority population group
People with Learning Disabilities and neurodevelopment conditions including autism. People with emotional and mental health wellbeing needs. Children and young people with complex needs.
Key enablers
Integrated planning and commissioning (RIF guidance)
New or existing investment
Existing
Estimated total cost
£185,714

Start date	**Estimated completion date**
2022	**2025**

Regional investment model

Select the funding element which the project will be set against. Repeat the table and rationale below for each project.

Title of project to support Model of Care (programme)	
Housing Development for Independence	
Funding elements	**Select**
Element 1 - Acceleration funding year 1	
Element 1 - Acceleration funding year 2	
Element 2 - Embedding fund year 1	**x**
Element 2 - Embedding fund year 2	
Element 2 - Embedding fund year 3	
Element 3 - Legacy integrated pooled fund	
Element 4 – National priorities (Dementia and Memory Assessment Services/ Diagnostic Support)	

Provide the rationale for the element selected.

B

Working model has been proved: Project is operational in each county and work will continue to support the capital programme including the HCF and new housing developments to meet the recommendations of the regional needs assessment.

Outcomes of the project to date have been reported to and monitored by the Regional Improving Lives Partnership board (West Wales) and the Dream Team. Monitoring reports are available to prove the effectiveness of the programme. Monitoring and evaluation of the project will continue to be provided to these forums.

This is a task and finish post that sits alongside the HCF fund –while the HCF is operational it ensures a link between the capital and revenue programmes. Once the capital programme is complete the post will no longer be required. The HCF is a 4-year work programme. At the end of the embedding period if further funding is required then the post will be moved to considered for legacy funding for 50/50 continued funding for the final year.

Delivery Partners	Welsh Government contribution	Partner match monetary	Partner match resource	Total funding required
Local Authority	£130,000	£55,714	**Staffing / Buildings / Income**	**£185,714**
Social Value Sector				
Health Board				

B

Title of project to support Model of Care (programme)
Regional Progression Project
Any additional Models of Care the project will contribute towards
Community based care – complex care closer to home
Project Summary

Purpose

The purpose of the project involves funding staff to undertake progression reviews of people with mental health and learning disabilities to determine if they can move to more independent living.

Context

The Progression project aligns with a number of priorities including:

West Wales Population Needs Assessment:

- Increasing access and availability of appropriate, suitable local housing and accommodation to enable people with a learning disability to live as independently as possible, in a place of their choice .
- Right-sizing' existing packages of care to ensure they meet current needs, facilitate personal development, increase independence and deliver cost-effective services that ensure best outcomes for service users.
- Maximising opportunities from regional collaboration, partnership and integrated working to deliver high quality, cost effective services

WWAP Delivery plan objectives:
2.13 Reduce residential packages for people with learning disability in favour of supported living schemes and improve access to opportunities within the wider community Increasing access and availability of appropriate, suitable local housing and accommodation to enable people with a learning disability to live as independently as possible, in a place of their choice

3.7 Where people with a learning disability require ongoing care and support, ensure assessment is based around individual outcomes, they play a part in all decisions

The Learning Disability – Improving Lives Programme (Welsh Government, June 2018) -

- To ensure there is choice of appropriate housing solutions integrated in communities for young people as well as adults to ensure everyone has access to a decent, sustainable home, wherever possible.
- To provide accessible and integrated social care, health and housing options and services for vulnerable people especially those with a learning disability.
- To develop integrated housing, health, social care models & guidance learning from previous examples that provide accessible services for vulnerable people especially those with a learning disability. Utilising part of the Integrated capital and revenue care fund.
- Build capacity within local services and preventative approaches to ensure people are housed in their community and to progress the repatriation agenda for those with complex needs.

Summary

The project is a regional collaboration between three local authorities and the health board.Itsupports the provision of a team who:

- Coordinate progression reviews of individuals currently in residential or institutional inpatient care.
- The team undertakes assessments to determine if individuals are ready to move to more independent living.
- To work with those individuals to get accommodation nearer their family and community in line with their personal wishes.
- Each partner will employ a small team (LD & MH Nurses, Social Workers and OTs) to undertake reviews with an integrated and collaborative approach. Activity between partners will be coordinated to ensure efficiency. Joint reviews will be undertaken where both the LA and Health contribute to the cost of the placement to ensure a shared focus on repatriation and progression.
- Reviews will identify if individuals are appropriately supported or can progress into more independent living options.
- The progression team will support MDT's to develop progression plans and support individuals to step down into independent accommodation options or make adjustments to packages in a timely way.
- Reviews will also consider the views of the wider MDT including families views to establish the most appropriate solutions and develop a plan to optimise their independent living skills and transition arrangements.
- Occupational therapy input will be used to confirm any environmental considerations and adaptations
- The project will also inform the development of capital projects by identifying potential candidates, and their specific accommodation needs.

Key Outcomes

- The project will also deliver cost efficiencies by ensuring that existing placements are appropriate to current needs and maximising the use of supporting living options. This will help ensure sustainability for Health & LA partners and allow opportunities for alternative investment of resources in community based services.
- The work will increase choice and control for service users through progression to more independent living options and reduce the current over reliance on residential care.
- People are more involved in the design of accommodation to meet their needs The progression reviews will work with individuals to assess their needs, understand what is important to them and their future aspirations to establish their specific accommodation and support requirements..
- People have more choice about where they live and with whom. The progression plans developed will be person centred to include the individuals skill development needs, aspirations and support needs. This will also include consideration of their family and community needs, leisure, education, employment and compatibility requirements.
- The project links with the provision of Community based care:Complex care close to home. appropriate and adjusted to meet current needs or identify if they could progress into more independent living options with a progression plan to ensure their transition

and support needs are met. This will include consideration of community and third sector options to meet needs and environmental or technology enabled solutions.

Impact

Key measures of success involve:

- Number of individuals moved to more independent living
- Reduction in individuals in institutional and residential care

The project has reported to the Regional Improving Lives Partnership board (RILP) and the Dream Team on progress made and outcomes delivered. Quarterly monitoring reports and case studies are available. In the last 18months the Health team have supported 17 people to step down to more independent living and a further 6 are in the process of moving soon
The progression project carries out reviews with people who live in residential care and will help them to live more independently in their own home wherever possible.
More chances in life.
Through progression to supported living people are able to be more involved in their community and do the things that are important to them with support if they need it.
More choice & To be listened to.
The review team always consider the persons wishes and needs in supporting them to make changes to their care plan and support service.

Priority population group	
People with learning disabilities **People with emotional and mental health wellbeing needs**	
Key enablers	
Integrated planning and commissioning	
New or existing investment	
Existing ICF project	
Estimated total cost	
£622,254	
Start date	**Estimated completion date**
2018	

Title of project to support Model of Care (programme)	
Regional Progression Project	
Funding elements	**Select**
Element 1 - Acceleration funding year 1	
Element 1 - Acceleration funding year 2	
Element 2 - Embedding fund year 1	**x**

B

Element 2 - Embedding fund year 2	
Element 2 - Embedding fund year 3	
Element 3 - Legacy integrated pooled fund	
Element 4 – National priorities (Dementia and Memory Assessment Services/ Diagnostic Support)	

Provide the rationale for the element selected.

This is an existing established ICF project and the model has been developed in part. The previous project focused solely on LD and dual diagnosis service users but will now be expanded to include all Mental health placements. In addition Occupational therapy input will become a core part of the project to improve the assessment and progression planning process. This will provide a greater focus on ensuring environmental needs and adaptations are considered in progression plans and provide functional assessment of skills to improve independence.

The project has reported to the Regional Improving Lives Partnership board (West Wales) and the Dream Team on progress made and outcomes delivered. Quarterly monitoring reports and case studies are available.

The project has potential to provide significant cost efficiencies through reduced use of residential care and the intention by partners would be to utilise some of this resource on a spend to save basis to fund a mainstream core funded service. This could continue on a regional collaborative team basis or develop on a regional team basis depending on the appetite of partners following the development period.

Match funding will be provided by equivalent staff resources employed by each partner.

Delivery Partners	Welsh Government contribution	Partner match monetary	Partner match resource	Total funding required
Local Authority	£260,601	£111,686	**Staffing / Buildings / Income**	**£622,254**
Social Value Sector				
Health Board	£174,977	£74,990	**Staffing / Buildings / Income**	

Title of project to support Model of Care (programme)
Step up/down & Intermediate Care Accommodation
Any additional Models of Care the project will contribute towards
• Community-based Care – prevention and community coordination • Promoting good emotional health & wellbeing • Home from Hospital services
Project Summary

Purpose

The purpose project involves the provision of dedicated accommodation and staffing resources to support people on discharge from hospital and / or those at risk of admission to hospital or residential care.

Context

The project aligns with key messages outlined in *A Healthier Wales* in terms of developing preventative services and promoting independence.

Assessment of Specialist Housing and Accommodation Needs for Older people in West Wales, November 2018(Housing Lin). West Wales Population Needs Assessment, February 2022 makes it clear that people are living longer and are experiencing increasingly complex issues but want to remain independent in their own home.

In addition, the research identifies clear scope to increase the development of 'step-down' housing-based models of care as part of a wider reablement strategy to ensure timely discharge from hospital and/or prevent unnecessary readmissions. There is also the need to help older people to remain independent through the development of digital and telecare.

Summary

The project involves bed spaces identified in, or close to residential care settings.

Accommodation is located at:

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

Key aspects involve:

- The accommodation will enable people to be supported within the community as an alternative to hospital admission.
- The project is supported by a multi-disciplinary team and appropriate specialists
- The step-down provision allows a reduced level of care and links to reablement.

- There is a focus on reablement so people can return home safely and prevent future hospital admission.
- There is a specialist provision for those with mental health needs
- The service will help people identify and attain personal goals set as part of their assessment of needs.
- The bungalow accommodation has installed with an array of assistive technology designed to support people to live as independently as possible. People will be able to trial technologies that they may wish to use on return to their own home and thus gain the experience and confidence needed to return home with as little ongoing support as possible.
- The service will help people identify and attain personal goals set as part of their assessment of needs.

Outcomes

- The accommodation will enable people to be supported within the community as an alternative to hospital admission.
- The average length of stay in hospital will be reduced and patient flow in hospitals will be improved.
- More people will be able to live independently resulting in more people who can return to their own home
- Reduced level of ongoing domiciliary support.

Priority population group
• Older people including people with dementia • People with emotional health and mental well-being needs
Key enablers
• Technology and digital solutions – Ongoing support and advice from the TEC Lead Officer in relation to the use of Assistive Technology.
New or existing investment
Existing
Estimated total cost
£1,375,800

Start date	**Estimated completion date**
1st April 2022	**31st March 2025**

B

Title of project to support Model of Care (programme)	
Step up/down & Intermediate Care Beds	
Funding elements	**Select**
Element 1 - Acceleration funding year 1 (Ty Pili Pala)	**X**
Element 1 - Acceleration funding year 2	
Element 2 - Embedding fund year 1	**X**
Element 2 - Embedding fund year 2	
Element 2 - Embedding fund year 3	
Element 3 - Legacy integrated pooled fund	
Element 4 – National priorities (Dementia and Memory Assessment Services/ Diagnostic Support)	

Provide the rationale for the element selected.

Havenhurst/Hillside continuation of existing ICF project. Ty Pili Pala has been completely reconfigured

The project needs to be sustained in the future as it could however lead to increased length of inpatient stay and people remain in hospital until sufficiently recovered to return to their home environment. There is also a potential increase in use of standard residential beds for interim arrangements which are proven to be less effective than intermediate care / rehab beds.

Over time there is the potential to realise cost efficiencies because of reduced time in hospital and reduction in care costs. The costs will need to be mainstreamed as the funding is reduced.

Delivery Partners	Welsh Government contribution	Partner match monetary	Partner match resource	Total funding required
Local Authority	£660,643	£283,133	**Staffing / Buildings / Income**	**£1,375,800**
Social Value Sector				
Health Board	£302,417	£129,607	**Staffing / Buildings / Income**	

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