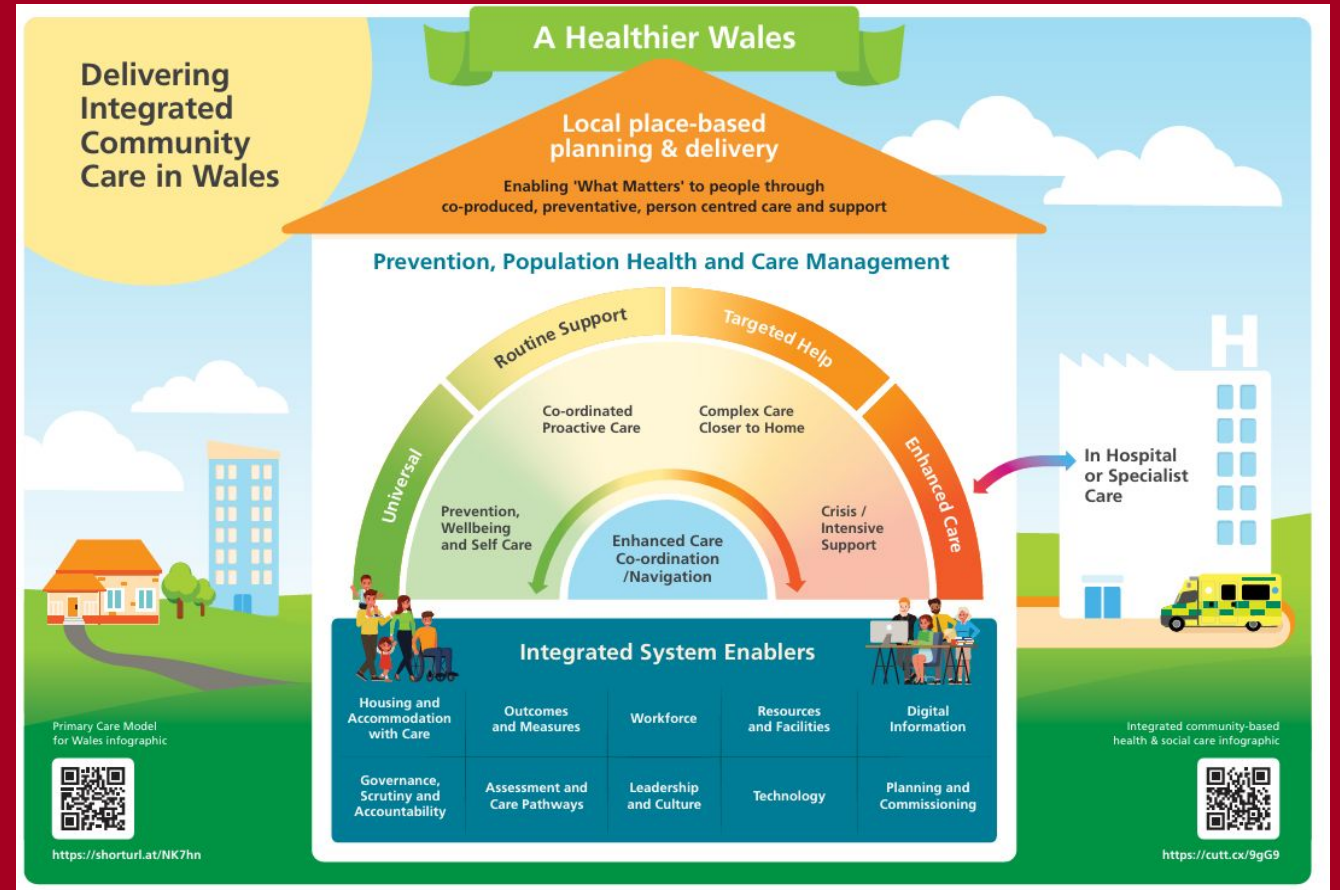


Building an Integrated Community Care System (ICCS) for Wales

Moving from strategy to delivery

Shelley Davies

*Deputy Director for Futures and Integration
Welsh Government*



Hello!

Shwmae!

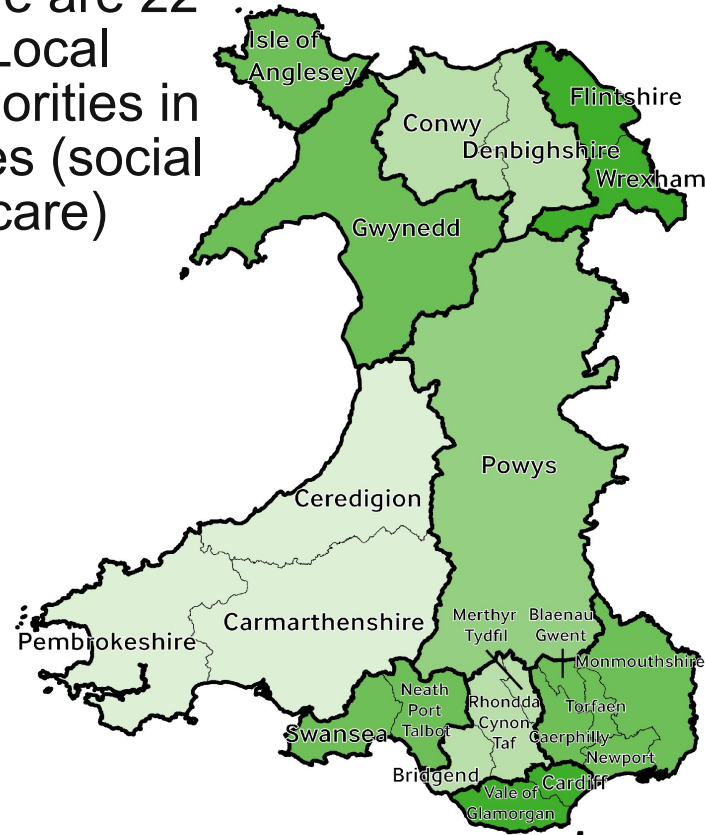
Hola!

Kaixo!

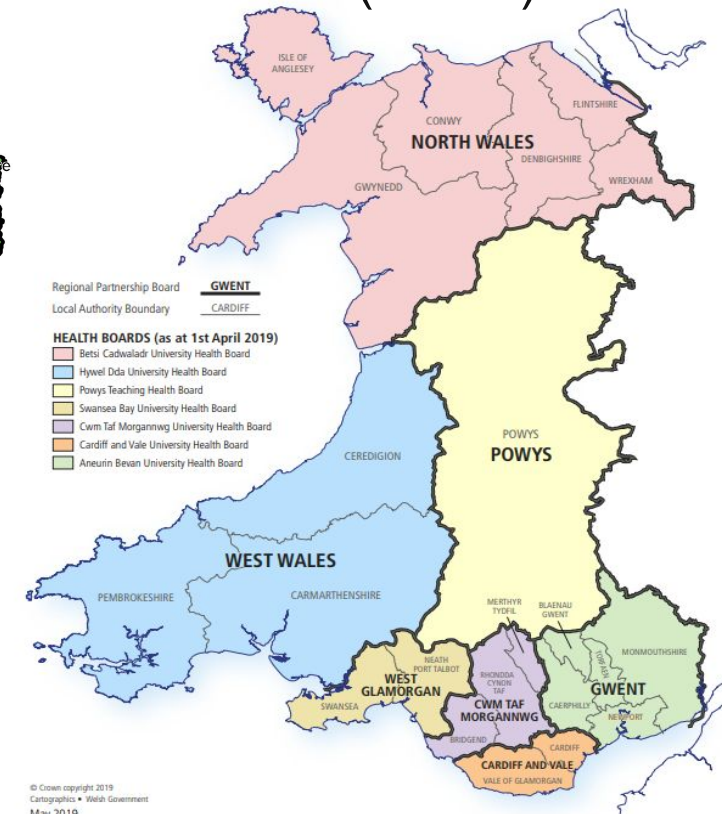


- **Population:** 3.1 million people. (4.8% of the UK population)
- **Size:** 20,800 square km
- **Constitution:** Devolved nation with responsibility for key areas such as health, education, social care, housing.
- **Political:** - New Political leadership for the first time since its inception - Plaid Cymru
- **Culture:** A distinct Welsh heritage, culture and language

There are 22
Local
Authorities in
Wales (social
care)



There are 7
Health Boards
in Wales
(health)



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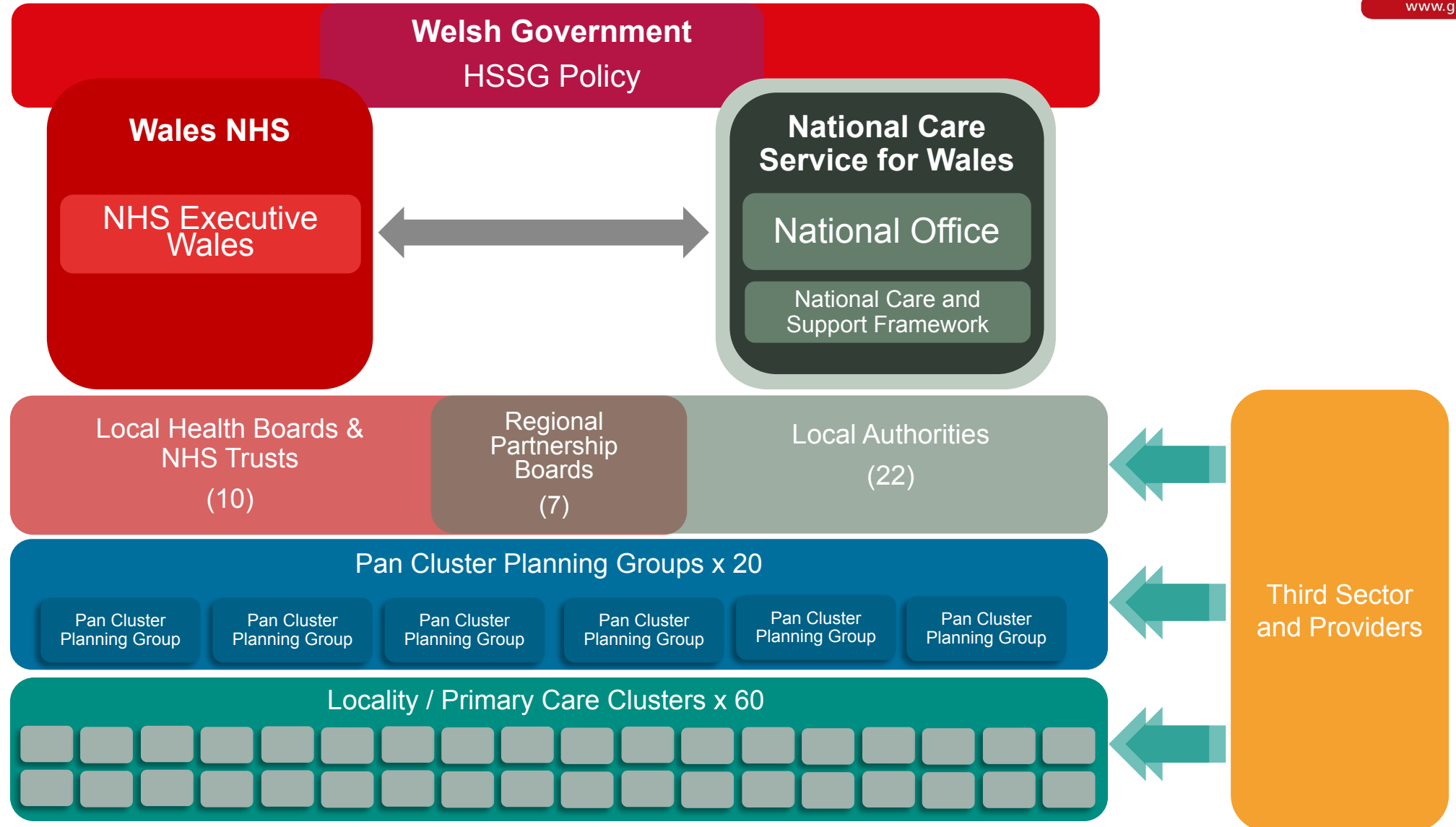
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The developing Health and Social Care architecture for Wales



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Timeline for Wales – A perfectly made plan?



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Legislation (Mandate)

- Social Services and Wellbeing (Wales) **Act 2015** – Health and social care specific (incl pooled budgets)
- Wellbeing of Future Generations (Wales) Act 2016 – Wider determinants of wellbeing

Structure (Space)

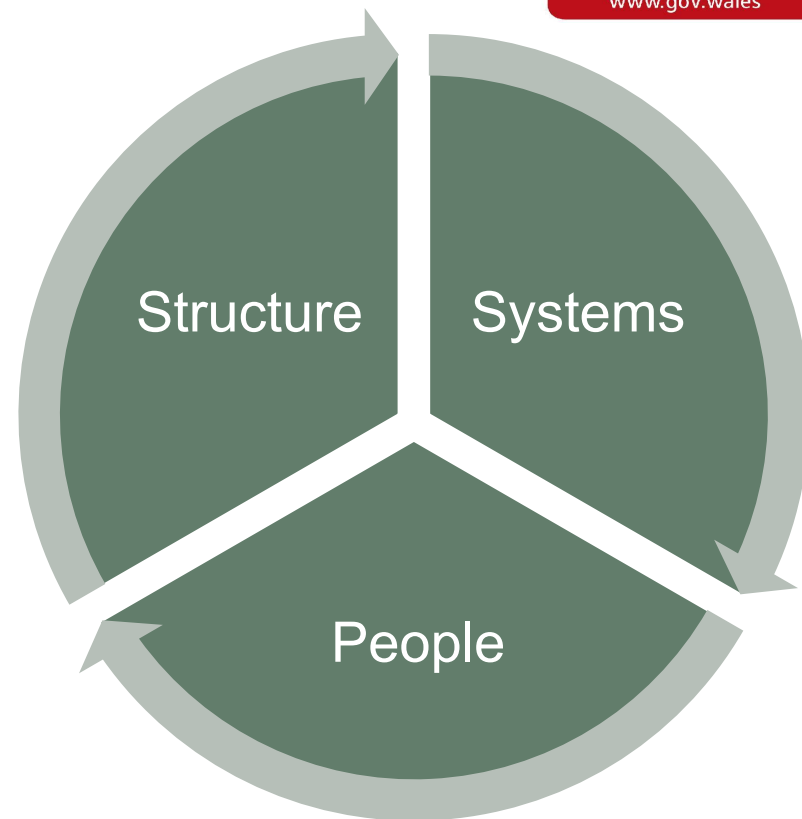
- Regional Partnership Boards (RPBs) established in 2017 - Population Needs Assessments
- Public Service Boards (PSBs) established in 2017 – Wellbeing Assessments

Systems and Strategy (innovation and practice)

- £89m Integrated Care Fund Launched in 2017 – managed via RPBs (now £146m RIF)
- 2018 – Launch A Healthier Wales, our 10 year plan and £50m Transformation Fund
- 2018 – Launch Integrated Care Capital Fund
- 2022 – Launch Regional Integration Fund and Integration and Rebalancing Capital Fund

Review and development

- 2023 – Review of Partnership legislation ;
 - No corporate legal entity for RPBs
 - Clearer definition, vision and purpose for an integrated community care system (ICCS)
 - Linking regional to local
 - Flexibility with pooled budgets – position within commissioning
 - Clearer Accountability
 - New members
- 2023 - Creation of the Integrated Community Care System Blueprint

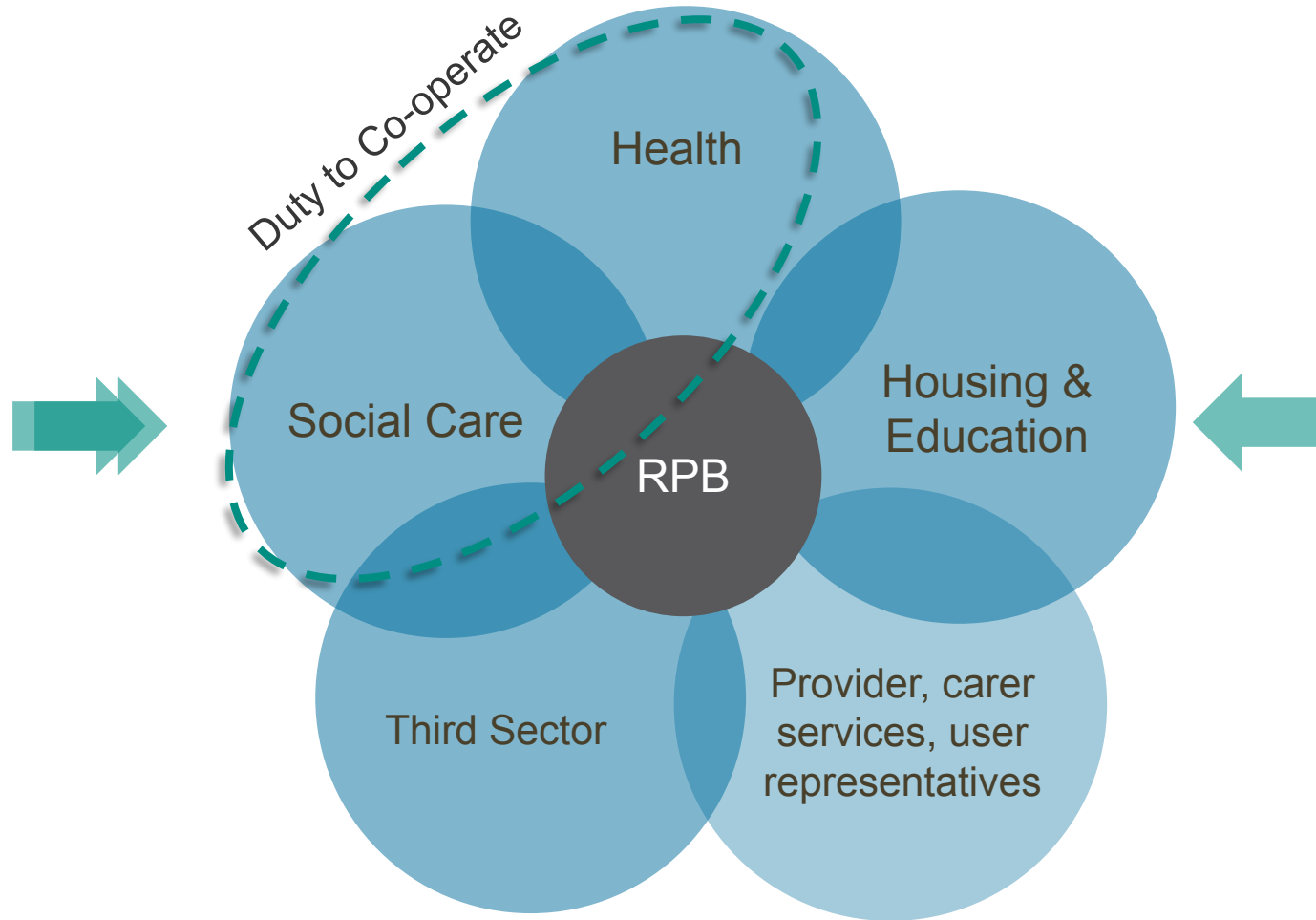
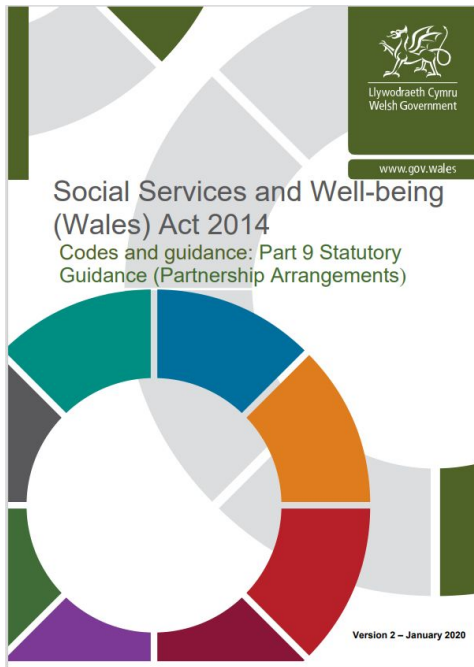


Arrangements that create space for integration – *7 Regional Partnership Boards*



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National Investment through RPBs

Revenue - £146m

Match funding from
Partners £90m

Capital - £130m



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The need for Clarity....



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“What do we mean by Integration? “

“Where is the vision?”

“What does good look like?”

“How do we get a consistent offer for the people of Wales?”

“ How do you measure the impact?”





Differing Perspectives

National – looking for consistency (spread and scale), whole system accountability

Local – Looking for flexibility, separate agency drivers and pressures

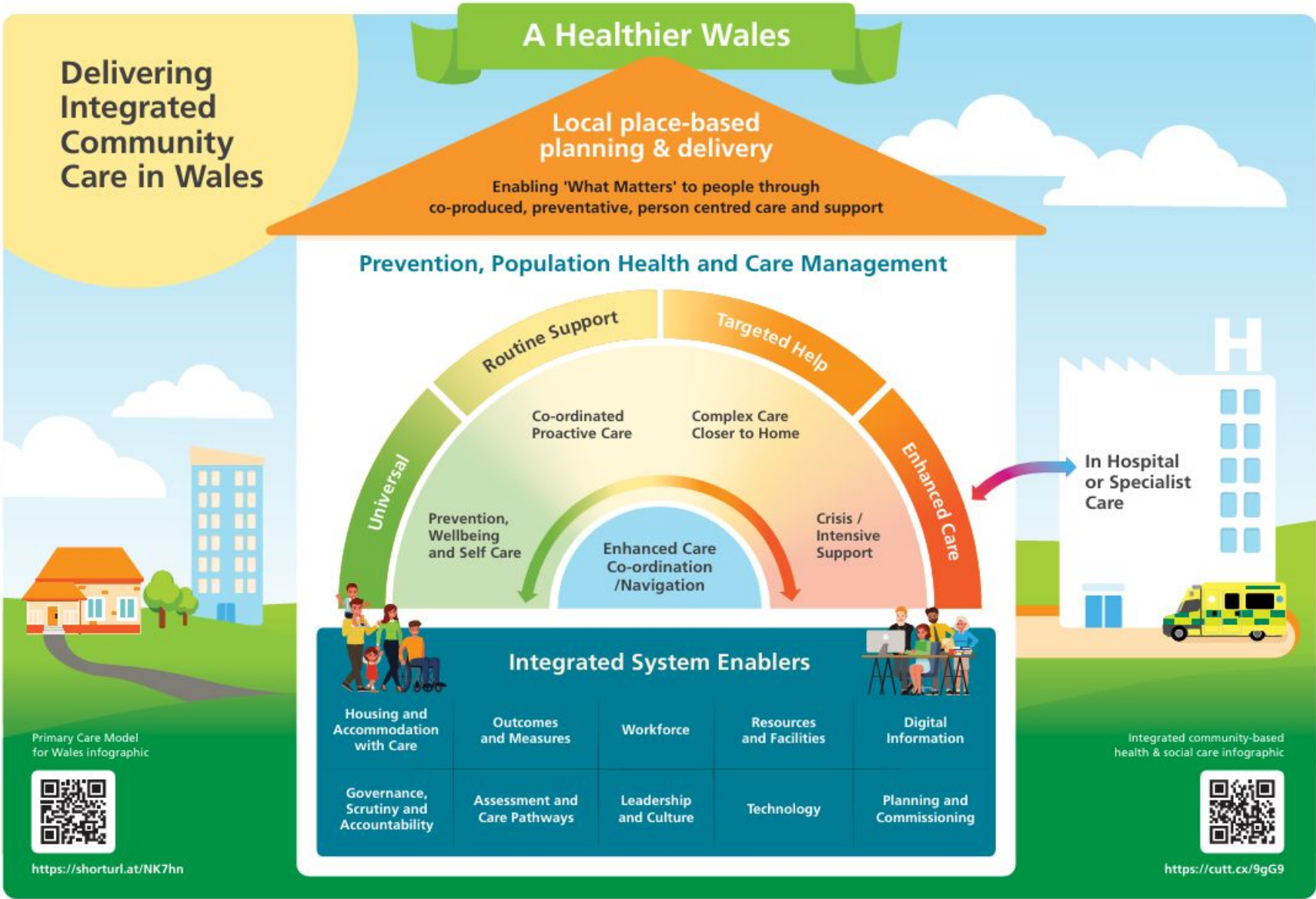


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Our Goal

Delivering an Integrated Community Care System in Wales (ICCS)



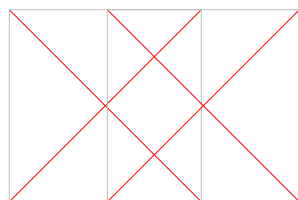
Describing what good looks like.....



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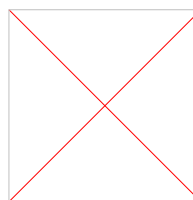
ICCS “I” and “We” statements for older people and people living with frailty



I don't have to repeat my story many times, because services talk to each other and work together.

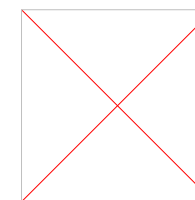
I can get support from one team, instead of having different appointments with lots of separate services.

I get the right help more quickly, because health and social care organisations work together better.



We work together as one team, which helps us give better and more joined-up care.

We share information and plans, so it's easier to support people without delays or confusion.



We work more closely across organisations, creating a smoother experience for the people we support.

We make better decisions together, using shared data and joint planning.

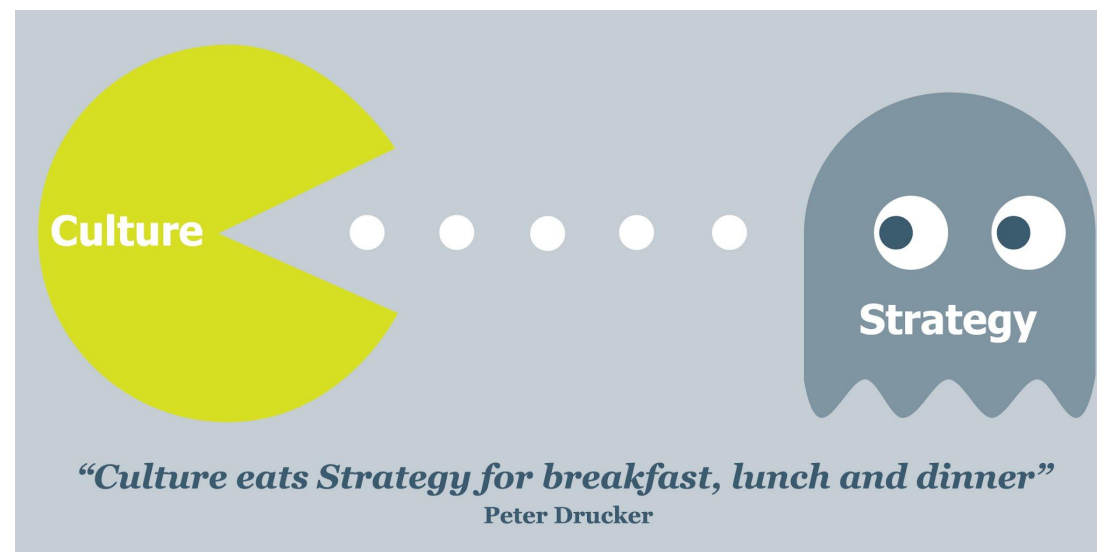
We act more like one joined-up system, not separate services working in isolation.

“Culture eats strategy for breakfast.”

Integration becomes real when people act as one system, even when organisations remain distinct.

A plan can set the destination. Culture determines whether the system moves together.

- | | | |
|----|----------------------------------|--|
| 01 | SHARED PURPOSE | One vision for people, not separate organisational priorities. |
| 02 | COLLECTIVE ACCOUNTABILITY | Leaders own whole-system outcomes across boundaries. |
| 03 | EVERYDAY BEHAVIOURS | Trust, openness and collaboration turn integration into reality. |





Continued Challenges

1. Separate Budgets and financial pressures
2. Separate accountabilities and inspection arrangements
3. Difference in sector cultures
4. Parity of esteem between Health and Social Care
5. Grown demand and complexity of need against a challenged system
6. Ability to spread and scale



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Case Study 1 [Shared Understanding and Purpose] – Winter Planning (50 day response) – All Wales

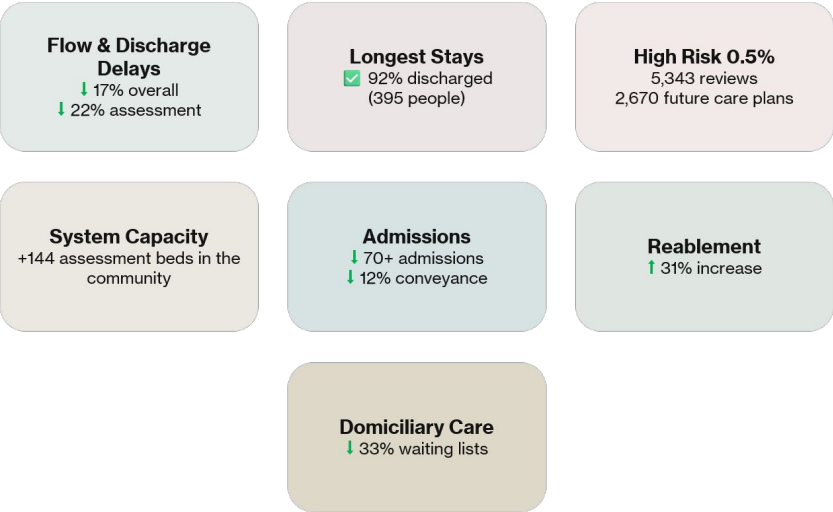
50-Day Integrated Care Winter Challenge - 10 Interventions

1. Optimal Hospital Flow Framework
2. 7-Day Health and Social Care Working
3. Complex Assessments in the Community
4. Integrated Navigation Hubs
5. Weekly Review of Length of Stay (LOS)
6. Primary Care DSS for High-Risk Population
7. Strengthening GP Support for Care Homes:
8. Trusted Assessor Model
9. Home First Principles
10. Community-Based Falls Response Pathways

Key Success Factors

- Shared understanding of system issues supported by data
- Greater clarity on partner contributions to a wider system issue
- Focus on 10 interventions to support consistency
- National leadership and accountability
- Regional Co-ordination through RPBs

Outcomes and Benefits



	National target	Dec '24 – Dec '25
Total delays	↓ 15%	↑ 6%
Days delayed	↓ 20%	↓ 30%
Assessment delays	↓ 20%	↓ 26.5%
Average Length of Stay		↓ 34%



Moving from strategy to implementation – success factors

**Coordination
through Regional
Partnership
Boards (RPBs)**

**Cross-Sector
Leadership**

**Governance and
Integrated
Working**

Cultural Change

**Strategic and
Operational
alignment:**

**Prevention and
Proactive
Management in
the community**

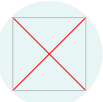
Case Study 4 – [Shared commitment/person centredness]
(North East Wales Multi-Systemic Therapy for Young People)

Keeping young people safely at home

Intensive, whole-family support for 11–17-year-olds at risk of care, custody or family breakdown

Health Board +
2 local authorities

2025/26 OUTCOMES

**25**

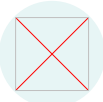
successful case closures

All 25 young people remained at home

**7**

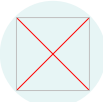
young people reunited with family

4 returned home + 3 further reunifications

**96%**

remained living at home

MST Community

**96% | 100%**

in EET | no further arrests

During the intervention period

How the model works

**Home-based** Therapeutic support is delivered intensively in the family home.

**Whole-family** Support addresses behavioural, social and environmental drivers of risk.

**Multi-agency** Health, social care, youth justice and education work together.

What this delivers

- Young people remain safely within their families and communities
- Stronger family functioning, relationships and resilience
- Lower risk of offending and care or custody placements
- Better engagement in learning, work and emotional wellbeing

Critical enabler: specialist therapists, continuous supervision and investment to maintain model fidelity

Case Study 3 – [Shared Culture]

Discharge to Recover and Assess Team (DART) – North Wales



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- Marleyfield House is a purpose-built care home that will facilitate a Discharge to Recover and Assess provision (the DART Team) in the county.
- We have invested national Revenue and Capital funds in its development through the RPB
- 16 DRA beds in the home offering 6 week interventions to support return home
- The DART Team provides short-term assessment, recovery and reablement support for people leaving hospital who are not yet ready to return directly home.
- Using the Discharge to Recover and Assess approach, the team helps people regain confidence, skills and independence before longer-term care needs are considered.
- DART brings together health and social care professionals to provide coordinated, person-centred support focused on recovery
- The service supports timely hospital discharge, reduces unnecessary delays, and helps ensure people receive the right care in the right place.
- ***They describe their shared understanding, team ethos and ‘no blame culture’ as a key factor in their success***



Recovery through a shared culture

Discharge to Recover and Assess Team (DART) • Marleyfield House, North Wales



16

DRA beds

at Marleyfield House



6 weeks

short-term intervention

focused on recovery



3,491

people accessed the service

2025/26



2,376

avoided escalation of need

2025/26

What DART provides



Recover closer to home

Short-term assessment, recovery and reablement for people leaving hospital who are not yet ready to return home.



Decide longer-term needs later

People rebuild confidence, skills and independence before longer-term care needs are considered.



One coordinated team

Health and social care professionals provide person-centred support focused on recovery and timely discharge.

The shared culture is the difference

“Shared understanding, team ethos and a no-blame culture”

This allows partners to work across organisational boundaries around one goal: helping people recover and return home safely.

Case Study 3 – [Shared Action] Delta Wellbeing (West Wales)



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Description

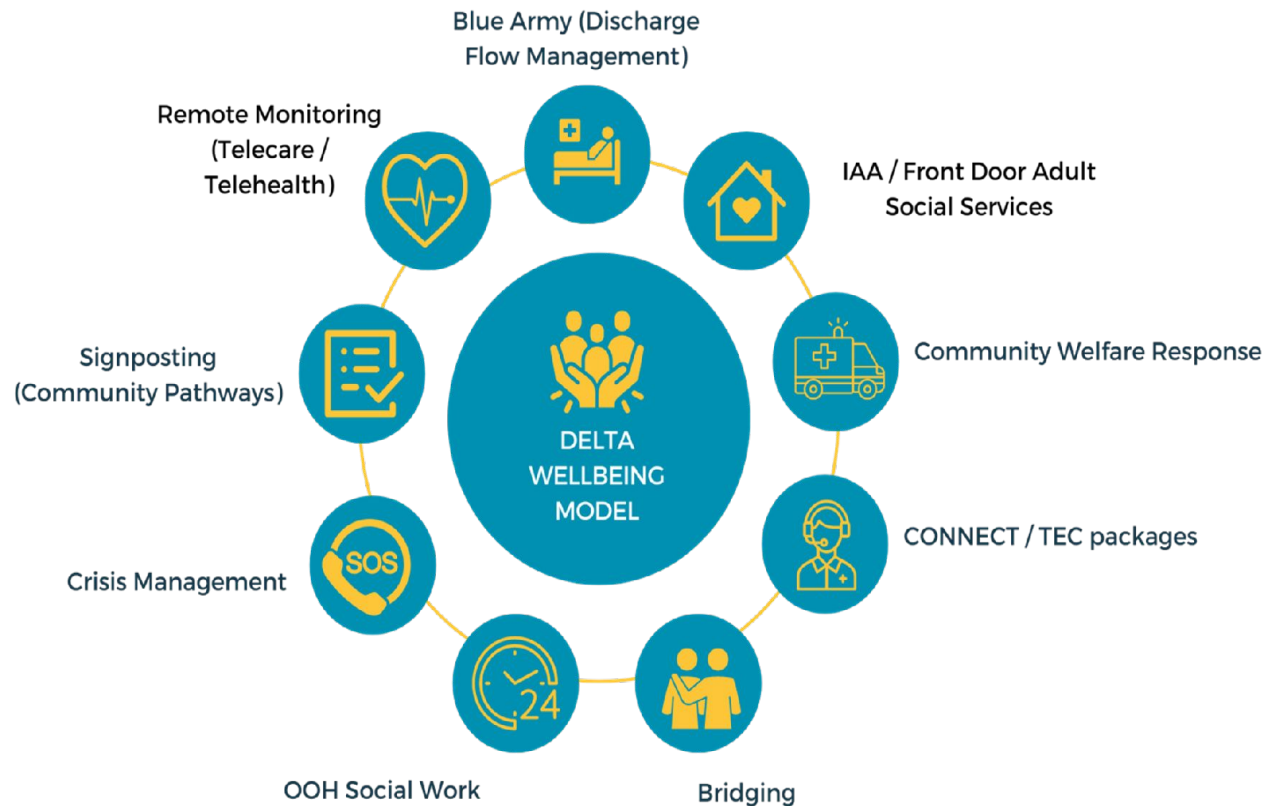
- Integrated health and social care single point of contact combining technology-enabled care, wellbeing support and community response services.
- Delivers proactive, person-centred support to help people remain independent at home
- Connected care that acts before crisis

Outcomes and Benefits

- Supports independence and prevents crises and reduces demand on hospitals.
- Enables earlier discharge and avoids admissions (250–300 admissions prevented per month through SPoA activity)
- Delivered 1,778 bed days saved through care at home in West Wales.
- Around 94% of Alarm Receiving Centre calls dealt with by DELTA response service (Nov 2025), with only 6% requiring referral to ED.

Key Success Factors

- Strong partnership working across health, local authorities and third sector, and pooled resources
- Prevention culture and home-first approach.
- Effective use of technology-enabled care.
- Coordinated, person-centred delivery model



Delta at a glance

IMPACT SNAPSHOT

DELTA

Preventing escalation, supporting people earlier and making better use of health and care resources

IAA FRONT DOOR

1

21,292

social care enquiries

during 2024–25

40.87%

resolved through prevention

2024–25

25/26 Q1

55.48%

with some weeks above

70%



HOMEFIRST

2

685

front door turnarounds

admission prevention, Jan–Jul 2025

≈ 50 per week

9–5, Mon–Fri

CONNECT

3

467.06%

return on investment

Unlocking non-cashable gains by maximising existing health and care resources

Keeping people on the right pathway

Delta response and SPoA intervention activity

ARC RESPONSE

94%

6% onward referral to ED

dealt with by Delta responders

SPoA INTERVENTION

4

250–300

estimated hospital admissions prevented each month

How

Professional-to-professional advice

Calls pulled from the 999 stack and rerouted to alternative pathways

Periods and measures vary by service. Figures shown exactly as supplied.



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Next steps....

Review current architecture

Deepen system integration
and strengthen
accountability

Shift health resource and
capacity from hospital to
community

Strengthen Social Care and
create a National Care
Service for Wales

Thank you!

Diolch!

Gracias!

Eskerrik asko!

Shelley.Davies052@gov.wales