**Cwmtawe Pathways Service**

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## Introduction

Cara Lougher is the Coordinator and Wellbeing Practitioner for the Cwmtawe Pathway Service and has been working in the cluster for five years.

## Background

The Cwmtawe Pathway Service was developed as a collaboration between Swansea Council for Voluntary Services (SCVS) and the Cwmtawe Cluster in 2021 (paused due to Covid) off the back of the social prescribing project that was already working within the cluster. The Social Prescribing service found they were working with adults with complex needs and beyond what they were able to offer.

During Covid lots of individuals were using substances and there was increased domestic violence in the cluster. Following consultation with Stakeholders, the cluster invested in a service to work with people holistically rather than just working on individual issues.

## The Cwmtawe Pathways Service

The Cwmtawe Pathway Service supports adults with complex and co-occurring needs. They might have experienced domestic abuse or sexual violence or be using substances to cope and manage. This could be alcohol or drugs. The service recognises their mental health, and physical health could possibly be impacted therefore the Complex Needs Worker and Support Worker work with individuals where there are two or more of these things happening or co-occurring. Often a host of other things, happening in the background, are picked up and the service will provide support for these too.

The service provides person-centred care to truly support individual needs and provide a bespoke package of care. It could include flexible appointments, whether by telephone in person or online. It could be in surgery, in the community, or a home visit.

The service can work with people for short term or for a longer term. Some people have been with the service for up to a year and have been supported through their journey by helping to coordinate their care as well as delivering an element of it.

## Case Study

A gentleman presented to the social prescriber through the Mental Health and Wellbeing hub. Social Prescribing is a lower-level support service that looks for support in local groups for the patient to attend. Through working with the practitioner, it was discovered that he had much more complex and co-occurring needs. The social prescriber brought that person to the virtual ward mental health hub and discussed whether it would be suitable to have some more one-to-one support for him to coordinate all the care needs he had. This gentleman had a history of domestic abuse and there was an issue with a marriage break up he was going through causing him considerable amounts of stress. He had very low income and wasn’t accessing all the benefits that he was entitled to. He also had a chronic health condition, and his home and tenancy were not suitable for his needs.

The Complex Needs worker was able to support him and work with him to create safety and stability in his life. Through that he developed a greater resilience. He was able to engage with other people more and was much more open to engaging with his GP and the Complex Needs Worker was able to advocate for him with his GP to support him with communications about medications for his chronic condition.

They also helped him navigate tenancy support, who were able to look at alternative accommodation which would be ground floor and much better for him. Through the virtual ward and mental health hub, the occupational therapist was able to do a joint visit and assess his physical needs and give a supportive statement for housing, which really helped the transition of moving things forward.

Working on a weekly, bi-weekly basis as needed, the gentleman was eventually ready to come back to the virtual ward now stable and secure. All the stresses had been managed and everything in the pipeline. He was now in a much better place to engage with the counselling that was going to be offered. The virtual ward helped access the right person at the right time and is a testament to how much holistic work is for the people and the beneficiaries that we support through the service.

## Evaluation

An economic return evaluation with Swansea University looked at the upstream costs saved through working in a person-centred approach over a longer duration and focusing on the needs of the patient. They were able to demonstrate that there was not just cost savings to health, but savings to other key stakeholders as well.

Eg. Mental health services. As this was a preventative measure, individuals were less likely to:

* need to be seen by a psychiatrist.
* need an inpatient appointment.
* be bed blocking in hospital.

Of the multiple savings across those key stakeholders, there was also evidence to show less crime.

## NHS Awards

The Complex Needs service won the award in the category of Providing Person-Centred Care with NHS Wales in 2023. That was a lovely tribute to the work undertaken within the cluster as a cluster initiative, and a whole systems approach working with people in the person-centred way.

The feedback received from winning the award was that there is not another service like it anywhere else in Wales. Panellists were impressed with the flexibility in the approach. Asking patients how they would like to be contacted, when they would like to be seen, how they would like to meet , how often they would like to meet, what they wanted to cover, what their needs were, and what mattered to them.

It is not about an agenda as a practitioner, it really is determining the other issues, that were not substance use, domestic abuse issues or mental health, and being able to focus in on them.

## The Future

The Cwmtawe Pathway Service has secured another two years’ funding; moving into year five and six.

The team recently expanded with the addition of a support worker, providing valuable assistance in managing patients and administrative tasks. There is optimism that winning the NHS award—both for the project itself and its role in the wider whole systems approach—will lead to broader adoption.

The success of the Cwmtawe Cluster hub and virtual ward is seen as an exemplar model, particularly as other clusters without similar setups are facing these challenges. There are hopes that shared data and outcomes will help integrate this approach across other clusters.