Relational Practice in Wales: what's still needed

What practitioners, mentors and leaders are telling us about the conditions needed for relationship-centred public services

A practice-based discussion paper from Gwrando
May 2026

This report draws on follow-up reports, mentor evidence and senior leadership reflection from the Collaborative Communication Skills Programme across Wales.

Executive summary

This report draws together practice learning from the Collaborative Communication Skills Programme, a long-running programme in Wales that has supported relational, strengths-based and outcomes-focused practice across social care and wider public services. The programme has been delivered across almost every local authority in Wales over the last twelve years, with an estimated reach well into the thousands and there are currently around 400 active mentors supported by Social Care Wales.

The evidence base for this discussion paper is practice-rich rather than formally evaluative. It includes reviewing approximately 100 follow-up reports from recent years, each typically representing the views of a group of around ten practitioners, alongside some mentor evidence and senior leadership reflections. This gives a substantial qualitative dataset of practitioner and leader experience across children's services, adult social care, housing, hospital discharge, community services and integrated front-door contexts.

The central finding is clear: relational practice is not failing because practitioners do not believe in it. Across the reports, practitioners describe strong commitment to listening, collaboration, curiosity, strengths, voice and control. They also describe clear examples of impact: better engagement, more meaningful personal outcomes, reduced defensiveness, more proportionate support, improved reflective capacity and stronger attention to the person's own story. The difficulty is that these approaches are being practised in systems marked by high demand, rising complexity, poverty, risk anxiety, workforce pressure, fragmented initiatives and limited reflective space.

The strongest implementation message is that relational practice cannot be sustained by frontline skill alone. Training can create confidence and shared language, but the reports repeatedly show that practice change depends on leadership, culture, supervision, time, trust, workload, integration and the extent to which organisations align their processes with the values they ask practitioners to live out.

Headline message
Wales does not lack relational ideas or commitment. The challenge is creating coherent organisational conditions that allow those ideas to be practised consistently, especially when risk is high, demand is relentless and staff are stretched.

Headline findings

Theme	What the data shows	Significance
Relational practice is alive in everyday work	Practitioners are using listening, reflective statements, curiosity, strengths and outcome-focused questions in real conversations with people and families.	The approach is not simply being remembered as training; it is being translated into practice.
The main barriers are conditions, not commitment	Time, caseloads, staffing, lack of private space, administrative pressure, risk culture and fragmented systems repeatedly make relational work harder to sustain.	Effective and sustained implementation needs to move beyond training into leadership, mentoring, culture and system design.
Reflective practice is valued but vulnerable	Teams value structured reflective spaces, supervision, mentoring and peer debriefs, but these are	Reflection needs to be treated as core practice infrastructure.

	often the first things to disappear when staffing or demand pressures rise.	
Leadership is decisive	Where leaders model the approach, protect time, listen and remove barriers, staff describe more confidence. Where managers are absent from the approach, or where managers are isolated in holding the approach, practice becomes inconsistent.	Leaders at all levels need to be trained, supported and held accountable for creating relational conditions. Operational managers are KEY to enabling practice conditions, but they too need support to enable them to do this.
Risk pulls practice towards control	High-risk contexts can shift practice from curiosity and collaboration towards urgency, surveillance, directive responses and defensive recording.	Relational practice should be understood as good risk work, not as a softer alternative to risk management.
Initiative overload is undermining coherence	Staff encounter many aligned approaches - trauma-informed practice, Signs of Safety, Ask and Act, contextual safeguarding, recovery approaches and co-production, compassionate leadership etc - but they are perceived as separate initiatives.	A coherent relational practice strategy could connect these approaches and reduce ideology fatigue.
Women carry much of the relational load	Over 95% of participants in the follow-up sessions are women, broadly reflecting the feminised social care workforce in Wales. Many describe exhaustion, overwork and emotional strain (without necessarily using the language of burnout).	Workforce wellbeing needs to be understood through gender, emotional labour, caring expectations and organisational culture.

1. Purpose and scope of this report

This report is intended as a practice-based discussion paper. It is not a formal programme evaluation and does not claim causal impact. Instead, it does something different: it brings together repeated practitioner, mentor and leader reflections from across Wales and asks what these tell us about the real conditions needed for relational practice to take root.

The report is written at a point of transition: from the long-standing work developed through Achieving Sustainable Change and Rhoda Emlyn Jones, towards Gwrando as a new vehicle for relational, collaborative and embodied practice development. The intention is to honour what has already been built, while being honest about what the next phase requires if we are to progress this movement.

The report uses the language of relational practice as an umbrella term. This includes strengths-based, outcomes-focused, collaborative, trauma-informed and relationship-centred ways of working. It also recognises that similar principles are present in other major schools of thought and policy directions,

including Signs of Safety, contextual safeguarding, Ask and Act, recovery-oriented mental health practice, co-production, psychologically informed environments, Human Learning Systems and The Relationships Project.

Purpose of the report
To describe what practitioners, mentors and leaders are learning about relational practice in Wales; to identify what enables and inhibits it; and to argue that the next stage of implementation requires leadership, cultural coherence and protected conditions, not more training alone.

2. Methodology and evidence base

The evidence used in this report comes from the Collaborative Communication Skills Programme and related reflective sessions. The programme usually includes two days of experiential training, a one-day follow-up, a three-day mentor programme and, in some areas, leadership and train the trainer input. The follow-up sessions provide space for practitioners to reflect on how the approach is being applied in live practice, what is changing, what is difficult and what would help the approach embed.

For this report, the main dataset is approximately 100 follow-up reports from recent years across multiple local authorities and some third sector organisations. With each group averaging around ten people, the findings represent the experiences and reflections of several hundred practitioners.

The analysis is thematic. Reports were reviewed for repeated patterns across the headings practitioners themselves commonly use: what is working well, what gets in the way, what would make a difference and what leaders need to understand. Themes were then compared with relevant research and policy evidence.

There are limitations. The reports are not independent research interviews, and participants are drawn from groups who have already engaged with the programme. However, the consistency of the findings across geography, service area, role and time gives them weight. They are particularly valuable because they capture what implementation feels like in everyday conditions, not only what policy intends or training describes.

A note on tone
The findings should not be read as a criticism of practitioners, managers, health colleagues or local authorities. They describe people trying to practise humanely inside pressured systems. The report therefore focuses on conditions, not blame.

3. The Welsh context: relational practice is already policy

The findings sit within a distinct Welsh policy context. The Social Services and Well-being (Wales) Act 2014 places well-being, voice and control, prevention, co-production and strengths at the centre of social care. The Act expects practitioners to work with people, families and communities in ways that identify what matters and build on strengths rather than beginning with service deficits alone.

This direction is echoed in Social Care Wales resources on strengths-based practice and outcomes, and in the earlier Social Care Wales evaluation of the Collaborative Communication Skills Programme, which found that outcomes-based practice needs whole-system support if it is to become embedded rather than remaining a training intervention (Practice Solutions and Imogen Blood and Associates, 2019).

The wider public service context is moving in a similar direction. Contextual safeguarding asks services to understand harm within the places, relationships and inequalities that shape people's lives (Firmin, 2020). Signs of Safety offers collaborative ways of thinking about danger, safety, strengths and next steps (Turnell and Edwards, 1999). Ask and Act, in the homelessness and housing context, relies on confident, safe and

purposeful enquiry. Recovery-oriented mental health practice emphasises hope, identity, agency and community connection. Trauma-informed approaches emphasise safety, trust, choice, collaboration and empowerment.

The problem, therefore, is not that Wales lacks aligned ideas. The problem is that these ideas are often implemented as separate initiatives, with different language, training pathways and reporting expectations. This can leave frontline staff with ideology overload: lots of good frameworks, not enough coherent strategy pulling them together nor these being understood as practical and applicable in practice.

4. The context in which relational conversations happen

A recurring message across the reports is that relational conversations do not happen in calm, ideal conditions. They happen in living rooms, hospital wards, housing offices, contact centres, duty systems and multi-agency meetings where people may be frightened, angry, ashamed, exhausted, mistrustful or under pressure.

This matters. Around 31 per cent of children in Wales are living in relative income poverty, and poverty has remained stubbornly high over the last decade (Welsh Government, 2026). The Joseph Rowntree Foundation also highlights deep poverty pressures in Wales, including higher poverty rates among larger families and very young children (JRF, 2025). These are not background statistics; they are part of the emotional and practical landscape of social work conversations. When families are asked to change, engage, plan or reflect, they may also be dealing with debt, poor housing, insecure work, hunger, trauma, poor health and services that feel hard to access.

Adult social care carries parallel pressures. Wales has an ageing population, increasing complexity, rising dementia and chronic health need, and significant pressures on hospital discharge and community provision. Recent Welsh policy documents describe sustained pressure, rising demand and reform across social care. Practitioners in the reports describe this in lived terms: more complex need, higher demand, reduced prevention, service gaps and the sense that people reach services later, with less scaffolding around them.

Within this context, relational practice is sometimes described as if it were an optional quality improvement. The findings suggest the opposite. Relational practice is one of the mechanisms by which practitioners make sense of complexity. It helps people regulate, think, trust, disclose, disagree, plan and take part in decisions that affect their lives. It is therefore central to quality, risk and resource use.

5. What is working: practice impact from the reports

Across the dataset, practitioners describe the Collaborative Communication approach as a reset rather than a brand-new philosophy. It gives structure and confidence to things many practitioners already value: listening, empathy, curiosity, strengths, silence, reflection, affirmation and outcome-focused conversations.

The strongest practice examples are modest in the best sense. They are not usually dramatic transformations. They are changes in the direction of a conversation: a parent opening up; a housing customer feeling heard; a practitioner noticing they are pushing too hard; a meeting becoming less conflictual; a care package being adapted rather than simply increased; a person’s own words appearing more clearly in an assessment; a worker feeling less alone after reflection.

Practice learning
The reports repeatedly show that small shifts in the quality of conversation can produce larger shifts in trust, understanding and the fit of support. This is why the approach should be treated as core practice, not as communication polish.

5.1 Personal outcomes and assessment quality

Mentors and practitioners describe improvement in how personal outcomes are elicited and recorded. Rather than moving quickly to service questions, workers describe spending more time understanding what matters to the person, what they hope for, what strengths are already present and what support would make life more possible.

This reflects the mentor evidence that the quality of the conversation shapes the quality of the plan. If assessment begins with deficit and service gap, planning is more likely to become service-led. If assessment begins with identity, relationships, strengths and what matters, planning is more likely to become proportionate, personalised and preventative.

5.2 Right support, not simply more support

Several examples show practitioners moving beyond the presenting request. This is not about denying support. It is about understanding whether the request is naming the real issue. In the mentor report, a request for more replacement care became a more nuanced conversation about the fit of support, leading to a different model rather than an automatic increase in hours. This is resource-conscious because it is person-centred, not because it is restrictive.

This is where Collaborative Communication has particular promise for public services under pressure. Better conversations can reduce waste: support that does not fit, plans that escalate because the real issue has not been understood, repeat assessments caused by low trust, or packages that grow because no one has had time to ask a different question.

5.3 Stronger engagement in difficult conversations

Practitioners describe relational approaches helping in multi-agency meetings, safeguarding conversations, housing contexts and emotionally charged family work. In some reports, practitioners noticed a meeting changing tone because they used listening, reflection and curiosity rather than blunt challenge. In others, staff described families responding quickly when they felt listened to, changing the dynamic of the visit or meeting.

5.4 Reflective practice as the place where learning becomes practice

Reflective practice appears in almost every set of findings as both an enabler and a fragility. Teams value structured reflective sessions, the Heart of the Matter tool, informal debriefs, clinical supervision, team discussions and mentor-led spaces. These spaces help staff process emotional impact, think beyond immediate fixes and learn from each other without shame.

6. What gets in the way: the recurring barriers

The barriers across the reports are strikingly consistent. They are not primarily about practitioners rejecting relational practice. They are about the conditions within which practitioners are trying to practise.

6.1 Time, space and capacity

Time is the most common barrier, but practitioners usually mean more than busyness. They mean the absence of relational space: time to prepare, listen, think, visit, reflect, write thoughtfully and follow through. They also mean literal space: private rooms to meet people, accessible offices, safe places to talk and enough capacity to avoid every conversation being squeezed between crises.

Some reports describe social work teams with very uneven caseloads and housing officers holding large numbers of cases. Staff also note that raw case numbers do not capture complexity. Ten very complex pieces of work can carry more emotional and practical demand than twenty more straightforward ones. This suggests that workload management needs to account for complexity, risk, emotional labour, travel, multi-agency work and administrative load, not only numerical allocation.

6.2 Risk, anxiety and the pull towards surveillance

High-risk contexts pull practice towards urgency. Practitioners describe becoming more directive, more procedural, more focused on immediate risk and less able to explore context, strengths or ambivalence. They also describe organisational cultures where recording, accountability and defensiveness can become dominant.

Lucy Treby's Cardiff University doctoral research is highly relevant here. Her study of supervision and home visits in statutory child and family social work in Wales found that supervision and home visiting sit within systems dominated by anxiety and fear, where organisations, supervisors and social workers can respond through surveillance and proceduralisation (Treby, 2026). She also identifies the endurance of surveillance as one way the system manages fear and anxiety. This gives academic backing to what the follow-up reports repeatedly describe: when risk rises, the system often narrows, even when practitioners still believe in relational practice.

This does not mean process is wrong. Safeguarding requires clarity, evidence and accountability. The issue is what happens when process becomes the main source of reassurance. In those moments, practitioners may feel safer because forms are completed and decisions are recorded, but the quality of relationship, understanding and engagement can reduce. The evidence suggest that relational practice is needed most precisely at the points where risk and anxiety make it hardest.

6.3 Office culture and the drift back to doing

Some practitioners describe relational practice feeling easier with families, in homes or direct conversations, than back in the office. The office can pull people back into task, deadline, recording, email and managerial demand. Newer staff, in particular, may feel they need permission from the top to spend time reflecting rather than doing.

This is an important implementation finding. If the culture around practitioners values speed, compliance and productivity more visibly than reflection, curiosity and relationship-building, practitioners will quickly learn what is really rewarded. Culture is not created by statements of intent; it is created by what organisations repeatedly protect, notice and measure.

6.4 Fragmentation and ideology overload

Another barrier is initiative overload. Practitioners across Wales are engaging with multiple aligned approaches: trauma-informed practice, contextual safeguarding, Signs of Safety, strengths-based practice, Ask and Act, recovery approaches, psychologically informed environments, co-production, motivational interviewing and outcomes-focused practice. These are not competing ideas. Most share a family resemblance: they value relationships, voice, context, strengths, safety, collaboration and power-sharing.

The difficulty is implementation in silos. Staff experience repeated training, new language and changing priorities without enough time to embed. This creates fatigue and can make good ideas feel like passing initiatives. This suggest that the next phase should not be another model competing for attention. It should be a coherent relational practice strategy that shows how these approaches connect and what they mean in everyday decisions, supervision, panels, recording, commissioning and leadership.

6.5 Integration with health: empathy and realism

Hospital and integrated teams describe both strong promise and real difficulty. Shared training with health colleagues can break down barriers and create enthusiasm. However, sustaining momentum is harder when the wider multi-disciplinary system is spread across sites, under discharge pressure, led by medical risk narratives or without senior health participation.

The reports are careful not to blame health colleagues. This matters. Health services are also working under immense pressure, with their own workforce stress, performance expectations and risk responsibilities. The finding is not that health is resistant to relational practice. It is that integration needs relational infrastructure: shared language, protected time, senior sponsorship, reflective spaces, role clarity and practical mechanisms that fit the pace of hospital work.

Research on integrated care supports this. Structural integration alone does not create collaboration. Effective integrated care depends on relationships, trust, shared purpose, psychological safety and practical opportunities for professionals to understand each other's work. Collaborative Communication therefore holds promise not only as a social care practice approach, but as a shared language for health, housing and social care teams navigating complexity together.

7. Leadership, supervision and culture: the decisive conditions

The strongest finding across the whole dataset is that relational practice depends on leadership and culture. Practitioners can learn and use the skills, but they cannot by themselves create the conditions for sustained practice change.

7.1 What leaders heard when they listened

The senior leadership reflective workshop in one authority is significant here. Leaders discussed their own experience, as leaders, of trust, psychological safety, visibility versus availability, meeting overload, burnout, the need for routine story-based reflection and the risk that some reflective practice tools become reductive if treated as process rather than ethos.

This is a mature leadership finding. It recognises that leaders themselves can become trapped in the same pressures they are asking staff to resist: relentless diaries, transactional meetings, loneliness of decision-making, anxiety about risk and the pressure to produce visible progress. The implication is not that leaders should simply tell staff to be more relational. Leaders need support and structures to practise relationally themselves.

Leadership learning
If senior leaders are operating in back-to-back meetings without thinking time, missing breaks and carrying anxiety alone, it becomes much harder for them to create calm, reflective, relational conditions for others.

7.2 Supervision as part of the intervention

Treby's research is particularly useful in strengthening the argument about supervision. She begins from the proposition that supervision is not separate from practice: it is part of the intervention process and has implications for the quality of service delivery and the experience of families. Her study asks whether the nature of interactions between supervisors, workers and managers corresponds with how workers then interact with families (Treby, 2022).

This maps directly onto the follow-up reports. Practitioners notice when the approach is mirrored in supervision, and they say this helps embed it. They also notice when managers have not attended training or do not share the language, leaving staff pulled between the approach and the system. This suggests a simple but important principle: organisations cannot expect practitioners to work collaboratively with families if supervision and management are experienced as purely directive, anxious or compliance-led.

7.3 Psychological safety and learning culture

Several reports call for reflective spaces where staff can say, without shame, that a conversation did not go well or that they felt pulled into fixing, bluntness, defensiveness or avoidance. This is an example of psychological safety: the ability to speak honestly about uncertainty, mistakes and learning without fear of humiliation or punishment (Edmondson, 1999).

Psychological safety is not softness. In safeguarding and public service work, it is essential to quality. If staff cannot talk about what they are unsure of, what they have avoided, where they felt frightened, or how they used authority, then organisations lose access to the very information needed for learning and risk management.

7.4 What leadership needs to do differently

The reports suggest that leadership for relational practice is practical and visible. It includes attending the training, modelling listening, protecting reflection, making time for stories, reducing unnecessary meetings, aligning quality assurance, challenging metric-only reporting, supporting mentors, using staff feedback, addressing caseload disparity and communicating change with courtesy and clarity.

Leaders do not need to perform perfection. The opposite may be more useful. Staff need leaders who can name complexity, acknowledge pressure, admit uncertainty, hold boundaries and still remain connected. This is relational authority at organisational level.

8. Gender, emotional labour and burnout

A notable feature of the programme experience is that over 95% of participants in follow-up sessions are women. This is higher than, but consistent with, the wider social care workforce in Wales. Social Care Wales reported in 2025 that women occupied 81.1 per cent of social care roles in Wales. The point is not to essentialise women as naturally relational. Rather, it is to notice that much of the emotional labour of relational public service work is being carried by a predominantly female workforce.

This matters for how we understand barriers. Practitioners frequently describe exhaustion, overwork, shielding colleagues, not switching off, carrying distress, feeling responsible and continuing to function. They may not use the word burnout, but the pattern is familiar: emotional depletion, reduced capacity for reflection, irritability, numbness, difficulty switching off, and a narrowing of thinking under pressure.

Burnout research has long emphasised emotional exhaustion, depersonalisation or cynicism, and reduced personal accomplishment (Maslach and Leiter, 2016). In social work, studies have linked burnout and retention pressures to workload, emotional demands, organisational support, supervision quality and exposure to trauma and risk (McFadden et al., 2015; Kinman and Grant, 2017). Dr Claire Plumbly's clinical writing on burnout adds a useful nervous-system lens: burnout is not simply tiredness, but a state where chronic stress changes how people think, relate and recover (Plumbly, 2024).

This has direct relevance for relational practice. A depleted workforce cannot simply be asked to be more empathic, more curious and more reflective. When people are chronically stressed, they are more likely to seek certainty, act quickly, avoid emotion, become directive or withdraw. This is not failure; it is human physiology. It is also why workforce wellbeing is not separate from practice quality.

The gendered dimension also matters because women are more likely to carry caring responsibilities outside work and may experience additional mental load. Welsh Government equality reporting continues to show gendered differences in employment and economic inactivity linked to caring responsibilities. For a predominantly female workforce, expectations of emotional availability at work may sit alongside unpaid caring responsibilities at home. This raises serious questions for leaders about boundaries, workload, rest, flexibility, psychological safety and whether organisational cultures unintentionally reward self-sacrifice.

Implication for leaders
If relational practice depends on presence, curiosity and emotional availability, burnout is not only a wellbeing issue. It is a practice quality and safeguarding issue.

9. Impact if the approach is embedded

The reports suggest impact at three interconnected levels: people and communities, workers, and organisations. These impacts are not yet a formal outcomes evaluation, but they offer a credible framework for future measurement.

9.1 Impact for people, families and communities

Where relational practice is embedded, people are more likely to experience conversations that feel human, respectful and useful. The reports suggest stronger voice and control, clearer personal outcomes, less defensiveness, better attention to strengths and a greater chance that support will fit the person's life rather than simply the service pathway.

In children's services, this may support more honest engagement, better understanding of family context, and more meaningful safety planning. In adult services, it may support proportionate care planning, carer involvement, autonomy, independence and community connection. In housing and community settings, it may support earlier trust, better understanding of need and less escalation caused by people feeling unheard or passed around.

9.2 Impact for workers

For practitioners, the approach appears to increase confidence in difficult conversations, permission to slow down, ability to use empathy intentionally and capacity to reflect on power, authority, risk and emotion. Mentoring and reflective spaces reduce isolation and help staff process the emotional demands of the work.

The approach may also reduce moral distress. Many staff enter social care because they want to work with people in humane and purposeful ways. When systems pull them into task-only practice, this creates dissonance. Relational practice, when organisationally supported, can reconnect workers with professional values and give them practical tools to act on those values.

9.3 Impact for organisations and systems

For organisations, the promise is better quality assessment, more proportionate support, stronger engagement, improved staff retention, better integrated working and more useful evidence of impact. This should not be over-claimed as a simple cost-saving intervention. However, the practice evidence suggests plausible areas of cost avoidance: avoiding support that does not fit, reducing unnecessary escalation, preventing premature residential or institutional responses, improving discharge planning and reducing repeat work caused by poor engagement or low trust.

A credible impact framework should combine qualitative stories with measurable indicators: outcome quality in assessments, evidence of strengths and voice, redesigned rather than increased support, step-down decisions, avoided escalation, staff confidence, retention, sickness, mentor activity and reflective practice participation.

10. Conditions for sustaining the approach & recommendations

Condition	Why it matters
Visible senior leadership sponsorship	Staff need explicit permission to work relationally, especially when pressure and risk make task-only practice feel safer.
Leadership participation in the approach	Practitioners repeatedly say implementation is limited when managers and decision-makers have not attended or understood the training.
Protected reflective practice	Reflection must be scheduled, led and protected as core work, not left to pinched minutes or the goodwill of one practitioner.
Mentor time and role clarity	Mentors are the bridge between training and practice. Without time, recognition and support, the mentor role becomes another add-on.
Supervision aligned with relational practice	Supervision should mirror the approach: reflective, purposeful, emotionally containing, clear about risk and not only task-monitoring.
Coherent initiative strategy	Leaders should connect trauma-informed practice, contextual safeguarding, Signs of Safety, Ask and Act, strengths and recovery under a shared relational practice framework.
Workload and caseload realism	Relational practice requires capacity. Case complexity, emotional labour and administrative demands should be considered alongside numbers.
Integrated cross-agency ownership	In hospital, housing and community settings, shared language and senior sponsorship across agencies are essential.
Quality assurance alignment	Audits, panels and performance systems should look for voice, strengths, context, relational risk and proportionality, not only process completion.
Gender-aware workforce wellbeing	The emotional labour carried by a predominantly female workforce should be recognised in workload, supervision, wellbeing and leadership strategies.

Recommendations For Social Care Wales and national partners:

- Continue supporting the mentor network as a national asset for sustaining relational practice.

- Use the learning from this dataset to inform national conversations about implementation, supervision, leadership and workforce wellbeing.
- Encourage local authorities and partners to treat relational practice as a whole-system approach, not a workforce development event.
- Support the development of common language across aligned approaches to reduce fragmentation and initiative fatigue.

11. Conclusion

The findings from the follow-up reports, mentor evidence and leadership reflection point in the same direction. Relational practice is already happening across Wales. Practitioners are using it in difficult conversations, safeguarding work, housing contexts, hospital discharge, assessment, supervision and peer reflection. They are seeing impact. People feel heard. Conversations shift. Outcomes become clearer. Support can fit better. Workers feel more connected to their values.

But the same findings also show that relational practice is fragile when left to individual commitment. It is squeezed by time, risk, workload, burnout, fragmented initiatives, poor communication, lack of leadership alignment and systems that continue to reward speed and process over relationship and learning.

The next stage, therefore, is not simply to train more practitioners. It is to build the conditions around them. That means leadership that models the approach; supervision that contains and develops practice; workload systems that recognise complexity; reflective spaces that are protected; integrated partners who share language; and organisational cultures that trust staff enough to let them think.

Wales already has a strong policy foundation for this work. The challenge now is implementation with enough coherence, courage and patience to stay with it long enough to see results.

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