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NORTH WALES
REGIONAL PARTNERSHIP BOARD

North Wales Regional Partnership Board

Annual Report

2026

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 privilege to introduce the North Wales Regional Partnership Board Annual Report for 2025/26. This report reflects what can be achieved when partners across health, social care, housing, education, the third sector and communities work together to improve well-being and help people across North Wales live the best lives they can.

Over the past year, we have continued to focus on prevention, early support and care closer to home. Progress has been made through community hubs, social prescribing, dementia support, community resource teams, reablement, Home First approaches, emotional health and well-being support, and services for children, young people and families.

Key achievements include the North Wales Memory Support Pathway, the Dementia Friendly Communities Scheme, improved dementia screening for people with Down's Syndrome, the new North Wales Domiciliary Care Agreement, The Wellbeing, Prevention and Anchor Charter Framework and continued investment in community hubs, respite, supported living, extra care and small group homes for children.

Excellent partnership working was central to the success and value of Winter Sprint 1 and 2. Strengthened collaboration between BCUHB, Local Authorities and Regional Partnership Board partners enabled the system to maintain grip on Pathway of Care Delays during sustained winter pressure. Regular regional and local touchpoints improved communication, trust, shared situational awareness and collective problem-solving, while avoiding escalation becoming business as usual. The use of shared data, particularly the Right Patient Right Place dashboard, helped partners work from a common understanding, reduce duplication and focus on patient-centred actions.

The importance of this partnership working lies not only in short-term performance improvement, but in the development of stronger relationships, shared ownership and mature system behaviours. These foundations helped partners respond more effectively to pressure, support local ownership within a regional framework, and create a platform for more sustainable, coordinated improvement across North Wales.

The Regional Integration Fund has supported 36 programmes across the six models of care. This includes support for unpaid carers, preventative services and social value schemes, all helping to strengthen community-based, person-centred care.
We know the pressures facing health and social care remain significant. Demand is increasing, people's needs are becoming more complex, and workforce, funding and data challenges continue. However, this report shows the strength of our partnership, and the difference collaborative working is making for individuals, families, carers and communities.

The RPB Priorities sets out an ambitious programme for 2026/27 and as we look ahead, our commitment is clear: to keep working together with purpose, compassion and ambition, so that every collaborative step we take makes a real difference to people, families and communities across North Wales.

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

Thank you,
Councillor Dilwyn Morgan

Highlights and achievements from the year

We have:

- Refreshed the North Wales Dementia Strategy following engagement with more than 1,000 people and developed a regional response to help shape the new Welsh Government Dementia Action Plan.
- Supported more than 1,300 people through Community Navigator services, improving access to well-being support in the community.
- Agreed and implemented the new North Wales Domiciliary Care Agreement, bringing together 97 providers under a regional arrangement worth up to £171 million and broadening support for adults, children, young people and carers.
- Supported people with learning disabilities to achieve greater independence through supported living, employment opportunities and digital innovation.
- Developed and agreed a regional Shared Purpose for Transfer of Care, setting out a common approach to improving hospital discharge and patient flow across North Wales.
- Delivered training and awareness programmes that promote neuro-inclusive approaches across health, social care and education services.
- Progressed major capital developments including Ty Croes Atti, Coed y Ddraig, Canolfan Glanhwfa, respite facilities, supported living schemes and extra care housing developments.
- Advanced digital transformation by facilitating implementation of a new social care case management system across all six North Wales local authorities and adopting the Welsh Local Government Association Digital in Social Care Framework.
- Strengthened regional workforce development through collaborative training, recruitment initiatives and the continued promotion of careers through the We Care North Wales campaign.
- Developed a regional Prevention Framework and Anchor Charter, bringing together partners across health, local government and the third sector to strengthen prevention, well-being and community resilience across North Wales.

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 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

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 0-25 years. 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:

- Childrens Regional Partnership Board
- 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 key health board officers (including the Interim Executive Director Transformation and Strategic Planning) who lead on collaborative efforts across the system
- Directors: Social Services Directors
- NWASH: North Wales Heads of Adult Services
- NWHOCS: North Wales Heads of Children's Services.
- Strategic Planning and Service Change Group

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.

Alongside the self-assessment, work undertaken during the year identified opportunities to further strengthen alignment across organisations, particularly in relation to planning cycles, delivery approaches and the pace of implementation of regional priorities. Whilst governance arrangements provide strong oversight and

accountability, their complexity can at times affect clarity and decision-making. Partners also recognised the importance of continuing to strengthen information sharing, communication and the use of data to support more coordinated delivery across North Wales. These themes will continue to inform the Board's development priorities during 2026/27.

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 but for example:

- We've secured agreement by the Leadership Group for the establishment of the Strategic Planning Forums (SPFs) to collaboratively plan future activities.
- We've been able to develop the Well-being, Prevention Framework and Anchor Charter in collaboration with PSBs
- Challenges will always be present and this report outlines some of the activities undertaken in partnership to overcome those identified during the past year.
- The further development of the 'good news' stories group has outlined the positive work undertaken to increase publicity about the board in an integrated way.

We will continue to reflect and improve on these recommendations during 2026/27 with the establishment of the SPFs, the embedding of the Well-being, Prevention Framework and Anchor Charter, further collaborative efforts to tackle the challenges and see a more hopeful, optimistic and positive narrative being developed by the sector in general across the region.

We will also be scheduling this year a revised self-assessment to aide future improvements and secure clarity about our role as a board into the future.

Regional Integration Fund Programme Summary

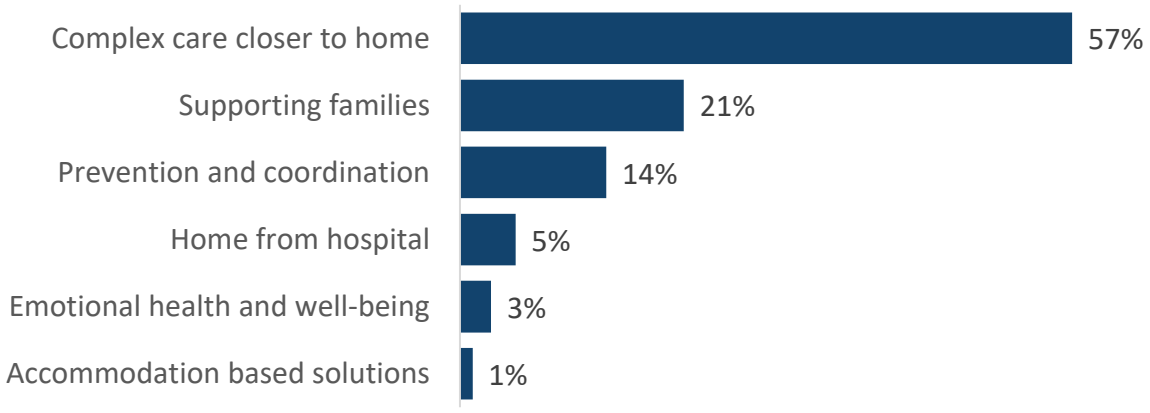
The Regional Integration Fund (RIF) in North Wales supported 36 regional programmes across the six models of care in 2025/26. The total investment was over £79 million. Welsh Government provided £30.5 million of this investment and partners provided £35.4 million of match funding. Of this funding £5.2 million was used to support unpaid carers and £5.3 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	£8,272,902	£10,779,415
Community Based Care – Complex Care Closer to Home	£6,081,329	£45,120,980
Home from hospital	£3,506,219	£4,099,501
Supporting families and children to stay together	£10,537,926	£16,501,485
Accommodation Based Solutions	£763,349	£934,426
Promoting good emotional health and well-being	£1,371,795	£2,299,919
Total	**£30,533,519**	**£79,735,725**

Chart 1: Proportion of investment in each model of care



Ripple Effects Mapping

We held Ripple Effects Mapping workshops for projects in five of the Models of Care. 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.

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 £10,779,415 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

114,072 people accessed the service, 13,346 for the first time.

4,677 maintained or improved their emotional health and well-being.

99% of people were satisfied with the information, advice and assistance they received.

Our projects support older people, people living with dementia, people with learning disabilities and neurodevelopmental conditions including autism, people with emotional and mental health and well-being needs, and unpaid carers. They include projects specifically to support these groups of people, such as Carers Support, Single Point of Access (SPOA) teams and Regional Learning Disability Supported Employment. Key achievements and successes within this Model of Care can be seen below.

Community Hubs and early intervention

Over the past year, we have strengthened support within local communities to help people access support earlier and remain connected. Community hubs and social prescribing services have been expanded, providing more accessible local support and helping to prevent needs from escalating.

We have completed the Canolfan Glanhwfa dementia centre, improving accessibility

and increasing participation in community activities. Alongside this, a wide range of weekly and monthly activities has been delivered, supporting connection, reducing loneliness and building resilience.

The Nantlle Valley community resilience pilot has been developed, strengthening collaboration across 13 hubs and improving access to local services. We have also transformed libraries into integrated community hubs, creating accessible spaces that bring together a range of services for local communities.

Social prescribing and community navigation

Over the past year, we have strengthened social prescribing and community navigation to help people access support at the right time. More than 1,300 individuals have been supported through Community Navigator services, improving access to well-being support and helping people find the help they need closer to home.

We have delivered awareness sessions and Talking Points to improve understanding of available services and encourage people to seek support earlier. This has helped reduce pressure on public services by preventing inappropriate referrals and enabling earlier intervention. Throughout this work, we have strengthened partnership working across sectors, improving coordination and extending the reach of support.

Single point of access

We have continued to strengthen the single point of access as a key gateway for preventative support, providing timely information, advice and assistance. We use “What Matters” conversations to support a more person-centred and strengths-based way of working.

We have introduced threshold guidance and new referral processes to improve consistency and support clearer decision-making. Alongside this, new initiatives such as community-based clinics have been developed, helping to reduce demand on public services and provide support in more accessible settings.

Learning disability support and independence

We have supported people with learning disabilities to develop their independence through progression and transition services, including moves into supported living.

Work has progressed on the North Wales Learning Disability Strategy for 2026 to 2036 through co-production and engagement, ensuring the priorities reflect people’s experiences and aspirations.

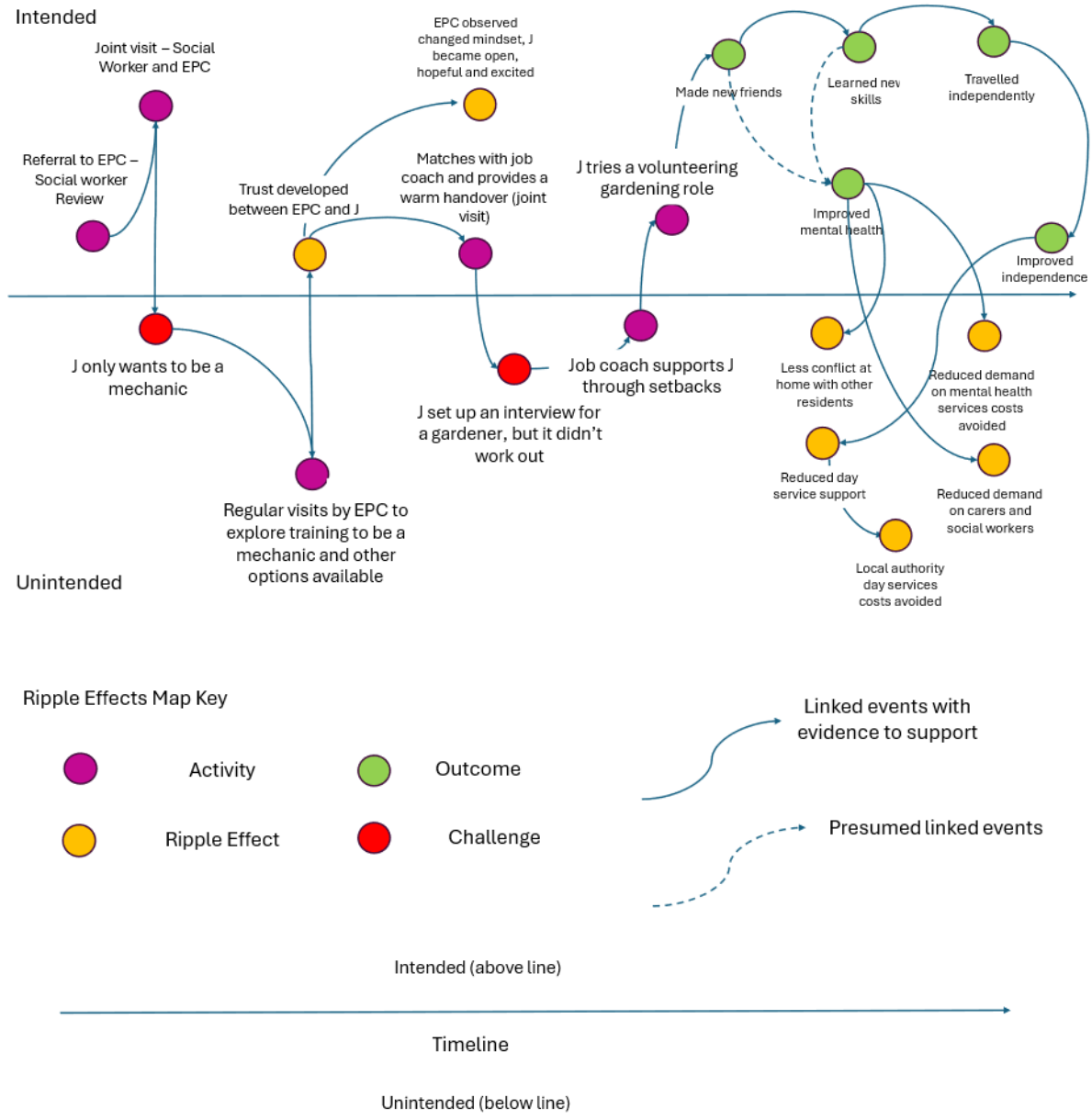
We have also introduced digital approaches, including communication and activity apps, to improve accessibility and engagement. Opportunities for well-being and participation have been expanded through a range of regional activities and programmes, supporting people to be more connected in their communities.

Supported employment

Supported employment services have continued to help people move towards meaningful work. Over the past year, 374 referrals were received into supported employment services, resulting in 46 people getting a paid job and others receiving other opportunities outside of paid work.

We have supported people to sustain employment, with an average duration of more than six months. Between 72% and 79% of individuals supported reported that they maintained or improved their well-being through this support.

Ripple Effects Mapping



The Regional Supported Employment service is underpinned by an evidenced based approach to supporting people with people with learning disabilities to find a paid job and offer ongoing support in the workplace to both the employee and the employer.

The above was mapped by the collaborative team (service manager, social worker, Employment Pathway Coordinator (EPC and job coach) who reflected on individual journeys through the service. J is in his forties and he lives in a supported living setting. Before he met the Supported Employment team the social worker described how he was frustrated and dissatisfied with life, as a result there was sometimes conflict in his household, and he would often ring the social worker or spend a lot of time with them when they were visiting other residents. He attended day services, but he did not feel it was the right fit for him.

The Employment Pathway Coordinator is key to implementing the model – they work closely with individuals, social workers and job coaches to ensure smooth transitions and carefully manage the change process. This map shows how the EPC acts as the catalyst to changing the individual's mindset. "The Employment Pathway Coordinator has time to work with individuals that the social workers do not have, they add real value to our service".

The aim of the service is to support people into paid employment; the map illustrates the individual's improved outcomes as a direct result of working in a voluntary role as a gardener. During the session the job coach expressed disappointment he was not in a paid job. The service manager said, 'but he is now in a voluntary placement, he has a sense of purpose, he says he is 'happier than he's ever been in his life'. He is no longer in day services, so the council are making savings, and he's contacting his social worker less, so there are reduced levels of demand on time. You said his whole household is calmer.' She highlighted how much of an achievement this was and how the support provided was truly person-centred, even though the individual was not in paid employment, the ultimate objective of the service.

Further Faster programme

Over the past year, Welsh Government funding through the "Further Faster" programme has supported a coordinated and system-wide approach to strengthening community care across North Wales. The investment has enabled regional partners to deliver against key priorities including community capacity, anticipatory and palliative care, domiciliary and residential care, and social prescribing, with a clear focus on improving outcomes and reducing demand on acute services.

The programme has supported significant expansion of community capacity, particularly through increased domiciliary care, reablement services and innovative models such as microcare and single-handed care approaches. This has improved the availability and flexibility of care within local communities, supported more timely hospital discharge and reduced delays associated with care provision. It has also

strengthened workforce capacity and resilience, enabling services to respond more effectively to demand and maintain continuity of care.

Further Faster investment has also enabled the development of more proactive and preventative models of care. This includes enhanced anticipatory care planning for those most at risk of urgent care, expansion of Enhanced Care at Home, and improved access to specialist palliative and end of life care, including at weekends. These approaches have supported earlier intervention, improved coordination of care and reduced avoidable hospital admissions, while enabling more people to remain at home in line with their preferences.

In addition, the programme has strengthened access to community-based and non-clinical support through social prescribing and wider community services. These services have helped address social isolation, improve well-being and provide earlier support, reducing reliance on statutory and health services. Integration within community resource teams and multidisciplinary models has further supported a more joined-up and responsive system of care.

Overall, the programme has contributed to improved system flow and increased resilience across community and hospital pathways. By aligning workforce, services and preventative approaches, Further Faster funding has supported a more integrated model of care, improving outcomes for individuals and supporting a sustainable shift towards care closer to home across the region.

Dementia programme

Strengthening dementia support across North Wales

The North Wales dementia programme continues to strengthen integrated, person-centred support for people living with dementia and unpaid carers. A regional memory support pathway now brings together memory assessment services, dementia centres, pre- and post-diagnosis support, hospital navigator roles, peer support, advocacy, benefits advice, community engagement and local dementia-friendly activity.

Referrals to the third sector pathway have increased from 3,598 in 2022 to 2023 to 5,026 in 2024 to 2025, alongside a 21 per cent increase in hospital navigator referrals in 2025 to 2026. Improvements in memory assessment services have reduced waiting times, improved data quality and strengthened oversight.

System changes, including redesign of the Welsh Patient Administration System, dashboards and the memory support pathway tracker role, have improved flow and visibility. Community activity, transport developments and the Memory Bank forum have strengthened access, awareness and lived experience input.

Overall, the programme shows the value of a coordinated regional approach in improving access, integration and support within communities.

Regional Engagement, Prevention and Brain Health

Good progress has been made in delivering against the regional priorities of the All Wales Dementia Care Pathway of Standards, with a strong focus on engagement, prevention and preparation for the Brain Health Campaign. The North Wales Dementia Strategy was refreshed in May 2025, informed by extensive engagement with over 1,000 people, alongside partners across health, social care and the third sector. This ensures the regional approach reflects current needs and aligns with national policy.

The region has collated a coordinated response to Welsh Government to help inform the development of the Dementia Action Plan 2026-36. This aims to ensure that partners and people with lived experience play a central role in shaping the new national priorities.

The response reflected feedback from a wide range of stakeholders, including all six local authorities, Betsi Cadwaladr University Health Board (BCUHB), and third sector partners such as the Alzheimer's Society, Carers Trust, Carers Outreach, and NEWCIS. In addition, input was gathered from two carer and lived experience groups, representing the voices of over 50 people.

In preparation for the past year, significant engagement activity has taken place across the region to better understand the experiences and priorities of people affected by dementia.

This includes the regional Dementia Listening Campaign, which was carried out in all six counties. Communities were invited to share their views on dementia care, generating hundreds of responses that informed eight key regional priorities, including access to care and support, person-centred care, support for unpaid carers, and the development of dementia-friendly communities. These priorities are now guiding a more coordinated and person-centred approach to dementia services in North Wales.

Alongside this, and in preparation for the Brain Health Campaign, a regionally agreed awareness session has been developed, focusing on dementia prevention and risk reduction. As part of this work, resources for the campaign have been developed to support consistent delivery of key messages across the region, ensuring they are accessible, practical, and grounded in current evidence. This has been co-produced with partners to ensure consistency and a shared approach to promoting brain health.

A Train-the-Trainer model will support delivery, with training to be delivered throughout 2026/27.

Dementia friendly communities

Working in partnership, the guidance documents for the Dementia Friendly Communities accreditation scheme have been reviewed and updated. This provides a consistent, clear and supportive framework for communities working towards recognition across the region. Panels have also been established to support and assess applications.

Over the past year, Dementia Friendly Communities across the region have continued to grow and strengthen. There are now 14 accredited Dementia Friendly Communities and three Dementia Friendly Councils across the region. Tywyn has achieved recognition in Gwynedd, with increasing interest from other areas including Porthmadog, Pwllheli and Caernarfon. In Conwy, Abergele has been successfully re-recognised, alongside growing engagement from a wide range of local businesses and organisations.

Denbighshire has made further progress, with multiple towns achieving Dementia Friendly Community status and others moving towards accreditation, supported by the regional panel process. In Wrexham, the approach has expanded to include a wider range of community settings such as schools, churches and leisure facilities, helping to embed dementia awareness more widely in everyday environments.

In Flintshire, a voluntary sector organisation has been commissioned to lead the development and delivery of the Dementia Friendly Communities initiative. This includes an oversight steering group made up of a range of community partners, including Dementia Friendly Communities in Holywell and Flint, to support and guide the work.

Ynys Môn has been accredited as a Dementia Friendly Council through the regional scheme. This represents a significant step in strengthening a whole-system, community-led approach to supporting people affected by dementia.

Unpaid carers support

The North Wales Carers and Young Carers Operational Group continues to oversee delivery of the regional carers action plan in line with the Welsh Government Strategy for Unpaid Carers and the duties set out in the Social Services and Well-being (Wales) Act 2014. In line with the Code of Practice, partners across health, local authorities and the third sector work collaboratively to ensure carers are identified, involved as partners in care, and supported to achieve their own well-being outcomes.

Services funded through the Welsh Government Carers Support Fund and regional programmes, including hospital-based carers support provided by NEWCIS and Carers Outreach, and the provision of short breaks through Amser funding, have continued to support carers across North Wales. These services provide vital information, advice and assistance, support hospital discharge, and offer flexible and personalised breaks

which contribute to maintaining carers' well-being and sustaining their caring role.

During 2025–26, Operational Group has been strengthening a coordinated regional response to the challenges identified through national scrutiny and improvement activity. This has included the development of a shared set of regional priorities, informed by the Public Services Ombudsman for Wales, the ADSS Cymru Unpaid Carers Project, and regional engagement with carers. These priorities focus on improving early identification of carers, strengthening access to information and advice, improving the consistency and quality of carers' needs assessments, supporting workforce practice, and ensuring the voice of carers and young carers informs service planning and delivery.

Looking ahead, partners will continue to deliver these priorities through the Operational Group, supporting a more consistent and effective approach across the region. This work reflects the core principles of the Act, including prevention, partnership and co-production, and will support North Wales in responding to the emerging National Strategy for Unpaid Carers and improving outcomes for carers and the people they support.

Well North Wales

There has been significant progress this year in developing a regional Prevention Framework for North Wales, bringing together partners across health, local government and the third sector to strengthen a whole-system approach to prevention. The Framework includes shared priorities, an Anchor Charter, and a focus on learning from existing good practice. Extensive regional engagement, including a system-wide event, has demonstrated strong support and highlighted the need for clear leadership, collaboration and practical action. This approach aligns with the Social Services and Well-being (Wales) Act 2014, including the Code of Practice, which emphasises prevention, early intervention and partnership working to improve well-being outcomes. The next phase will focus on embedding the Framework into organisational plans, strengthening joint working, and delivering measurable improvements in well-being and reducing inequalities across North Wales.

Capital programme: Increasing Respite Provision

Capital investment continues to strengthen preventative support and community coordination by expanding access to respite provision and enabling families to remain resilient within their communities.

Investment in respite services is improving access to planned breaks and coordinated support for both individuals and unpaid carers.

In Anglesey, a new day respite centre for children with learning disabilities opened in August 2025, supported by £655,000 from the Welsh Government's Housing with Care Fund. The centre provides flexible support for up to twenty children at any one time, including weekends and school holidays. Purpose-designed facilities include a sensory room, activity areas and accessible changing provision, with a two-bedroom residential respite unit also in development on site.

In Wrexham, an extension to an existing children's respite facility has increased capacity and improved accessibility for children with more complex needs. This enables more children to access respite care closer to home, supporting families and reducing reliance on out-of-area placements and providing consistent support for families and carers.

These developments are strengthening preventative support and helping to sustain family and care arrangements within local communities.

Challenges

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

Demand and complexity

Increasing demand and more complex needs.

Workforce and capacity

Recruitment and staffing pressures.

Access and variation

Rural access and inequalities

Opportunities to consistently embed and scale effective practice across the region are still developing

Integration and systems

Coordination and data sharing challenges.

Long-term funding constraints.

Information sharing, communication and coordinated delivery can be strengthened.

Digital and data capability remains an area for development.

Opportunities remain to scale good practice consistently across the region.

Next steps

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

- Further expand community hubs and social prescribing, ensuring wider reach and consistency across North Wales.
- Continue to develop early intervention models, reducing escalation and demand on statutory services.
- Increase focus on recruitment, retention and workforce development, particularly within front-door and community services.
- Explore new delivery models and skill mix approaches to maximise capacity and efficiency.
- Support staff through training and development, including strengthening person-centred and “What Matters” approaches.
- Work towards more consistent service delivery and pathways across all counties.
- Improve data sharing and system interoperability, enabling better information flow across services.
- Strengthen evidence of impact and cost avoidance, supporting future investment decisions.

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

Complex care closer to home is focused on delivering integrated, person-centred health and social care services for people with complex needs. The aim is to support individuals to remain independent, avoid hospital admissions, and receive care at home or close to home through coordinated, multi-agency approaches.

Funding

This model of care received £6 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

31,184 people accessed the service, 2,798 for the first time.

4,534 people who received support were prevented from escalating their level of need.

99% of people were satisfied with the information, advice and assistance they received.

Community resource teams

Over the past year, we have strengthened community resource teams to deliver more coordinated, multidisciplinary care across 16 localities. This has improved collaboration between health, social care and primary care, supporting better communication and more joined-up care.

- Introduced dedicated general practice referral pathways, alongside improved follow-up communication, improving referral quality and continuity of care.
- Held regular multidisciplinary meetings, enabling a more holistic approach to complex cases, shared decision-making and more consistent support.

Complex and intense support services

We have expanded community-based urgent care and specialist services, helping to reduce attendance at emergency departments and avoid hospital admissions.

- Delivered positive behaviour support using practical, in-environment approaches, improving outcomes for people with more complex needs.
- Strengthened multi-agency working and reflective practice, improving staff confidence and the quality of support.
- Supported people through specialist occupational therapy interventions, enabling independence and reducing the need for longer-term care.

Reablement services and falls prevention

Reablement services have supported people to recover, regain independence and remain at home, reducing reliance on ongoing care and support. Over the past year, 235 people were supported through reablement, with only nine per cent going on to require longer-term care.

- Delivered falls prevention interventions and training to support safer living in the community and reduce risk.
- Achieved a 75% non-conveyance rate (the Ambulance Service were able to avoid taking people to hospital), helping to avoid unnecessary hospital admissions.
- Strengthened pathways between ambulance, community and primary care services.
- Improved data systems and intelligence sharing to support more targeted prevention work.

Care sector support

We have supported the care sector to build capacity and strengthen workforce sustainability.

- Delivered training programmes for care staff, including medication, moving and handling and well-being.
- Supported micro-care providers and small enterprises, increasing capacity within the sector and supporting more flexible, community-based care.
- Developed standardised training approaches and digital resources, improving workforce capability and consistency.

Empowering independence

We have supported people to have greater choice and control over their care and support.

- Supported people with learning disabilities to shape their support and activity programmes, improving engagement and well-being.
- Promoted and supported direct payments, enabling more flexible and person-centred care arrangements.

- Supported skills development and independence, helping to reduce longer-term reliance on services.

Below is an example of how projects support community-led initiatives to build confidence, develop skills and improve well-being for individuals.

Podcasting is something that a lot of people have asked to be involved with on Ynys Môn and it is very popular in general. Tape community music and film helped us to get started. We have been able to attend workshops and purchase the equipment. The plan is to publish regular podcasts on a variety of subjects. This project has been started by the individuals and completely driven by them; they have been involved from the start. I organised the equipment, the venues we use, coordinate the interviews and help with planning.

What worked well, what didn't work so well:

The support we have received from Tape has been brilliant and because the project is something that has been requested, the group is very active in making it a success. At the moment everything has been going very well.

What 'good' or 'success' looks like:

The involvement and enjoyment of the group have been brilliant; the whole group has contributed to the project. The outcome will be the finished podcasts which will be published. The group has decided to meet every month to continue the project and as the equipment is portable we can move around Ynys Môn.

What has been learned:

The group and I have learnt how to program a podcast, to use the equipment and record them and to publish them on the correct platform. The most important things for me are that the project is entirely driven by the individuals. Their voice, choice and control.

Outcomes:

"I am learning new skills and it's helping me build my confidence."

"I'm excited to be involved and it's a good opportunity."

"I'm getting experience."

"I'm getting to know new people."

"We are learning from each other and have made friends."

Conclusion:

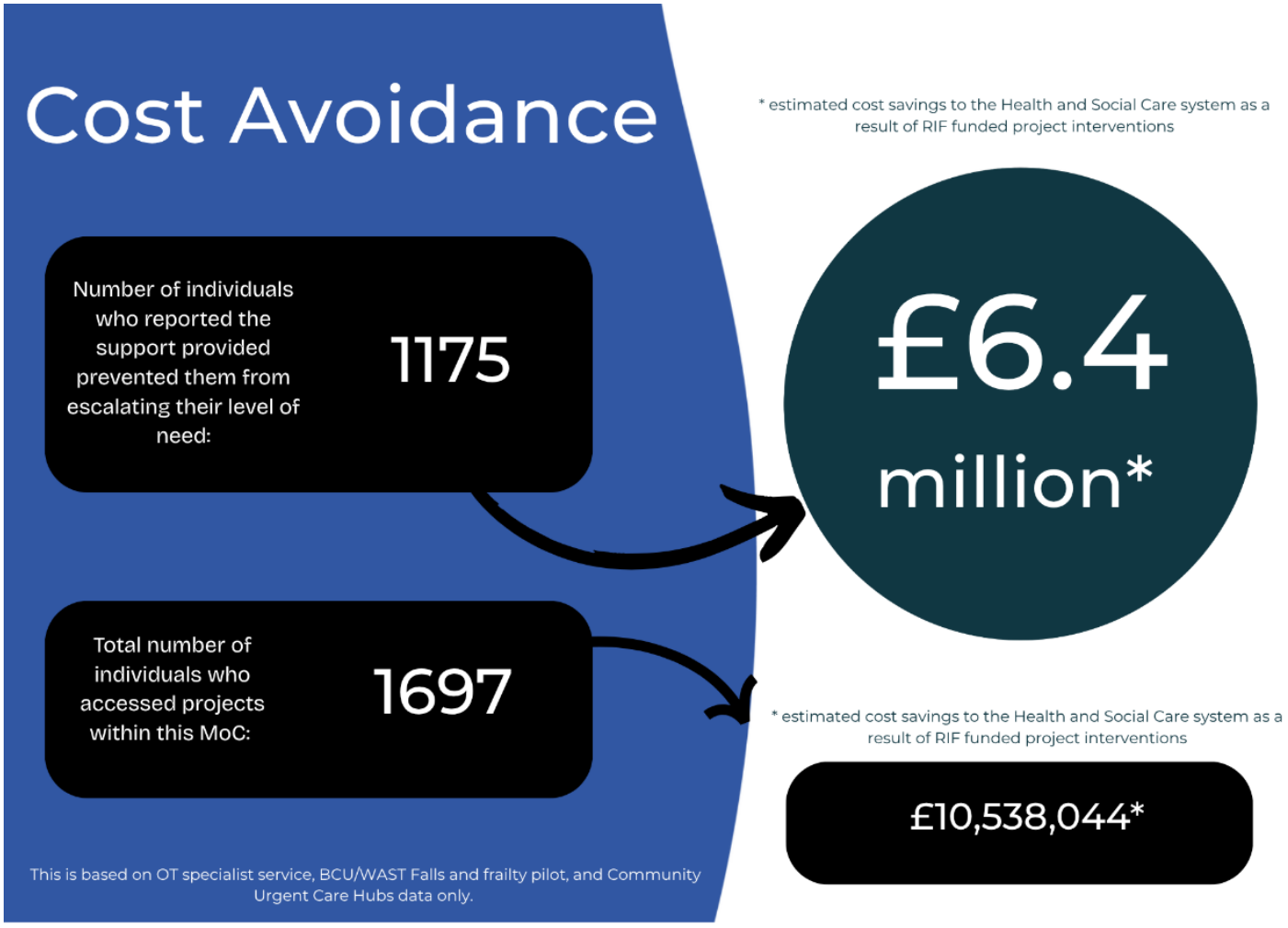
It has been brilliant to see the group grow in confidence; the whole experience has been positive. The group have lots of plans to move the project forward.

Cost avoidance

A cost avoidance exercise has been carried out to estimate the potential savings from RIF funded projects delivered through the model of care.

The calculation estimates how many hospital stays were avoided by identifying people whose needs did not escalate and applying typical assumptions about hospital stay length and daily cost. It then takes into consideration the value of those avoided costs to the cost of running the services to show how much benefit is gained for every pound spent.

An infographic has been produced using available performance data from these projects, submitted throughout the 2025 to 2026 financial year.



Further Faster Programme

Welsh Government funding through the "Further Faster" programme has continued to support the development of community-based care across North Wales, with a focus on enabling people with more complex needs to receive care closer to home. The programme has supported a coordinated approach to strengthening community provision so that hospital care is used only where it is the most appropriate setting.

Across the region, this funding has been used to improve access to community-based services, including reablement, domiciliary care and care home provision. This has helped increase the availability of support within local communities and enabled more people to receive care closer to home, supporting more timely discharges from hospital and reducing reliance on acute services.

There is evidence of this investment being delivered through a range of place-based approaches. In the West, funding has supported community frailty approaches, enabling earlier identification and support for people at risk of deterioration. In Central areas, investment has supported anticipatory care planning and palliative care, alongside step up and step down provision to support care outside of hospital settings. In the East, funding has supported enhanced community care and more coordinated approaches to supporting people with complex needs.

These developments reflect a shift towards more proactive and community-based models of care. They support people to remain independent for longer and receive care in settings that are appropriate to their needs and preferences.

Domiciliary Care Regional Commissioning Agreement

Domiciliary care (care at home) is provided by a range of agencies across North Wales. Local authorities and the health board undertook a procurement process to renew the North Wales Domiciliary Care Agreement, with Denbighshire County Council leading the work. Around 100 care providers submitted bids and 97 have been appointed. The agreement has a potential value of around £171 million and can be used for up to eight years.

This large-scale, collaborative procurement reflects the principles set out in the *National Framework for Commissioning Care and Support: Code of Practice (2024)*, including partnership working, transparency and a consistent regional approach to commissioning.

The agreement sets out the terms and conditions that providers are required to meet. It is flexible, allowing partners to work with care providers to develop and expand the range of home care and support services available across the region. This supports the Code's emphasis on delivering high-quality, outcome-focused services and enabling innovation and continuous improvement within commissioning arrangements.

The scope of the agreement has also been extended. It previously focused on standard

domiciliary care for adults. It now includes support for children and young people, complex domiciliary care, and respite care (short breaks) for children, young people, adults and their families and unpaid carers. This broader scope reflects a more integrated and preventative approach, supporting people to remain independent at home and aligning with the Code's focus on meeting diverse and changing population needs.

The agreement went live on 1 April 2025. Since then, waiting times for care packages across the region have decreased. This is linked to an increase in the number of providers within the agreement. Some providers have also expanded their services into areas that have historically been harder to reach. These outcomes demonstrate how a coordinated, regional commissioning approach can improve access to services and deliver better outcomes for people, consistent with the Code's focus on value, quality and well-being.

This work demonstrates joint commissioning in practice and supports the delivery of the National Framework for Commissioning Care and Support. It represents a continued shift towards a more sustainable, outcomes-based model of care that meets the needs of people receiving care and support across North Wales, while recognising that further work will be needed to fully embed all aspects of the Code in future commissioning arrangements.

Capital programme: Learning disabilities supported living

Capital investment is supporting the development of community-based accommodation and services that enable people with complex needs to live within their own communities, in environments designed to promote independence, recovery and long-term well-being.

Sylva Gardens in Conwy County is a residential development comprising three two-bedroom apartments for young people with learning disabilities who are looked after by the Local Authority. The scheme was part-funded through the Welsh Government's Housing with Care Fund, secured by First Choice Housing Association.

The development is now fully occupied, with the first resident moving in during May 2025. It has enabled young people previously placed out of area to return to their local communities, maintaining connections with family and support networks while receiving care in a more suitable setting.

These developments are reducing reliance on out-of-area placements and supporting people to live more independently within their communities.

Supported Living Commissioning Agreement

The North Wales Supported Living Agreement, which combines independent housing with tailored care and support, is due to be renewed in April 2027. Preparatory work is underway to review and refresh the contract and plan for the re-procurement process.

This work reflects the principles set out in the *National Framework for Commissioning Care and Support: Code of Practice (2024)*, with a focus on delivering high-quality, outcome-based services that promote independence and well-being, and ensure sustainable models of care and support.

Denbighshire County Council will lead the procurement, working with all local authorities and the health board. A dedicated working group is in place to support this work, bringing partners together to take a coordinated, regional approach to commissioning. This collaborative model aligns with the Code's emphasis on partnership working, shared responsibility and the effective use of collective resources to deliver improved outcomes.

Plans are in place to go out to the market later in 2026, with the intention of establishing a new regional contract from April 2027. The re-procurement process provides an opportunity to further embed the principles of the Code, including a focus on quality, social value and sustainability, and to ensure that supported living services continue to meet both current and future needs across North Wales.

Challenges

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

Demand and complexity

Increasing demand and more complex needs.

Workforce and capacity

Staffing shortages and capacity pressures.

Access and variation

Inequalities in access and service engagement.

Opportunities to consistently embed and scale effective practice across the region are still developing

Integration and systems

Coordination, information sharing and data sharing challenges, with opportunities to further align delivery approaches and scale effective practice across North Wales.

Financial pressures and long-term sustainability risks.

Consistent implementation of effective practice across the region.

Improved information sharing and coordination.

Better use of shared data and intelligence.

Next steps

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

- Improve digital integration by standardising IT platforms and developing data infrastructure and sharing.
- Address workforce and capacity challenges through expansion of training and upskilling initiatives, exploring new delivery models and supporting staff retention.
- Deepen integration and whole system working through the development of clear pathways and referral protocols across services and further strengthening MDT working.

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.

The approach aligns with Discharge to Recover and Assess (D2RA) and wider system priorities, helping to improve patient flow through hospitals and ensure access to acute care for those who need it most.

Funding

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

What we achieved

3,491 people accessed the service, 166 for the first time.

2,376 people who received support were prevented from escalating their level of need

100% of people were satisfied with the information, advice and assistance they

Home First and discharge coordination - supporting timely discharge

Over the past year, we have strengthened Home First approaches to support timely discharge and recovery at home. Multidisciplinary working has been embedded within

Home First teams and community resource teams, improving decision-making and coordinated care planning.

- Increased capacity through expanded routes and improved workforce availability, helping to respond more quickly to demand.
- Supported over 1,300 people through Tuag Adref, enabling recovery and reablement at home.

Admission avoidance

We have strengthened front door services to support earlier intervention and avoid unnecessary hospital admissions.

- Enhanced therapy services in emergency and assessment units, supporting timely assessment and intervention.
- Helped reduce length of stay and prevent deconditioning through earlier support.
- Provided equipment and follow-up support, enabling people to remain safely at home.

Step up and step down and intermediate care

We have continued to develop step up and step down and intermediate care to support people to recover outside of hospital settings.

- Delivered step up and step down beds, supporting timely discharge and helping to prevent hospital admissions.
- Enabled multi-agency assessment and care planning through integrated teams.
- Adapted provision to focus on spot-purchase beds, improving value for money and responsiveness.

Discharge from hospital and patient flow

Over the past year, partners across North Wales have continued to work together via oversight and reporting to the RPB, to improve the flow of people out of hospital and support timely transfer to the right place of care.

There is a clear and shared commitment to ensuring that once people are clinically ready to leave hospital, they are supported to return home as soon as possible, in line with a Home First approach.

Significant progress has been made in strengthening collaboration across health, social care and partner organisations. This has included joint work to review current arrangements, respond to national expectations following audit activity, and agree a shared vision for improving hospital discharge. A range of improvement activity has supported this work, including audits, workshops and system-wide engagement to better understand current practice and identify priorities for change.

A key milestone has been the development and agreement of a shared purpose for transfer of care across North Wales.

Shared purpose

The shared purpose has been developed to enable people to live their best lives safely in their communities, they should access health services appropriately only when required and be supported to return home as soon as possible.

Agreed actions

- Transfer to D2RA pathways 1–3 will be actioned within 48 hours of being deemed clinically safe to transfer.

- People who are on a pathway 0 will be transferred from hospital by midday.

- We are committed to supporting people appropriately, in the right place, at the right time to optimise outcomes and experience, to improve their quality of life.

- No decision about long-term care needs will be made in acute setting.

- People will have the opportunity to access a D2RA pathway for up to a maximum of six weeks.

- Provide prompt support to transfer home from hospital.

- Ensure that people have access to the right amount of care, if required.

- A home-first approach will be taken to maintain people's independence where possible.

- To develop the practice of a Trusted Assessors model further.

In agreeing the shared purpose and agreed actions we will collectively make the best use of existing resources and deliver excellent outcomes for people by working in an integrated manner.

This sets out a clear, strengths-based ambition to support people to live their best lives safely in their communities, accessing hospital care only when needed and returning home at the earliest appropriate point. This shared purpose has been developed collaboratively with senior leaders from across organisations and formally agreed as the basis for a more consistent, system-wide approach.

Alongside this, partners have committed to developing a Memorandum of Understanding to support delivery of the Home First approach, including discharge to recover and assess pathways and Trusted Assessor arrangements. This reflects national expectations and provides a clearer framework for how organisations will work together to improve patient flow, reduce delays and ensure more consistent practice across the region.

Investment through national programmes has supported the development of community-based services to enable discharge and reduce reliance on hospital care. This has included strengthening reablement, domiciliary care and wider community support, helping more people to return home safely and receive the right care in the most appropriate setting.

Improving flow out of hospital remains a significant regional priority. Learning from the Winter Sprint approach has demonstrated the value of sustained collaboration, shared situational awareness and more consistent use of data to support decision-making across the system, with data being used to support collective understanding rather than escalation.

During 2025/26 a strengthened use of the Right Patient Right Place dashboard has improved visibility of pathways, reduced duplication and enabled more efficient working, with some teams reporting time savings of up to 2.5 hours per week, allowing greater focus on progressing care and discharge. While increasing demand, the complexity of people's needs and capacity pressures across community and care services continue to influence the timeliness of discharge, these developments reinforce the importance of maintaining coordinated, system-wide approaches to ensure people receive the right care, in the right place, at the right time.

Looking ahead to 2026 and 2027, there is a clear opportunity to build on the progress made to date. A system-wide improvement plan will be developed and delivered in line with the agreed shared purpose, with a continued focus on strengthening coordination, embedding consistent approaches and making best use of community capacity via the establishment of a complex adaptive system.

Delivery will be driven through established regional governance arrangements, with oversight provided by the Leadership Group and regular reporting to the Regional Partnership Board.

Overall, this work provides a strong foundation for delivering sustained improvement in hospital discharge, supporting people to receive care in the right place, at the right time, and improving outcomes and experience across North Wales.

Capital Programme

South Ynys Mon Extra Care development

Anglesey Council has secured funding of £10.1 million from the Integration and Rebalancing Capital Fund, £3 million from the Welsh Government's Housing with Care Fund, £3 million from the Land Development Fund, £5.5 million from the Social Housing Grant and £10.4 million of local authority capital investment to develop a new extra care scheme and associated residential care provision.
The development will include:

- a 45-bed extra care facility
- a 28-bed residential care home providing specialist dementia care
- dedicated space for a community resource team to deliver integrated services locally

The scheme is expected to be completed in 2028 to 2029. This integrated approach will support people to live independently for longer, while ensuring they can access care and support at the right time.

Royal Alexandra Hospital

The business case for the development at Royal Alexandra Hospital, Denbighshire has received Welsh Government approval of £33.6m for Phase 1 of the Royal Alexandra Hospital development.

Betsi Cadwaladr University Health Board has secured £10.4 million from the Integration and Rebalancing Capital Fund and £23.2 million from the National Health Service All Wales Capital Fund to deliver phase 1.

The new facility will include a minor injuries unit treating over 20,000 people a year and a 14-bed reablement unit supporting people to return home, bringing health and social care teams together.

Expanded radiology and new dental facilities will improve access to care, contributing to more effective discharge pathways, shorter hospital stays and better outcomes closer to home.

Challenges

Demand and complexity

System pressure and patient flow delays.

Workforce and capacity

Recruitment difficulties and capacity constraints.

Utilisation

Difficulty in identifying appropriate users for services/evolving demand in complex cases

Measurement and data

Inconsistent reporting and limited impact evidence.

Next steps

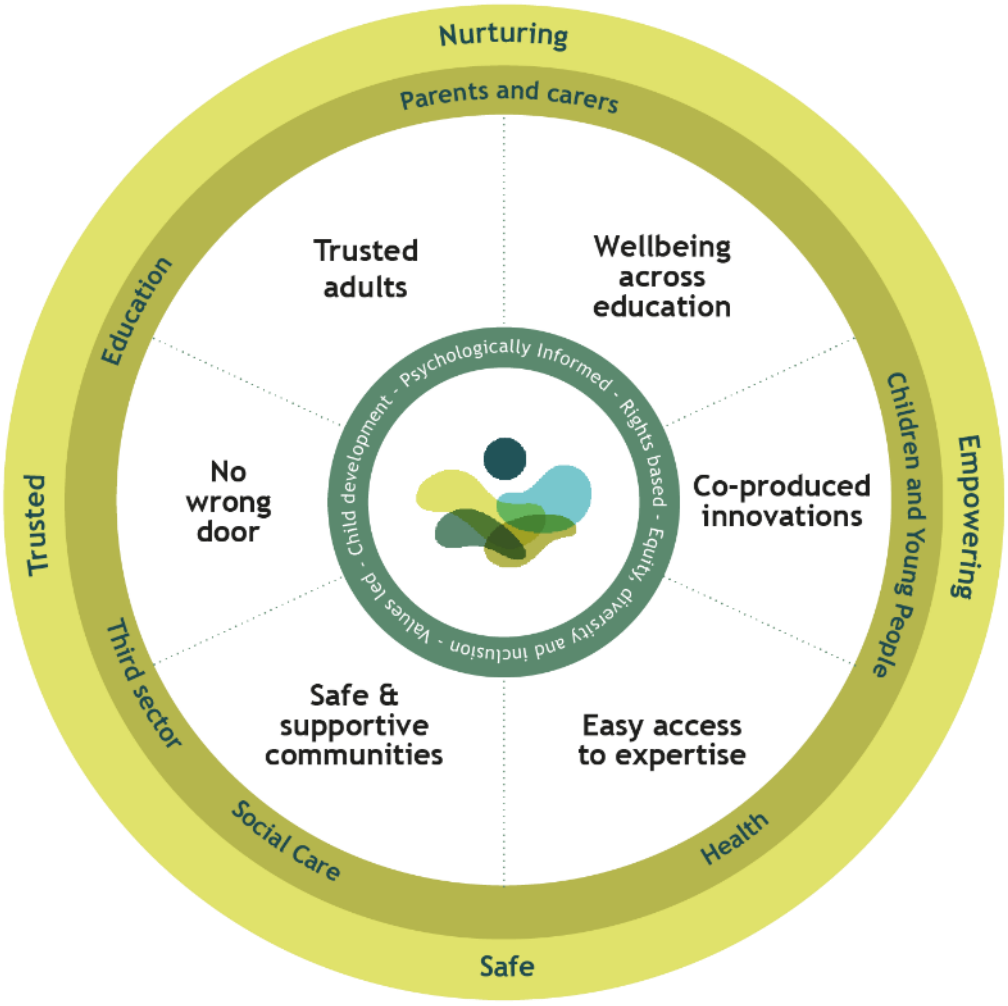
Based on these successes and challenges, next year we will:

- Continue to expand Home First and community-based discharge models.
- Strengthen data quality and reporting, particularly around escalation prevention.
- Develop a regional 12-month improvement plan to support Individuals' Safe and Timely Transfer Home to their Communities from Hospitals Across North Wales.

Section 4: Supporting families and children to stay together safely

Supporting families and children focuses on ensuring children, young people and families across North Wales can access the right support at the right time. The model spans early intervention through to specialist and intensive support, with a strong emphasis on keeping families together, improving well-being, and preventing escalation wherever possible.

This model of care is based around our strategy 'The Right 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 capital grants to support this model of care.

What we achieved

What we achieved

15,802 people accessed the service, 4,140 for the first time.

1,700 people who received support were prevented from escalating their level of need.

100% of people reported they felt their independence had improved or remained the same.

Early intervention and prevention

Strengthening families

We have:

- Introduced tools and approaches to capture children's voices, including digital innovation (e.g. MoMo App).
- Expanded young carers support, including trauma-informed approaches and targeted well-being programmes.
- Provided information, advice and assistance services, including fast-track triage for high-risk cases.
- Expanded Together Achieving Change (TAC) to improve coordinated early help for families.
- Delivered community-based drop-in support in schools and local settings.

Building family resilience

Preventing escalation

We have:

- Supported families through behaviour programmes, trauma-informed practice and neurodiversity profiling.
- Expanded family group conferencing, linking families to early help and strengthening networks.

Intensive and specialist support

Supporting children with complex needs

We have:

- Delivered intensive residential and therapeutic support enabling reunification with families.
- Supported children through specialist multi-disciplinary team residential services.
- Expanded supported lodgings and small group homes, increasing local placement options.
- Improved transition pathways to independence, focusing on emotional readiness and life skills.

"I must express that without the care from all of you and Ty Nyth we would have lost our son for good. He was so adamant to go into care thinking it was the best place to be, and without all your support and the placement in Ty Nyth we would have lost our son forever, who is not only our boy but also a very important member of our family.

All the hard work, referrals, all the work going on around him, and everyone's understanding of his behaviours has been absolutely above and beyond. Without this help we would have lost him forever in a full time residential setting that he would of hated.

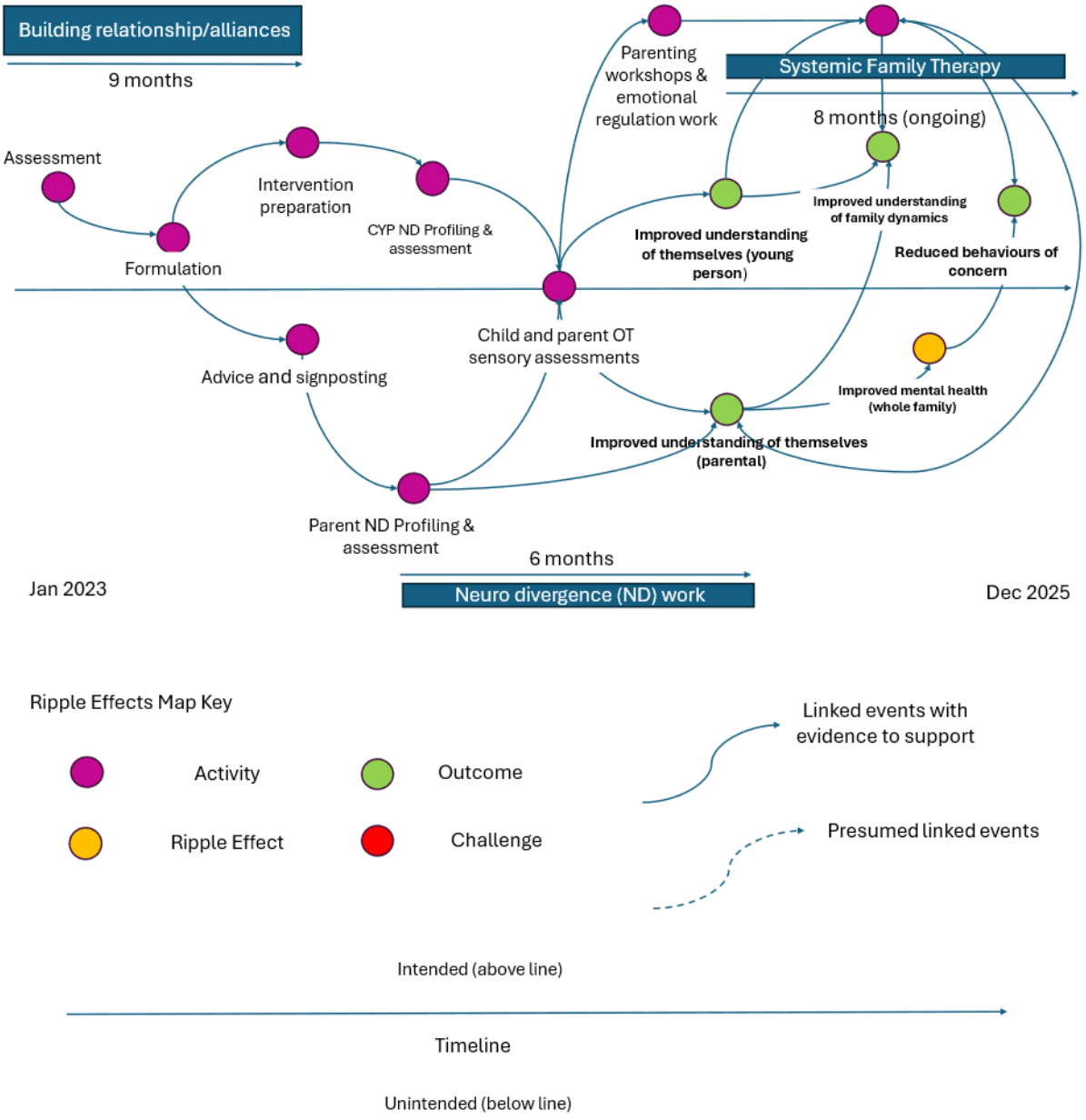
We as a family, are so grateful, and it makes me emotional just thinking how much you have all cared and gone above and beyond to help us.

"Ty Nyth is a more than valuable service that saved our family. You have kept our loving, caring family complete. Thank you."

(Parent).

Ripple effects mapping

Working with families with complex needs



This map shows how an integrated team working with families with complex needs address the needs of the whole family as one system, using a range of interventions over a two-year period.

Above the line we see intended activities and outcomes, below we see the unintended work the team were well placed to support along the way. This has created a shared understanding of the length of time it takes to work with families, what works well in practice and the outcomes and ripple effects on the wider system.

‘I want to be able to say to our funders, this is why our service takes time to deliver outcomes, and we’re constantly curious as to how we may change our ways of working to improve outcomes for children and families’ Team manager.

The team consists of clinical psychologist, systemic family therapist, occupational therapist, specialist family support workers, and wellbeing navigators. Following a mapping workshop, the RIC Hub facilitated a sense making session with the team to reflect on what was learned.

What does the information tell us about why improving outcomes takes time?

- Relationships and alliances take significant time to develop as families have an increased likelihood of trauma, attachment issues and negative experiences with health and social care which has resulted in lack of trust ‘we have to show up and do what we say we will, time after time, to develop trust’- Family Support Worker
- Trust is commonly developed during significant life events such as bereavement or divorce, where the team were able to support families through periods of transition.
- The team work collaboratively with schools, health, social care, third sector and families to address behaviours of concern, they do not refer onto other services, they engage with them and work together.
- Increasing prevalence/awareness of neurodivergence within families has led to close working relationships with health colleagues, who have created a profiling tool, currently scaling up across North Wales.
- The team work with the families once per week compared to intensive systemic complex care models including residential placements and 24/7 community support for family members (MST-FIT)
- Specialist interventions and access to clinical neurodevelopment healthcare consultation have led to an understanding of behaviour which has been the catalyst to change in behaviours of concern and improved family mental health.
- Once parents and children have improved understanding of their own behaviours, systemic family therapy can then support understanding how their behaviour impacts on the family dynamic,

Whole system learning

Behaviour is communication of unmet need.

There is a growing evidence base of behaviour change (leading to improved outcomes and wider system impact) using systemic, person-centred approaches (within RIF this includes Multi Systemic Therapy, Positive Behaviour Support, systemic family approaches). The models use clinical tools and techniques as part of the approach (for example Dialectal Behavioural Therapy, Cognitive Behaviour Therapy). Bringing together these methods and collaborating with all partners in the families eco system (school,

social care, wellbeing supporters, and health) at practitioner level maximises outcomes. Early indications from REM Mapping show systemic approaches create longer lasting outcomes compared with time limited interventions focussing on the individual.

Systemic approaches address drivers of behaviour.

Systemic approaches are leading to reduced behaviours of concern resulting in less residential placements, out of county placements, reunifying children home (MST), supporting families to stay together (LIFT, MST Community). These services not only reduce intensity of support needs in the community, but families are also discharged without the need for social care or health input in the community (MST).

Collaboration is key at practitioner level to address drivers.

RIF funded projects support well-being from across models of care are key enablers in supporting systemic approaches to behaviour and mental health. For example, advice and signposting to support ensure peoples environmental and physiological needs are met, ensuring a stable base before therapeutic intervention can begin.

There is a significant amount of work happening to support individual schools funded by RIF by children and families projects led by local authorities. The neurodevelopment profiling tool has provided an opportunity to work with local authority education partners at a regional level to strengthen relationships and continue to support education services, a key partner in influencing behaviour

Improved children's mental health is reliant whole family mental health and well-being support.

Through a whole family approach, "we are seeing stories transform from problem saturated stories to stories of resilience" – Systemic Family Therapist

Ripple Effects Mapping is influencing changes in thinking from 'proving to improving'.

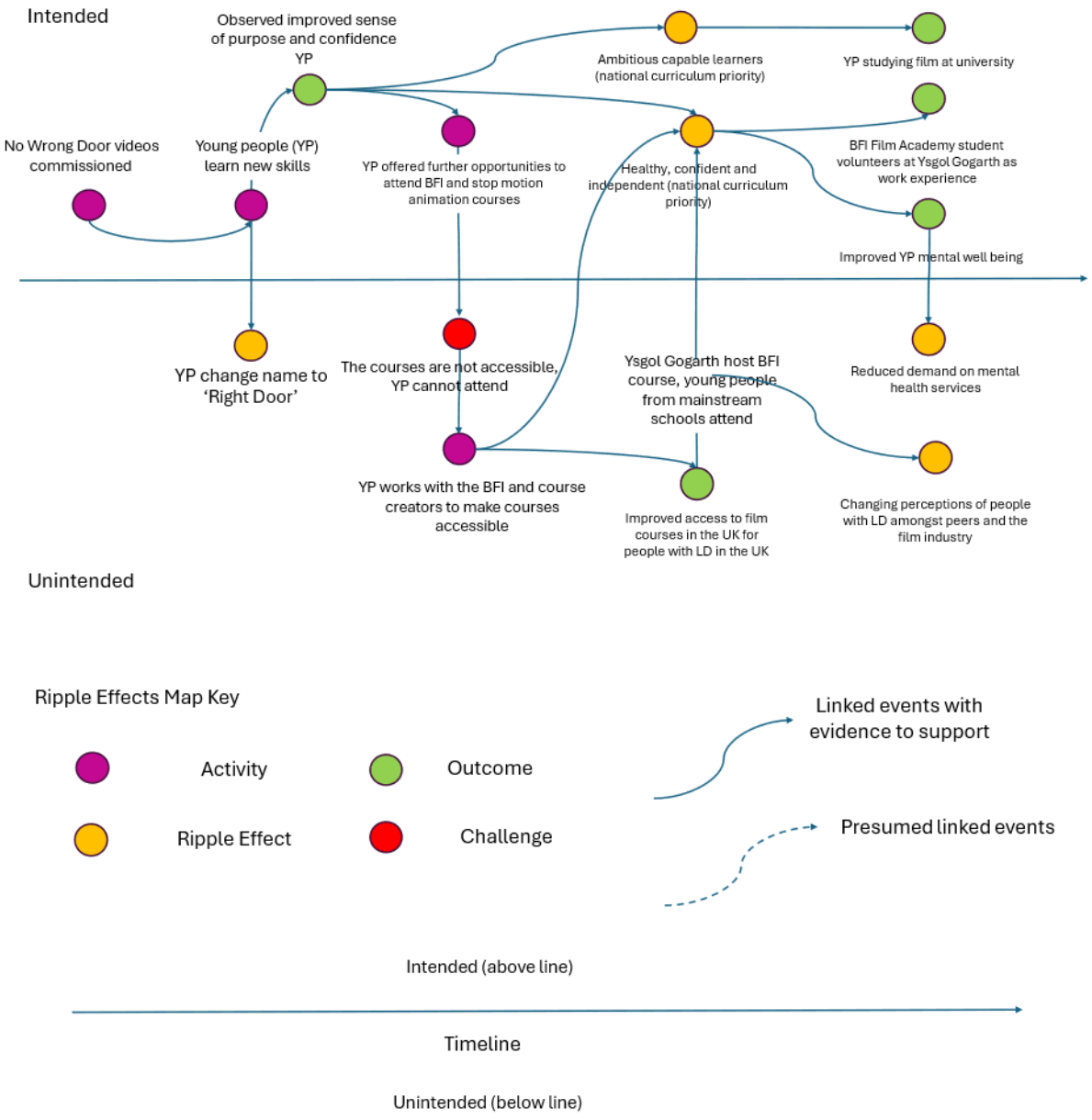
The RIC Hub and RIF team continue to build supportive and trusting relationships with partners to enable positive change and understand what works. The approach maximises use of funding and adds value through offering opportunities for continuous improvement. Ripple Effects Mapping is reaching out into the wider system through service leads which will deepen our understanding of how services impact on each other, understand what works and why and inform funding priorities.

"I want to better advocate for the services I manage; Ripple Effects Mapping will help me to develop an understanding of the key aspects of delivery which lead to improved outcomes" – CAMHS Service Manager, BCUHB

What is missing/would we do differently?

- This holistic intensive model requires long term funding to reflect the length of time the service works with families.
- The team reflected on the high level of activity in the first nine months, advice and signposting is valuable in ensuring families are supported and feel safe to engage, but there have been times when the team has recognised it was too soon for a specific intervention "maybe we need to slow down to move forward, it is tempting to want to jump straight in and 'fix' things" – team manager

No wrong door Ripple Effects Map



The above Ripple Effects map illustrates the improved outcomes for young people who have been part of a group commissioned to create a series of 'No Wrong Door' videos for Welsh Government. It shows the ripple effects over time on wider systems including school, health services the British Film Institute and the film industry.

TAPE, a local production company trained the young people, they describe themselves as creative advocates – Steve from TAPE says, 'that means giving people the opportunity, show them what to do and stand back and assume competence'. Young people from Ysgol Y Gogarth, a school for students with additional learning needs, participated in training in all aspects of managing a filming project, from dealing with clients, holding meetings, drafting emails and film production.

As a result of participating in the project, one young person was offered the opportunity to attend British Film Institute (BFI) Training, but the course was not accessible. As a result, she worked with the BFI to make the training accessible. This led to an inclusive course for all; she repeated the process with another BFI course and another young person with animation course. Every challenge they meet they are creating awareness and learning in the film industry.

Hope Productions continue to create ripple effects on the film and TV industry through work with BFI, BBC and Final Draft and others, challenging perceptions of the capability of people with learning disabilities to make film and TV and making courses and every element of the production process more inclusive and accessible.

The headteacher of the school involved discussed how the project has supported the school to meet the priorities of the curriculum and how that has led to further study at mainstream college and university.

Young people are finding new ways to express themselves, learn new skills, raising aspirations, improving independence and mental well-being.

Capital programme: Small group homes for children

Capital investment across Conwy, Ynys Mon, Gwynedd, Flintshire and Wrexham has enabled the development of small, community-based homes for children, providing high-quality and supportive environments for those unable to remain with their families.

These homes are designed for small groups, creating stable and homely environments supported by consistent staffing. Developments include both new-build and refurbished properties across urban and rural areas.

This model enables children to remain closer to their communities, maintain important relationships, and experience greater stability in their care arrangements.

These developments are supporting improved outcomes for children by providing care

closer to home, while contributing to the transition towards not-for-profit provision across the region.

Challenges

The challenges continue to be around:

Demand and complexity

Higher referral rates across services and growing complexity of cases including neurodiversity, mental health and trauma.

Workforce and capacity

Challenges in recruiting to specialist/therapeutic roles and services operating at capacity, leading to waiting lists and prioritisation of highest-risk cases.

Access and engagement

Long waiting times for diagnosis/specialist services (e.g. CAMHS) and increased time needed per case to build relationships which is affected by capacity issues.

Placement sufficiency and flow

Insufficient availability of foster carers/supported lodgings and local placements for complex needs. Reduced system flow leading to blocked pathways, increased costs and pressure on residential and specialist services.

Changes to legislation which have come into force reducing use of for profit placements, compounding insufficient availability of placements.

Next steps

Based on these successes and challenges, next year the Children's Regional Partnership Board will continue to deliver on the strategic vision for each of their three priorities:

Neuro Diversity: Supporting children and young people to have equal life opportunities

Strategic focus:

- Organisations working effectively together to deliver the right door approach - right help, right time, right way
- Improvements in early years and school neuro-affirmative environments and transitions
- Expansion of knowledge across the whole workforce about neurodiversity and well-being
- Shift from medical model of diagnosis/ treatment to needs led social model where society is more inclusive and accessible
- Early intervention and support for people on waiting lists
- Transition from children and young people to adult services
- Compliance with Autism code of practice by all organisations and respond to transition to the Neurodivergence Code of Practice

Supporting Mental Well-being: Together we commit to building a joined up system across North Wales, that prioritises equitable support for mental well-being for babies, children, young people and families who don't meet the criteria for mental health support.

"right help, right time, right way" (0 – 25 years)

Strategic focus:

- Embed a needs led, whole system approach across health, education, social care and community services, delivered by organisations working effectively together in a coordinated, proactive, equitable, and sustainable way.
- Provide a needs led early intervention offer at the point of access, through co-located services (virtual or in person), enabling streamlined access to support.
- Empower staff at all levels to achieve change, through a shared understanding of what we are trying to achieve and use of a common shared language.
- Enable smooth transitions, when needed for babies, children and young people.
- Link with Neurodiversity priority activities

Not For Profit: Commitment to remove private profit from the care of children looked after

Strategic focus:

- Developing a regional placement strategy with shared goals and regional provision
- Engage children, young people and adults with looked after lived experience in a timely and appropriate way
- Organisations working together regionally to sustain our workforce with a joint workforce strategy
- Ensure care for looked after babies, children and young people becomes everybody's business, with a community driven approach

Section 5: Promoting good emotional health and well-being

Emotional health and well-being focuses on providing holistic, person-centred support to improve mental health outcomes for individuals, families and communities. The model promotes early intervention, prevention, community connection and independence, helping people manage their well-being and reducing escalation into statutory services.

Funding

This model of care receives £1.3 million from the Regional Integration Fund.

What we achieved

18,747 people accessed the service, 4,849 for the first time.

90% maintained or improved their emotional health and well-being.

100% of people who received support were prevented from escalating their level of need.

Community well-being and early intervention

Over the past year, we have strengthened community-based support to promote emotional well-being and early intervention. A wide range of activities has been delivered to support independence, confidence and social inclusion.

- Enabled people to take part in meaningful activities such as arts, sports, gardening and community events.
- Supported people to shape services through co-production and person-centred planning.
- Increased opportunities for social connection and participation within local communities.

iCAN Hubs – Open Access Mental Health Support

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.

This year, we have delivered a regional network of open-access mental health hubs, providing early help without the need for referral, diagnosis or thresholds.

- Enabled people to access support through one-to-one sessions, group activities and well-being planning.
- Reduced isolation and improved well-being for people accessing support.
- Increased confidence and self-management.
- Helped prevent crisis and reduce reliance on statutory services.

Training, skills and awareness

We have strengthened awareness and understanding of emotional well-being and neurodiversity across services.

- Delivered autism awareness training across social care, schools and early years settings.
- Promoted neuro-inclusive approaches across services.
- Improved workforce understanding of emotional well-being and how to support people more effectively.

Community well-being officers and targeted support

We have provided more targeted and tailored support for people with more complex needs, helping them to maintain independence and well-being.

- Delivered bespoke, person-centred support for people with complex needs.
- Provided respite support to 98 people, helping to sustain families and unpaid carers.
- Embedded positive behaviour support approaches to improve outcomes and reduce distress.
- Increased workforce capacity and strengthened skills through specialist training.

Supporting independence and community participation

This case study below highlights how project help individuals to build independence, confidence and meaningful participation in their communities.

Case study

SH lives with their parent and is a very sociable person. They have a lot of friends that join our groups. SH is a happy and outgoing person and likes to be in the company of their friends.

SH comes to our social evenings and knows that we offer bus training. SH wanted to complete the bus training because it would be beneficial for future volunteering roles, and so that SH would be able to come to groups independently. SH was referred by their social worker so they can live a more independent life and help with possible volunteering in the future.

What 'good' or 'success' looks like:

I provided ongoing travel support to SH by accompanying them on the bus from their home to the nearest big town. This support continued for several weeks, during which time SH gradually developed the confidence and skills needed to undertake the journey independently. Once SH felt ready, they began travelling on their own to meet me, and they also returned home independently using the bus. This progression demonstrated a significant increase in SH's confidence, independence, and ability to use public transport safely.

Outcomes:

As a result of the travel training and ongoing support, SH has significantly increased confidence and independence in using public transport. They are now able to travel independently from their home to the nearest big town and back, demonstrating improved problem-solving skills, and awareness of public transport routines. SH's ability to meet at an arranged location and return home without support reflects their enhanced self-reliance and reduced need for staff intervention. This outcome contributes positively to SH's overall well-being, independence, and participation in their community. After the bus training SH has started attending weekly dance groups which she travels independently to.

Conclusion:

"Bus training was good, I'm able to see friends often. I'm happy to go on the bus independently."

Capital programme: Community health and well-being hubs

Developments such as the Dolgellau Learning Disability and Community Hub in Gwynedd show how capital investment can bring services together in one place, improving access, reducing stigma and supporting earlier intervention.

The Dolfeurig Hub creates new opportunities for individuals, including training and employment initiatives for people with learning disabilities, while strengthening connections with the local community.

These hubs support a more joined-up approach to care, helping people access the right support at the right time within their communities.

The £3.6 million scheme includes £1.8 million of Welsh Government investment through the Integration and Rebalancing Capital Fund, matched by £1.8 million from Cyngor Gwynedd, and is expected to be completed in summer 2026.

Challenges

Demand and complexity

Particularly within early intervention services.

Workforce and Capacity

Recruitment and retention challenges impacting service sustainability.

Access barriers

Especially in rural areas (transport and digital inclusion).

Long-term funding uncertainty

Potential impact on the long-term sustainability of services and the ability to plan and deliver longer-term system-wide improvements.

Across emotional health and well-being services, a number of challenges remain. Increasing demand and growing complexity, particularly within early intervention services, continue to place pressure on available provision. Workforce sustainability is also affected by ongoing recruitment and retention challenges, which can impact service capacity and continuity. Access to support can be more difficult in some areas, particularly in rural communities where transport and digital inclusion remain barriers. In addition, uncertainty around long-term funding may affect the ongoing sustainability of services and limit the ability to plan and invest for the future.

Next steps

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

- Expand community-based early intervention and prevention services.
- Strengthen workforce capacity, well-being and skills development.
- Enhance accessibility, particularly for rural and digitally excluded populations.
- Develop long-term sustainable models, including the iCAN programme.

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 £11.5 million from capital funds and £763,349 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.

Over the past year the capital programme has seen the completion of a number of capital projects:-

Ty Croes Atti - A 56 bed provision in Flint (Flintshire) which combines longer-term residential care with intermediate reablement services, supporting safe hospital discharge and person-centred recovery in a community setting.

Coed y Ddraig – provides a purpose-built community and well-being hub in Mold (Flintshire). The provision provides day and work opportunities service for individuals with learning disabilities, autism, and mental health support needs. The hub has with integrated service provision from social services and health board teams.

Canolfan Glanhwfa – An Integrated Community Hub in Llangefni, established to provide support for older people, people living with dementia, unpaid carers, and the wider community. The project developed renovations, lift installation, and restoration works to extend the usable area and create a new accessible hub, which now permanently hosts the Anglesey Dementia Centre and North Wales Memory Assessment Service.

Llanrwst Family Centre - Conwy County Borough Council acquired and refurbished Llanrwst Family Centre to extend the services offered to families and increase opportunities for partnership working. As a result of the investment, more services can be delivered at the same time in the upgraded space, saving rural families repeated long journeys to the centre. The centre offers a range of support, including weekly baby clubs co-delivered with health visitors, young carers groups, and domestic abuse support for people of all ages.

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.

1246 people accessed the service, 49 for the first time.

95% of people satisfied with the information, advice and assistance provided.

100% of individuals reporting they feel their independence has improved or remained the same with the support of the project.

Digital, Data and Technology Partnership Board

This year, the digital, data and technology partnership board agreed to adopt the Welsh Local Government Association's Digital in Social Care framework. This aligned well with our priorities and gave us a shared structure for our work.

Big change

The national Connecting Care Programme includes procuring and implementing new case management systems for social care, mental health and community health and developing shared care records for health and social care. Progress is now underway in implementing the new social care case management system across North Wales.

Bright ideas

Last year's digital showcase event continued to support innovative practice long after the event itself. It led to applications to the Iechyd a Mwy innovation support panel and to Contracts for Innovation funding and encouraged technology companies to become involved in the Digital in Social Care framework. We have written up what we learned and shared this on our website to support others planning similar events: Digital showcase – what we learned.

We also continued to update our list of innovative projects, which we shared with the Welsh Local Government Association to support the national 'bright ideas' work programme.

Brilliant basics

As a regional team, we work closely with colleagues from the six local councils in North Wales, the health board and other partners. A common request was for a simple way to share documents and collaborate on regional projects - we now have three pilot regional SharePoint sites in place.

Building knowledge

This part of the Digital in Social Care framework focuses on identifying, evaluating and sharing existing practice, pilots and projects. This is an area we want to strengthen, starting with the development of a strategy for technology-enabled care in North Wales.

During the year, we also worked with Social Care Wales, Welsh Government and the Office for National Statistics to provide feedback aimed at improving data sharing platforms.

Cross-cutting themes

Our work also considers cross-cutting themes such as cyber security, infrastructure, inclusion, procurement and leadership. Digital inclusion remains a key priority in North Wales, and we continue to work closely with Digital Inclusion Wales. We are also working with Ambition North Wales to improve digital infrastructure, including WiFi and 4G coverage across the region.

Regional Innovation Coordination (RIC) Hub

The North Wales Regional Innovation Coordination Hub supports health and social care partners to test ideas, learn from practice and improve services across the region. The impact of the team can be seen throughout this report in evaluation of the Regional Integration Fund projects, the digital, data and technology workstream, communications and website development.

Care and support – what matters to you

The RIC Hub team produces the Population Needs Assessment, which underpins the work of the Regional Partnership Board. The next assessment is due to be published in April 2027, so our focus this year has been on the following activities.

- We produced research bulletins that show how many people need different kinds of care and support. This included a population profile for North Wales and a bulletin focused on unpaid carers.
- We summarised research evidence about different care and support needs, including evidence relating to domiciliary care and neurodivergence.
- We collated people's stories from engagement activities across North Wales.
- We shared a survey to understand what matters to people who need care and support.

Warmer homes, easier breathing: support that finds the people who need it

Staying warm in winter can help us stay healthy, especially for people living with conditions like asthma and arthritis.

Two Regional Innovation Coordination (RIC) Hubs have been exploring how health data can help identify people who would benefit most from extra support. In Cwm Taf Morgannwg, the team helped residents apply for Pension Credit, giving them more money for essentials like heating. In Gwent, the focus was on improving home insulation. Both approaches led to fewer people needing hospital care for breathing difficulties over the winter.

Welsh Government now want to see similar approaches adopted across Wales through their new Innovations Working at Scale Programme. In North Wales, the RIC Hub has been meeting with people across health, housing and benefits teams to understand what's already working in the region. And to explore how this kind of targeted support could make a difference for local residents.

The team are looking at linking data to see where targeted help would make the most difference for people.

If you'd like more information or to be involved in this project, please contact us at nwrich@denbighshire.gov.uk.

Please follow us on Bluesky @nwrich.bsky.social, Twitter/X @_NW_RICH, sign up to our newsletter and visit the RIC hub webpages for more information.

Workforce developments

The North Wales Workforce Board works to deliver the overarching priorities set out in the Workforce Strategy 2024 to 2026. These priorities are:

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

The board has continued to focus on the overall strategy, with each meeting centred on a different priority theme to support progress across all areas.

There has been continued development in the successful collaboration with Health Education and Improvement Wales across the region. This partnership brings together local authorities and the health board to support the commissioning of occupational therapy training places. Work is now progressing to develop a regional approach to student placements and postgraduate opportunities. This demonstrates how working together as one region can strengthen collaboration and lead to positive outcomes.

The social work workforce pipeline in North Wales is under increasing financial and capacity pressure. While Grow Your Own routes continue to show strong retention and value, there are ongoing challenges. These include limits on student finance, rising training costs and continued reliance on agency staff.

The Workforce Board has engaged with Social Care Wales to highlight these risks. Work has now begun on:

- influencing the bursary review, with a focus on increasing funding for social work training.

- developing a consistent, region-wide costing model for Grow Your Own social work training.
- developing a regional model for workforce projections to support medium- and long-term planning.
- incorporating Welsh language requirements into workforce forecasting to support bilingual training pathways.

The Social Care Wales Workforce Development Grant continues to make an important contribution to workforce development across Wales. It supports equal access for all social care providers and reflects the profile of the sector across each region. The grant supports the five 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

This aligns with the National Framework for Commissioning Care and Support: Code of Practice (2024) expectation that commissioning should support learning, innovation and continuous improvement across the system.

However, the grant has not increased over the last three years, while demand for training across partner organisations has grown significantly. This means local authorities are required to do more with the same level of funding.

The We Care North Wales campaign continues to promote opportunities across the sector and has attended a range of events throughout the year. The National Eisteddfod in Wrexham was a key success, with a dedicated We Care day that included the launch of the Children's Residential Booklet. This booklet is a regional recruitment resource developed by partners to provide information about working in children's residential care.

The GradCon event was held in North Wales for the first time, with a dedicated We Care presence at Tŷ Pawb in Wrexham. The event attracted over 130 graduates and provided an opportunity to promote careers across the sector, with a handful of graduates signing up to complete the Introduction to Childcare course.

In January 2026, a Regional Partnership Board meeting focused on the Anti-Racist Wales Action Plan, which is one of the board's priorities. The session included guest speakers from Welsh Government, Social Care Wales and Betsi Cadwaladr University Health Board. Feedback was positive, and the session increased awareness of the subject and encouraged meaningful discussion. A follow-up workshop is planned for later in 2026. This reflects the National Framework for Commissioning Care and Support: Code of Practice (2024) and the emphasis on equality, fair work and inclusive practice across commissioning activity.

There continue to be ongoing workforce challenges across the sector. The North Wales Workforce Board will continue to work with partners and stakeholders to support the workforce and respond to these challenges.

Mwy na geiriau

The regional Mwy na geiriau group aim to strengthen the use of the Welsh language within health and social care sectors. They have been revising their terms of reference and extending membership to more non-Welsh speakers to help expand awareness of the Welsh language. This is to help make sure all health and social care staff understand the positive difference that learning and using Welsh can make to the care experience.

North Wales Social Value Steering Group

The North Wales Social Value Forum Steering Group continues to bring together partners from Betsi Cadwaladr University Health Board, local authorities, housing associations, and the third/voluntary sector to support delivery of Section 16 duties under the Social Services and Well-being (Wales) Act 2014. In line with the Code of Practice, the group provides a regional platform for commissioners, providers and partners to develop a shared understanding of social value, promote co-production, and support the development of social enterprises, co-operatives and third sector provision.

During 2025–26, the focus has been on strengthening the foundations of the forum to ensure alignment with statutory expectations and regional priorities. This has included reviewing membership, clarifying the purpose and role of the forum within the wider Regional Partnership Board landscape, and working collaboratively to refresh and agree a shared regional definition of social value. This work reflects the requirements set out in the Part 2 Code of Practice to support collaboration, shared learning and the development of a consistent approach to delivering social value, particularly in relation to prevention, early intervention and 'what matters' outcomes for individuals and communities.

Looking ahead, the Steering Group will prioritise the delivery of a structured programme of activity aligned to the refreshed workplan. This will include strengthening

engagement with providers and commissioners, supporting capacity building across the sector, and improving approaches to evidencing impact. This next phase will support the forum in moving from development to delivery, ensuring it plays a more active role in shaping commissioning, promoting good practice and supporting sustainable, community-based models of care and support across North Wales.

Communication and engagement

Our 'good news' stories group brings together communications teams from across the six local councils and the health board. The group meets regularly to identify stories that show the impact of the Regional Partnership Board's work and to share them widely through press releases and other channels.

This year we shared the following press releases across North Wales:

- **June and July 2025** North Wales Together: Learning Disability Week Hiking and Biking Challenge
- **November 2025** North Wales Together: Regional Supported Employment Service
- **January 2026** Care and support in North Wales – tell us what matters

These sit alongside the regular blog posts we share about work happening across the region. Our most popular posts during the year included the Eisteddfod launch of new resources to support children and families, a blog about age and dementia friendly Holywell and an update about the Digital Social Care Showcase 2025.

The top five most visited pages on the Regional Partnership Board website were:

- North Wales Regional Partnership Board (2,900 views)
- North Wales Memory Support Pathway (2,500 views)
- North Wales Population Needs Assessment (1,400 views)
- North Wales Dementia Centres (1,300 views)
- Emotional Health, Well-being and Resilience Framework (730 views)

Annual delivery plan 2026/27

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.

In supporting **children and young people** we will work on the following priorities:

- Priority 1: Neurodiversity: Supporting children and young people to have equal life opportunities
- Priority 2: Supporting Mental Wellbeing: Together we commit to building a joined-up system across North Wales, that prioritises equitable support for mental wellbeing for babies, children, young people and families who don't meet the criteria for mental health support.
- Priority 3: Not for profit in care: Commitment to remove private profit from the care of children looked after

In supporting the delivery of the **complex care closer to home** and **home from hospital** models of care we will work on the following priorities:

- Priority 1: Enabling a safe and timely transfer home by reducing avoidable system delays
- Priority 2: Developing and implementing a Regional Falls Prevention & Response Service
- Priority 3: Increase Anticipatory Care Planning
- Priority 4: Using health and care data to target warm homes support via the Innovations Working at Scale Programme.

In supporting the delivery of the **community based care prevention and coordination** and **emotional health and well-being** models of care, we will work on the following priorities:

- Priority 1: Work to increase reablement and domiciliary care capacity – considering alternative delivery models
- Priority 2: Increase community care capacity
- Priority 3: Further develop early intervention and preventative community hubs
- Priority 4: Work with partners to continue to identify, value and support unpaid carers and ensure their voices are heard.

In supporting **Accommodation Based Solutions**, we will take a strategic, population-needs led approach to developing accommodation options that support care closer to home and align with the emerging regional mental health strategy:

- Priority 1: Deliver the 12-month expectations related to the 10-year Capital Programme (HCF, IRCF capital streams)
- Priority 2: Ensure we demonstrate the benefits realised from the delivery of completed capital schemes
- Priority 3: Develop a regional accommodation and supported living approach for adults with learning disabilities, including those with complex and co-occurring mental health needs, informed by shared data and demand analysis to increase timely, person-centred local provision and reduce reliance on out-of-county and high-cost placements.

In supporting the **future planning of RPB initiatives** and sharing its positive collaborative initiatives we will work on the following priorities:

- Priority 1: Undertake a review of the current RIF programme, to ascertain system pressures, strategic risks and financial implications.
- Priority 2: Further evaluate Regional Integration Fund (RIF) and Capital projects, to support planning for the end of RIF funding and to prepare for different future funding scenarios
- Priority 3: Develop scenario planning for potential funding exit, transition or implementation of new funding programme.
- Priority 4: Further progressing the Good News Stories group, thereby sharing RPB press releases regularly with communications teams from across the six local councils and health board. Promoting and updating the Regional Partnership Board website and social media presence.
- Priority 5: Promote the use of the Welsh language across the system by further progressing the Mwy na Geiriau North Wales Forum.

We will use **digital, data and technology** well to create integrated, seamless, sustainable services and improve health and well-being by adopting and applying the Digital in Social Care (DiSC) framework and implementing the following priorities:

- Priority 1: Rolling-out the Connecting Care Programme, completing the procurement of the new mental health system and starting to work towards a shared care record for health and social care.
- Priority 2: Working with heads of adult and children's services to explore approaches to managing digital sales pitches, keep digital innovation mapping up to date, and facilitate the North Wales Innovation Network.
- Priority 3: Deliver against our brilliant basics initiative by establishing a regional SharePoint to enable document and calendar sharing.
- Priority 4: Work with the DiSC framework to explore ways to identify, evaluate and share existing practices, pilots and projects, and develop a digital strategy for adult social care.

In addressing the development of our **workforce** and **future needs** that'll be placed on the sector, we will focus on the following priorities:

- Priority 1: We will stabilise the existing workforce to remain within the health and social care sector and support and drive a continual attraction and recruitment activity.
- Priority 2: We will create a workforce which is competent, capable and confident to perform their role, which includes ensuring that the workforce is digitally ready to support new digital initiatives.
- Priority 3: We will work with partners to capture relevant workforce data to inform and improve future workforce requirements and planning.
- Priority 4: We will complete the research and engagement required for the revised Population Needs Assessment (PNA) to be published in April 2027, working closely with Public Services Boards to make links with the Well-Being Assessments.
- Priority 5: We will work on the Market Stability Report to be published in 2027, working closely with all partners, ensuring we link into all regional relevant projects and data including the Population Needs Assessment.
- Priority 6: We will embed the Anti Racist Wales Action Plan in partnership with other partner organisations.

Our **commissioning** priorities where we will deliver under the guidance and lead of our partnership Commissioning Board are as follows:

- Priority 1: We will issue and implement the North Wales Pre-Placement Agreement for Care Homes including a accompanying Care Home Specification.
- Priority 2: We will renew and refresh the North Wales Supported Living Agreement for implementation by 1 April 2027
- Priority 3: We will produce develop a Regional Commissioning Strategy for residential homes and nursing homes based on the findings from the Market Stability Report and Population Needs Assessment.
- Priority 4: We will work with the Children's Regional Partnership Board to develop a Regional Commissioning Placement Strategy for Children's services.

Appendix 1

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

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

Dementia specific measures North Wales only	Definition
DEM1. Number of carers supported by the service (total per Qt)	The total number of carers who access the service during a quarter
DEM2. Number of people living with dementia receiving what matters discussions	The number of individuals who received what matters discussions
DEM3. Number of people living with dementia attending activities /groups / dementia centres	The number of individuals who attend activities /groups / dementia centres
DEM4a. Number of people living with dementia who achieved what matters to them	The number of individuals who report they achieved what matters to them.
DEM4b. Number of people living with dementia were asked the question and gave an answer as to if they achieved what matters to them	The number of individuals who were asked and responded that they achieved what matters to them.
DEM5a. Number of carers who feel supported to continue in their caring role	The number of carers who report they feel supported to continue in their caring role
DEM5b. Number of carers who were asked the question and gave an answer as to if they feel supported to continue in their caring role	The number of carers who were asked and responded that they feel supported to continue in their caring role

Difference Made Measures	Definitions
DM1. Number of individuals feeling less isolated as a result of project support 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.	The number of individuals who report feeling less isolated after receiving support from the project.
DM2. Number of people reporting that they	The number of individuals who report

Difference Made Measures	Definitions
are maintaining or improving their emotional health and well-being. 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.	maintaining or improving their emotional health and well-being after receiving support from the project.
DM3. Number of people reporting they feel they have influenced the decisions that affect them. DM3a. The number of individuals who were asked and gave an answer as to having influenced the decisions that affect them.	The number of individuals who report feeling that they have influenced the decisions that affect them.
DM4. Number of individuals reporting they feel their independence has improved or remained the same with the support of the project. 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.	The number of individuals who report feeling that their independence has improved or remained the same with the support of the project.
DM5. Number of individuals who feel more confident accessing services following project support. DM5a. The number of individuals who were asked and gave an answer as to whether they feel more confident accessing services following project support.	The number of individuals who report feeling more confident accessing services following the support of the project
DM6. Number of individuals who received support that has prevented them from escalating their level of need. 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	The number of individuals who report they received support that has prevented them from escalating their level of need

Local measures (North Wales only)	Definition
NWM 1a. Number of staff accessing training	The number of individuals accessing training sessions offered by the project.
NWM 1b. Number of citizens accessing training	The number of individuals accessing training sessions offered by the project.
NWM 2a. Number of training sessions delivered for staff	The number of staff training sessions delivered by the project.
NWM 2b. Number of training sessions delivered for citizens	The number of citizens training sessions delivered by the project.
NWM 5. Number of people receiving aids and adaptions	The number of individuals who receive aids and adaptations that help them.
NWM 6. Number of people starting an Assistive Technology Package	The number of individuals who start an assistive technology package provided by the project.
NWM 7. Number of people with increased knowledge of services/support available to them.	The number of individuals who report having increased knowledge of the services and support available to them.