



Health & Social Care Regional Integration Fund (RIF)

Case Studies

2022 – 2023 Q3 & Q4

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Community Based Care: Prevention and Community Co-ordination Model of Care

RIF Project Level Case Study

Project Reference Number: CBC PC 01
Project Name: Community Hubs - Navigators, Agents & Connectors, Local Asset Co-ordinators (Gwynedd Community Resilience)
Project (activity): Establishment of the Community Resilience Framework

Background summary - provide the context:

Gwynedd Council is committed to working with local communities and across partner agencies to ensure that people in Gwynedd, no matter where they live, get the right help, at the right time, in a way that builds on their strengths and the strengths of their community.

Together we have agreed that we need to do the following to help this happen:

- Work together to make the best use of resources
- Have shared values
- Ensure people have easy access to information and support when needed, to avoid crises
- Provide support that is based on strengths, and on building independence, control, and relationships in a community
- Invest in individuals and communities
- Do things together so that everyone starts from the same place.

These principles have been used to establish the Community Resilience Framework in Gwynedd. It is made up of three connected elements. How these are being developed and what they will do is outlined below. The Local Network and Hub and the People's Wellbeing Support are funded via the Regional Integration Fund.



Local Network and Hub

Creating a local network of organisations that work together to help people locally. The network will be supported with a physical hub or place in the community. This will bring services, activities, local groups, and agencies together to shape their local response to the area's needs.

Supporting Communities

Supporting Communities Officers will help communities establish their Area Plans as part of the Regeneration Framework. They will bring community groups together and support them shape local solutions/projects to address the area's opportunities and challenges.

People's Wellbeing Support

The service will listen to people and will use good conversations to understand what really matters to them. Time will be taken to get to know people, seeing people as experts in their own life and supporting people through community connections and local networks. (* This service will be commissioned in 23/24 with an anticipated start date of 1/7/23 –person stories, will be the foundation of the monitoring and development of this service).

The Local Network and Hubs are currently operational across 10 of the Regeneration areas in Gwynedd. The evaluation conducted in 2022 noted that:

Many of the hubs have successfully increased collaboration and communication between health and wellbeing services across sectors and have made a range of support services easier to access for their communities.

Lead organisations for the Hubs include small (legally constituted) community groups, local charities, community benefit societies and social enterprises to larger housing associations. Hubs differ considerably in size, structure, location and the communities they serve (some serving small rural villages, others serving more densely populated towns).

Each of the hubs has an established framework of partners who are a mix of agencies and services. These partnerships range from well-established wide coverage across a range of issues to embryonic relationships with limited-service coverage.

redacted s40(2)

The primary function of the Hubs is to provide a local co-ordination role, pulling in partners to bring provision into a place-based setting so that people living in communities have improved access to a range of services, interventions and opportunities to help them to live a good life. Whilst this particular element of the framework has a focus on how people can link into what communities are doing, how services can link into what communities are doing and how services can link into where people are going, we do recognise that data to show the reach of the hubs is important as it gives an indication of footfall in the hubs that could provide some evidence of the volume of demand that is being responded to within a community setting. We have some simple data collected by some hubs that helps to illustrate this:

redacted s40(2)

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

Gwynedd Council has commissioned an independent evaluation of the Hubs. There was an initial evaluation in 21/22 and a further evaluation was carried out in 22/23. The evaluation is playing an integral role in our learning and in the development of the Hub model. Here is a summary of the key findings from the independent evaluation of the Gwynedd hubs conducted in 2022.

- Community Support Hubs provided an effective and accessible way for communities to access a range of support
- Hubs had high levels of understanding of their communities' need and engagement preferences as well as barriers to accessing support
- Partnerships were informal and flexible but there was an emerging need to clarify expectations with simple agreements and guiding principles
- Hubs had not formally mapped or assessed their service provision or partnerships but recognised that a systematic and formalised approach would be useful at each stage of the hub's development
- Hubs communicated well with partners but needed to facilitate opportunities for partners to meet each other in order to maximise the benefits of the hub partnership model
- Relationships with local authority services were mixed and patchy
- Hubs struggled to build partnerships across council departments, often struggling to locate the 'right person'—they felt that the relationships were often one-way and arm'slength and that opportunities to share learning and insights were missed.
- Where hubs had a relationship with Gwynedd Council's Community Hubs coordinator, experiences of interacting with the council were positive and hubs reported better outcomes and greater collaboration—the coordinator's role was valued highly and recognised as an important component of facilitating new and effective ways of working across sectors

There were some key recommendations made from the 21/22 evaluation and we have been actively involved in having a programme of work to respond to these recommendations. The Hubs were involved in decisions relating to the priority of these recommendations through the monthly Hub meetings:

Ym mha drefn ddylem ni weithio ar yr argymhellion?



What 'good' or 'success' looks like:

The key focus of the Hubs is in creating a local network of organisations that work together to help people locally. The network will be supported with a physical hub or place in the community. This will bring services, activities, local groups, and agencies together to shape their local response to the area's needs.

All of the Gwynedd Hubs, have a framework of partners with whom they co-ordinate provision within their community. There are a range of partners across a number of key themes that include food poverty, housing, fuel poverty, caring for loved ones, being active in the community. The partnership framework is a shared resource providing opportunities for Hubs to engage with and identify new partners. The monthly hub meetings in Gwynedd have also been used to host a series of 'Show and Tell' sessions where key agencies/services including Gwynedd Council services have presented themselves to the Hubs with the aim of building relationships and connections and increasing the hubs awareness and understanding of the range of provision that they can 'tap into' to bring help and support closer to people in communities.

Key themes:

During the winter of 22/23 Gwynedd set out a programme to respond to the challenges facing people and communities because of the cost-of-living crisis. The community hubs were an integral part of the programme.

The Hubs were part of the front-line response to supporting people facing difficulties and challenges, distributing food and fuel vouchers and hosting cost of living events with key partners.

We have some data from the hubs who were part of this programme and some case studies highlighting the type of support offered.

The data collected by hubs shows that 2700 people were supported with access to food, clothes, and fuel between November 22 and March 23. The hubs also hosted weekly drop in's offering a warm space with access to advice and information. These events hosted

approximately 20-50 individuals with Hubs reporting that they had witnessed an increase in the amount of people attending events.

Some of the key themes highlighted in case studies included:

- Individuals experiencing emotional distress as a result of the cost-of-living crisis.
- Individuals experiencing hardship as a result of time taken in transition from work to Universal Credit and PIP benefits commencing.
- Families experiencing increased stress in coping with the additional pressures of Christmas.
- Difficulties by individuals and families living in households where benefits were the only source of income.
- Difficulties experienced by individuals living alone with no local connections.

Hubs reported that the help offered made a difference to individuals for the following reasons:

- Reduced emotional strain and worry
- Enabled families and individuals to keep warm
- Enabled families and individuals to have food
- Made individuals feel cared for and looked after in their community
- Increased confidence and encouraged individuals to engage and volunteer in their community.

What has been learnt:

Please refer to What worked well, what didn't work so well:

Meeting the needs of the priority population group(s):

A key principle in developing the framework for community resilience was that when people in Gwynedd need support, they will be able to go to those they trust and those with whom they feel they can have a relationship with organisations working together to make sure the help people need happens locally.

As we are developing the framework with hubs in place across most of the regeneration's areas in the county, we are starting to see some evidence about the volume of people who are accessing their local hub as the place they go to when they need help and support across a range of key themes referred to in the data. The partner framework that each Hub has, also gives clear evidence that partners linked in with the hub and forming part of the local network are connected to all the priority population groups

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

Conclusion:

The Community Resilience Project in Gwynedd is evolving. There is a focus on continuous learning and in creating the right conditions and opportunities for learning to take place with and between all partners involved in shaping and delivering the programme.

Our next steps will focus on:

- Appointing a provider through a tendering process to lead and facilitate the Supporting People's Wellbeing Service.
- Expanding Hubs into the remaining three Regeneration Areas in Gwynedd.
- Actioning recommendations from the third phase evaluation.
- Collectively with all partners understanding the importance of gathering evidence and working collaboratively to create the right conditions for its use.



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NORTH WALES SOCIAL CARE AND WELL-BEING
SERVICES IMPROVEMENT COLLABORATIVE

RIF Project Level Case Study

Project Reference Number: CBC PC 04
Project Name: Dementia Community Support Services
Project (activity): Dementia Aware Denbighshire Grant Scheme – DVSC DEM 28

Background summary - provide the context:

- Summary of the Project
- Who is involved, why and key relationships e.g.:
 - Delivery partners who are part of the project and role
 - Which priority population groups
 - Other stakeholders involved
- What types of data/evidence is being collected and tools used to inform the case study

To help kick start action within local communities Dementia Awareness raising events/activities were held. which can be difficult if funding is not available.

ICF and RIF grant schemes have been part of the project since its commencement and Denbigh in particular has utilised the scheme via a variety of different groups/individuals

In 2019/20 Denbigh in Bloom were awarded funding to assist the development of a Sensory Garden

In 2020/21 redacted s40(2) local redacted s40(2) was awarded funding to work in the local care homes to make fantasy film forget me not flowers which subsequently were displayed in the Sensory Garden. redacted s40(2) were also awarded a grant to work with Denbighshire Arts to run a series of intergenerational art workshops, activity boxes for care homes and outdoor art session during the summer months.

In 2021/22 The Denbigh Workshop were awarded funding to create a choir specifically for people living with dementia and Grwp Cynefin were awarded funds for a Friendship bench project which is currently ongoing. DFD were also awarded funding to run a 'Forget me not treasure hunt' during Denbigh's Midsummer Festival which allowed for art workshops to be run in the local schools and care homes to make forget me not flowers which were then displayed in 38 shops/businesses in Denbigh town as part of the treasure hunt. This got people talking about dementia starting with the school children who had Dementia Friends' sessions and made the flowers giving them a sense of ownership, the businesses and shops who were approached to display the flowers and the people who took part in the treasure hunt itself.

In 2022/23 Kings Garden a social enterprise based in Denbigh has been awarded funding to run Nature Session once a month for the next year which allow people to come together and learn and take part in activities around nature in a safe environment - which they may not otherwise get the opportunity to do. The sessions are open to all and designed to be inclusive

of people living with dementia. DFD attend all the sessions to provide information to people if required.

All the groups have worked closely with DFD when applying for the grants and good links have been made within the community.

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

- Identify the key features of what worked well and what change occurred as result of what is being or has been delivered
- Be open about what may have not worked well or as originally intended – it's part of the learning process
- What other unforeseen changes and how they were dealt with
- Challenges and limitations
- Present the observable and credible evidence.
- Drawn upon the experiences of multiple perspectives and individual cases studies

The grant scheme has meant that Denbigh has been able to become a good example of how a Dementia Friendly Community can work and bring different groups together/build links which were not previously there providing an inclusive community for people living with dementia.

Uptake of the grant in other towns within the county has to date not been as successful so we are looking to promote the grant more heavily to try and encourage uptake from other areas.

What 'good' or 'success' looks like:

- Consider each individual case and drawn together cumulatively
- Ensure observable evidence is presented and avoid assumptions
- Highlight the key aspects of what 'good' or 'success' looks like and for whom

That a town / community comes together around the issue of Dementia. Links are made between groups and individuals which were not necessarily there before, and people of all ages are inspired to get involved and make a difference. Links between schools and care homes have strengthened and new links made.

Regarding the Denbigh '*Forget me not hunt*' one participant said 'We've found 32. Having a stop for coffee now. What a fab idea this is'

Key themes:

- Outline the themes from across the individual case studies that have been developed □ Qualify those themes though the evidence (give examples) □ Where the themes consistently reported?
- What can be drawn from those themes?
- What is/has been the project contribution to the Model of Care?

The grant scheme has meant that Denbigh has been able to become a good example of how a Dementia Friendly Community can work and bring different groups together/build links which were not previously there providing an inclusive community for people living with dementia.

Denbigh has now been chosen as the Town to undertake the listening campaign with for the All Wales Dementia Pathway of Standards Regional Community Engagement Tash Group to find out what the people of Denbigh think Dementia Care should look like.

What has been learnt:

- Ensure there is a clear link to the evidence
- The benefits
- Draw upon individual case study examples and consider from multiple perspectives

The grant scheme has meant that Denbigh has been able to become a good example of how a Dementia Friendly Community can work and bring different groups together/build links which were not previously there providing an inclusive community for people living with dementia.

Meeting the needs of the priority population group(s):

- ☐ Consider the impact and outcomes for people
- ☐ Consider are people better off and to what extent

Denbigh is a rural community with many Welsh speakers which is something always considered by applicants for the grant. Dementia Friendly Denbigh for example always ensure that any information they produce is bi-lingual as a matter of course and any other groups applying for the grant will be encouraged to consider the importance of having resources/services available in Welsh.

Outcomes:

- ☐ Are the higher level outcomes of Model the project is aligned to being met or have been met by providing information on how and in what circumstances

The outcome of the grants has had a positive impact on Denbigh as a town who have raised a lot of awareness and continue to do so. It is hoped that Denbigh can be used as an example of how the grant can be utilised by other towns/villages to make a difference in their communities.

Conclusion:

- Summarise the key points and outstanding features of the project
- Outline what is felt to be important to share and learn from
- Provide reflection: Is the project activity sustainable and if so why and how? Is it spreadable? Next steps

The grant scheme continues to run, and we will continue to promote this opportunity throughout our work on the project as raising awareness is key to making a difference to the lives of those living with dementia. We will be increasing the limit from redacted s40(2) to redacted s40(2) as the lower limit often restricts what people can/want to be able to do.



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RIF Project Level Case Study

Project Reference Number: CBC PC 12

Project Name: Carer Support Officers (Gwynedd Young Carers Wellbeing Project)

Project (activity):

Identifying and supporting young carers within a health setting.

Supporting young carers suffering with depressive symptoms and are not eligible for CAMHS support / waiting to be seen by CAMHS.

Delivered by Action for Children

Background summary - provide the context:

- We are predominantly supporting young carers who are awaiting a CAMHS assessment, intervention, or have been discussed at the CAMHS school hubs. This allows us to identify some of the most vulnerable young carers, who are often at crisis point.
- Supporting young carers referred to the 'Looking After Me' programme. Using CES-D scoring, we measure depression symptomatology. If the young person is identified as at risk of developing depression, they are offered a 121 'Looking After Me' programme which takes place over 5 sessions (5 consecutive weeks). To date, the CES-D scoring system evidences that each young carer who has participated in the programme has reduced risk of depression.
- Young carers referred through RIF also have access to the Gwynedd Young Carers Service as a whole and can participate in monthly groups, breaks from caring via trips/activities trips, school drop-in sessions, 1-2-1 emotional support, financial support, and low-level advocacy.

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

- Since attending CAMHS hubs in Gwynedd, we have seen an increase in referrals.
- 10 referrals received in Q4 from CAMHS practitioners and CAMHS hubs.
- 18 currently open.
- 8 received an assessment and closed.
- 5 assessments completed this quarter.
- 8 referrals to the 'Looking After Me' / 'Living with Loss' programme.
- 2 'Looking After Me' programmes completed, 1 'Living with Loss' programme completed, 3 in progress, 2 waiting to be seen.
- We have supported the development of Gwynedd's Wellbeing Festival.

Gwynedd and Ynys Môn

- The young carers supported through RIF have taken part in a range of activities this quarter. These include monthly groups, 121 sessions, trip activities i.e. climbing and underground golf, and emotional wellbeing sessions.
- redacted s40(2) supported through RIF funding had the opportunity to attend a redacted s40(2) young carers who attended the retreat had been identified as at risk of developing depression / mental health difficulties. Feedback from the young carers and parents was very positive. Feedback included redacted s40(2) On return from the trip, a

parent commented that the retreat had redacted s40(2)The young carers have remained in touch via WhatsApp and continue to be a source of support for each other.

- We have received positive informal feedback from our young carers and parents following the 'Living with Loss' and 'Looking After Me' programmes. We are in the process of developing a feedback sheet, which will allow the participants to formally share their positive and constructive feedback.
- The project offers a holistic approach to each young carers, which involves also working with the families. As part of the work, we also attend child protection, Team Around the Family and educational review meetings.
- The young carers have also been able to access additional funding. As shared in the individual case study, one family was offered redacted s40(2) to support with the redacted s40(2)
- We have continued to raise awareness through our multi agency working (sharing information/workshops/presentations).

What didn't work well.

- Young carers were often referred to the 'Living with Loss' programme by their parents. On few occasions, the young carers were coping with their loss better than their parents perceived and therefore the programme was not suitable. From next quarter, we are producing a screening tool to assess need before the young carers begin their 'Living with Loss' programme.
- Arranging a 5-week wellbeing programme through school can be challenging. We have to factor in young carer sickness, exams, and revision days etc. On these occasions, the wellbeing programmes can take longer than anticipated.

What 'good' or 'success' looks like:

- Seeing an increase in referrals from CAMHS / CAMHS hubs.
- Identifying hidden young carers.
- Continuing to reduce depressive symptoms in young carers through the group (Blues) or 121 wellbeing programmes.
- Ensuring the young carers are offered a service plan that meets their needs.
- Continuing to engage in multi-agency working, ensuring the children we are working with have a safe and happy childhood.
- Continue to raise awareness through presentations.
- Continued good working partnership with CAMHS

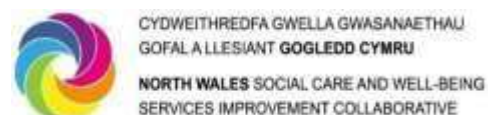
Key themes:

- Young carers feeling anxious and low in mood.
- Strain on families where there is a family member needing care due to illness, disability, physical illness or mental health problems. Current financial crisis adding to this.
- Young carers not being included by health care professionals in decision making about the cared for.

What has been learnt:

- ☐ We have had more success focusing on one health agency (CAMHS).....
- ☐ Valuable to attend school hubs. Through the hubs we have been able to form stronger links with other professionals i.e. school nurse.

Meeting the needs of the priority population group(s): • We have been able to identify more hidden carers. • We have been successful in reducing depressive symptoms for our young carers who are identified as at risk of developing mental health difficulties
Outcomes: • Identify hidden young carers within the health care setting. • Improved health and emotional wellbeing of young carers
Conclusion: • The 'Looking After Me' and 'Living with Loss' have been successful. This is evident through the CES-D scores and young carer feedback. • We hope to continue to see an increase in referrals from health / CAMHS. • As the project develops, we are seeing the importance and benefit of co-working with other agencies. This is evident in the increased referrals, and in the individual case study. • Outcome Measures evidence that the project is making a difference to the young carers, and reducing risk of subsequent mental health difficulties.



RIF Individual Level Case Study

Project Ref Number: CBC PC 14
Project Name: Regional LD Communities (North Wales Family transition service)
Project (activity): Transition Planning - Family transition planning is a member-led activity which allows young people to have direct input into the direction and approach of their future development. Our officers meet families or individuals in a space in which they feel comfortable (in their home, at our officers or in a suitable setting) to plan their goals, objectives and ambitions. This case study is an on-going case, relevant information has been altered to keep member anonymous. Case study created with the individual but will refer to the member as redacted s40(2)

Background summary

redacted s40(2) when completing tasks outside the home and does not receive support from council services. Our officers met with redacted s40(2) family within the family home to plan redacted s40(2) goals, objectives and ambitions.

redacted s40(2) has been engaging with the service for 13 months intermittently due to health reasons. We developed goals for s40(2) and broke these down into steps to help redacted s40(2) to progress. redacted s40(2) is able to communicate verbally during the planning process and is consistently directing the transitional support. Sessions usually take place in the home, but redacted s40(2) responds well to redacted s40(2) like s40(2) and walking to break up the sessions.

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

Describe what you felt worked well and what change occurred as result of what is being or has been delivered?

redacted s40(2) has responded well to consistent support (4X per month) so that we can reflect on progress. We work face-to-face in our sessions which has allowed redacted s40(2) to communicate redacted s40(2) thoughts and opinions either verbally or through redacted s40(2). This has helped as redacted s40(2) often does not feel comfortable disagreeing or challenging a decision. Short 45-minute sessions provide us insight on how redacted s40(2) is dealing with on-going health problems to alter the speed and expectation of achievements in a given time period. We are always joined by redacted s40(2) in these sessions who provides great insight to navigating the topics with redacted s40(2).

Things may not have gone as well as you would have thought or liked

redacted s40(2) and the group acknowledge that the time taken to produce outputs and achieve objectives has been a lot longer. This has been at times due to the limited number of formal structures that currently complement the holistic person-centred approach.

Were there unforeseen changes - how they were dealt with?

redacted s40(2) which meant support stopped. We needed redacted s40(2) to reengage when he felt it was time as we could not force him to continue. The family have applied for redacted s40(2) but dialogue between the two

parties has broken down every time. This has left the family unable to access 1-1 support or redacted s40(2)

What 'good' or 'success' looks like: From your perspective what do you think 'good' or 'success' looks like from the activity you benefitted from or were involved with?

Based on redacted s40(2) dream/ ambitions, redacted s40(2) would consider the activity a success if he could: Join an s40(2)

We believe, from the prospective of support, a good result for redacted s40(2) would be:

To participate in 3 days of activities, s40(2) improve his independence through ILS activities and start a volunteer placement (reflective of s40(2) benefits claims).

What has been learnt:

The importance of planning a standard transition before the transition is taking place

Outcomes:

Did the project activity achieve what you expected?

What do you think has been the results and impact of the project activity you benefitted from?

What is happening for you at the moment?

During the case period, redacted s40(2) has started redacted s40(2) completing small independent living tasks in the home and is open to visiting activities within the community. redacted s40(2) case is still on-going, redacted s40(2) confidence has been improving since redacted s40(2) return. The family and redacted s40(2) have identified a clear path for the future.

Conclusion:

Overall, what do you feel is important to share and what you think

What next – what would you like to happen in the future? How can people learn from your experience.

Standard transitions such as leaving college can be pre-empted but families experiencing unforeseen transitions should be signposted to the service.

redacted s40(2) would like to participate in social activities with young people his age, continue to play football and be more independent.

RIF Project Level Case Study

Project Ref Number: CBC PC 14

Project Name: Regional LD Communities (North Wales Family transition service)

redacted s40(2)



Community Based Care: Complex Care Model of Care

RIF Individual Level Case Study

Project Ref Number: CBC CC 04
Project Name: Response Service
Project (activity): Additional step-down capacity in residential home in order to facilitate a hospital discharge.
Background summary S40(2) Due to non-availability via the care agency, individual was able to access a s40(2) This enabled the individual to leave hospital to a more comfortable and appropriate setting and ensured that a hospital bed was freed up
What worked well, what didn't work so well: Good partnership working between social care and hospital and community staff to ensure this smooth and timely discharge to a step-down bed helped flow at the busy acute unit. There are s40(2) There has been positive MDT response to this whereby a s40(2) visited individual at the home and confirmed that s40 (2) medications were also reviewed. Guidance was given to the home and recommendations that s40(2) were commenced. S40 (2) Although there has been deterioration in condition, this case clearly demonstrated effective use of s40(2) and MDT working to ensure the best possible outcome for the individual.
What 'good' or 'success' looks like: Individuals are moved from hospital as soon as they no longer require hospital care. Appropriate services are put in place as soon as reported change in behaviour Care homes being fully supported by the MDT.
What has been learnt: Individuals' circumstances can change quickly meaning that the assessed level of need and intervention can change in a short period of time. This is when having a strong MDT around the individual is crucial. S40(2) This was not a bad or inappropriate placement, as the change of behaviour is highly suggestive of new (acute) or recurrent physical illness - however minor, which was investigated promptly to ensure the individuals wellbeing.
Outcomes and Conclusions Timely and appropriate hospital discharges. Additional capacity of step down community beds are crucial particularly when there are exceptional dom care recruitment and community provision.



Home from Hospital Model of Care

RIF Project Level Case Study

Project Reference Number: HfH 03
Project Name: SUSD - Cynllun Penyberth
Project (activity): Reablement support to support discharge and prevent admissions
Background summary - provide the context: This scheme provides reablement support to individuals to promote recovery after a stay in hospital / giving support to individuals to prevent deterioration of a situation and avoid admission to hospital. Who is involved, why and key relationships e.g.: Home care providers supported by the Community Resource Team Priority population group is Older people Other stakeholders involved are GPs and Acute Hospital teams What types of data/evidence is being collected and tools used to inform the case study This case study was informed by information taken from the home care provider's notes about the number of individuals supported, how long they stayed, why they came to Penyberth and what the end result was following their stay.
What worked well, what didn't work so well: • redacted s40(2) • People able to go home with either a reduced or no care package • People given the opportunity to have a period of enablement in a non-clinical setting • Due to system pressures, some individuals not suitable for reablement were placed here and stayed for long periods. This impacted capacity for those in need of reablement. • Therapy resources need to be increased • Not enough focus on data and information collection
What 'good' or 'success' looks like: An individual is discharged from hospital to Penyberth with a recommended care plan e.g. three calls a day. After a period of enablement and they return home with a reduced or no care package and are able to live well independently. Suitable individuals are identified are for the scheme.

Key themes:

- Staying in Penyberth for enablement work is a positive first step towards regaining independence, resulting in confidence to return home and intervention from specialist services were avoided.
- Need to ensure appropriate patients are identified for the scheme, as some individuals were not suitable because they had more complex needs which could not be met
- Timely communication and close working between acute and community hospitals, CRTs, care home staff is key
- Need to address wait for minor modifications as this delayed return to home in some cases

What has been learnt:

Draw upon individual case study examples

- redacted s40(2) – the units are small enough and therefore ideal for someone who is used to a 'bay' in a hospital; not having to go far to the toilet or the kitchen; the environment is lovely too. redacted s40(2)
redacted s40(2)

Meeting the needs of the priority population group(s): Consider the impact and outcomes for people

□ This scheme helps people to remain independent for longer and regain their confidence.

Consider are people better off and to what extent

This scheme enables early discharge from hospital, to a similar environment to home. The individual units at Penyberth mean that people can live privately and independently but with enablement support. Resources like a canteen are on site as well which helps with the transition from 3 meals provided on a hospital setting to preparing and cooking own meals at home.

Conclusion:

Is the project activity sustainable and if so why and how? Is it spreadable? Next steps

The scheme is in its infancy and so a further period for the scheme to become established is required with robust outcome data collected and analysed for a meaning evaluation.



RIF Individual Level Case Study

Project Ref Number: HfH 02
Project Name: D2RA Therapy Capacity (Patient B)
Project (activity): D2RA - Therapy Assessment and Intervention with service to support timely discharge
Background summary • redacted s40(2) • MDT Therapy assessment completed later in the day of admission- when Patient B was deemed s40(2) post investigations • Patient B was very keen for discharge • Patient B assessed as s40(2) for discharge. • Family support patient B needs and s40(2) • Home first discharge with further therapy assessment within patient primary home environment arranged for next day. • S40(2) transported Patient B home in s40(2) • Next day Therapy functional, environmental assessment within s40(2) REDACT enabling compensatory equipment requirements to be assessed. • Equipment issued and fitted at time on initially home assessment. • S40(2) • Onward referral to third sector to support with s40(2)
What worked well : • redacted s40(2) • Extended working hours of D2RA Therapy Team • Availability of D2RA Therapy team for next day home visit • D2RA team links with community teams and 3rd Sector What didn't work so well: • Time of day of referral to D2RA Therapy team - redacted s40(2)
What 'good' or 'success' looks like: • Timely discharge, with OOH assessment confirming patient functional needs and therapy fit for timely discharge home • Falls prevention provided, risk of further fall or readmission reduced. • Timely next day home visit for functional assessment within patient's primary environment. • Enabling the required compensatory equipment to be assessed supplied and fitted there and then.

What has been learnt:

- Benefit of extended hours of service
- Difference of supportive families in Patient outcomes
- Benefits of functional assessments within patient's home environment

Outcomes:

- Timely discharge achieve, reducing risks with prolonged admission
- redacted s40(2)

Conclusion:

- Importance of extended hours weekdays and weekend cover
- Importance of early intervention Therapy to support timely discharge □ Flexibility within the team to complete next day home visits
- Third sector and community links added value to patient's well being



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NORTH WALES SOCIAL CARE AND WELL-BEING
SERVICES IMPROVEMENT COLLABORATIVE

RIF Individual Level Case Study

Project Ref Number: HfH 02
Project Name: D2RA Therapy Capacity (Patient W)
Project (activity): D2RA Front door discharge
Background summary • redacted s40(2) referred to D2RA OOH OT & PT service on redacted s40(2) • D2RA OOH OT and PT service able to respond immediately • redacted s40(2)
What worked well, what didn't work so well: • We were able to respond quickly to a referral received out of usual service hours. □ Discharge concerns were identified and services put in place to mitigate risks. • redacted s40(2) was discharged as planned in a much 'safer' discharge. • redacted s40(2) • Not so well – time taken to contact red cross services – several emails and phone calls.
What 'good' or 'success' looks like: • What matters to patient – in this case was to return home as soon as possible. • The out of hours assessment of function and social needs ensured a prompt safe discharge with support in place for return home. • Identification of previously unidentified needs and opportunity to put appropriate support in place

What has been learnt:

- The importance of holistic thorough social history taking to identify issues that may not initially be obvious.

Outcomes:

- Safe discharge achieved.
- What matters to patient achieved.

Conclusion:

- Important to identify issues early to allow planning time for safe discharges.
- The value of 3rd sector services in assisting with hospital discharges.



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Supporting Families & Children Model of Care

RIF Project & Individual Level Case Study

Project Ref No:	SF&C 04
Project Name:	Intensive residential support for children with complex needs Step up step Down – Enhanced Foster Care model
Contact name:	redacted s40(2)
Date:	redacted s40(2)

Purpose of Report

To provide an update on the progress of the project

Project/Programme description

The Psychology element of the Enhanced Foster Care project is provided by CAMHS embedded within Children's Services and differs from general CAMHS work in that it contributes to core Social Work practice (including training and development, contribution to assessments or provision of complementary standalone developmental assessments to inform placement and care with particular attention to defining the kind of therapeutic input that would be appropriate, developing pathways and facilitating access to CAMHS, neurodevelopmental and other services, integration of the network, joint casework with Social Work colleagues, supervision of relevant, specialist elements of Social Work colleagues' casework, and provision of a psychological perspective to the network when requested although not involved in casework). The aims are to promote placement stability and prevent placement breakdown, prevent escalation into residential placements for children at risk of this, and facilitate 'stepping down' from residential settings.

Work completed in this reporting period

Actions completed to date are:

- Forms of access to psychology and the manner of co-working have been developed and re-established after a period of time without a psychologist in post. The means of accessing psychological input has been shared with colleagues in Children's Care. There is no referral form or waiting list but instead colleagues can directly book consultation sessions through Childcare and Fostering in the soonest available appointment slot which is provided ahead of time by the psychologist. Consultations between Social Worker and Psychologist are used to ascertain whether there is a role for the Psychologist and if so to define what it will be. The aim as it was when the service was established is to maintain fluidity in the process with timing being paramount as many requests are to offer support for placements. The risk is of flooding of the service.

- Robust pathways have been re-established for Children Looked After into CAMHS and the Neurodevelopmental Team. The principle psychologist from the neurodevelopmental team now spends one half day per month in the Looked After Children's team which was established to have easier and quicker access to specialist opinion for young persons within the Looked after Children's team who have or are suspected to have presenting issues associated with neurodiversity. We have been able to establish a pattern of joint working and shared responsibility/delegation of assessment that has improved access and increased the opportunity for more timely assessment where this relates to issues with placement stability and risk.
- Alongside this, joint initial assessments can be and have been provided where it seems a joint decision would be most appropriate. The Psychologist has taken a lead in the role of joining colleagues together to provide joint assessments with the relevant specialisms present.
- Operational meetings have been held with key partners in CAMHS redacted s40(2) and there has been progress in defining the administrative pathway to support the clinical pathway as well as defining the pathway for referrals into CAMHS. This has formed part of the Psychologist's practice for cases entering CAMHS, allowing the prioritising of referrals without diminishing the fluidity of access.
- A further element of the CAMHS pathway achieved to date is to establish a handover model, such that the Psychologist embedded within the Looked After Children's team provides time limited brief direct interventions for carers or children where there is a wait for transfer to CAMHS general team colleagues. There is also work established and carried out that aims to facilitate engagement by the Psychologist where children or carers are initially reluctant to meet with CAMHS.
- Key elements of training and skills development for Social Workers has successfully begun for the general teams. The redacted s40(2) completed (in January/February 2023) the Basic Training for redacted s40(2) which will allow him to supervise ongoing practice of the Social Work team following their targeted training in redacted s40(2)
- Training has also begun for foster carers which is ongoing.
- Regular 'Reflective Practice' sessions have been re-introduced as a forum in which redacted s40(2) can provide joint supervision and guidance to Team Managers. This reflective practice has also been extended to the Permanency and Pathway team and the Fostering team members.
- redacted s40(2) are in contact a possible service related research project using data collected from the consultation process. It is hoped that the research may produce relevant and usable data, advice from findings, and publication in journals to increase the influence and profile of our approach.
- Collaboration with CAMHS colleagues to provide training regarding understanding young people's mental health and developmental trauma has been completed. This has led to the delivery of two half days of training for foster carers and relevant professionals held between December and March. Further sessions are planned for future dates.

- Feedback has been excellent from Social Workers. Feedback from foster carers and young people is pending and will be included in the next quarterly update report.

Work planned for next reporting period

Actions to be completed are:

- To set up and deliver further mentalizing based training for Foster Carers as well as kinship carers facilitated by the Psychologist with Social Worker involvement so placements can be supported in utilising this intervention.
- To continue with the internal reflective practice groups that have been established.
- To continue working with CAMHS, Neurodevelopmental Service and other health teams to consolidate and extend links and shared working so that the pathways are robust.
- To continue to work with CAMHS to increase resources relevant to children Looked After (e.g. access to dyadic, live interventions such as the 'ParentChild Game').
- To establish regular operational meetings between CAMHS, Early Intervention and the Neurodevelopmental Team.
- Further training to be offered to follow up and consolidate mentalization skills as well as training around Reflective/Therapeutic Parenting.
- Progress to be made towards creating a working research proposal.

Breakdown of input provided

- The caseload of the Psychologist has been steady at around 15-20 cases. Contributions to cases not directly allocated to the psychologist has also been made in an indirect manner where there have been brief intervention or opinion offered but not requiring substantive involvement.
- The total cumulative number of cases seen stood at 35 covering a period of 6 months. The types of work completed include (some cases enter more than one category hence total may be more than total cases):
 - Transition work (into or between placements) = 2
 - CAMHS pathway (following detailed/brief assessment) = 10
 - Neurodevelopmental Pathway (following detailed/brief assessment) = 5.
 - Education based input = 1
 - Placement stability = 13
 - Facilitation of Step Down = 1
 - Guidance for Carers = 10
 - Screening for CAMHS resulting in alternative = 3.
 - Screening for Play Therapy:
 - Recommendation of alternative = 13.
 - Agreement of plan of input = 2.
 - Recommendation of OT specialist sensory assessment = 1.
 - Recommendation of and facilitation of Life Story Work = 3.
 - Network advice only = 4.



Brief Case Study (placement stability)

redacted s40(2)

Service Feedback

Results from Survey Monkey Feedback Questionnaire:

Team managers and social workers were asked to complete questions eliciting feedback regarding their experience of the psychology provision integrated within the Looked After Children's service. Overall number of respondents was low with only four respondents completing the feedback survey.

Q1. *What difference did working with our psychologist make?*

- redacted s40(2)

Q2. *Did you find that working with the psychologist helped to join up the people involved in parenting, including yourself, your supervising social worker and your child or young person's social worker?*

- YES = 80%
- NO = 0%
- Not Sure = 20%

Q3. redacted s40(2)

Q4. *Did you feel more informed about the topics you were working on at the end of the period of time working with the psychologist?*

- Yes a lot = 100%
- Yes a little = 0%
- No remained the same = 0%
- No felt less informed = 0%
- Not sure = 0%

Q5. *If your answer was yes, please describe more about what you learned ...*

redacted s40(2)

- Q6. If you have attended training provided by the psychologist did you feel more informed about the topics you were working on by the end of the training?
- Yes a lot = 100%
- Yes a little = 0%
- No remained the same = 0%
- Not sure = 0%

Q7. *Please tell us anything else you noticed about working with the psychologist ...*

redacted s40(2)

RIF Individual Level Case Study

Project Ref Number: SF&C 06

Project Name: Intensive support teams for children with complex needs (Tim Emrallt)

Project (activity):

This is a specialised harmful sexual behaviour team for young people and their families. It embeds a multi-agency approach and provides a framework for and support to practitioners managing young people with harmful sexual behaviours. Tim Emrallt ensure that the process from identification, assessment, intervention and moving away from behaviours is conducted in an appropriate and timely fashion.

Background summary

redacted s40(2)

Tim Emrallt held regular multi-agency meetings throughout the assessment and continue to meet with parent and all agencies involved. This has also included holding RAMP (Risk and management Planning) meetings with the school that the young person attends.

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

By having a clear framework and process to share and promote with all involved prevented any potential 'drift' in the completion of the AIM assessment.

By having regular arranged meetings for all to attend ensured that everyone involved was kept up to date and any changes to the safety planning or intervention were made through group agreement.

The contact with the residential placement was invaluable in terms of having regular updates regarding progress made or any further behaviours seen so discussions could be had regarding the action needed.

Meetings have continued to be held over MST due to distance however despite this it has provided Tim Emrallt with a good working relationship with the residential provider and understanding of what they can offer to others in the future.

There have been no unforeseen changes during this time and once again has evidenced the importance of consistency regarding workers both from social care and the home environment for young people.

What 'good' or 'success' looks like:

redacted s40(2)

What has been learnt:

This has evidenced to practitioners involved the importance of all agencies taking a role in working with young people and their families displaying harmful sexual behaviours and the importance of sharing information.

redacted s40(2)

The understanding and skills gained will provide her with the confidence to work with other young people and their families in the future.

Again, it has confirmed that the service that Tim Emrallt provides is a valuable resource to families and practitioners across all agencies in the Gwynedd area.

Outcomes:

This piece of work achieved what was hoped and is an example of good practice. Tim Emrallt's role as an advisory project is to ensure that practitioners are provided with a clear framework the importance of identification, assessment, intervention and moving away from harmful sexual behaviour.

The benefits of a multi- agency approach, building an appropriate team around the child and family is highlighted by this case. Social Care, parent, health, and education have all played a significant role in ensuring that this young person has received the correct level of intervention and support in a timely fashion.

Conclusion:

Overall, this piece of work has shown the benefits from having a specialised harmful sexual behaviour team in Gwynedd for young people and their families. It also evidences that the approach Tim Emrallt has taken in embedding a multi-agency approach is one that clearly has many strengths. Whilst the team has been intrinsic in terms of coordinating and supporting agencies all practitioners have benefited from their involvement and it is hoped that their individual confidence and knowledge gained will be taken forward in future work.



Emotional Health & Well Being Model of Care

RIF Project Level Case Study

Project Reference Number: EH&WB 03
Project Name: Community Wellbeing Officers
Project (activity): Intergenerational Community Development Officer
Background summary This scheme provides an Intergenerational Community Development Officer The intergenerational Community Development Officer supported by redacted s40(2) organised a Summer of Fun, which was intergenerational activities for children redacted s40(2) and surrounding areas) to help and encourage children to work in the outdoors together with others in their community and to work to the 5 Ways to Wellbeing.
What worked well, what didn't work so well: The scheme helped to improve the emotional health and well-being of children, it built a sense of belonging within their communities and improved community support across generations. It provided local activities, easy to access for children and families unable to attend other summer holiday activities because of the cost implications and/ or transport Issues. redacted s40(2) is a rural village you drive through, there is no school and no shop redacted s40(2) redacted s40(2) attended the Nature Based Activity Session there and the positive impact reported by both parents and children was outstanding. redacted s40(2) has a label as a place where there are social problems. redacted s40(2) attended the Nature Based Activity Session there from the age of redacted s40(2)
What 'good' or 'success' looks like: 1. Parents and children within the communities connect 2. Children are more active 3. Children and parents take notice of their environment and each other 4. Both Children and parents learn new skills 5. Both Children and parents are able to share their new skills and their local knowledge
Key themes & what has been learnt: The need for easily accessible local community activities to be organised and made available particularly in rural communities where children and their families may feel isolated and suffer poor mental health.

To engage with schools, youth services, hubs and clubs to promote, to create awareness and encourage individuals to give it a try. Word of mouth works really well with individuals who have attended encourage friends and relations to attend.
Meeting the needs of the priority population group(s): This scheme meets the needs of children and Young People and their families as well as Older People. The children who attended these activities were accompanied by their parents / carers / relatives – it was a great opportunity for the parents / grandparents to meet new and old friends and for them to work together. redacted s40(2) attended 3 different activities, on each occasion and built a good rapport with the group members and leaders. redacted s40(2) asked to be able to come to more sessions in the future.
Conclusion: Building on the success of the Summer of Fun, the Intergenerational Development Officer continues to develop community activities to connect redacted s40(2) parents and grandparents with local youth services, community hubs, clubs and organisations to improve emotional well-being by building strong relationships in the community.



Accommodation Based Solutions Model of Care

RIF Project and Individual Level Case Study

Project Reference Number: ABS 03
Project Name: Future Care Provision
Project (activity): Accommodation Based Solutions
Project Level Information There are 2 elements to this scheme: - Digitalisation of Telecare - Penrhos Care Village Digitalisation of Telecare Work is progressing well on the digitalisation of the telecare provision in Gwynedd. Working alongside TEC Cymru to commission provision of new digital, modern and fit for purpose monitoring and other telecare devices. New technology is being piloted. Success will be the rollout of digital devices across Gwynedd, and the expansion of the technology available. We have learnt that significant resources will be needed to replace devices/fit new digital devices. We have identified a funding stream to finance the purchase and rollout of the new digital devices. We have also learnt that communication and consultation is vital during the digital transfer, and that any information needs to be clear, simple and concise, and as free of jargon as possible. We expect the older people of Gwynedd, including individuals with dementia, individuals with disabilities, and their carers to benefit from digital devices that are more fit for purpose and more dependable. There will not be any additional cost to individuals, and people will be better off without having to pay any more for the service. Over the course of the project we will be monitoring : - Number of individuals benefiting from technology enabled care across Gwynedd (i.e. number of people accessing the service). - % of technology enabled care packages that have been transferred over to digital devices. - Number of people satisfied with information provided (around technology enabled care and how it helps them). redacted s40(2) The redacted s40(2) is also progressing well. This is a partnership scheme between Cyngor Gwynedd, Betsi Cadwaladr University Health Board and Clwyd Alun Housing Association on

the development of a care village which will include a local authority/health board run nursing home, the first of its kind in North Wales.

The stakeholders have visited several 'care villages' across the Country, and have visited redacted s40(2) site as a group to plan accordingly. The capital Outline Business Case is almost complete and will be submitted for IRCF / HCF funding.

This scheme can be expanded and replicated across Wales, helping to rebalance the care sector, and nursing beds specifically.

The redacted s40(2) will initially meet the needs of older people including individuals with dementia, and individuals requiring nursing care in their local area. Eventually however, the care village model will meet the needs of all priority population groups.

Individual Level Case Study

redacted s40(2)

