STORY OF CHANGE TEMPLATE

Reporting Period	End of Quarter 2 – Financial Year 2023-24
Strategic Partnership	West Glamorgan Regional Partnership
Programme Name	Communities and Older People Programme
Programme Reference	

Programme Overview

This programme focusses on the development of new models of financially sustainable and integrated community health and care to support people to remain living safe and well within their own homes and communities.

The Aims of the Programme are to:

- Enable individuals to remain as independent as at all possible and in the own home for as long as possible.
- Increase Respite Services in line with increasing demand.
- Develop and Enhance Prevention approaches to reduce the need for acute and long-term care.
- Reduce social isolation and loneliness.
- Develop and enhance falls prevention care.
- Ensure safe and timely discharge from hospital
- Strengthen the Discharge to Recover and Assess Pathways and ensure we support the individual in what matters to them.
- Continue to make West Glamorgan a Dementia Friendly Region
- To Ensure Sustainable Care Provision and High-Quality Care Homes

In 2012, the West Glamorgan Regional Partnership implemented “What Matters to Me” model of care. This was based on developing and coordinating community services across the region to support individuals to remain at home for as long as possible and avoid/reduce unnecessary hospital or care home admissions by providing the right support at the right time.

Over the years, this model has changed and adapted to suit the needs of the individuals within the communities across the region, and further work and funding has been spent to provide the very best Regional Preventative Approaches.

The Intermediate Care Services initiative aims to support and anticipate the needs of individuals and continue to support the prevention of admission to hospital or a care home. To do this, we have developed regional services that will deliver the same high-quality care and support in a person’s place of residence, and not in an acute setting where individuals are at risk of deconditioning and or infection.

It was identified early on that the best way to support individuals to live as independently as possible was to provide them a whole system approach providing care and well-being support locally with good quality information and advice, developing community resilience so people feel safer, less isolated and more able to achieve their personal outcomes, promoting less reliance on more formal health and social care services.

The main aims of the programme can be defined as:

- To make sure that all service delivery within the model maximises independence, is outcome focussed and is based on each individual's specific needs.
- To implement a Whole System approach across the region of West Glamorgan to avoid hospital admission and to safely discharge individuals via the Discharge to Recover Assess Model.
- To implement a consistent regional Discharge to Recover and Assess model, based on a "Home First" ethos across the West Glamorgan footprint to avoid hospital admission where appropriate, and facilitate timely discharge with relevant support.
- To expedite discharges to ensure there is flow through the hospital and social care system to match the expected discharge profile, through the facilitation of safe and timely discharge, allowing for a period of recovery before any assessment of long term care need is undertaken, therefore maximising outcomes and improving service user's experience.

The West Glamorgan Regional Partnership has undertaken a huge amount of transformational work in the area of intermediate Care Services and has been a leader in the implementation of the Discharge to Recover then Assess (D2RA) national model, steps ahead of many other regions within Wales.

There a multiple teams aligned to Intermediate Care Services and partnerships are integral part of the culture. The service is very much a 'Team of Teams' inclusive of Health Board, Local Authority and Third Sector staff aligned and working together to support timely flow and outcomes for patients admitted to the pathways.

Delivery Partners

Statutory partners included in the delivery of the programme are:

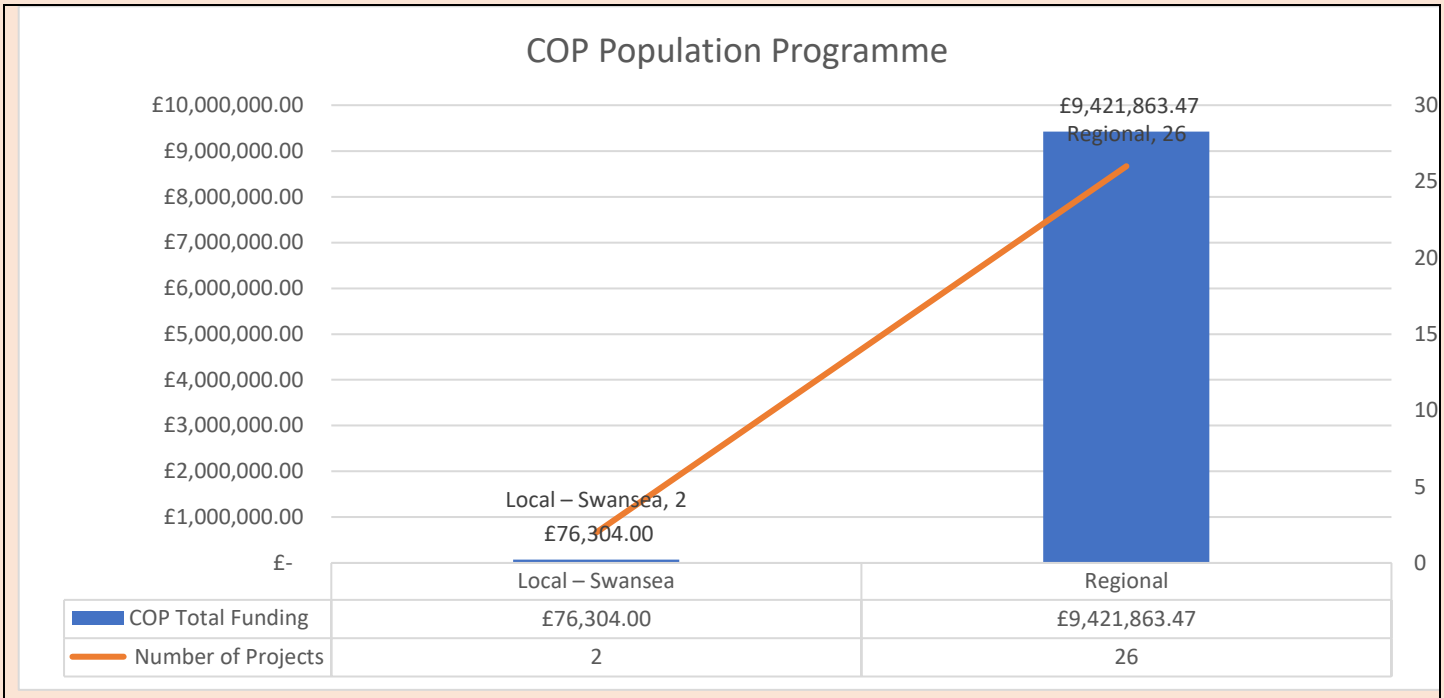
- Swansea Bay University Health Board
- Neath Port Talbot County Borough Council
- Swansea Council
- Along with third sector organisations, citizens and parents/unpaid carers

All partners work together through the West Glamorgan Regional Wellbeing and Learning Disability Programme Board and review delivery of projects across the region, what's working well and what opportunities are arising.

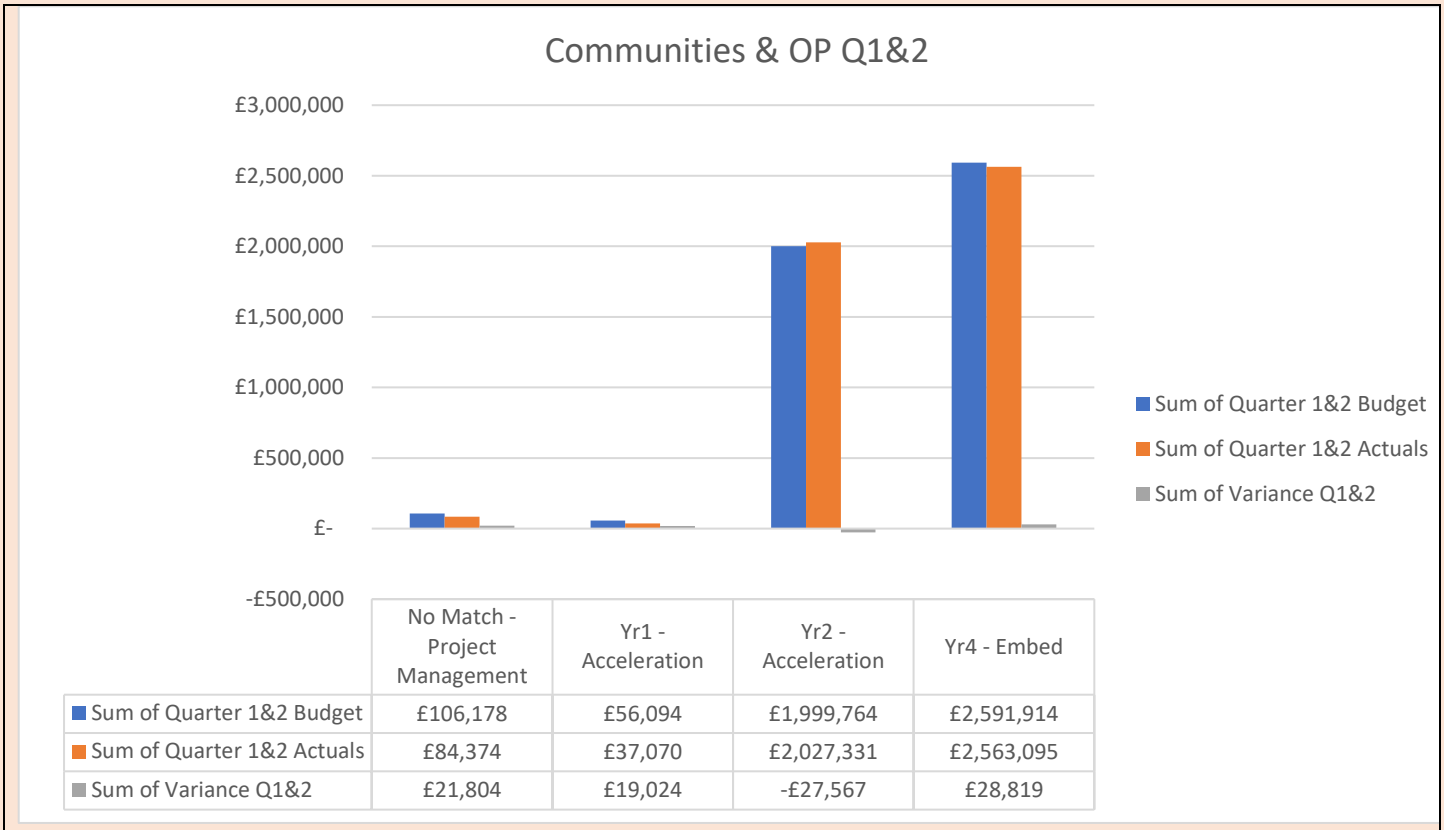
Funding Utilisation

The total RIF funding allocation for the Communities and Older People Programme is £9,498,167. One of the key areas under the C&OP Programme is Intermediate Care Services and work is underway to complete the revised s33 partnership agreement. The total RIF funding contribution included is £7,223,134, although the partner contributions from core costs are significantly higher.

Another key area of investment is for the wider prevention and community co-ordination projects which include building community assets, which is phase 2 of the Our Neighbourhood Approach, the volunteering project and a number of third sector schemes supporting prevention. The total RIF funding is £2,218,953.


COP Population Programme
£10,000,000.00
£9,000,000.00
£8,000,000.00
£7,000,000.00
£6,000,000.00
£5,000,000.00
£4,000,000.00
£3,000,000.00
£2,000,000.00
£1,000,000.00
£-
30
25
20
15
10
5
0
£9,421,863.47
Regional, 26
Local – Swansea, 2
£76,304.00
Local – Swansea
Regional
COP Total Funding
£76,304.00
£9,421,863.47
Number of Projects
2
26


Communities & OP
£6,000,000.00
£5,000,000.00
£4,000,000.00
£3,000,000.00
£2,000,000.00
£1,000,000.00
£-
Third Sector
Statutory
No Match - Project Management
Yr1 - Acceleration
Yr2 - Acceleration
Yr4 - Embed
Third Sector
£32,893.97
£408,312.00
£379,392.00
Statutory
£212,357.50
£38,048.00
£3,591,216.00
£4,835,948.00



	No Match - Project Management	Yr1 - Acceleration	Yr2 - Acceleration	Yr4 - Embed
Sum of Quarter 1&2 Budget	£106,178	£56,094	£1,999,764	£2,591,914
Sum of Quarter 1&2 Actuals	£84,374	£37,070	£2,027,331	£2,563,095
Sum of Variance Q1&2	£21,804	£19,024	-£27,567	£28,819

Assessment of Delivery

The Community and Older Peoples programme is a newly established programme which was launched in September 2023 within this new programme we have identified work streams which include Prevention and Early intervention, Volunteering steering Group, Falls Prevention and Accommodation solutions

Below is an outline of deliverables that we plan to progress in line with the programme priorities.

Priority & Model of Care (MoC)	**Action – *What we as a region need to deliver based on the priorities on the Community and older peoples programme***
Enable individuals to remain as independent as at all possible and in the own home for as long as possible	• Increase the use of community-based solutions • An increase of 'Community capacity' of services and other responses that enable people to live more independently, in or near too their own homes.
Reduce social isolation and loneliness	• Suitable services for citizens to access (community groups, Social & Micro Enterprises), eg informal social groups
Increase Respite Services in line with increasing demand	• More respite services available to the carers and individuals (delivered by the carers programme)
Develop and enhance falls prevention care	• To provide a Falls Response Service (FRS) to the people residing in Swansea and Neath Port Talbot
Strengthen the Discharge to Recover and Assess Pathways and ensure we support the individual in what matters to them	• Reduced unscheduled care admissions for Over 65's • Reduced length of stay in hospital following an unscheduled care admission (again for over 65's)

	• Earlier support and discharge. • Reablement services that enable people to live within their communities and reduces the need for a long-term care package. • Reduced length of stay in hospital following an unscheduled care admission (again for over 65's)
Develop and Enhance Prevention approaches to reduce the need for acute and long-term care	• An increase of 'Community capacity' of services and other responses that enable people to live more independently, in or near to their own homes. • A developed community care model with a full range of preventative and early intervention services so they are available locally. • A reduction in over prescription of social care. • Increase the use of community based solutions • Bedded reablement services that enable people to return home to their communities and reduces the need for a long-term care home placement.
To Ensure Sustainable Care Provision and High Quality Care Homes	• A quality standard which is utilised across the region when commissioning placement in Care Homes. • A quality standard which is utilised across the region when commissioning Domiciliary Care

Quantitative Measures

There are 24 projects being delivered as part of this programme, 14 of these are delivered by third sector organisations and the rest include statutory partner projects along with support staff to deliver the programme and coproduction support costs.

The projects support the national models of care of:

Placed Based Care: Prevention and Community Coordination – 14 Projects

Home from Hospital – 10 Projects

Total investment to the Communities and Older Persons Programme via the Regional Investment Fund is £9,494,167, however the statutory partners also invest significant core funding to support the Intermediate Care Service via 2 section 33 legal agreements and schedules.

Number of people supported – 26,279
Number of people accessing the service for the first time – 2,146
Number of contacts – 16,786

Of these

1904 people received information advice and assistance

11,782 people received early help and support

12,758 people received intensive support such as reablement services

Work has to be undertaken to improve the collection of How Well and Difference Made data for this programme as the PROMS and PREMS system currently only collects data for individuals accessing one of the Discharge to Recover and then Assess pathways. However, of the data collected to date we know that

over **8000** individuals agree that they have influenced the decisions that affected them.

8400 individuals' independence has improved or remained the same with the support of the project.

over **8000** individuals feel more confident in accessing services following support from the project.

Qualitative Indicators

What we did and why (Input and Outputs in the last 6 months)

Please refer to the Model of Care Section of the report

What is being done differently?

Please refer to the Model of Care Section of the report

Reach: Who we worked with (priority population groups – older people including people with dementia, children and young people with complex needs, people with learning difficulties and neurodevelopmental conditions, unpaid carers, people with emotional and mental health wellbeing needs).

According to Social Care Wales, the over 65 population for the West Glamorgan region stands at 79,212 (as at 2020).

The table shows a steady increase in the number of people aged 65 and over within our region since 2017. This paints a positive picture, but the resulting rise in pressures on health and care social services also requires consideration.

Number of people 65+ years

Year	Neath Port Talbot	Swansea	West Glamorgan
2017	29,159	47,549	76,708
2018	29,530	48,049	77,579
2019	29,981	48,720	78,701
2020	30,254	48,958	79,212

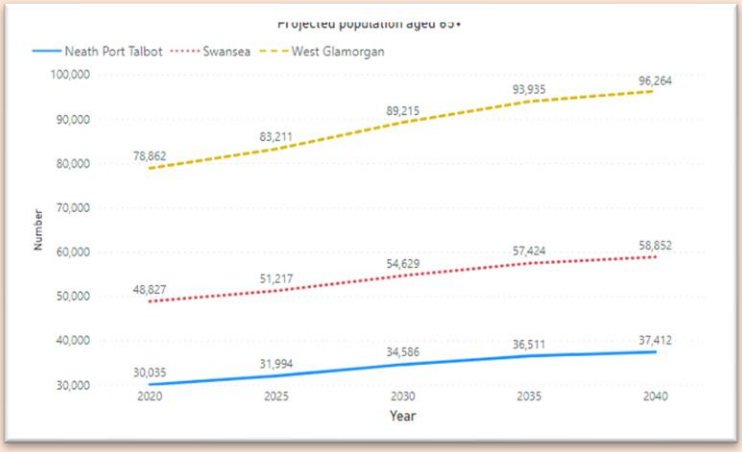
As a region, predictions from Stats Wales show that the over 65 population will increase to 96,264 by the year 2040 - an increase of just over 20%.

Please note that the population projections are based on mid-year estimates from 2018.

The mid-year estimates for 2020 supplied by Office of National Statistics (ONS) shows the female population in West Glamorgan for over 65s is 43,700, whilst the equivalent number for the male population is 35,500.

Information on specific cohorts of the population will become available when the 2021 Census results are published. However, the region recognises that there is a gap in regular data capturing for specific characteristic groups, and this will be addressed over the course of the next assessment cycle.

"In Wales, the central demographic projects that in 20 years (by 2038) 1 in 4 of the population will be over 65. The population aged over 75 in Wales is also projected to increase from 9.3% of the population in 2018 to 13.7% in 2038."



(Office for National Statistics, 2019).

"Longer lives inevitably mean more years spent in retirement and for many, retirement offers the opportunity to try new things and live the life we chose. The National Survey for Wales shows some positive results for older people. For example, 69% of people aged over 75 said they have sense of community compared to only 51% of people aged 46–64. 35% of people aged 64-75 volunteer. 90% of older people feel in control of their lives and 80% feel they can do what matters to them."

In 2018, the report, 'Living Well for Longer: The economic argument for investing in the health and well-being of older people in Wales' (Bangor University) found that the economic value of the contribution made by older people in Wales was estimated to be £2.19 billion per annum. However, an ageing population does bring new challenges for governments, communities and individuals.

The impact of COVID-19, deep rooted social and economic inequality, austerity and the rising number of older people living with complex conditions cannot be ignored.

How have people felt about what has been delivered

Below are some feedback examples from the family members of individuals who were supported by the service:

"*Such a wonderful professional and dedicated team who put my mother has needs and wishes first. Without their advocacy and support my mother would not have had her wish to spend her last days at home".*

"I would like to take the time to compliment JT, one of your officers that is dealing with my brother. It's early days yet but the support he is giving me, and my family is outstanding. My brother at this moment in time is in a very dark space but it is very re-assuring that JT is keeping us updated and doing all that is possible to help.

I know full well he can't go into details of what is happening. Will you be so kind as to pass on my sincere thanks to JT just for being there for me and my family, and more so my brother".

"Over the last six months I have had a lot of contact with Social Services over the care of my partner. I would like to thank all those involved, especially three workers that I cannot praise highly enough, they could see I was at the end of my mental and physical strength and did all that they could to help me. So, thank you once again".

This way of working is not only beneficial to the individuals that the services support, but also the staff that work within wider services.

Here is some feedback we have received from the workforce:

"They are the bolts that help turn the cogs and always support".

"This service has been instrumental in helping us develop good working relationships with the wider hospital team their support has been invaluable".

"Working closely with Home First has enabled us to shape the Wellbeing Service based on needs and gaps. We genuinely feel part of a wider team that support safe hospital discharges in Swansea".

What have we learned about things that went well? What have we learned from any challenges that occurred?

Please see the system outcomes, benefits and system constraints section.

Changes to System

System Outcomes/Benefits

1. We have a well established intergrated team which include staff from the two local authorities, the Health board and the third sector who have come together and developed an excerllant MDT function which has the individual at the fore front of everything they do, this was also recognised at the Swansea Bay living values award ceromony in September 2023 where the team won an award for partnership working.
2. There is now Local Co-ordination representatives across the whole of Swansea and Neath Port Talbot, this means more individuals can be supported in the community and where possible will be supported to avoid escalation of need and aviod the need for statutory services.
3. Links formed with Third Sector colleague's have helped to avoid hospital admission to hosital or care homes and escalate discharges through Pathway 1, third sector support and community services.

Lessons Learned

Recruitment and retention of staff has been a challenge. This in part due to the pandemic but also the demand for specialist roles. In order to alleviate the issue, partners worked together to look at other opportunities to recruit by widening the reach internationally, but also explored more innovative solutions focusing on specific job roles for people. For example – could an assessment be undertaken by a Care Support Worker rather than a fully qualified Social Worker (within the bounds of legislation)?

The cost of living crisis has also resulted in increased demand for community services. The preventative element of the service has meant that the demand for core services has stabilised, however there is more work to do if we are to reduce or level out the increasing demand on statutory services.

The development of reporting systems have also been problematic. This is due to different partners and services within those organisations using varying data and ICT systems. However, the leadership of the West Glamorgan Regional Partnership understood that all data should be pulled togther and a single Performance Dashboard developed. This has enabled operational and strategic decisions to be taken on all the component parts of the intermediate services across the region.

We have learnt that team intergration is essential to ensure a smooth and functioning service. Local Authority, Health Board and Third Sector colleagues have come together and developed a excellent multi discpinary function which has the individual at the forefront of everything they do. Recently the team received the Swansea Bay University Health Board Living Our Values (LOV) Award for Partnership Working.

Links established with Local Area Co-ordinators (which cover the whole of Swansea and Neath Port Talbot) and Third Sector colleagues have supported individuals with low level needs to remain at home or return home more quickly after a hospital stay. The type of support form these teams include meal preperation, shopping assistance, or provide support to build confidence and make connections within the community. This approach alleviates the pressure on the core services and provides the individual with more independence.

System Constraints

1. Recruitment and retention of staff has been a challenge, this in part due to the pandemic but also the demand for specialist roles. National shortage of Allied Health Professions, in addition to local service developments in other areas has depleted the therapy workforce.
2. The cost of living crisis has meant an increase demand for community services.
3. The development of reporting systems have been problematic this is due to differant areas using different systems, however the west glamorgan performance team are now developing a regional dashboard which will be able to report on all intermediate services across the region.

National Models of Care (NMoC)

Depending on regional structure, include reporting NMoC relevant to the programme (maybe single NMoC Contribution or multiple) For each NMoC section you complete you must consider:

- *How is the project meeting the outcomes of the Model of Care to which it is aligned?*
- *The activities you have delivered which you think could be important 'ingredients' (e.g., specific activities/components) of a national Model of Care, and explain why you think this is so*
- *What have been the gains / advantages for people brought about by those activities or components?*
- *If you were looking to help another team provide a service similar to yours, what would be the important things that you would want them to include?*
- *What advice would you give them about this? What might they avoid?*

NMOC: Prevention & Community Co-ordination NMOC – Outcome Statements:

1. People's well-being is improved through accessing co-ordinated community-based solutions
2. Local prevention and early intervention solutions support people to avoid escalation and crisis interventions

Theme 1: People's well-being is improved through accessing co-ordinated community-based solutions

In 2012 before the development of the Regional Partnership Board (RPB) West Glamorgan Regional Partnership implemented a regional "What Matters to Me "model, this model was based on developing and coordinating community services across the region to support individuals to

remain at home for as long as possible and avoid/reduce unnecessary hospital or care home admission by providing the right support at the right time.

Over the years this model has changed and adapted to suit the needs of the individuals within the communities across the region and further work and funding has been spent to provide the very best Regional Preventative Approaches

The Intermediate Care Services Programme aims to support and anticipate the needs of individuals and continue to support the prevention of admission to hospital or care home. To do this we have developed regional services that will deliver the same high-quality care and support in a person's place of residence and not in an acute setting where individuals are at risk of deconditioning and or infection.

It was identified early on that the best way to support individuals to live as independent lives as possible was to provide them with services to do so. To Support care and well-being locally and offer good quality information and advice, to support individuals and community resilience so people feel safer, less isolated and more able to achieve their personal outcomes with less reliance on more formal and traditional health and social care services. We have provided more resource which enable individuals to remain at home and as inpendant as possible for as long as possible.

This Resource Includes:-

- Local Area Coordinators,
- Our Neighbourhood Development Officers,
- Access and Information officers at the front doors
- Review Officers
- Third Sector Projects

With the above additional resource we have been able to support individuals to be self surficient by providing them with the advice, information and support they require to support themselves and/or their family with any quires of issues they may have.

Local area Coordinators

With the funding made available to us we have been able to employ additional Local area coordinators to cover the whole of Swansea and Neath Port Talbot to support individuals to

- Make new connections and friends.
- Get involved in groups and activities.
- Overcome personal challenges.
- Get their voice heard.
- Think about what a good life looks like for them.

As mentioned above the Local Area Coordinators are operational across the whole of Swansea and Neath Port Talbot. This mean that Adults across the region can access a coordinator via a referral, or they can make a connection during a coffee morning, specific activity or simply by meeting their coordinator whilst out and about in their community.

There is no specific remit or thematic requirement to meet with a coordinator and there is no set length of time a coordinator will walk alongside an adult.

The focus of the team is person lead and therefore the offer or input from a co-ordinator can be varied and far reaching, it is believed that these services work best when support needs are low level and of a preventative in nature, ideally before formal services become involved.

The role is described as 'walking alongside' the individual as they see the adult as the lead and director of what needs to happen. This could mean linking individuals and families to activities in

their community, referring/signposting them on to other agencies or activities or they could work with an individual to coordinate and plan appointments if that is what is required.

Although this service may be considered better situated at the lower ended of the continuum, since the Pandemic local area coordinators report that they have been supporting adults with much greater need including supporting individuals in crisis.

Our Neighbourhood Development Officers

In addition to the Local Area co-ordinators we have funded Neighbouhood development officers via our third sector partners CVS

This service uses ‘Asset-based’ principles but not following a particular asset or community development model, the service will identify strengths and resources in communities through asset mapping and development and the involvement of community members in change efforts.

Our Neighbourhood Approach supports the development and delivery of a range of community initiatives to support wellbeing and increase community resilience. The project supports the development of new and existing groups within the community that offer a range of different approaches to improve wellbeing, including volunteering, peer support and wellbeing focused actitivies.

The Neighbourhood Development officer role aims:

- To support the development of an ‘asset map’ of the area, linking with ward-based maps developed by the local authority.
- To recruit and support volunteers to run locally based projects and schemes.
- To work from the grassroots to develop trust and relationships with local people which enable their own organising of community activities and collective action, increasing self-belief to move from being passive recipients of external help to decision makers in own lives and positive change makers in their community.
- To develop community profiles that can provide vital information to statutory and other agencies that help to shape services based on local community strengths and needs.
- To act as a ‘Cluster lead’ for development of Digital Support across all ONA areas.
- To work as art of a multi-disciplinary locality-based team, to include ONA and Social Prescribing colleagues.

These teams help ensure People's well-being is improved through accessing coordinated community-based solutions which help individuals explore and build on their strengths and support them to share their skills and gifts/ideas with others in the community.

As well as the above resource we have a number of third sector projects that are funded via the Regional Intergration Fund (RIF) these projects also ensure People's well-being is improved through accessing coordinated community-based solutions

Shared Homes Project

The Shared homes project aims to enable Individuals to be supported to live well at home for longer. Any deterioration of the householder is noticed by the presence of the home sharer who can seek support before crisis.

The Home sharer project also helps reduce hospital admission and support safe discharges home

Quote: Mr B (Home share NOVUS): "I really valued my independence, but it was getting harder for me to cope all on my own and I needed the security of knowing that someone else was in the house to help me out. I didn't need a live in carer or a residential care home, what I needed was a helping hand here and there and to keep my independence. When I heard about the Home share scheme I knew it was perfect for me and after taking time to understand my needs they matched me with my home sharer Miss P"

The regular support offered from home sharers can include taking to health appointments and collecting medication; keeping the homeowners health managed by Primary Care and out of secondary care. The Home sharer will be in the home when the householder is discharged from hospital, so can help with the tasks that family might do to offer support e.g. making sure the house is warm, there is food in the house, cooking and taking meals to the householder etc. Three of the referrals for Householders have come from the Pathway 0 Team (SCVS). All three individuals have been discharged from hospital and live alone. They have all signed up to Shared Homes Swansea for some practical help at home (cleaning, food shopping and cooking) but mainly for the companionship at home with an overnight presence.

The Good Neighbourhood Scheme.

The Good Neighbourhood Scheme has vital importance to older people of gaining access at a community level to support and provide an information services relating to preventative measures associated with providing guidance upon choices aimed at reducing the likelihood of requiring access to either urgent, or prescribed health or social care services.

Age Connects Neath Port Talbot work includes working with other agencies in a coordinated manner to ensure the broadest possible range of information, support and choices can be provided.

The Good Neighborhood Scheme model has a delivery mechanism to respond to a range of well evidenced needs facing older people and their carer's related to maintaining health and wellbeing. In delivering this scheme via salaried support worker staff and trained community-based volunteers, the project is able to reach out and remove barriers for a broad cross section of older people and those that care for them.

Theme 2: Local prevention and early intervention solutions support people to avoid escalation and crisis interventions.

In addition to the above the funding has enabled us to employee additional Advice and information assitants to support the front door community services, this means Individuals have a point of contact where they can get the most up to date information and advice as and when they may need it.

The Front Door of our community services has a statutory responsibility to provide information advice and assistance, The common access point in Swansea and the Single point of Contact (SPOC) in Neath Port Talbot deal with all adult service enquiries and requests for support.

Access and Information Assistants are the first point of contact for adult services across the region they will talk to the individuals using their strengths-based communication skills to ensure a clear picture is formed of an individual's current situation, this helps to evaluate the need for services or advice and signposting.

To ensure the right information is provided the A&I assistants ensure they are up to up to date with all the information and services available Once the Individuals need is identified The Advice and Information assistants will direct individals to the appropriate community services or provide information to the individuals as appropriate.

However where an A&I assistant feels they cannot support with information, advice, or signposting, because the individual is presenting with a more complex situation, they will create a referral for the Multi-Disciplinary Team (MDT). This information will then be sent to a Team Leader/Manager for screening before being allocated to the MDT, some of these referrals may require support from Social Works and/or Therapist. The MDT will then make plans to support the individual as appropriate and in most cases avoid escalation and crisis intervention.

We all have third sector projects that individuals can contact such as

Our Elders; Our Heritage "Help is Available" Project –

The aim for this project is for Swansea and Neath to be one of the best cities in which to grow older. Regardless of peoples background or circumstances.

The project aims to see ageing as something that our society should value; growing older is not just a fact of life, it is something that brings opportunities for individuals and our community as a whole.

A key part of this work is bringing about a change in people's attitudes and experiences, so that everyone shares a positive view of growing older. This needs to be a priority as negative attitudes towards age and ageing have a damaging impact on the health and well-being of older people.

The aim of this project is to build on the success they have already had in the last 24 months providing mental health support for service users which are predominantly younger generation, however there has also been lots of request via the helpline from the older generation and in particular those from ethnic minority backgrounds. .

The helpline reached full capacity during the pandemic restrictions, and the project introduced "Wellbeing Mondays" that encouraged service users to walk into the project office to get support, it has been recognized however that during the course of training and listening services the project couldn't progress further efficiently to support some of the elderly community due to lack of capacity.

Building back healthier communities step-by-step - Ospreys in the Community -

Walking rugby is a growing movement arising from the local community that inclusively brings together old and new lovers of rugby who can no longer partake in the original game due to age, health or mobility. The Welsh Rugby Union (WRU) strongly encourages the development of walking rugby initiatives to the devolved regions, and Ospreys have led the way in supporting and developing this initiative in many local teams in the South Wales region. Working in partnership, Ospreys in the Community and Swansea University, pump-primed by West Glamorgan Social Partnership, conducted pilot exploration in a sub-set of South Wales walking rugby clubs that have uncovered worrying mental, metabolic and cardiovascular health issues in new attendees.

Preliminary evaluation of walking rugby in South Wales was conducted and focused on observational analysis to better understand the population that are currently engaging with this community initiative.

NMOC: Complex Care

1. People are more involved in deciding where they live while receiving care and support
2. Complex care and support packages are better at meeting the needs of people and delivered at home or close to home

Theme 1: People are more involved in deciding where they live while receiving care and support

The Home First service is based on a discharge pathway model which is called D2RA (Discharge to Recover and Assess), Individuals that fall under the Complex Care category will be discharged from the acute setting on Pathway 3

Pathway 3 COMPLEX SUPPORT

During a hospital admission/episode, the Home First ward team will use the information and advice provided by the family, carer, or care home to minimise risks of deconditioning and inform discharge decisions. The principles of good but proactive discharge planning will be adhered to, including multi-disciplinary team (MDT) discussions to confirm suitability for D2RA Pathway 3, ongoing dialogue with the individual, their families will continue through the process.

The need to access advocacy will always be considered as per national policy, this support must be identified and actioned as soon as possibly (and well before the patient being declared clinically optimised) to prevent avoidable delays to discharge.

Prior to transfer, the individual, trusted assessor/care co-ordinator and facility manager will participate in relevant assessments in order to co-produce an agreed plan.

Particular attention must be taken to ensure that individual's health and wellbeing needs will be fully met on D2RA Pathway 3 by providing:

- Contact details for the trusted assessor/ care co-ordinator, social worker, and planned support services.
- Follow-up appointments.
- Details of roles and responsibilities for the recovery period and, following this, the assessment of need. Facility staff will have a key role to play in the assessment process, using the strengths-based approach.

The co-ordinator will ensure that the facility is provided, before or at the time of transfer, with the necessary equipment, medication etc. to support the individual whilst on D2RA Pathway 3.

D2RA pathway 3 patients often need a period of time to 'settle' into the new environment before assessments are started.

During their period of supported recovery and assessment in D2RA Pathway 3, the next steps for the individual will be agreed with them, their families, the facility, and the relevant support services.

Pathway 3 supports individuals who require bed-based 24-hour care: this includes people discharged to a care home for the first time or an individual returning to an existing care setting with a change in need.

Those discharged will have such complex needs that they are likely to require 24-hour bedded care on an ongoing basis following an assessment of their long-term care needs outside of an acute hospital setting.

Individuals that fall within this pathway category include but are not limited to:

- *Individuals requiring a new long-term bed, assessment bed.*
- *Complex/significant health and/or social needs in usual residency.*
- *Significant change requiring new appropriate placement.*

- *Longer term placement.*
- *Life changing health care needs.*
- *Complex end of life or mental health needs.*

By initiating pathway 3 early it will help

- Avoid further deconditioning and loss of confidence in hospital.
- Minimise exposure to in-patient infection risk.
- Maximise any possible recovery and independence.
- Provide an appropriate pathway and environment for further assessment where the patient is/has been unable to meaningfully engage in rehab/reablement.
- Provide a seamless transfer to longer-term support in the community (including home with support), if required.

This Process an information will be shared with the individual and all family/ careers and support networks (as appropriate) by the Dedicated Home First Multidisciplinary Team (MDT)

The Home first MDT includes Discharge Liaison Nurses, Flow Facilitators, Occupational Therapists, Physio Therapist and Social workers this team will work alongside individuals to enable them to have the best possible outcome according to their individual needs, the Home First MDT will complete the appropriate assessments in the appropriate setting to ensure individuals have a chance to decide (if appropriate) where they want reside post discharge from the acute setting.

NMOC: Home from Hospital

1. People go home from hospital in a more timely manner with the necessary support in place at discharge
2. People have a better understanding of the discharge process and are more involved in pre and post discharge planning

Theme 1: People go home from hospital in a timelier manner with the necessary support in place at discharge

Home First Background

The Home First service is an additional component of work to support the overall Whole System approach for Intermediate Care Services. The Home First Service started in 2019 which was then called Hospital to Home, and based on a model created by Professor John Bolton, which focused on a cohort of patients over the age 65 with a potential to regain independence or establish a small care package to allow the person to live as independently as possible in their own home. However due the demand the pandemic had on our services and the need to get people out of hospital and back to their original place of residence, the service quickly changed its criteria and became Rapid Discharge to Access (RD2A) following guidance from Welsh Government and then in 2021 was renamed the Home first Service.

The new direction of work with the Discharge to Recover and Assess model sets an ambition to transfer all assessments of patients needing support on discharge out of the acute hospital and into the primary care and local authority services. Patients will require a timely and proportionate referral process into community services with an opportunity to be supported in their recovery at home or in a step-down intermediate care bedded facility.

Further work streams commenced in July 2020 with regional and service representation to implement processes for referrals into community services and expedite discharge home from hospital.

Initial funding streams from the Welsh assembly facilitated a small uplift of therapy and domiciliary care with services being delivered by existing establishments. Hospital to Home developed into the

Home first Programme with a focus on the development of 5 steering groups to support each pathway and further funding streams.

Nursing posts were added to the service to support quality and safety for a higher acuity patient cohort and bolster the MDT with additional Therapists and Nurses to support an in-reach function onto the wards from community Home first teams. The work streams look to align processes for patients across the region within the Health Board to work towards enabling care closer to home and improving the patients' experience.

Home First- Present Day

Home First operate a Discharge to Recover and Assess model, based on a "Home First" ethos across the West Glamorgan footprint to avoid hospital admission where appropriate, and facilitate timely discharge with relevant support once all necessary clinical interventions that can only be undertaken in an acute setting are complete and an individual is considered clinically optimised.

The Programme will expedite discharges to ensure there is flow through the hospital and social care system to match the expected discharge profile, through the facilitation of safe and timely discharge, allowing for a period of recovery before any assessment of long-term care need is undertaken, therefore maximizing outcomes, and improving service user's experience.

To define this Programme in measurable terms we will aim to achieve the below objectives throughout the Programme and its work streams/projects:

Objectives

1. Development of a consistent Regional Discharge to Recover and Assess model as defined and mandated by Welsh Government
2. Admission avoidance through the promotion and delivery of a range of wellbeing and prevention focussed services where appropriate and relevant alternative provision exists.
3. Earlier facilitation of discharge from hospital in a timely manner once an individual is clinically optimised therefore reducing acute hospital lengths of stay.
4. Improved flow across the health and social care systems
5. Enhanced service user focussed outcomes and experiences.
6. A reduction in reported harm
7. A reduction in those needing long term care and / or support or placement.
8. Undertake a review of the current pooled fund Section 33 arrangement for intermediate care and Home First Services to develop a whole system pooled fund.

As a rolling Programme, this list of objectives will be constantly reviewed to ensure that we continue to focus on the strategic direction of the partnership and the needs of the people of West Glamorgan.

The key aim of this Programme is to help older people who become unwell to remain in the comfort of their own home, avoiding a hospital stay unless it is absolutely necessary. If an older person does need to go into hospital, the service supports them to return home as soon as they are well enough to be discharged. People are also given support to live independently in their own homes for as long as possible.

The service is underpinned by a 'what matters to you?' approach, rather than 'what's the matter with you?' and comprises of several elements that have been implemented consistently across the region made up of several different professions and across sectors including doctors, nurses, social workers, occupational therapists, physiotherapists, and health care support workers.

To enable individuals and staff to identify the best possible outcome for the individuals 4 pathways have been developed these pathways are outlined below.

D	2	R	A
DISCHARGE	TO	RECOVER	ASSESS
Pathway 0	Pathway 1	Pathway 2	Pathway 3
			
NO ADDITIONAL SUPPORT REQUIRED FOR DISCHARGE	SUPPORTED HOME FIRST	SHORT TERM SUPPORTED FACILITY	COMPLEX SUPPORT
• Fully independent – no further support required • Multidisciplinary Team assessment within hospital 'front door' units to avoid full admission. • Patient returns to usual place of residence (including Care Home) • Restart Package of Care (POC) with no changes • Has pre-existing community services in place	• Patient returns to usual place of residency with short term support. • Preventative services delivered in collaboration with third and voluntary sector organisations. e.g Meal provision, shopping, housing • New POC or increase of existing package. • Short term reablement to maximise independence. • Assessment and some additional care and support (including therapy, nursing, pharmacy, domiciliary care & new equipment). E.g Community Resource Teams • Safe between calls/overnight.	• Patient is transferred to a non-acute bed and receives rehab/reablement and assessment until able to return safely home. • Unsafe to be at home overnight/between care calls. • Currently needing some care (eg: ADL) support/intervention 24/7 • Includes specialist rehab. (e.g Stroke, Neuro, T&O)	• Patient is transferred to a new long term bed, assessment bed or usual residence and receives the complex support including rehab/reablement and/or assessment for their needs. • Complex/significant health and/or social needs in usual residency. • Significant change requiring new placement. • Longer term placement • Life changing health care needs • Complex end of life or mental health needs.

To ensure the correct pathway is identified we have a dedicated Trusted assessor model, this means we have professional resource of Discharge Liaison Nurses, Occupational therapist, Physio Therapists and social workers that are able to identify and support individuals out of hospital and back to their appropriate place of resistance as well as the trusted assessors we have flow facilitators who ensure contact and information is shared with the individual, families and colleagues which helps streamline the discharge process. Once in their appropriate place of residence we have a dedicated team of reablement staff that ensure a person is assessed for their care needs, to ensure nobody is prescribed an inaccurate package of care. This reablement period can be up to 6 weeks with a full wrap-around service to ensure where possible a person is left independent of care or with the appropriate amount of care to ensure they can live their best possible life.

To ensure the Care package stays relevant we have dedicated review officers that work alongside the Home First Team and review packages of care on a regular basis, to do this they will also use assistive technology to monitor a person's progress or decline.

Our Assistive Technology resource has enabled the roll out of offers including 'Just Checking' – a support tool for individuals, carer's and assessors to better understand and evidence the activity and movement patterns of people in their own home. With this discreet monitoring practitioners and carer's are able to build upon conversations to better understand people's needs and avoid unnecessary or pre-emptive escalation of support. This service has directly prevented referrals and admission to residential care environments.

The assistive technology team have also developed a digital demonstration suite to aid community resources (LAC / Third Sector) and practitioners along with individuals to test and loan easily accessible technology for the home including tech such as door sensors and falls detectors, mobile digital devices including lifelines as well as kitchen/food preparation aids and communication devices to improve the quality of day to day living and health of individuals. This resource is soon to be linked with SCVS Digital Volunteers initiative and the healthy eating and cooking Programme to be delivered to individuals recently discharged from hospital.

However, before any Care is provided pathway 1 is considered Pathway 1 is Third sector support to facilitate discharge to assess and recover pathways, utilising the brokerage function to the wider third sector (Currently provided by the CVCs) (SCVS has 2 posts). To act as the central point of contact for referrals to the Home First Pathway 0 Service (Wellbeing Service) and implement procedures for signposting and referral to third sector organisations.

A Pathway 0 co-ordinators Collaborate with the individuals referred to the service to undertake initial assessments, jointly identify goals and develop personalised plan, identifying support needs to ensure maximum engagement in improving health and well-being. CVC officers participate in multi-disciplinary team meetings and input into clinical reviews, as deemed appropriate.

To support he pathways a reliable wrap around in-reach services has been put in place to support this recovery and assessment period, this includes Discharge liaison Nurses, Physio Therapists, Occupational Therapists, Social Workers and reablement care assistants, this dedicated Home First Resource also provided to support to care homes if the person Is placed in one.

This approach is also applied to those patients who are determined as requiring a new placement. Whilst all opportunities for reablement and recovery will be explored prior to placement for some individual's ceilings of care at home have been exceeded and informal care networks have become unsustainable. Therefore, on the basis of a best interest decision or in agreement with the individual a long-term placement is the chosen discharge destination. Following the D2RA process for his cohort of patients reduces the need for extended hospital stays to undertake assessments and where necessary DSTs.

To help people avoid further hospital admission this third sector project supported by RIF, **Dance to Health** provides a choice to older people at risk of falling, Dance to Health tackles the 'dull' problem by smuggling FaME and Otago into creative, sociable, fun dance activity. Sheffield Hallam University evaluated the pilot and confirmed the programmers' fidelity to FaME and Otago. Dance to Health also addresses the lack of maintenance - three groups were created in the South Wales pilot: Gorseinon, Pontardulais and Porthcawl and 10 more are currently being delivered across the Health Board.

The proposed activity is a two-year Programme consisting of 12 new sustainable Local Groups. Each group will be delivered with Local Partners. These are local organisations whose mission includes improving the lives for older people.

In addition to the above project, another project supported by RIF is **Care and Repair –** Care and Repair helps provide safe and rapid hospital discharge for medically fit older people in hospital and reduce housing risks to their health, thus reducing the potential risk of being re-hospitalised due to poor or inadequate housing.

Having a flexible, well-targeted adaptation resource in support of discharge & prevention outcomes supports hospital bed flow, this service provides a targeted resources for prevention and low-level intervention through referrals from Health & Community teams. This service allow statutory resources to be targeted to those more complex cases requiring additional support and higher-level intervention.

The service will be for any person requiring discharge from hospital, focusing on older people with complex needs and long-term conditions (including dementia). Embedding the Caseworker in the Discharge Teams linked to Trusted Triage Teams will promote an efficient, effective, flexible, and responsive pathway and service in acute and recovery bed environments.

Theme 2: People have a better understanding of the discharge process and are more involved in pre and post discharge planning

The Home First service has developed robust communication documentation which is shared via the Hospital team, this information outlines the 4 pathways and explains the value and ethos behind the process.

The Home First team will speak with individuals and their family /support network to ensure everyone is clear on the service being offered and that the individual is involved in planning the next steps of their care journey. This communication will continue post discharge and contact information is provided to the individual should they need to contact the Home First Team at any point.

Financial and Economic Data

The Intermediate Care Services model is predicated on reducing individuals requiring long term care and supporting the reduction of unscheduled care admissions. The aim of West Glamorgan both supports the wishes of the individual via "What Matters to Me" whilst supporting the long term financial resilience and sustainability of all partners.

An example of this approach is demonstrated below:

Bon-y-Maen House (BMH)

BMH is a 24-bed residential home which is used to support individuals across the region out of hospital or as a step-up service if someone is struggling at home.

When an individual is admitted to BMH, they are provided with a period of reablement with a team of therapists and care staff from across Swansea Council and Swansea Bay University Health Board. The team co-produce a care plan with the individual to meet their goals, and once these have been achieved the individual will be discharged to their appropriate place of residence. This approach allows individuals to gain confidence and realise their potential before returning home.

Between January 2023 and September 2023, 172 individuals were admitted into Bon-Y-Maen House. Of these, 159 individuals left the service independent of care

Programme Case Studies

Dance to Health Final (vimeo.com)