



BWRDD PARTNERIAETH RHANBARTHOL  
**GOGLEDD CYMRU**  
**NORTH WALES**  
REGIONAL PARTNERSHIP BOARD



# North Wales Regional Partnership Board

## Annual Report

### 2025

This report has been produced to meet the requirements set out by the Welsh Government in the Social Services and Well-Being (Wales) Act 2014



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## Foreword by the chair of North Wales Regional Partnership Board (NWRPB)



It is my great privilege to introduce the North Wales Regional Partnership Board (NWRPB) Annual Report for 2024/25. Working in partnership, allows us to continue to work together to improve our service and enable people in North Wales live the best lives they can.

This report highlights just some of the work that the Regional Partnership Board has delivered to improve the lives of people living in North Wales. I would like to thank everyone involved in our work for their commitment to working together to deliver seamless services that focus on the needs of local communities.

The past 12 months have seen positive changes to the workings of the NWRPB. Following extensive consultation with board members a review and refresh of the Terms of Reference and governance was undertaken and adopted in July 2024. Meetings previously held monthly are now every two months and have moved into the strategic realm. Workshops are held for the first part of meetings covering topics such as ‘The Patients Journey’ – a whole systems shift to preventative models; to focussing on the prevention agenda together considering a regional approach to developing partnerships built around wellness and improving wider factors of health and well-being.

2024/25 continued to be challenging for the health and social care sector with no indication that there will be any significant change as we go into 2025-26. This makes it even more imperative that we continue to work together to address these issues and to build on the good work already been done. We have seen significant progress in the prevention agenda here in North Wales. In addition to our Annual Report, further information can be found by visiting [our website](#).

On 5 March 2025 we brought together digital technology providers with people who plan, provide and use social care for the first North Wales Digital Social Care Showcase, the first event of its kind in Wales. Funded by sponsorship from technology companies like Synanetics, it was a great success with over 190 visitors seeking spaces to connect and reflect about how we use digital technology and try things out for ourselves.

Another first in Wales was the Designing Success Together: Neuro-affirmative innovations two-day workshop that was hosted by the North Wales Children’s Regional Partnership Board in Llandudno. A follow on from the Welsh Government and All-Wales NHS Accelerated Design Event held in November 2024 to stimulate critical, systemic and needs led transformation of children’s neurodevelopmental pathways. An introduction to the event in Llandudno by Sarah Murphy, Senedd Minister for Mental Health and Wellbeing; saw representatives from the health board, social care, third sector, education and lived experience working intensively over the two days, codesigning solutions to the current challenges faced by Children’s Neurodevelopment Services in North Wales.

One of my key priorities as chair is to continually raise awareness of the excellent work of the board as well as hear and share stories within health and social care. From experience, stories are moving and powerful ensuring action through learning and development. Through being united in our talking and thinking we can ensure that our work is known by the people of North Wales who, with far greater input, enables us to achieve the outcomes that matter to them.

Finally, on behalf of my RPB colleagues, I would like to thank everyone who has supported the RPB's work over the last year.

Coming together is a beginning, staying together is progress, and working together is success.

Best wishes,

Councillor Dilwyn Morgan.

## Highlights and achievements from the year

We have:

- Implemented the North Wales [North Wales Memory Support Pathway](#) to make sure we work better together so that people living with dementia and the people who care for them get the support they need.
- Agreed the new extended [home care regional commissioning agreement](#). The joint agreement includes around 100 care providers with a potential value of around £171 million.
- Implemented our own [North Wales Dementia Friendly Communities Scheme](#).
- Brought practitioners together to share ideas about how best to support people through Ripple Effect Mapping sessions. This is spread and scale at a local level, helping us adopt innovative ways of working across the region. More robust evaluation helps identify what works here.
- Held the first Welsh Digital Social Care Showcase on 5 March 2025, funded by external sponsorship. We've also facilitated procurement of a new social care case management system, which will put all six North Wales social care departments onto the same system for the first time, ready for future record integration.
- Improved dementia screening for people with Down's Syndrome.
- Held a successful 'Designing Success Together: Neuro-affirmative Innovations' event in March 2025 with over 100 participants, including people with lived experience and service providers, to develop an action plan for the next twelve months.
- Refurbished buildings to provide community hubs and high quality places for people with care and support needs to live safely as part of their community.
- Continued to implement the 10-year strategic capital plan to support the models of care. Schemes in development include Tŷ Croes Atti Flintshire, which will relocate a council-run care home for older people so it can expand, to be completed in Summer 2025.
- Increased local small group homes for children in care, with a £4 million investment. This helps improve options for children to live within or close to their local communities.

# About the Regional Partnership Board

As a Board we have been continually working together to ensure the health and well-being of people of all ages in North Wales.

The North Wales Regional Partnership Board works with health, social services, education and other services to identify and meet the needs of the people in our region. This includes people who use care and support services such as:

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

## Models of care

Part of the way we work is by implementing the national new models of care to improve the way organisations work together based around what matters to the people we support. A model of care is a description of the way services are organised and provided. This report sets out what we've achieved in the last 12 months for each of the models of care, which are:

1. **[Community based care – prevention and community coordination.](#)** Community services that help to protect residents from longer term health or well-being problems, including befriending groups, community hubs, support for carers and access to well-being services.
2. **[Community based care – complex care closer to home.](#)** Help to improve recovery following a period of ill health and to be more independent in the long term.
3. **[Home from hospital.](#)** Some people will always need treatment in hospital so we help people to be discharged and recover at home safely and quickly. When they do need hospital care they can access it easily.
4. **[Supporting families and children to stay together.](#)** Health, social care and education partners work together with families to help them stay together safely and prevent the need for children to become looked after by the local authority.
5. **[Promoting good emotional health and well-being.](#)** Creating and improving services for people who need emotional health and well-being support.

**[Section 6](#)** of the report thereafter includes system enablers, which are the essential behind-the-scenes elements that make it possible to provide new models of care.

- Capital programme and accommodation based solutions – providing buildings, equipment and facilities to support integrated services and safe and supportive living environments.

- Digital, data and technology – tools to support the Regional Partnership Board to improve well-being.
- Regional Innovation Coordination Hub – provides research and innovation support including project evaluation and the Population Needs Assessment.
- Workforce – planning what kind of jobs we need to provide care and support and working together to recruit and retain the right people in those roles.
- Mwy na geiriau – strengthening the use of the Welsh language within health and social care in North Wales.
- North Wales Social Value Steering Group
- Communication and engagement
- Safeguarding – working together to protect children and adults with care and support needs from harm. More information will be available in the [safeguarding annual report](#).

## How the Regional Partnership Board works

The Regional Partnership Board (RPB) includes members from Anglesey County Council, Cyngor Gwynedd, Conwy County Borough Council, Denbighshire County Council, Flintshire County Council, Wrexham County Council, Betsi Cadwaladr University Health Board and others. [A membership list is available on our website](#).

The Children’s Regional Partnership Board provide leadership on a wide range of issues facing different age groups from babies to young adults. [Learn more about the Children’s Regional Partnership Board including the mission statement, guiding values and principles](#).

Regional boards and groups which report to the Regional Partnership Board include:

- North Wales Safeguarding Boards
- Integrated Learning Disability Board
- Regional Dementia Strategic Group
- Integrated Autism Services Board
- Together for Mental Health Board
- Regional Commissioning Board
- Regional Workforce Board
- Digital, Data and Technology Board

The Regional Partnership Board team also support partnership meetings including:

- Leadership Group: Directors from the six local authorities and health board
- Directors: Social Services Directors
- NWASH: North Wales Heads of Adult Services
- NWHOCS: North Wales Heads of Children’s Services.

We plan to reflect, review and revise the purpose, membership and plans for these

boards and groups over the next 12 months.

## About North Wales

There are six local council areas in North Wales, Anglesey, Gwynedd, Conwy, Denbighshire, Flintshire and Wrexham.

Sometimes we plan and provide services at a sub-regional or area level, which is where we work across two of the local council areas as below:

- West (Anglesey and Gwynedd)
- Centre (Conwy and Denbighshire)
- East (Flintshire and Wrexham)



## Self-assessment

We carried out a self-assessment in 2024 to reflect on how we work together as a partnership. Overall, we felt we had a clear vision with joint aims and objectives, a diverse and inclusive membership and a high level of trust between partners.

Brings people together. Acts as a place where colleagues can develop relationships, raise issues, understand the role of other agencies.  
(RPB member)

We thought that we could be clearer about the governance structures for the board, accountability and decision-making processes. Our recommendations were:

1. Review the Regional Partnership Board governance structures and clarify decision making processes including links with the local Public Service Boards and primary

care pan-cluster planning groups.

2. Produce clear information about the Regional Partnership Board governance structures, the regional team structure and the way decisions about funding are made. Share this information on the website and as an information pack for new members.
3. Consider how to improve the way we address challenges facing health and social care.
4. Increase publicity about the work of the board and its successes, including case studies about the difference board decisions have made.

We've made good progress against these recommendations, which can be seen throughout the report for example in the ['good news' stories](#) work to increase publicity about the board in an integrated way. We will continue to reflect and improve on these recommendations during 2025-26.

# Regional Integration Fund Programme Summary

The Regional Integration Fund (RIF) in North Wales supported 36 regional programmes across the six models of care in 2024/25. The total investment was over £85 million. Welsh Government provided £30.1 million of this investment and partners provided £55 million of match funding. Of this funding £5.2 million was used to support unpaid carers and £5.5 million was invested in social value schemes and services.

All the projects collect case studies and stories about their impact. We've shared a few throughout the report, where people have agreed we can share their story in public. They also report against a set of All Wales performance indicators (see Appendix 1).

## Summary of RIF investment in each model of care

Model of care	Welsh Government funding	Total including partner match funding
Community Based Care – Prevention and Coordination	£7,990,000	£9,600,000
Community Based Care – Complex Care Closer to Home	£6,150,000	£51,900,000
Home from hospital	£3,450,000	£4,000,000
Supporting families and children to stay together	£10,500,000	£16,300,000
Accommodation Based Solutions	£690,000	£900,000
Promoting good emotional health and well-being	£1,320,000	£2,300,000
<b>Total</b>	<b>£30,100,000</b>	<b>£85,000,000</b>

## Ripple Effects Mapping

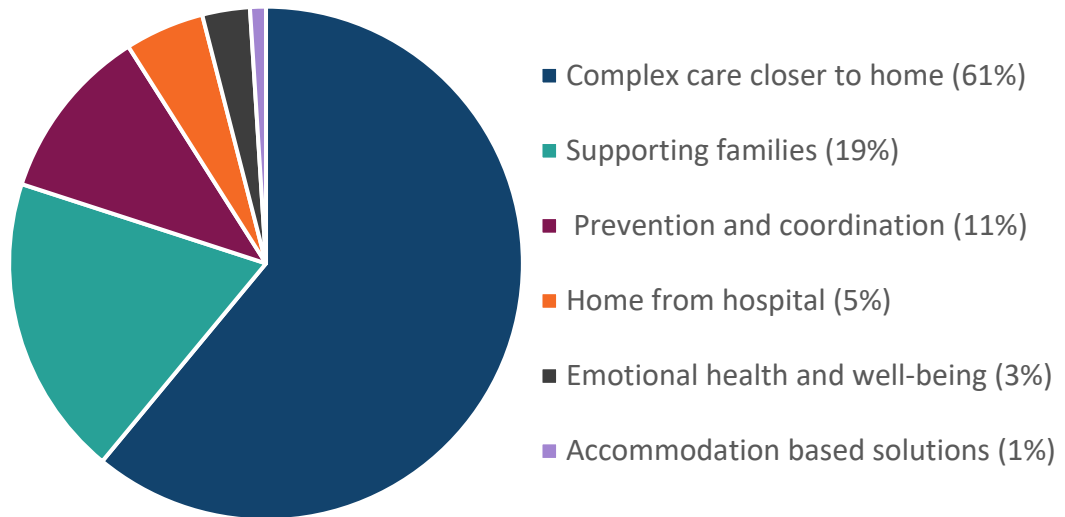
We held [Ripple Effects Mapping](#) workshops for 15 of the projects. This is an evaluation method we use to capture the wider intended and unintended impacts of our projects. It brings people with an interest in the project together to reflect on achievements, learn and improve. This report includes examples of some of the maps we created together, including one showing how Regional Partnership Board work back in 2017 is having an impact on improving well-being for people with learning disabilities in 2025 through the [Supported Employment Model](#).

## Capture and compare initiative

'Capture and compare' is a way to review, compare and analyse similar projects across the region. It can help us identify similarities and differences in delivery and staffing models and highlight where and why there is variation. We can then share and capture learning in a consistent way.

The first exercise looked at the Community Resource Teams across the region and is due to report by July 2025.

**Chart 1: Proportion of investment in each model of care**



## Section 1: Community based care – prevention and community coordination

Prevention and community coordination is about helping people understand how they can achieve good health and well-being. We want to create a sense of community and belonging in North Wales to reduce social isolation and loneliness to help people stay independent and improve their mental and physical health.

### Funding

This work is funded by £9,600,000 from the Regional Integration Fund, plus funding from the Dementia Action Plan, Further Faster and Capital grants to support this model of care.

### What we achieved



**81,600** people accessed the service, 2,800 for the first time.



**9,900** people received support that prevented their needs escalating (100% of those who gave feedback)



**4,700** people felt less isolated (94% of those who gave feedback)



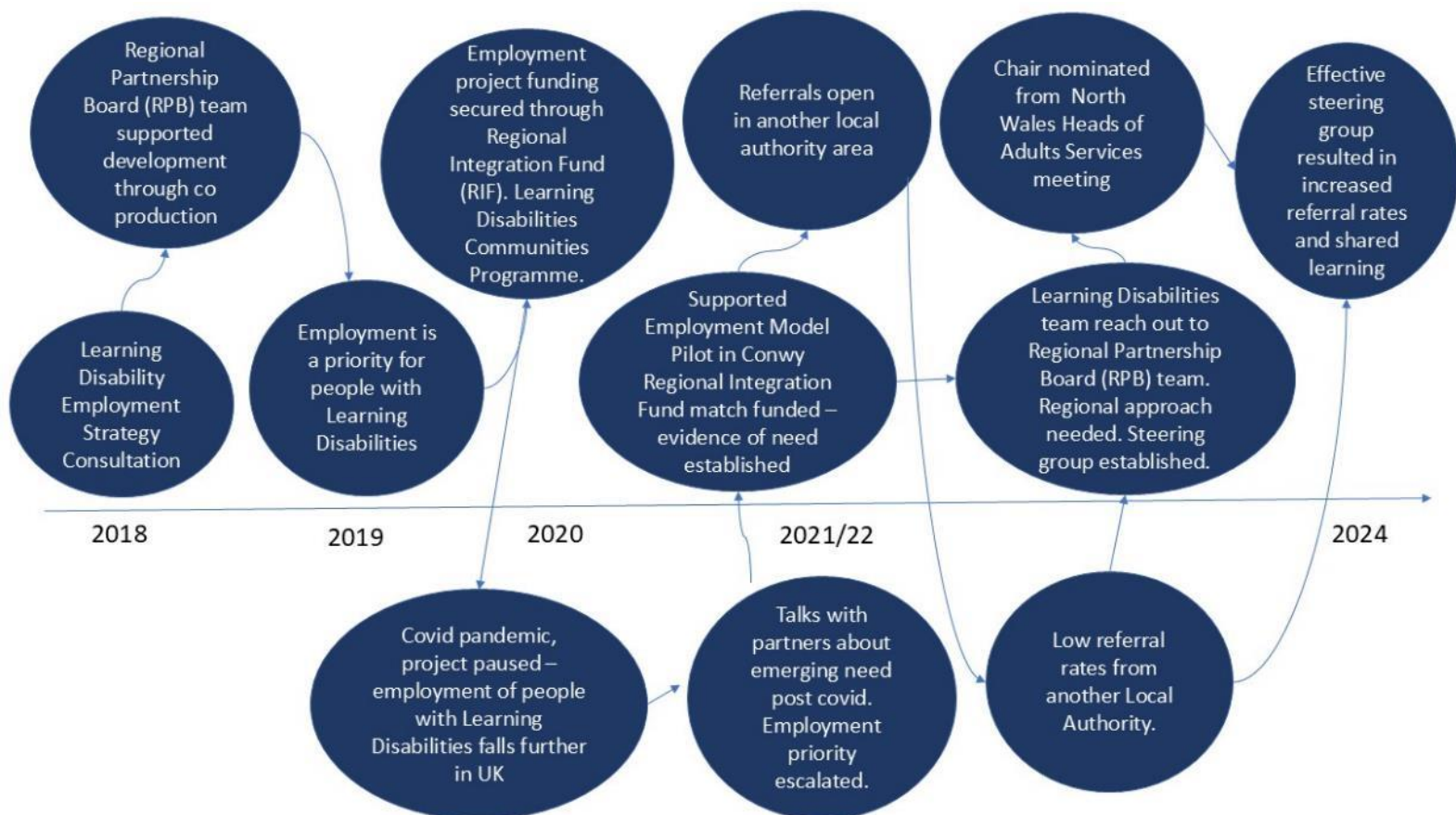
**1,600** people living with dementia had discussions about what matters to them

Our projects support older people, people living with dementia, people with learning disabilities and neurodevelopmental conditions including autism, people with emotional and mental health well-being needs and unpaid carers. They include projects specifically to support these groups of people, community connectors and Single Point of Access (SPOA) teams.

### North Wales Supported Employment Strategy for People with Learning Disabilities

This year we published the [North Wales Supported Employment Strategy for People with Learning Disabilities](#). At the heart of the strategy is the voice of people with learning disabilities and the step change they told us is needed to enable more people to have access to paid employment.

The model was created in response to the Learning Disability Strategy the Regional Partnership Board published in 2018. The Ripple Effects Map below illustrates the contribution of the Regional Partnership Board and Regional Integration Fund towards implementing this as part of the model of care. It also shows how it was piloted and then scaled across the region.



## Dementia community support services: successes and new activity

### Short term placement beds

"Opens up the world of respite and care homes to individuals who may not have considered it before or who have been unable to consider it before."

#### Achievements:

Reduction in referrals for admission to hospital.  
Earlier intervention - reducing the impact of carer stress and breakdown of care.  
Medication titration in a safe space.

### Dementia Actif Gwynedd (DAG)

Intergenerational Boccia Tournament.

The Dementia Actif Team have organized 6 dates throughout Gwynedd with Training2Care's Virtual Dementia Tour. All sessions have been fully booked with over 170 people receiving the training - including home care staff, family carers, social workers and first responders.

### Dementia Support Workers

Co-location and partnership working with the CRTs and local dementia centres continues to be beneficial. The support workers continue to facilitate numerous health appointments to ensure that a person can be as healthy as possible and remain at home, e.g., memory clinic, optician, podiatry and audiology appointments.

### Forward Thinking Forward Planning

This quarter, time has been invested in visiting community hubs and local organisations. Several new carers have been registered with the organisation and benefited from support from other internal projects.

## Dementia Projects Successes and new activity

### Dementia Actif (Môn)

Collaborating with other projects across population groups to support the local community (Mencap Môn). Collaboration with other services (Local Authority) to innovatively improve the active offer within the service, facilitating needs.

### Dementia support in extra care

Residents at Llys Raddington are located on a specific memory floor and receive bespoke support, including support in a dedicated lounge area which is less busy and impacted by noise than the main scheme lounge. An activity coordinator provides activities specifically for those living with dementia, as well as activities to integrate residents with the wider scheme resident group.

### AHP Dementia Team

The AHP team has supported 206 people living with dementia from April 2024 - March 2025. (Wrexham 109 and Flintshire 97). We have also supported the carers/family of People Living with Dementia to improve mobility, improve safety in home environments, support communication, manage dietary changes, increase engagement in meaningful activity and signposting to support services.

## Learning disabilities community activities: successes and new activity

### **The Happiness Project**

Throughout January, they focused on delivering the Happiness Project, a dynamic and uplifting initiative designed to bring joy and connection to participants during what can often be a challenging time of year. This project was designed and developed by our Project Sparc team. Activities included: Interactive workshops, art and craft and social events.

### **Making Sense - Sensory Parcel Service**

Increased engagement and interest from Ty Pawb - a gallery in Wrexham in working with Making Sense and the Sensory Parcel Service. They collaborated with London based artist Liaqat Rasul to make a sensory parcel based on his solo show at Ty Pawb and were able to offer a workshop at the gallery to a small group from Cunliffe House day centre in Wrexham.

### **Sex Education Company - SPARC Project**

Supported a cross-county Christmas social event at Trilogy nightclub by attending with freebies including Mistletoe and Lip Balm - discussing romance and consent with attendees. Continued support in development of the LGBTQ club in Gwynedd Networked and represented the project at the Stand Disability Roadshow and Learning Disability Wales annual conference.

### **Bingo Banter**

Monthly Bingo Banter events have continued to thrive. The most exciting development has been their transition to being entirely participant-led, with individuals and their support teams taking on greater responsibility for planning and delivery.

## Community Activities

### **Ripple Effect Mapping (REM)**

The Learning Disabilities Regional Communities project participated in REM sessions looking at four projects: Mencap Mon, Making Sense - Sensory Parcels, Outside Lives, SPARC - Sex Education.

### **Conwy Connect and STAND activities (West)**

Reached out to local groups to take activities in and get STAND NW and CC4LD recognised in the area. A drama session at Galleri Caernarfon went well and another has been booked. Four clay sessions have been booked to take place at Canolfan Addysg y Bont with parents and children together. They have a monthly meeting with Mencap Mon and Gwynedd to discuss collaboration and joint events including - a sports taster day and a later sports day in the summer.

### **Outside Lives (East)**

Growth across the Sparc Project, with the continuation of existing standout activities such as Tuesday sessions at Brymbo Enterprise Centre, alongside a programme of training courses, on-the-road events, and new collaborations with organisations such as First Choice Housing to deliver activities to residents.

### **Conwy Connect Regional Self-Advocacy Officer**

Continued collaboration with the North Wales Flyers developing easy read documents for self-advocacy groups, improving resources/ accessibility Officer has been attending local and national advocacy events, including Tea At Three. Continued implementation of the Regional Self Advocacy Strategic Plan.

## Further Faster programme

Welsh Government invested additional resources to support community care, called 'Further Faster'. We used this funding to expand social prescribing in Conwy and fund a Moving with Dignity Facilitator and equipment in Denbighshire. This meant that people could be supported at home by one person rather than needing two people, which freed up the capacity of home carers so they could support more people.

We funded a community frailty project to provide pro-active rather than reactive, patient-centred care to individuals within their own community, which has led to fewer people attending Emergency departments and being admitted into hospital.

## Social prescribing

Following the launch of the [National Framework for Social Prescribing in Wales](#) we now have Social Prescribing Champions across North Wales who are contributing to the national work to develop a data set and competence framework.

We held a social prescribing event for practitioners and funders in March to celebrate achievements, share best practice and success stories of social prescribing in action, examine the evidence proving the value of social prescribing and discuss challenges. More than 80 people attended with 40 organisations brought together.

In addition to established social prescribing projects across the region, we've set up local action groups to identify local requirements and maximise future available sources of funding.

## Dementia programme

### Improving dementia screening for people with learning disabilities

To improve care for people with learning disabilities, a team of learning disability nurses in Denbighshire started screening the people they support for dementia. They carry out a baseline check when people turn 30 and then look for changes every few years after that. This helps to pick up people who are developing dementia at an earlier stage to make sure they get the best possible care.

As a pilot approach it's worked really well and the team are keen to share this model with other areas. There was just one problem. The system for identifying who needs to be checked for what and when was extremely complicated and involved a lot of time trawling through files. It made the approach a very hard sell.

That's where we came in. Our Research and Innovation Coordination Hub worked with the team to try and simplify that process. We came up with a simple Excel spreadsheet powered by some very elegant formulas that make it easy to see who needs to be

checked for what and when. And it's worked! The team now just need to glance at the spreadsheet and then get on with what they do best – supporting people to live well.

Phase 2 of this project is now underway. We've identified champions in each local authority who are starting to test this approach ready to adopt this new way of working.

### **Dementia listening campaign**

We carried out a listening campaign in each of the six counties to ask communities what they think about dementia care, and received hundreds of thoughtful responses. This led to the eight regional priorities below. We have a plan to work on each of these, which will lead to more coordinated and person-centred dementia services in North Wales.

1. Access to care and support
2. Person-centred care
3. Support for unpaid carers
4. Access to services
5. Groups and activities
6. Dementia friendly communities
7. Transport
8. Welsh language

### **Dementia friendly communities**

We launched a new regional scheme on 1 January 2024 to embed dementia-friendly practices across North Wales, following the closure of the Alzheimer's Society Scheme. Our scheme includes the six county voluntary councils, six local councils, the health board, and four voluntary sector partners (who provide the Memory Support Pathway). It's coordinated by the Regional Partnership Board Team and the Regional Dementia Project Manager.

We've formally accredited and recognised Isle of Anglesey County Council for its commitment to dementia-friendly practices. They designated 25 community centres across Anglesey as dementia friendly communities.

In Gwynedd, Tywyn have received dementia-friendly communities recognition and interest is growing in communities such as, Porthmadog, Pwllheli, and Caernarfon.

Throughout Conwy, many towns are increasing dementia-friendly awareness, and Abergele has recently been re-recognised as a dementia friendly community. Numerous local businesses and organisations, including shops, pubs, supermarkets, golf clubs, post offices, and more have also engaged in the initiative.

Across Denbighshire, towns including Rhyl, Prestatyn, Ruthin, and Llangollen have received dementia-friendly communities recognition, with others currently working towards accreditation.

Wrexham has extended recognition to local leisure centres, supermarkets, churches, primary schools, and the university, all actively contributing to a more inclusive

environment for people living with dementia.

Wrexham and Flintshire had dementia-friendly council status before our scheme started, and their work is still a model of best practice.

This collaborative regional effort demonstrates strong local commitment to building inclusive, supportive environments for individuals living with dementia and their carers, ensuring the continuity and expansion of dementia-friendly initiatives across North Wales.

### **Rollout of dementia public information film**

Following an initial premiere in Spring 2024, we've rolled out a new [series of films designed to create a better understanding of dementia](#).

The films were created by Eternal Media Ltd in Wrexham and involved people living with dementia and unpaid carers of people with dementia. The films are being viewed by a wide range of audiences as they work well as stand-alone information films and teaching aids.

The five films can be viewed separately or as a continuous 32-minute film and address the following topics:

- What is dementia?
- When to seek help
- Getting a diagnosis
- Living with dementia
- Planning for the future

### **Older people's mental health Prevention and Support Team Project**

The Occupational Therapy Prevention and Support service teams provide early intervention to people with a diagnosis of dementia or mild cognitive impairment. Once they've had an assessment from the Memory Assessment Services, they receive post-diagnostic Home Based Memory Rehabilitation, Cognitive Stimulation Therapy, strategies to improve independence, and support to help carers to cope. This enables people living with dementia to remain in their own home and prevents admissions to hospital or an increase in services at home. The team is also starting to offer support to people who have not had access to occupational therapy on their journey through memory services, to broaden its scope.

100% of unpaid carers who gave feedback reported that they found occupational therapy helpful to their caring role and would recommend it to others. 93% of unpaid carers also reported an improved quality of life and carer life balance while 85% identified an improvement in their confidence and independence in their caring role after receiving occupational therapy support.

## **Unpaid carers support**

The North Wales Carers and Young Carers Operational Group carried out their Regional Carers action plan which follows the Welsh Government Strategy for Unpaid Carers.

North East Wales Carers Information Service (NEWCIS) and Carers Outreach Service provide a Hospital Discharge Facilitation Service funded through Welsh Government's Annual Carers Grant. This service supports unpaid carers when the person they care for needs health care. Hospital Carers Facilitators help patients leave hospital as soon as they are well enough. They do this by supporting and involving their unpaid carers in the process, providing information and advice, carers assessments and what matters conversations, as well as providing 'carer aware' training and development for hospital staff. Around 200 carers across North Wales are supported by this service in every three month period.

Short breaks for unpaid carers are paid for with Amser funding, targeted at those who most need a break. These include traditional services along with more flexible and creative breaks tailored to the carer. Meaningful breaks from caring responsibilities helps improve the carers well-being and continue to provide unpaid care. Carers say the breaks improved their relationship with the person they care for and help them to feel valued. Examples of short breaks include therapeutic activities, microgrants or vouchers to support hobbies and activities, organised day trips and social events for both adult and young carers, overnight stays, camping trips and holidays.

The group supports the Regional Partnership Board to recruit a team of carer representatives to act as a voice for carers, ensuring their perspectives are heard and considered in the work of the board.

## **Well North Wales**

The building blocks for good health include having enough money, fair work, a good education, and a safe and warm home. The Regional Partnership Board met in September 2024 to look at how we can build a healthier North Wales together. We set up a task and vision group to create a vision, scope and plan for this work, due to report during 2025/26.

## **Single point of access (SPOA)**

Single Point of Access teams provide information, advice and assistance for people with health and social care needs. We held a Ripple Effects Mapping session with a Single Point of Access team and a local authority prevention team. In the map below you can see the positive impact that the different teams had in supporting a child – impacts that can emerge even after their direct involvement ended.

# Ripple Effect Mapping Key

Catalyst event

What we did

Ripple Effect

Challenge

Outcome

Intended outcomes (above line)



Date (from)

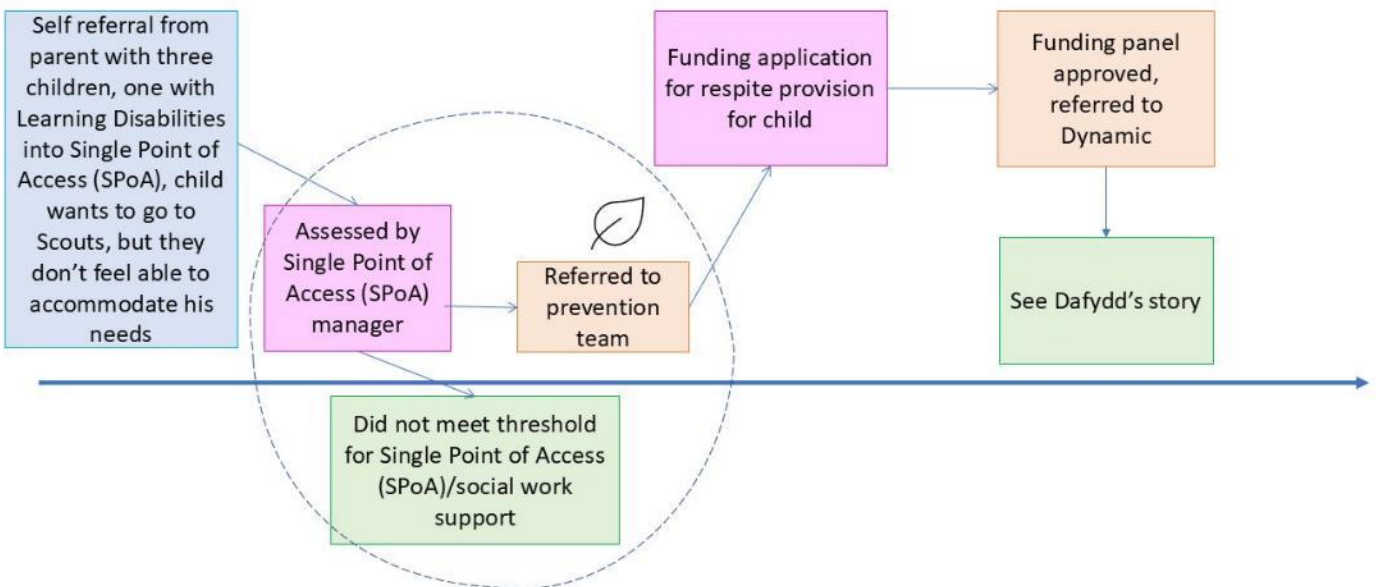
Timeline

Date (to)

Unintended outcomes (below line)

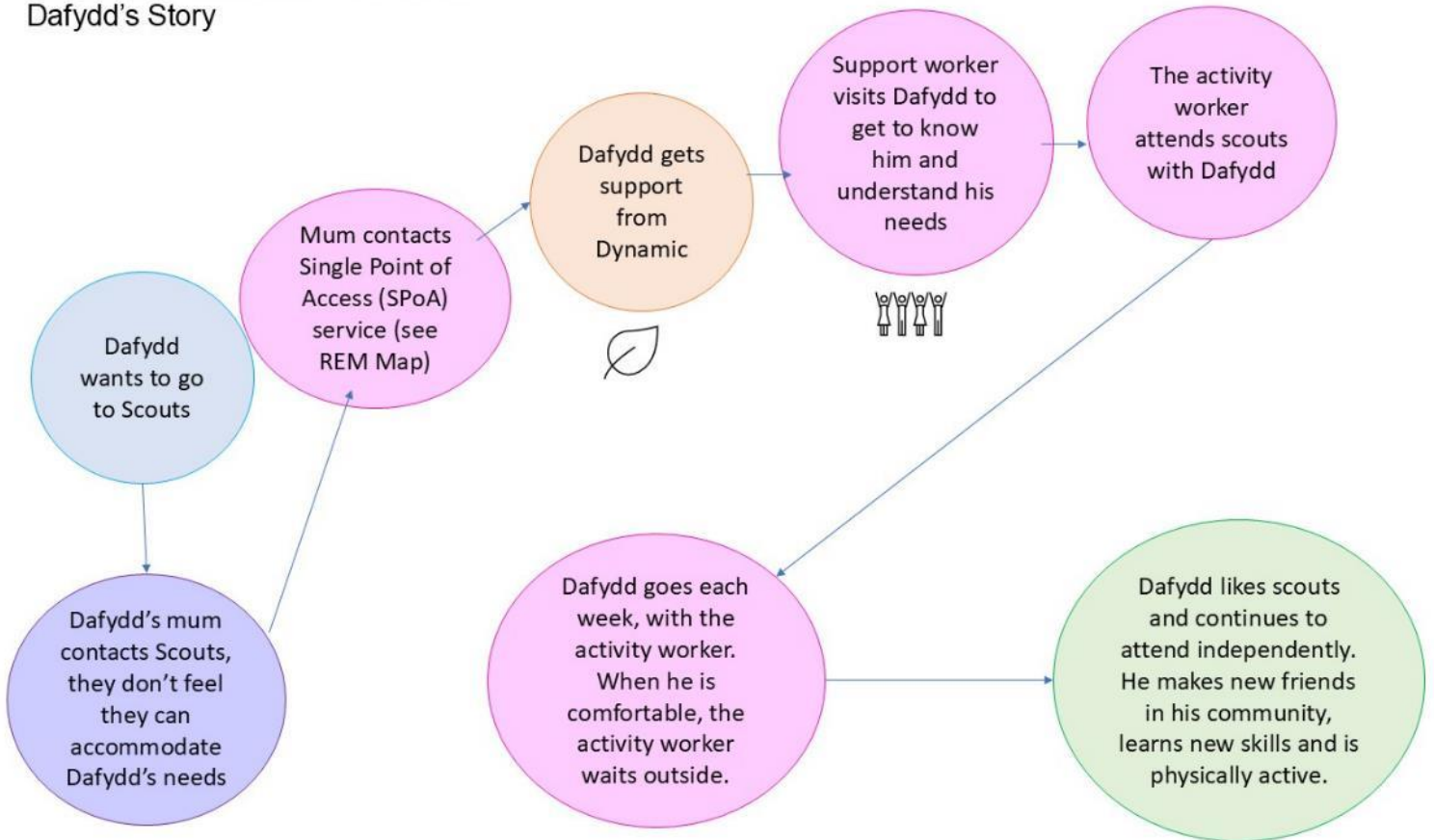
## Single Point of Access – Wrexham The Ripple Effects of a referral from SPoA

Intended outcomes



Unintended outcomes

Single Point of Access – Wrexham  
Dafydd's Story



**Capital programme: Canolfan Glanhwfa**



We're transforming a former chapel in Llangefni into a fully accessible, multi-agency space. It will offer support for older people, people living with dementia, unpaid carers, and the wider community. The scheme includes lower floor renovations, lift installation, and restoration works. It will permanently host the Anglesey Dementia Centre and North Wales Memory Assessment

Service. Designed around the needs of the local community, the hub will reduce loneliness, provide tailored dementia support, offer intergenerational activities for parents and children, and deliver music, culture, and safety-focused training sessions. It will serve as a welcoming, inclusive space that promotes well-being, community connection, and access to essential services. Canolfan Glanhwfa has received £1.1 million from the Integrated Rebalancing Capital Fund and is due to open autumn 2025.

## Challenges

Lack of understanding of what services can provide/offer e.g. the role of a 'social prescriber'.

Quality of referrals causes delays in implement appropriate intervention.

Managing expectations of service users.

Transport to access services - particularly in more rural areas of North Wales.

Engagement with, and uptake of new projects/models, for example, employers and the Supported Employment Model.

Recent increase in National Insurance employer contributions and Real Living Wage - challenges for the ongoing sustainability of projects - particularly those operated by third sector organisations.

# Challenges

Sharing of information between services/ systems creates duplication and the need for those accessing services to continuously repeat and retell their story.

Difficulties in consistent high quality service monitoring and data collection - largely due to capacity and staffing.

Consistency in programme delivery due to high staff turnover/ recruitment issues.

Capacity and resource constraints.

Short term funding cycles can make it difficult to retain staff due to uncertainty.

Increased need, demand and complexity within communities and across population groups.

## Next steps

Based on these successes and challenges, next year we will:

- Improve reablement and domiciliary care capacity, including alternative delivery models.
- Improve community care capacity.
- Further develop early intervention and preventative community hubs and resources.
- Continue to deliver projects to connect people with support in their communities.
- Refresh and deliver the North Wales Dementia Strategy.
- Continue to deliver the North Wales Together programme: Seamless services for people with learning disabilities.
- Develop a prevention framework for partner organisations to build on the Well North Wales approach.

## Section 2: Community based care – complex care closer to home

Integrated placed-based health and social care services to people with complex care needs to keep them well at home. Help to improve recovery following a period of ill health and to be more independent in the long term.

### Funding

This model of care received £6.2 million funding through the Regional Integration Fund, and funding from the Care Action Committee 50-day challenge, Further Faster and Capital grants.

### What we achieved



**16,100** people accessed the service, 2,200 for the first time.



**1,800** people received support that prevented their needs escalating (99% of those who gave feedback)



**2,600** maintained or improved their emotional health and well-being (97% of those who gave feedback)



**1,700** people now know more about the support available to them

The **Community Falls Team** reduce the risk of falls for older people. Their Care Home Bundle will help care homes to assess and refer people for falls prevention support, encourage care homes to manage the risk of falls to prevent them happening and give advice after someone has fallen. It will be out for consultation in May 2025.

We've created 16 **Community Resource Teams** each based in a local area to support people across North Wales. Community Resource Teams are delivering complex care closer to home. In January 2025 an enhanced care service model started in Colwyn Bay to prevent hospital admissions (also known as 'step up' care).

The **Positive Behaviour Support (PBS) team** trains staff to provide person-centred behavioural support to people with learning disabilities and/or autism. This improves people's quality of life by reducing behaviours of concern and promoting positive outcomes through evidence-based interventions

**Anglesey Response Team** supports people to live independently in their own homes for as long as possible using an integrated Community Resource Team (CRT) model.

The new enhanced personalised night-time support service means people now receive tailored care and reassurance during overnight hours. This helps people to feel safe and secure in their own homes and reduces the need for them to go to hospital.

## **Community Resource Team**

Below is an example about the experience of caring for someone from someone who works for the reablement service.

We had a referral to our Community Resource Team (CRT) Reablement Service for someone who had just left hospital. The person had learning difficulties and is also eligible for our service for older people.

She experienced a dramatic change in daily activities following her hospital stay. Her reduced mobility meant she could no longer access the day centre she used to attend multiple times a week. She was not able to get out of bed by herself and was living downstairs. There were also some challenging behaviours displayed towards strangers. This made it difficult to communicate about the importance of getting out of bed, being mobile, and being able to return to the day centre and get back to social activities.

The hospital Occupational Therapist worked with the Community Support Team Manager and Community Therapies to share information about the person's care needs. They visited them at home multiple times to assess manual handling and support workers also worked to support them to return to the day centre.

This involved meetings between the Disabilities Service, Occupational Therapist, social worker, District Nurses, the Disabilities Nurse, Support Workers from the Day Centre and Advanced Nurse Practitioner from the GP Surgery.

The individual progressed slowly to the point where they were able to sit on the edge of the bed and put their own slippers on, which was a huge achievement. The support is ongoing now that the Reablement Service has stopped, and a Domiciliary Care Agency has been put in place. Community Physiotherapists continue to visit to offer support.

The perfect outcome will be for the person to attend the day centre once more and regain her social activities and social relationships. More time may be needed to achieve this fully; but in the meantime, the joint working between different teams has helped get this process well on the way.

## **Care Action Committee priorities and 50-day challenge**

Welsh Government launched a 50-day challenge to help more people safely return home from hospital and to ease winter pressures on our health and care system. We set up an Urgent and Emergency Care Improvement Programme, which brought together people from the health board, local authorities and other partners.

The joint focus really helped make a difference to the care provided, along with an extra £2.4 million in funding. We were able to increase the number of people receiving care from around 7,650 to 7,800 between December 2024 and March 2025. This includes placements in care homes, at home and reablement (short term support to help people regain independence after illness). We also reduced the number of people waiting for care from 330 to 290 between December 2024 and March 2025. We still face challenges due to increasing demand and overstretched budgets, but this approach has helped to provide care closer to home.

Each local council used funding differently, depending on where it would have the greatest impact. This included providing equipment and adaptations to people's homes to help them get home from hospital or to avoid having to go into hospital in the first place. The funding was used to increase or sustain capacity in:

- domiciliary (home) care services
- social work provision
- occupational therapy provision
- care home staffing
- reablement teams.

There's more information about this programme in the [Home from Hospital model of care](#).

## **Further Faster Programme**

Welsh Government provided additional funding as part of the Further Faster Programme to increase the capacity of community care so that older people only need to stay in hospital when it's the right place for them.

Across North Wales the funding was used to give more people access to places in care homes, reablement and care at home (domiciliary care). In the West of the region funding was used for the Community Frailty Programme. In the Central area it was used for anticipatory planning so we know what people want to happen if their health needs change, palliative care, and the step up and step down scheme to provide care outside of hospitals. In the East we funded an Enhanced Community Care Scheme.

## **Domiciliary Care Regional Commissioning Agreement**

Domiciliary care (care at home) is provided by many different agencies across North Wales. The local councils and health board went out to tender to renew the North Wales Domiciliary Care Agreement, with Denbighshire County Council leading the procurement process. Around 100 care providers bid to be a part of the agreement and 97 have been appointed. The agreement has a potential total value of around £171 million and can be used for up to eight years.

The agreement means that providers have a contract setting out the terms and

conditions they need to meet. It's flexible, so that partners can work with care providers to develop the range of home care and support services across the region.

We've extended the scope of the agreement too. It used to be focussed on standard domiciliary care for adults. Now it includes children and young people, complex domiciliary care and respite care (carer breaks) for children and young people, adults, and their families / unpaid carers. The agreement can be used from 1 April 2025.

Creating the regional domiciliary care commissioning agreement between seven partner organisations and 100 different providers was a complex and demanding challenge for our team. The success of this project will help us make sure we have the right provision to meet the needs of people at home.

This work is a great example of joint commissioning in line with the National Framework for Commissioning Care and Support, which will help meet the needs of people receiving care and support and improve their well-being.

### **Capital programme: Learning disabilities supported living**



Supported living accommodation schemes enable people with learning disabilities to live independently within their own communities. New developments are creating accessible, lifelong homes that offer people choice, control, and the ability to live close to family, friends, and local networks. These schemes promote true inclusion, allowing people to participate fully in community life and

access tailored support where needed. We've invested £2.5 million in several projects to provide homes for 20 people. This includes buying property, refurbishing and construction. This expansion helps reduce the number of people living outside their county or region, helps us house people in a crisis and creates more meaningful, person-centred housing options across the region.

### **Challenges**

We didn't hear about the additional funding for the 50-day challenge until late into the year which limited what we could do with it. With more notice we could use it more effectively and sustainably.

The diagram below shows challenges identified by Regional Integration Fund projects.



## Next steps

Based on these successes and challenges, next year we will:

- Develop a regional falls prevention and response service.
- Increase anticipatory care planning for people most at risk of going into hospital so we can ensure they receive care closer to home.
- Continue the work of the 16 Community Resource Teams.

## Section 3: Home from hospital

Improvements in healthcare and addressing other causes of ill health means that people are living longer, and more people have long-term (chronic) health conditions which need life-long treatment. This is increasing demand on hospital care, when in many circumstances it would be better to provide care and treatment at home or in people's local communities.

The aim of 'home from hospital' is to get people home from hospital as safely and as soon as possible so they can recover at home. After they leave, we check to see what support they need, helping them recover more quickly and avoid spending more time in the hospital than necessary. This also helps hospitals and care services manage their space better, making sure that people who need urgent medical care can get it quickly.

Our goal is that within 48 hours of being well enough to go home, people are back at home with all the support they need in place.

### Funding

In addition to £4 million funding through the Regional Integration Fund, we have also used funding from the Care Action Committee 50-day challenge and Capital grants to support this model of care.

### What we achieved



**616** people accessed the service, 200 for the first time.



**190** people received support that prevented their needs escalating.



**123** maintained or improved their emotional health and well-being.



**175** people said they were as independent or more independent as a result of the project.

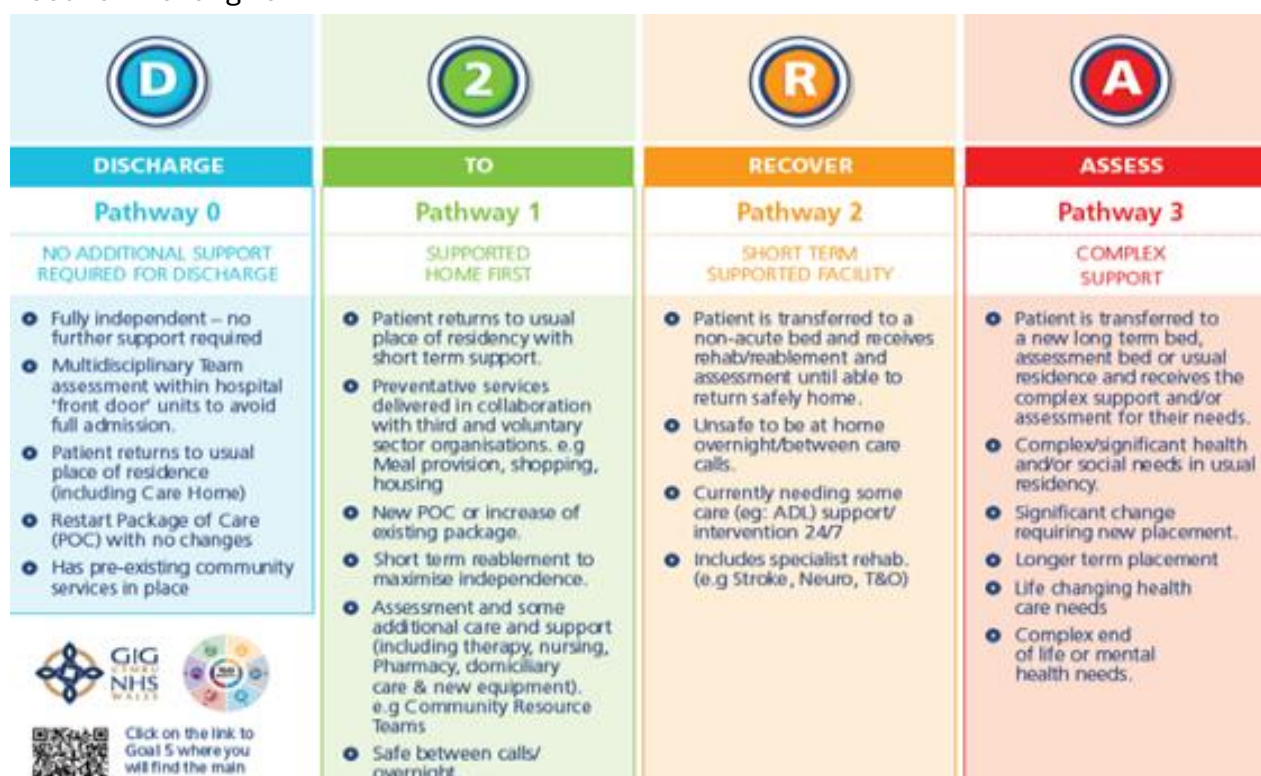
In the West area, our **Tuag Adref (Towards Home)** project provided reablement services (short-term interventions) to 1,600 people so they can go home as soon as they are well enough and avoid going to hospital unnecessarily.

In the Central area, the Conwy **Step Up Step Down Extra Care** scheme supported

people who are well enough to go home, but where there are other reasons that mean they can't go home. The team work closely with the Community Resource team so that people can have a short-term stay of about two weeks in one of five purpose-built flats in an Extra Care Housing scheme. While they are staying there a multi-agency team checks to see what support they need to get home. The Extra Care Housing Scheme is for people over the age of 55 who need domiciliary (home) care and have health needs that can be supported by the District Nursing Scheme. Domiciliary care is available 24 hours a day, seven days a week in the scheme.

In the East area, the **Home First Discharge team** supported 350 patients to get home from acute and community hospitals. They also support patients on the fast-track pathway that Hospice at Home are unable to support. The support they provide lasts an average of 27 days.

These projects are all part of the D2RA pathway show below, which means discharge to recover and assess. It sets out how we help people to get out of hospital to home if possible, or another place where they can recover and then check what support they need for the long-term.



## Care Action Committee priorities and 50-day challenge

The Care Action Committee priorities are:

- Reduce the pathway of care delays due to assessment
- Increase weekend district nursing and palliative care nursing hours
- Increase the number of people benefiting from 'step up' care as safe alternative to conveyance / hospital admission and 'step down' care from hospital.

Funding from the 50-day challenge helped us with our hospital from home model of care.

- We reduced pathway of care delays to 311, down 25% between April 2024 and March 2025.
- We reduced pathway of care delays due to a wait for an assessment to 140, down 32% from April 2024 to March 2025.
- The number of days of delays was 11,000 in March 2025. This was 17% lower than in April 2024.
- We increased the amount of time district nurses were available on weekdays and at weekends. We're also working with Welsh Government to test a new model to get data about district nursing availability from our IT systems.

Our Urgent and Emergency Care Improvement programme is working on:

- Support to prevent people from needing to go to hospital. This includes a community falls response to help people who have fallen.
- When people arrive at hospital, our 'Hospital Front Door' workstream provides the right support without people needing to be admitted to hospital wherever possible. This includes our front door frailty service and work with the ambulance service.
- The Optimal Hospital Flow Framework, which is about planning to help people leave hospital with 24 hours of them being admitted. This helps avoid deconditioning which is where people can lose strength and fitness from being in a hospital bed.
- Discharge from hospital. This is about health, social care and other services working together to make sure people can leave hospital as soon as they are well enough.

There are six national goals which the Urgent and Emergency Care Improvement Programme is working towards. The health board received £2.7 million for the programme.



1. Coordination planning and support for the populations at greater risk of needing urgent or emergency care.



2. Signposting people with urgent care needs to the right place, first time.



3. Clinically safe alternatives to admission to hospital.



4. Rapid response in a physical or mental health crisis.



5. Optimal hospital care and discharge practice from the point of admission.



6. Home first approach and reduce the risk of readmission.

## Capital Programme

### Tŷ Croes Atti Redevelopment, Flintshire



Relocating a council-run care home for older people so it can expand from 31 to 56 rooms. This £19 million scheme – funded by Welsh Government’s Housing with Care Fund (HCF) and Integration and Rebalancing Capital Fund (IRCF) alongside Flintshire County Council’s Capital Programme – is being delivered jointly with the health board to support integrated

health and social care. The new model will combine longer-term residential care with intermediate reablement services, supporting safe hospital discharge and person-centred recovery in a community setting. Key features include D2RA (Discharge To Recover and Assess) principles, a rapid-access Admissions Coordinator, and a reablement-led approach with wraparound support. Adapted from a successful model, delivered in Flintshire at the Marleyfield site, it aims to improve outcomes and satisfaction for residents and families. Completion is expected in Summer 2025.

## Challenges

The lack of available suitable short term nursing home placements for step down for patients with health needs remains a challenge. Due to the lack of care provision in the community the main challenge is handing patients back after the period of reablement. A lack of technology for reporting purposes and sharing information securely between teams and Home First Bureaus remains a significant challenge.

## Next steps

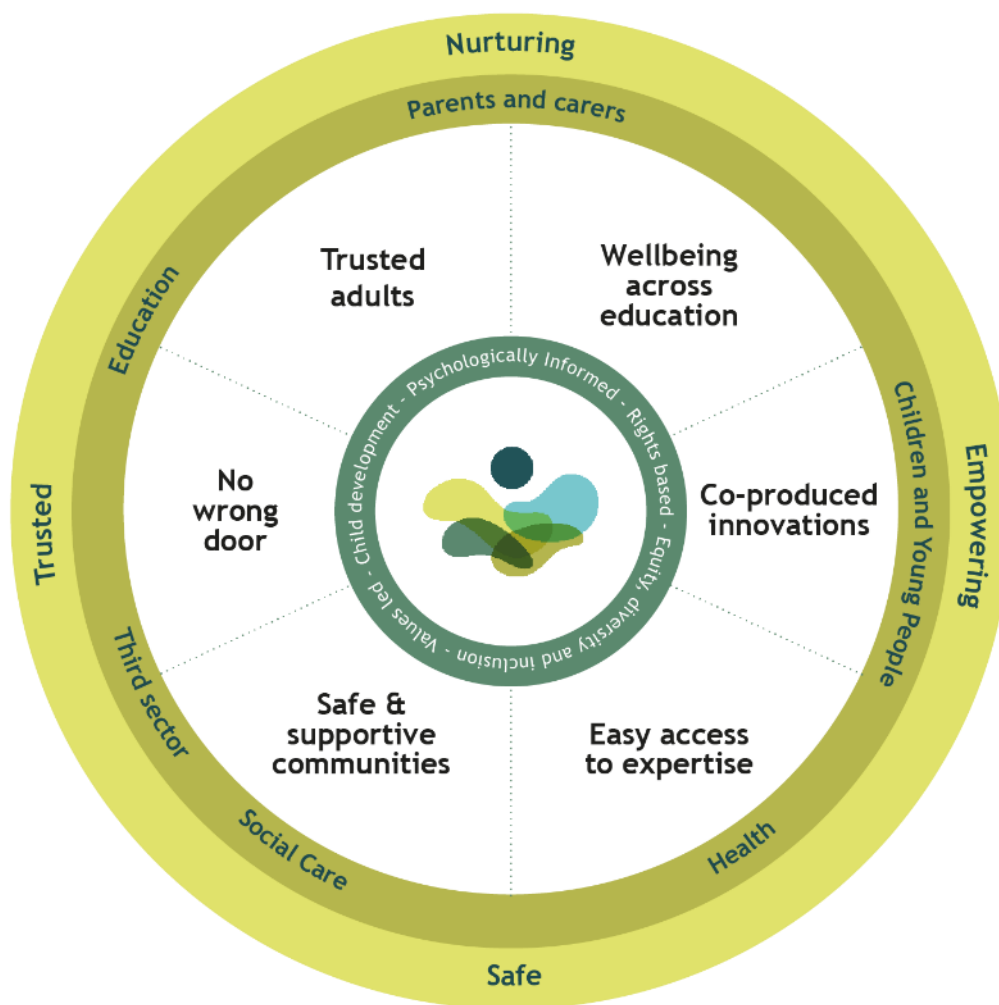
Based on these successes and challenges, next year we will continue to support:

- Home First Teams.
- Discharge to recover and assess.
- Step up step down. Step up care is to prevent hospital admissions and step down care is support for people who are well enough to leave hospital but where there are other reasons that mean they can’t go home.

## Section 4: Supporting families and children to stay together safely

We want children and young people to enjoy their best mental health and well-being. We do this by making sure the organisations that support them are easy to access, work well together, make sure results happen quickly and efficiently based on children and young people’s choices and those of their families.

This model of care is based around our strategy ‘The Right Door’ (previously known as ‘no wrong door’) and the NYTH / NEST framework shown below. This includes giving trusted adults, those closest to the child, easy access to expertise to support them to ‘hold on’ to children when they can instead of ‘referring on’. And where more specialist support is needed, we want there to be ‘no wrong door’. New ways of working will involve children, young people and their families and be based on what matters to them with their well-being supported across education and through safe and supportive communities.



## Funding

In addition to £10.5 million funding through the Regional Integration Fund, we have also used funding from the Neurodiversity Improvement Programme and Capital grants to support this model of care.

## What we achieved

Projects in this model of care are working more closely together, sharing knowledge, resources, and good practices as they grow. Efforts to guide people to the right services and make referrals based on individual needs have helped projects support each other in providing well-rounded, effective care. This has made better use of local resources and strengthened the system's ability to deliver the care that really matters to individuals and families.



**12,000** people accessed the service,  
2,300 for the first time.



**2,300** people received support that  
prevented their needs escalating.



**4,000** maintained or improved their  
emotional health and well-being  
(98% of those who gave feedback)



**3,200** people received a specialist  
intervention and 96% of those who gave  
feedback said they were satisfied with it.

## Neurodivergence Improvement Programme (NDIP)

The Neurodivergence Improvement Programme added capacity to existing neurodivergence services, reduced assessment waiting times and supported the piloting of innovative approaches to integrated delivery of neurodivergence services, which support the delivery of the Children's Regional Partnership Board vision.

We delivered 18 projects and a further 11 activities. The projects have been focused around four themes of work which have looked to:

- develop needs led advice and support pre and post diagnosis
- build skills and knowledge for both staff and families
- undertake research to support service development and
- pilot a new collaborative approach to working across health and education.

The work has resulted in more informed 'what matters' conversations that suit people's

circumstances, so they receive more tailored advice and support. This can prevent escalation and enables parents and carers to be in a better position to manage their own situations.

Staff knowledge of neurodiversity has increased generally across teams providing support to children, young people, and families through bringing in colleagues with specialist neurodiversity knowledge to the teams. This has enabled more targeted support to be provided and staff to feel better informed and more confident.

Individuals and their families say they feel better understood and less isolated and that the help they receive is helping them gain confidence and feel empowered to make decisions over day to day living situations. Improved mental well-being and cohesion within the family unit is helping reduce the risk of care proceedings.

The [focus on neurodevelopment information pack](#) we developed last year was used as a key part of the Welsh Government Accelerated Design Event. The pack pulls together a range of evidence about the experience of children, young people and families with neurodevelopmental conditions in North Wales.

A successful ‘Designing Success Together: Neuro-affirmative Innovations’ event was held in March 2025 with over 100 participants, including people with lived experience and service providers, to develop an action plan for the next twelve months.

### **Poem and comments made by a Wrexham Dad**

“Life is a race we are running in  
Its distance we’re not told  
With ups and downs and in-betweens  
The challenges unfold  
The journey is long and sometimes hard  
And sometimes quite rewarding  
One moment high above the clouds  
Then through thick treacle fording  
The challenges they come and go  
And deal with them we will  
Some sweetened with some sugar  
Some like a bitter pill  
That said we move with tiny steps  
And ever forward motion  
With toil and smiles and gratefulness  
Our hearts are filled with devotion

“On behalf of our family, I would like to say a huge thank you for all the advice support and resources that you have provided over the last several months, we are eternally grateful. All our best wishes.”

## Ripple effects mapping

### The Local Integrated Family Team (LIFT)

The LIFT team is a multi-disciplinary team that includes staff from the health board, Conwy County Borough Council and Denbighshire County Council. During a Ripple Effects Mapping workshop in 2025, the team shared how support from the Regional Partnership Board Team in 2017 enabled them to develop closer working relationships across health and social care. We were able to link together the ripple effects from LIFT and their local neurodevelopment service (funded through NDIP) to understand how facilitating regional working can support improved relationships across organisations to meet the needs of children, young people and families.

### Tŷ Nyth – Multi Systemic Therapy

The team at Tŷ Nyth mapped a young person's move back to the part of North Wales that they come from. Originally the plan was for the young person to move into a foster care placement but they are now living in a residential placement that suits their needs and has improved relationship with their dad and siblings. Ripple Effects Mapping supported the team to reflect on the journey, identify elements of the model which helped staff to support the young person to overcome significant challenges in regulating emotions and behaviour. This led to improved placement stability closer to home.

### Capital programme: Bwthyn Y Ddol – Sub-Regional Children's Residential Assessment Centre

Opened in winter 2024, Bwthyn Y Ddol is a pioneering sub-regional residential assessment unit delivered in partnership by Conwy County Borough Council, Denbighshire County Council, and Betsi Cadwaladr University Health Board.

The centre works with families in crisis and provide a place of sanctuary and assessment for young people with complex needs. They work with families to create positive change, **enabling children** to: remain home safely or return home safely, or develop an alternative placement plan, and **enabling parents** to challenge and change their own behaviours in order to meet the needs of their children. The team will work with children and their families:

- To prevent children going into care on a long term basis
- To provide a period of assessment to assess, plan and deliver intensive bespoke interventions
- To provide therapeutic respite for families in crisis
- To facilitate complex change
- For the small number of children unable to remain with parents or family to identify the most appropriate alternatives in a planned and responsive way

The £5 million scheme has received funding over a number of years.

## Early intervention

Early intervention projects include developing and piloting a regional Emotional Health, Wellbeing and Resilience (EHWR) Framework. Based on the five ways to wellbeing, it has been developed through coproduction with children, young people, families and carers, and professionals. The framework has been tested in various places from early years to secondary schools and across different groups to see where it's effective, for example, teachers have been using it as a discussion reference at parents evening. We've used this practice to inform a toolkit to accompany the framework in 2024/25. The regional team is using the Most Significance Change model to assess the impact of the framework and is identifying a range of stories with further work being undertaken especially gathering stories from parents, carers and children and young people.

## Challenges

Based on the challenges faced across North Wales, the Children's Regional Partnership Board has identified three priorities for next year.

- Neurodiversity – supporting children and young people to have equal life opportunities
- Supporting mental well-being – supporting children, young people and families with therapeutic needs who don't meet criteria for mental health support
- Not for profit in care – commitment to remove private profit from the care of children looked after

Challenges relating to neurodiversity include:

- Shifting support to be needs led with an early intervention and prevention focus, rather than having to wait for a diagnosis.
- Managing the increase in demand for support that is being seen regionally and nationally, coupled with a shortage of professionals with neurodevelopmental specialist knowledge in areas such as Social Work, Occupational Therapy and Teachers.
- Gaps identified in provision for mental health services for children and young people with neurodiversity needs.
- Raising awareness about unintended consequences for people with neurodiversity of decisions made by services, for example, in school settings.
- Raising awareness about neurodiversity and how reasonable adjustments can make a positive difference for individuals.

## Next steps

Based on these successes and challenges, next year the priorities for children will be:

- Neurodiversity – Regional Strategic Neurodivergence Group will oversee the programme action plan and develop work regionally and monitor overall via regular monthly meetings. Three Children's Area Groups will take local decisions, develop,

deliver and monitor by area – meeting every two months.

- Supporting mental well-being – supporting children, young people, and families with therapeutic needs who don't meet criteria for mental health support – Children's RPB to hold workshop to develop strategic focus in mid July, then develop a programme of work. Implement a regional strategic group to oversee the programme.
- Not for profit in care – commitment to remove private profit from the care of children looked after: Children's RPB to hold workshop to develop strategic focus in mid-September, then develop a programme of work. Implement a regional strategic group to oversee the programme.

## Section 5: Promoting good emotional health and well-being

Creating and improving services for people who need emotional health and well-being support and connecting them to support in their local community.

### Funding

This model of care receives £1.3 million from the Regional Integration Fund and £4 million from capital funds.

### What we achieved



**11,000** people accessed the service, 3,000 for the first time.



**38,000** contacts (some people were contacted more than once)



**2,900** maintained or improved their emotional health and well-being (97% of those who gave feedback)



**320** people received support that prevented their needs escalating.

Developed an interactive, classroom-based Autism Awareness session to help raise awareness of autism and the challenges Autistic people can face every day. People attending the session included those from HR, Project Management, Disability, Single Point of Access, Well-being Hub and Reablement teams.

Mencap Môn's community activities support people with a learning disability and their carers. Through partnership working with Dementia Actif Môn they work collaboratively to support people with learning disabilities with a greater risk of a dementia diagnosis.

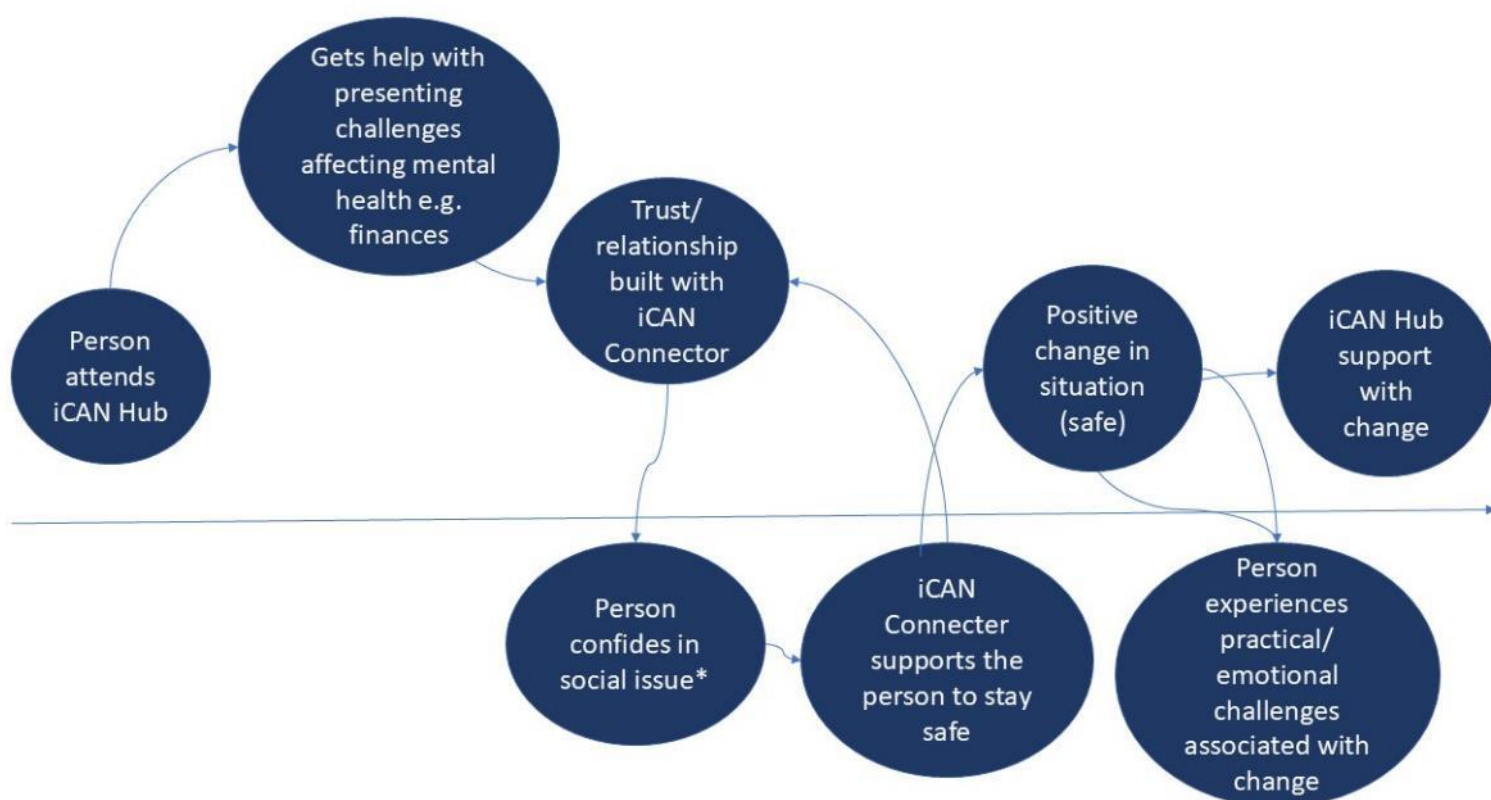
### iCAN

The health board's iCAN service supports people with mental health and well-being. It connects people to their communities and has great collaborative working between health and social care services and third sector partners. This includes GPs, Primary Care teams, Community Mental Health Services, pharmacies, the Integrated Autism Team, social workers, police, fire, and housing.

The iCAN Hubs give people an opportunity to step into volunteering and peer support

roles. During the Knowledge Exchange Event in March 2025 volunteers shared their experiences and explained the positive impact the volunteer role has had on their mental health and well-being.

The Ripple Effects Map below was produced as part of two workshops involving link workers and managers, police, community navigators, a substance misuse charity, and housing providers. It shows that the relationships between iCAN and the people they support helps people make changes for their own safety, support recovery and experience change. This may be practical support and advice about their situation, or emotional support responding to change in themselves or their feelings.



## Capital programme: community and health and well-being hub developments



In Flintshire, Coed y Ddraig in Mold will be a centrally located hub providing day and work services for people with learning disabilities, autism, and mental health support needs. The £5.7 million scheme – jointly funded by Flintshire County Council and the Welsh Government’s Integration and Rebalancing Capital Fund (IRCF)

– will support up to 80 people and create meaningful employment opportunities for service users. Construction is progressing well and we expect it to be complete by

summer 2025.

In Denbighshire, a new integrated Health and Well-being Hub in Denbigh will bring together children's and adult services including Community Resource Teams (CRTs), midwifery, mental health, and learning disability services. Betsi Cadwaladr University Health Board has secured £1.1 million for the site which is due to open in spring/summer 2026. It will improve access to coordinated care by co-locating health, social care, and third sector services in a single, community-focused facility.

## Next steps

Based on these successes and challenges, next year we will:

- Continue to develop the health board's iCAN service to support people with mental health and well-being.
- Provide training and development, community activities and Community Well-being Officers to promote good emotional health and well-being.

For 0 to 25 year olds, see [section 4, supporting children young people and their families](#).

## Section 6: Integrated system enablers

The essential behind-the-scenes work over the past 12 months that make it possible to provide new models of care are evidenced as follows.

### Capital programme: buildings and infrastructure

The regional programme is supported by £6.7 million from capital funds and £690,000 from the Regional Integration Fund. The programme delivers the [10-year Strategic Capital Plan](#). Each model of care above includes examples of how the work has been enabled by the capital programme.

This Regional Integrated Fund element is about enabling people to live where they want, in the way they want and to stay safe and well with support within their communities. This includes helping people gain or regain an independent life where appropriate. The diagram below shows the achievements for this aspect of the programme.



**244** people accessed the service, 38 for the first time.



**105** people received support that prevented their needs escalating.



**436** staff accessed training.



**100%** of people were satisfied with the specialist intervention provided.

### The Progression Service

The Progression Service helps people achieve independence, well-being and control. The service has helped prevent the need for and reduced impact on paid services through the support provided. The Progression Service also continues to work with the Employment Co-ordinator to enhance work opportunities for individuals to have meaningful employment for those with a learning disability. They have worked with local businesses / volunteering opportunities to achieve this.

## Capital programme



Increased local small group homes for children in care, with a £4 million investment. This helps improve options for children to live within or close to their local communities.

Invested £2.7 million in around 60 projects to adapt and refurbish property and provide specialist equipment and digital assistive technology.

### Arosfa

Refurbished the Arosfa Centre in Mold, which provides short term breaks and respite for disabled children, to provide high quality, safe and supportive accommodation. This means children and young people can receive complex support services in their local area. A transport programme supports young people to attend school, college and other education with increased independence. It's been a challenge to use the accommodation fully and safely at Arosfa and to implement safe and effective transport plans. Other challenges facing respite services (carer breaks) are that not many voluntary sector organisations provide them, increased referrals and demand, the cost of living, as well as the specialised staff and equipment needed.

## Digital, Data and Technology Board

### Priority 1: Getting the basics right – seamless secure access to systems and information at any time from any place.

Working in a multi-agency team can be frustrating when the IT gets in the way and our 'getting the basics right' workstream is trying to put this right. Last year local councils and health worked together to make sure staff could work together across organisations using Microsoft Teams and we're hoping to be able to roll out SharePoint and calendar sharing in the next stage.

### Priority 2: Innovation. North Wales Digital Social Care Showcase 2025

On 5 March 2025 we brought together digital technology providers with people who plan, use and provide social care for the first North Wales Digital Social Care Showcase. The event was funded by sponsorship from technology companies like Synanetics. It was a great success with spaces to connect and reflect about how we use digital technology and try things out for ourselves.

Workshops included:

- tips for using everyday technologies to help you live the way you choose.
- how to co-design a bespoke care solution using everyday smart technologies.
- mobile phone apps that you can use to help improve your health and well-being.

- how to help your organisation and your staff get ready for a digital future.
- a chance to see and try out medication management gadgets to support people to take their medication on time.

Around 190 people attended on the day, in addition to speakers, exhibitors and organisers. People told us their main highlights were networking, hearing from people with learning disabilities about their experiences, demos and user experience stories, the Welsh Local Government Association presentation, workshops, and exhibitions. We have also started mapping the ripple effects from the event, which includes improved relationships between partners for facilitating digital innovation and support to take forward innovative ideas.

More information: [Digital Showcase website](#), [video of the event](#), [social media story](#).

### **Priority 3: Digital inclusion**

The health board have continued their research programme into digital inclusion and exclusion and its impact on health and healthcare in North Wales.

### **Priority 4: Connecting Care integrated health and care records**

The main focus was on the Connecting Care (WCCIS programme). Market research found that there was no single system that would work for all the different departments in health and social care, so the decision was made to purchase the best system for each service area and then integrate them as the next phase in the project. This year we helped develop a business case and facilitated procurement of a new social care case management system, which will put all six North Wales social care departments onto the same system for the first time ready for future record integration. We work closely with colleagues from Betsi Cadwaladr University Health Board and the North Wales Local Authorities around the Connecting Care Programme.

## **Regional Innovation Coordination (RIC) Hub**

The hub provides health and social care research, innovation, and improvement support for the Regional Partnership Board.

The impact of the team can be seen throughout this report in the Ripple Effects Mapping evaluation, the Digital, Data and Technology workstream, communications and website development, and support for the Children's Regional Partnership Board [focus on neurodevelopment information pack](#), [communication and collaboration](#) and [Early Years](#) workshops.

The team produce the Population Needs Assessment which underpins the work of the Regional Partnership Board. Updates include:

- Key drivers of demand for children's services bulletin.
- Demand for care home places in North Wales bulletin.

- Housing and homelessness research bulletin.
- Dementia strategy statistics update.
- Updated area profiles for primary care clusters, unitary authority areas and local health areas.
- Updated prevalence estimates for dementia and neuro developmental conditions based on latest mid-year population statistics.
- Evidence summary: [Bringing care closer to home](#)
- Evidence summary: [Neurodiversity assessment – the views of children and young people](#)
- Evidence summary: [AI in health and care](#)
- A searchable collection of health and social care research related to the Regional Partnership Board priority groups that was published by people working in North Wales.

Please follow us on Bluesky [@nwrch.bsky.social](#), Twitter/X [@\\_NW\\_RICH](#), [sign up to our newsletter](#) and visit the [RIC hub webpages](#) for more information.

## Workforce developments

The North Workforce Board works on their overarching priorities from their [Workforce strategy 2024-26](#), which include:

- stabilising the workforce.
- learning and development.
- workforce intelligence and planning.

The board has extended its membership in the last 12 months to include additional partners responsible for delivering on the overall strategy. The board meetings focus on priority themes.

A key achievement for this year is the commissioning of six occupational therapy course places through Health Education and Improvement Wales (HEIW) which are ringfenced to North Wales local authorities. There is also ongoing work in place to explore post graduate opportunities across the partnership.

The board continued to campaign and lobby Social Care Wales to progress the work on the portability of Level 2/3 Health and Social Care qualifications. This is underway and should be completed over the summer of 2025 and will improve the overall learning pathway into the sector. It has benefited both Coleg Cambria and Grŵp Llandrillo Menai to develop a unified placement process for students studying these qualifications.

A workstream focussing on the first three years in practice for social workers has successfully updated the learning and development training plan and standardised this document across the region, so that newly qualified social workers (NQSW) are supported by a consistent development plan.

The Social Care Wales Workforce Development Grant (SCWWDP) grant provides a significant contribution to supporting the workforce development needs of the social care workforce in Wales, supporting equality of access to all types of social care providers in each region and reflective of the profile of the sector in each county and region. SCWWDP supports the 5 key themes of the health and social care workforce strategy:

- Building a digitally ready workforce
- Excellent education and learning)
- Provision of qualifying and post qualifying social work training
- Leadership and succession
- Workforce supply and shape

While the SCWWDP grant has not increased in the last 3 years, the demand within the wider social care partner organisations to access training has risen significantly. Local councils are having to do considerably more with the same level of funding.

In the autumn of 2024 the North Wales Workforce Board together with the North Wales Regional Skills Partnership and Isle of Anglesey County Council developed a pilot programme tailored for Year 9 across Anglesey secondary schools. The purpose was to provide an insight and awareness of occupations within the health and social care sector, what the different roles involve, and the career opportunities available. It also provided practical insights and experiences to complement theoretical knowledge and dispel myths, and facilitated exploration of various pathways into social care professions including social workers, occupational therapists, and management, in both adults and children's settings.

The event was held at all five Anglesey high schools and approximately 700 pupils attended. We will monitor whether there was an increase in the number of pupils choosing health and social care as a GCSE option from September 2024. To date Coleg Menai, Llangefni campus has received 53 applications to complete a Level 3 Health and Social Care course and 36 applications to complete a Level 2 Health and Social Care course for the next academic year (2025/26). This is approximately a 40% increase in applications to undertake a course compared to this time last year.

There continue to be ongoing workforce challenges throughout the sector and the North Wales Workforce Board will continue to work with partners and stakeholders to support the sector. This will complement the work of the national Fair Work Forum, and along with our work with overseas and international workers will help ensure the recommendations of the Anti-Racist Wales Action plan are implemented.

## Mwy na geriau

We promoted the use of the Welsh language including sharing [resources on our website](#) to strengthen the use of the Welsh language within health and social care sectors. This has been one of the most visited sections of our website.

## North Wales Social Value Steering Group

The North Wales Social Value Forum Steering Group has had new members since it was formed in 2016. New members include partners from Betsi Cadwaladr University Health Board, local authorities, housing associations, and third/voluntary sector. This group help meet the requirements of the Social Services and Well-being Act (Wales) 2014 and promote collaboration, partnership, and networking opportunities across sectors with an aim of maximising social value and co-production across all providers delivering health, social care and well-being services in North Wales.

In November 2024, in partnership with the North Wales Insight and Research Partnership, the group held its first North Wales Social Value conference. This well-attended event brought together providers, procurement and commissioning officers and managers from across North Wales to ensure a shared understanding about maximising the well-being of citizens and communities through commissioning activities. The focus was on delivering ‘what matters’ to the people of North Wales and how we could address social, environmental, economic and cultural needs through procurement and commissioning activities.

Over the next two years, the group will focus on:

- a learning and development programme.
- the 2025 Social Value Conference.
- working with the North Wales Social Value Network.
- measuring the impact of social value and how it is being delivered in North Wales.
- working with the voluntary services councils (the forum will focus on voluntary sector projects and using Regional Integration Funding to maximum benefit).

## Communication and engagement

We set up a ‘good news’ stories group which brings together communications teams from across the six local councils and health board. The group meets regularly to identify stories about the impact of the Regional Partnership Board and share them widely through press releases and other methods.

The first two stories the good news stories group shared were:

[Accessing the right support: North Wales Memory Support Pathway](#)

[North Wales Dementia Friendly Communities Scheme](#)

We created a new process for generating content for the Regional Partnership Board website to share good practice, improved the site structure to make it easier for people to find the information they need and developed a style guide to improve consistency. Popular pages this year included the [Population Needs Assessment](#), [Digital Social Care Showcase](#) and [North Wales Memory Support Pathway](#). One of the most searched terms that lead people to our website is 'mwy na geiriau', which takes people to the page: [Mwy na geriau: Resources to help strengthen the use of the Welsh language within health and social care in North Wales](#).

# Annual delivery plan 2025/26

The annual delivery plan was agreed following a Regional Partnership Board workshop, which reviewed the successes and challenges set out in this report. This is an ambitious work programme which no one organisation can achieve alone.

It will be delivered by partner organisations working together through Regional Partnership Board programmes and projects.

## Models of care

### **1. We will provide community-based care including prevention and community coordination by:**

- Improving reablement and domiciliary care capacity, including alternative delivery models.
- Improving community care capacity.
- Further developing early intervention and preventative community hubs and resources.
- Continuing to deliver projects to connect people with support in their communities.
- Refreshing and delivering the North Wales Dementia Strategy and the North Wales Together programme: Seamless services for people with learning disabilities.
- Developing a prevention framework for partner organisations to build on the Well North Wales approach.

### **2. We will provide community-based care including more complex care closer to home by:**

- Developing a regional falls prevention and response service.
- Increasing anticipatory care planning for people most at risk of going into hospital so we can ensure they receive care closer to home.
- Continuing the work of the 16 Community Resource Teams.

### **3. We will help people to get home from hospital by:**

Working together to address the reasons for pathway of care delays by continuing to support projects to address the causes of delays, including:

- Home First Teams
- Discharge to recover and assess
- Step up step down. Step up care is to prevent hospital admissions and step down care is support for people who are well enough to leave hospital but where there are other reasons that mean they can't go home.

#### **4. We will support children, young people and their families by:**

Focusing on the following priorities.

- Neurodiversity – supporting children and young people to have equal life opportunities
- Supporting mental well-being – supporting children, young people, and families with therapeutic needs who don't meet criteria for mental health support
- Not for profit in care – commitment to remove private profit from the care of children looked after

#### **5. We will promote good emotional health and wellbeing by:**

- Continuing to develop the iCAN service to support people with mental health and well-being.
- Providing training and development, community activities and Community Well-being Officers to promote good emotional health and well-being.

For 0 to 25 year olds, see [section 4, we will support children young people and their families](#)

#### **To enable the above to happen:**

#### **6. We will deliver the capital programme and provide accommodation-based solutions (safe and supportive places to live) by:**

- Developing and further progressing projects as set out in our 10-year [Strategic Capital Plan](#) including:
  - Opening the 56 bed provision in Flint – Croes Atti which combines longer-term residential care with intermediate reablement services, supporting safe hospital discharge and person-centred recovery in a community setting.
  - Completing and opening Coed y Ddraig in Mold which will be a centrally located hub providing day and work services for people with learning disabilities, autism, and mental health support needs.
- Providing places to provide respite care (carer breaks).
- Providing the progression service to help people with learning disabilities achieve independence, well-being and control and have safe and supportive places to live.

#### **7. We will work together to jointly commission services and promote social value by:**

- Reviewing the implementation of the new North Wales Domiciliary Care Agreement 2025 (Adults/Children and Standard/Enhanced).
- Issuing and implementing the North Wales Pre-Placement Agreement for Care Homes including an accompanying Care Home Specification.
- Reviewing the current Regional Supported Living Agreement and deciding whether a

new regional agreement is to be re-tendered which meets the needs of the commissioning partners and citizens.

- Developing a Regional Commissioning Strategy for residential homes and nursing homes.
- Working with the Children’s Regional Partnership Board to develop a Regional Commissioning Placement Strategy for children’s services.
- The North Wales Social Value Steering Group will focus on a learning and development programme, the 2025 Social Value Conference, working with the North Wales Social Value Network, measure the impact of social value and work with voluntary services councils to maximise funding and benefits.

## **8. We will work together on workforce planning and development by:**

- Stabilising the existing workforce to remain within the health and social care sector and support and drive a continual attraction and recruitment activity.
- Creating a workforce which is competent, capable and confident to perform their role.
- Working with partners to capture relevant workforce data to inform and improve future workforce requirements and planning.

## **9. We will use digital, data and technology well to create integrated, seamless, sustainable services and improve health and well-being by:**

- Getting the basics right: making sure people who work in health and social care have seamless, secure access to systems and information at any time from any place.
- Innovation: taking a joined-up approach to digital innovation and maximise use of funds.
- Digital inclusion: joined-up approach to developing digital skills and helping people get online.
- Integrated Care Records and Connecting Care oversight.

## **10. We will engage and communicate the work of the Regional Partnership Board by:**

- Continuing Good News Stories group with communications teams from across the six local councils and health board.
- Continuing Ripple Effect Mapping of Regional Integration Fund and Capital projects.
- Beginning research and engagement for the next Population Needs Assessment to be published in April 2027.
- Promoting and updating the Regional Partnership Board website and social media.
- Continuing the work of the Mwy na geriau board.
- Working with partners to continue to identify, value and support unpaid carers and ensure their voices are heard.

This work programme will be delivered using funding from Welsh Government and partners including the following funding streams: Regional Integration Fund, Further Faster, Regional Innovation Coordination Hub, Dementia Funding, Neurodiversity Improvement Programme, Carers Funding, Integrated Rebalancing Capital Fund, Housing with Care Fund, Winter Pressures Funding, Connecting Care and Social Care Wales Workforce Development Programme.

## Appendix 1

How Much Measures	Definitions
<b>HM1. Number of individuals accessing the service (total per quarter)</b>	The total number of individuals who access the project during a quarter.
<b>HM2. Number of new individuals accessing the service for the first time</b>  <b>You must also select HM1 if using the HM2 measure</b>	The number of individuals who access the project for the first time.
<b>HM3. Number of referrals received</b>	The number of individuals referred to the project.
<b>HM4. Number of contacts (count multiple contacts per individual)</b>	The number of times individuals have contact with the project.
<b>HM5. Number of people receiving IAA (universal)</b>	The number of individuals receiving Information, Advice, and Assistance (IAA) services.
<b>HM6. Number of people receiving Early Help and Support (Targeted)</b>	The number of individuals receiving early help and support services that target specific needs and issues. This could include groups and events.
<b>HM7. Number of people receiving Intensive Support (Targeted)</b>	The number of individuals receiving intensive support services that are tailored to meet their specific and more complex needs.
<b>HM8. Number of people receiving Specialist Intervention (Specialist)</b>	The number of individuals receiving specialist interventions that require advanced knowledge and expertise to deliver.
<b>HM9. Number of people completing a survey or providing feedback</b>	The number of individuals completing a survey or providing feedback

How Well Measures?	Definitions
<b>HW1. The number of referrals accepted by the project.</b>	The number of referrals accepted by the project.
<b>HW2. The number of individuals who report being satisfied with the IAA provided.</b>  <b>HW2a. The number of individuals who were asked and gave an answer as to whether they were satisfied with the IAA provided.</b>	The number of individuals who report being satisfied with the IAA they received from the project.

How Well Measures?	Definitions
<p><b>HW3. The number of individuals who report being satisfied with Early Help and Support (Targeted) provided.</b></p> <p><b>HW3a. The number of individuals who were asked and gave an answer as to whether they were satisfied with the Early Help and Support (Targeted) provided.</b></p>	<p>The number of individuals who report being satisfied with the EH&amp;S they received from the project.</p>
<p><b>HW4. The number of individuals who report being satisfied with Intensive Support (Targeted) provided.</b></p> <p><b>HW4a. The number of individuals who were asked and gave an answer as to whether they were satisfied with the Intensive Support (Targeted) provided.</b></p>	<p>The number of individuals who report being satisfied with the IS they received from the project.</p>
<p><b>HW5. The number of individuals who report being satisfied with Specialist Intervention (Specialist) provided.</b></p> <p><b>HW5a. The number of individuals who were asked and gave an answer as to whether they were satisfied with the Specialist Intervention (Specialist) provided.</b></p>	<p>The number of individuals who report being satisfied with the SI they received from the project.</p>

Difference Made Measures	Definitions
<p><b>DM1. Number of individuals feeling less isolated as a result of project support</b></p> <p><b>DM1a. The number of individuals who were asked and gave an answer as to whether they feel less isolated as a result of project support.</b></p>	<p>The number of individuals who report feeling less isolated after receiving support from the project.</p>
<p><b>DM2. Number of people reporting that they are maintaining or improving their emotional health and well-being.</b></p> <p><b>DM2a. The number of individuals who were asked and gave an answer as to whether they maintained or improved their emotional health and well-being.</b></p>	<p>The number of individuals who report maintaining or improving their emotional health and well-being after receiving support from the project.</p>
<p><b>DM3. Number of people reporting they feel they have influenced the decisions that affect them.</b></p>	<p>The number of individuals who report feeling that they have influenced the decisions that affect them.</p>

Difference Made Measures	Definitions
<p><b>DM3a. The number of individuals who were asked and gave an answer as to having influenced the decisions that affect them.</b></p>	
<p><b>DM4. Number of individuals reporting they feel their independence has improved or remained the same with the support of the project.</b></p> <p><b>DM4a. The number of individuals who were asked and gave an answer as to whether their independence has improved or remained the same with the support of the project.</b></p>	<p>The number of individuals who report feeling that their independence has improved or remained the same with the support of the project.</p>
<p><b>DM5. Number of individuals who feel more confident accessing services following project support.</b></p> <p><b>DM5a. The number of individuals who were asked and gave an answer as to whether they feel more confident accessing services following project support.</b></p>	<p>The number of individuals who report feeling more confident accessing services following the support of the project</p>
<p><b>DM6. Number of individuals who received support that has prevented them from escalating their level of need.</b></p> <p><b>DM6a. The number of individuals who were asked and gave an answer as to whether they received support that has prevented them from escalating their level of need</b></p>	<p>The number of individuals who report they received support that has prevented them from escalating their level of need</p>

Dementia Specific Measures North Wales Only	Definition
<p><b>DEM1. Number of carers supported by the service (total per Qt)</b></p>	<p>The total number of carers who access the service during a quarter</p>
<p><b>DEM2. Number of PLwD receiving what matters discussions</b></p>	<p>The number of individuals who received what matters discussions</p>
<p><b>DEM3. Number of PLwD attending activities /groups / dementia centres</b></p>	<p>The number of individuals who attend activities /groups / dementia centres</p>
<p><b>DEM4. Number of PLwD who achieved</b></p>	<p>The number of individuals who report they</p>

<b>Dementia Specific Measures North Wales Only</b>	<b>Definition</b>
<b>what matters to them</b> You must also select DEM5 if using the DEM4 measure	achieved what matters to them.
<b>DEM5. Number of PLwD were asked the question and gave an answer as to if they achieved what matters to them</b>	The number of individuals who were asked and responded that they achieved what matters to them.
<b>DEM6. Number of carers who feel supported to continue in their caring role</b> You must also select DEM7 if using the DEM6 measure	The number of carers who report they feel supported to continue in their caring role
<b>DEM7. Number of carers who were asked the question and gave an answer as to if they feel supported to continue in their caring role</b>	The number of carers who were asked and responded that they feel supported to continue in their caring role

<b>Local measures North Wales only</b>	<b>Definition</b>
<b>NWM 1. Number of staff accessing training</b>	The number of individuals accessing training sessions offered by the project.
<b>NWM 2. Number of citizens accessing training</b>	The number of individuals accessing training sessions offered by the project.
<b>NWM3. Number of training sessions delivered for</b> Staff	The number of staff training sessions delivered by the project.
<b>NWM4. Number of training sessions delivered for</b> Citizens	The number of citizens training sessions delivered by the project.
<b>NWM5. Number of people receiving aids and adaptations</b>	The number of individuals who receive aids and adaptations that help them.
<b>NWM6. Number of people starting an Assistive Technology Package</b>	The number of individuals who start an assistive technology package provided by the project.
<b>NWM7. Number of people with increased knowledge of services/support available to them.</b>	The number of individuals who report having increased knowledge of the services and support available to them.