STORY OF CHANGE TEMPLATE

Reporting Period	Reporting Period - End of Year 2023-2024
Strategic Partnership	West Glamorgan Regional Partnership
Programme Name	Communities and Older People

Programme Overview

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 Communities and Older Peoples (C&OP) 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 for as long as possible.

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.

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.

Providing individuals with good quality information and advice, that will support them and help build 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.

To support this, we have provided more resource which enable individuals to remain at home and independent for as long as possible. Key areas of work include:

- The **Intermediate Care Service** 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.

- Community-based projects that provide a preventative option for the people of the West Glamorgan region. These services provide advice and information on a range of different resources where individuals can go to get support and guidance were necessary with the aim being that we keep individuals safe and well in their homes and community for as long as possible.

To support this programme to achieve its aims and help identify priorities, work is being undertaken to develop a coproduced Communities and Older People strategy.

Delivery Partners

To support the delivery of the objectives for the programme we have several RIF Funded projects, these projects are delivered by.

- Swansea Bay University Health Board
- Neath Port Talbot County Borough Council
- Swansea Council
- Third sector organisations
- Citizens
- Paid and unpaid carers

All partners work together and are governed through the West Glamorgan Regional Partnership Board (RPB)

The RPB review the delivery of programmes across the region and consider what's working well and what opportunities are arising for more partnership working.

Theme 1 – Place Based Care - Prevention and Early intervention

- **Local area Coordinators** (Swansea and NPT Local Authorities)

  To help people avoid escalation and crisis intervention Local Area Coordinators (LAC) will walk alongside individuals and support individuals back into the community by helping them 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.

  Our Local Area Coordinator's get to know individuals on their terms and help them to exploring their ideas of a good life as well as help them make plans on how to achieve it.

  They also help individuals to find out about their community and introduce them to friendly, helpful people within it.

  LACs help individuals explore and build on their strengths and support them to share their skills and gifts/ideas with others.

- **Our Neighbourhood development officers** (Third sector partners SCVS and NPTCVS)

  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.

  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.

- **Assistive Technology (this service also supports additional themes)- Swansea Council**

  Assistive Technology has enabled the roll out of offers including 'Just Checking' – a support tool for individuals, carers and assessors to better understand and evidence the activity and movement patterns of people in their own home. With this discreet monitoring practitioners and carers 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.

- **Advice and Information Assistant (Swansea and Neath Port Talbot Councils)**

  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 individuals to the appropriate community services or provide information to the individuals as appropriate.

- **Regional Volunteering Strategy (All Partners)**

  In January 2021, thanks to investment from Welsh Government, the West Glamorgan Regional Partnership led the collaboration to explore regional approaches to volunteering.

  The aim of this project is to move towards a consistent approach to volunteering across the region and has since created a set of shared principles to inform a joint understanding about what volunteering is and the different types of support volunteers may need.

  The aim of the work is to create greater consistency in the volunteer experience across the region, where there will be greater appreciation and understanding of the role that volunteers can play in driving transformational change across the partnership area. There is greater understanding of the role that volunteers can play in preventative work.

  A regional group has come together to develop and deliver on a Regional Volunteering Strategy. As well as encouraging all partners to adopt the principles set out in the Volunteering Strategy, the workstream will coordinate the development and implementation of:

  - The creation of spaces where partners can come together to discuss volunteering:
    - Regional Strategic Volunteering Group

        - Volunteer Voices – Engagement and Coproduction with West Glamorgan and partner volunteers.
        - Regional Volunteer Managers – Network for sharing best practice and achieving regional consistency.
    - Ensure volunteering has a high profile across the regional partnership.
    - Providing training to partners and staff on the role of volunteering
    - Ensuring guides, toolkits and training are up to date.
    - Check and challenge how volunteering is happening among all partners.
    - Move toward consistent data collection which could lead to volunteers being able to move between organisations.

  A suite of resources has been developed to support and develop the knowledge, management and coordination of volunteers and volunteer involving organisations across the region. West Glamorgan Volunteering Support - West Glamorgan Regional Partnership

- **Shared Homes Project, SCVS**

  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.

  The regular support offered from home sharers can include taking the house holder 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.

- **The Good Neighbourhood Scheme, Age Connects Neath Port Talbot (NPT)**

  The Good Neighbourhood Scheme has vital importance to support older people to gaining access at a community level to support and provide an information service 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 Neighbourhood 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.

- **Our Elders: Our Heritage "Help is Available" Project, BAME Mental Health Support**

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

  The BAME Mental Health Support 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.

- **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.

- **Dance to Health, Aesop**

  Dance to Health is a well-evidenced, pioneering falls prevention programme. The programme uses PSI (Postural Stability Instructor), as recommended in the NICE guidelines and used by NHS physiotherapists. The PSI is embedded into creative dance co-designed with participants.

  Sessions are for two hours, 1.5 being the dance 0.5 being the tea and biscuits, although in the winter lots of people stay longer and have another cup and a chat as a social and a means to stay warm.

  The programme is a social prescribing model that has the added value that it not only reduces falls, but also helps to improve both physical and mental wellbeing for participants, helping to create long-term friendships.

- **West Cross Community Wellbeing Hub, Red Community Project**

  West Cross Community Hub co-ordinates and delivers a wide range of community-based interventions aimed at building stronger communities and enabling people to live as well as possible through challenges and transitions of life. The activities and groups that form the West Cross Community Hub have an important role providing early intervention to prevent escalation and/or crisis support being necessary.

Theme 2 – The Home First Service – Early Help and Support.

- **The Care and Repair service (Third Sector Service)**

  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 the outcomes support hospital bed flow, this service provides a targeted resources for prevention and low-level intervention through referrals from Health & Community teams. This service allows statutory resources to be targeted to those more complex cases requiring additional support and higher-level intervention.

  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.

  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.

- **The Regional Community Equipment Stores**

  The Community Equipment Service plays a vital role in providing early intervention solutions through the provision of community equipment as quickly as possible, and at the right time, preventing hospital admissions. The provision of Community Equipment plays a vital role in supporting hospital avoidance and care home admissions (This service also supports the previous theme)

- **The Regional Home First Service**

  The Home First Service operates 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 define this Programme in measurable terms we will aim to achieve the below objectives:

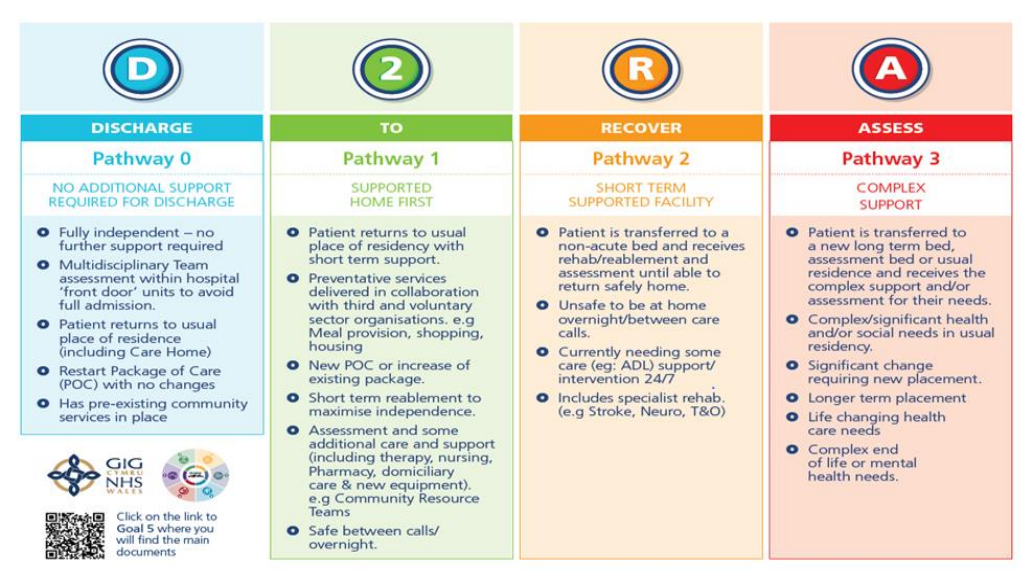
  Objectives

  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.

  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.

  The Home first Service is based on 4 pathways the diagram below outlines the definition for each pathway.



The pathway that is relevant to this model of care is Pathway 0

Before any care is provided pathway 0 is considered. Pathway 0 is a third sector supported pathway designed to facilitate discharge to assess and recover pathways, utilising the brokerage function to the wider third sector (currently provided by the CVCs). 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.

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

Theme 3 - Home from Hospital- Home First Service- Intensive Support - Pathway 1 and 2

We have the Home First Team, 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 Therapists, Physio Therapists and Social Workers that are able to identify and support individuals out of hospital and back to their appropriate place of residence, 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. This assessment period can take place in the individual's home or in a residential reablement setting (Step up/Step down bed facility).

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 (As mentioned above in the pervious theme)

Theme 4 Home from Hospital - Home First Service - Complex Care

As mentioned above, the Home First Service functions with 4 pathways, pathway 3 is the pathway which would identify if an individual required more complex support in a care home setting.

Pathway 3 is supported by the same resources as the other 3 pathways mentioned above.

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.

The Home First MDT 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.

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.

Assessment of Delivery

OBJECTIVE	METHOD OF DELIVERY	COMMENTS ON CURRENT PROGRESS
Theme 1 –West Glamorgan prevention and early intervention Model of care: Place Based Care - Prevention and Community Coordination -	This Theme is being Delivered through Community teams and projects such as Local Area coordinators, Our Neighbourhood Development Officers, and third sector community projects as well as the this we have a Volunteering Strategy which provides a suite of documents / info sheets to move towards a consistent approach to volunteering across West Glamorgan	Local Area Coordinator and Our Neighbourhood Development Officers continue to work within the community supporting individuals to recognise and achieve their goals. The volunteering strategy has produced A suite of resources have been developed and are available via the West Glamorgan website and all partners have been encouraged to view and use in relation to their volunteers for consistency. Community projects are continuing to support individuals with a range of different experiences from Walking rugby, Dance classes and support and information when needed to ensure individuals receive the support they require within their community,
Theme 2 – Home from Hospital (Home First) – Early Help and Support	This Theme is delivered via Care and Repair and The Wellbeing Service all of which sit under the Home First Service	This service continues to provide support to individuals on discharge from hospital ensuring they are given the right advice and supported with their day-to-day living (medication collection shopping, clean etc) and the correct adaptions and equipment to assist them to remain in their own home as long as possible.
Theme 3 – Home from Hospital	This Theme is delivered by the Home first Service	The home first service provides a wraparound service to an individual in discharge from

(Home First) – Intensive Support	(with the support from Care and Repair and the wellbeing service)	hospital, The individual is provided with a package of care which is aimed at retabulating them back to independence or if care is required it is monitored to ensure the right amount of care is provided. (this will be reviewed regularly to ensure it's appropriate for the individual and adjusted as necessary)
Theme 4 Home From Hospital- (Home First)- Complex Care	This theme is delivered by The Home First Team (Pathway 3)	The Home First team continue to work with individuals in a ward setting with ward staff to ensure they are prescribed the correct pathway, if it is decided an individual needs 24hr care the Home First team will ensure an individual is assessed in appropriate setting and where possible placed in a care setting of the individual's choice.

Update on Programme Delivery

Theme 1	Quantitative Measures	Qualitative Indicators
Strategy Theme 1 – Place Based Care - Prevention and Early Intervention	The Community and Older Peoples Programme projects delivering this theme - Place Based Care - Prevention and Early Intervention are can be viewed accessing the link below: **Theme 1 – Place Based Care - Prevention and Early intervention** The below information shows how individuals are benefiting from the all the projects: • **30,631** contacts made through the projects**.** • **17,912** individuals acceded the projects for the first time. • **8,432** volunteering hours provided**.** • **1,667** people reported that they felt less isolated**.** • **8,729** people received support that prevented an escalation in need. • **1174** individuals introduced to local area coordination. • **1270** individuals who feel more confident accesses services following project support. • **175** volunteers recruited.	Place-based care refers to collaborative arrangements between organisations responsible for arranging and delivering health and care services, as well as other stakeholders involved in improving health and well-being. These partnerships play a crucial role in coordinating local services and driving improvements in population health. The RIF funded projects have supported individual to access information advice and assistance when needed. The information below are direct quotes from individuals accessing the RIF services/projects. **Local Area Coordinator - service user quote** Local Area Coordinators walk alongside individuals to support them to meet their goals. ***"I feel so much more like the old me since meeting Cerri and getting out to the groups she has told me about".*** **Shared Homes Project- service user quote** The Shared homes project aims to enable Individuals to be supported to live well at home for longer. **"***It is so nice to know that I am not alone in the house at night".* **Our Elders: Our Heritage "Help is Available" Project** **Service user quote** *"I am super glad I have a place to go with any digital enquiries and thanks to the support of the staff who are always patient to answer my questions."* *"Thanks to my children who informed me about this gathering, I look forward to attending on a monthly basis and the opportunity to meet other parents from Swansea and Neath areas".* **Building Community Assets- SCVS**

		Our Neighbourhood Approach results in more provision of grassroots organisations and groups providing services that improve wellbeing including volunteering, peer support and wellbeing activities. The project supports these to be sustainable to offer long term community based, preventative solutions. *Individual supported by Digital Support:* *"…having the support to download the sound app and audio books will enhance my life so much". He now considering becoming a digital support volunteer.*
	Programme Contribution to Model of Care and exploration of what is different	**What have we learned about things that went well? What have we learned from any challenges that occurred?**
	All the RIF Projects and services mentioned above aim to enhance independence, reduce social isolation, and foster community participation. By doing so, they contribute to individuals' health and well-being, boost confidence, and ensure safety within their local communities. Ultimately, these initiatives help communities grow and become more self-sufficient, alleviating pressure on the health and social care sector.	The individual projects have given individuals confidence to go about their day to day lives and meet new friends along the way. Following the covid 19 pandemic where individuals where left feeling isolated from their communities these projects have supported individuals to regain confidence and helped rebuild their mental health and wellbeing by offering a helping hand or providing support where needed. Below is a summary of Success and the challenges faced by the projects. **Success** • Projects have reported that they have filled the gap of access to lower-level practical support at home and helped facilitate safe discharge home from hospital and prevention of admission / re-admission. They have Provided Preventative service which reduce the need to access social services, e.g. care, residential care. • It has been reported that Access to the services reduced anxiety and stress of unpaid family carers. • Projects have continued to support some of the most lonely, isolated, and marginalised older people in the community, who may either be at or near crisis point.

		• Project have also reported that they have maintained and further developed positive relationships and collaboration with partners across all sectors. **Challenges** **Staffing -** Staff recruitment/retention has continued to be a challenge during this reporting period. Some projects have started utilising Recruitment Agencies; however, this comes with additional costs. The recruitment of volunteers is also becoming more difficult. **Funding -** Projects report that Community development is a long-term approach, but they only receive funding on a yearly basis. this means it is harder to plan future services /projects. Another project reported, Volunteer run services such as befriending and shopping support, which were abundant during the pandemic, have had their funding cut and have been replaced with paid for services. This is resulting in the most vulnerable patients not always being able to access the services they need due to associated costs.

Theme 2	**Quantitative Measures**	**Qualitative Indicators**
Strategy Theme 2 & 3 – Home from Hospital	For the list of projects for these themes please click the links below: **Theme 2 – The Home First Service – Early Help and Support.** **Theme 3 - Home from Hospital- Home First Service- Intensive Support - Pathway 1 and 2** Using the PROMS and PREMS tool Pro Mapp to evidence individuals experience of the Home First Service. **4558** people accessed the Home first service of these people **80%** said they would continue with the service post discharge from hospital. **The Home First Service Pathway data for 2023/24**	The Home First service aims to support individuals remain at home and independent for as long as possible, however if an individual is admitted to hospital the home first service will support individuals when discharged. **The Home first Service Pathways 1&2 Service user Quotes** "I *can't thank the community Care Assistants enough I was treated with respect and kindness at all times "Pathway 1* *"I would like to thank the reablement team they have all treated my mum with the upmost respect and have been very cheerful and supportive, my mum has always been a very independent lady and it has taken her a while to accept the support, but this service has made the transition so much easier "Pathway 1* **"**To *all the staff at Bon-y-Maen House, immeasurable thanks*

	Pathway 0 &1 (third sector support, therapy only support and reablement support at home)***********Pathway 0 data unavaiable at the moment due to the collection systems not being mature enough****** Pathways 0 & 1 **supported 2919** indivuduals of these individuals. • **588** were supported via the wellbeing sevice (third sector support in the community) • **980** were supported to return home with a period of reablement. • **353** individuals required long term support via a Long Term Care Package (at home) • **109** required Step Down - Long Term Care Package of Care • **889** individuals required support from the Therapy teams only **Pathway 2 (step down residential reablement April 2023-March 2024)** Pathway 2 supported **221** on discharge from hospital of theses **117** indviduals reurned home independant (no care required)	*for the support and encouragement, love and understanding received, from everyone at Bon-Y-Maen House" Pathway 2* *OT Integrated Therapies North ordered a bed on rapid discharge for her patient to avoid hospital admission. Equipment was ordered via the phone, and bed was delivered within one hour.* *"Without CES early intervention, my patient would have been admitted into hospital. The service pulled out all stops, and I just wanted to feedback how amazing they all were" Community equipment stores.*
	Programme Contribution to Model of Care and exploration of what is different	**What have we learned about things that went well? What have we learned from any challenges that occurred?**
	The Home First service is a comprehensive initiative that brings together GPs, nurses, therapists, social care professionals, and NHS Continuing Healthcare (CHC) practitioners into a single integrated team. Its primary objectives are to: • Prevent unnecessary hospital admissions by working across both community and hospital settings.	The Home First service has firmly established itself in the West Glamorgan Region. Its robust Multidisciplinary Team (MDT) collaborates across hospital sites and within the community. This dedicated team comprises Discharge Liaison Nurses, Occupational Therapists, Physiotherapists, Social Workers, Community Care Assistants, and Third Sector Wellbeing Officers. Their collective efforts ensure that the individual remains at the forefront of all decisions, and hospital stays are

	• Facilitate timely discharge from local hospitals once an individual is clinically optimized, thereby reducing acute hospital lengths of stay. • Improve flow across the health and social care systems. • Enhance service user-focused outcomes and experiences. • Reduce the need for long-term care and support placements. The Home First service promotes rehabilitation and strives to return individuals home whenever possible, providing the necessary support. By doing so, it alleviates the strain on an already overwhelmed system. This approach ensures that people no longer have to wait unnecessarily for assessments in hospitals, leading to reduced delayed discharges and improved patient flow. To support the complex discharges and to provide an additional assessment setting for people with dementia we have 8 Dementia reablement beds based in Westfield House Westfield house is an 8 bedded unit within Ty Waunarlwydd residential care home it is a is a registered service that provides dementia care and residential placements, primarily supporting people that have dementia related support needs that are not categorised as nursing needs. Individuals can be stepped down from an acute hospital setting, once they are medically fit for discharge, these individuals live with complex dementia related needs, and require a settlement & assessment period to establish their future plan and move on. The Westfield house ethos is to provide. • A warm, dementia friendly, homely, enriched & safe environment. • Staff that are trained and qualified to support individuals through assessments helping identify outcomes and	minimized. As the service evolves, it remains adaptable to meet the challenges faced by the health and social care sector. However, some challenges we have come across are the lack of care placements and some processes can sometimes hinder the smooth flow through the system, including waiting lists for specialist services. Addressing suitable accommodation is a priority. The West Glamorgan Regional Partnership is actively developing an Accommodation Solutions Workstream to tackle this issue.

	needs for the future planning to move-on to longer-term care arrangements. • Enabling approach for people with dementia to live as well as possible and for as long as possible. • A person-centred approach ensuring that people feel safe, listened too valued & respected. • Integrated & collaborative working with families, significant others, and colleagues. • The benefit of staff champions, for example, Welsh language champions and Dementia champions. • Opportunities within the community. The benefits to individuals admitted into Westfield house are. • Time in an appropriate residential setting to assess and identify and tailor the right support. • Individuals will have opportunity to do the ordinary & everyday tasks that mean so much to them. • Individuals will be supported in a homely environment and have the privacy of their own room. • Relatives and families would be able to have contact with their relative in a less clinical, more homely setting. • Individuals will be supported to focus on their strengths and meet their outcomes. • Individuals will have the opportunity to socialise and develop positive relationships with others in the home.	

Theme	Quantitative Measures	Qualitative Indicators
Theme 4 Home from Hospital The Home First Services – Pathway 3 Complex Care	For the list of projects for these themes please click the link below: **Theme 4 Home from Hospital - Home First Service - Complex Care** 1084 individuals were supported via pathway 3 in 2023/24. **Westfield house** During this reporting period 36 individuals have been admitted into Westfield House Of these individuals • 7 went home with a Package of Care. • 13 went into a Long-Term Care Setting. • 3 were readmitted to hospital. • 4 Were discharged home without a Package of Care but with family support. • 2 went home without any care.	As above Work will continue to build on this information
	Programme Contribution to Model of Care and exploration of what is different	**What have we learned about things that went well? What have we learned from any challenges that occurred?**
	This theme is covered by Theme 2. The Home First Service uses the same resource across all pathways of care.	

System Constraints

Data

As many of the projects are preventative within the community, it can be challenging to collect and analyse data to fully understand the impact of the work, especially when trying to confirm the number of avoided admissions into hospital from the community.

Capacity / Resources

Delivery is occurring alongside statutory functions for operational delivery staff in a number of projects, therefore additional time required to develop and implement the new ways of working can be challenging.

Lessons Learned

As the Communities and Older People program evolves, it has become evident that we must collaboratively create a strategy with our partners, the third sector, and citizens.

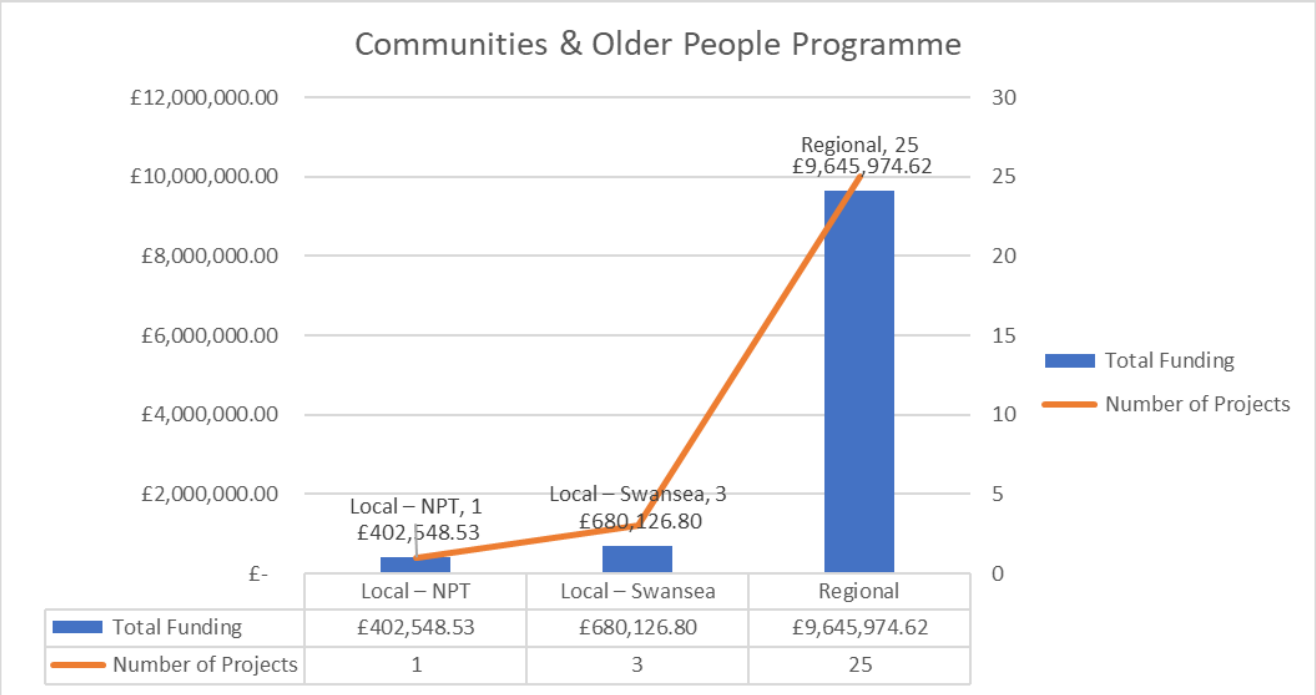
The absence of a strategy within the program currently leads to a lack of prioritization. Although we have recently set up a strategy workstream it is still in its early stages, our aspiration for the upcoming year is to co-produce a West Glamorgan Communities and Older People Strategy that will provide clear direction for the program and therefore benefit our region and our citizens in the years to come.

Funding Utilisation

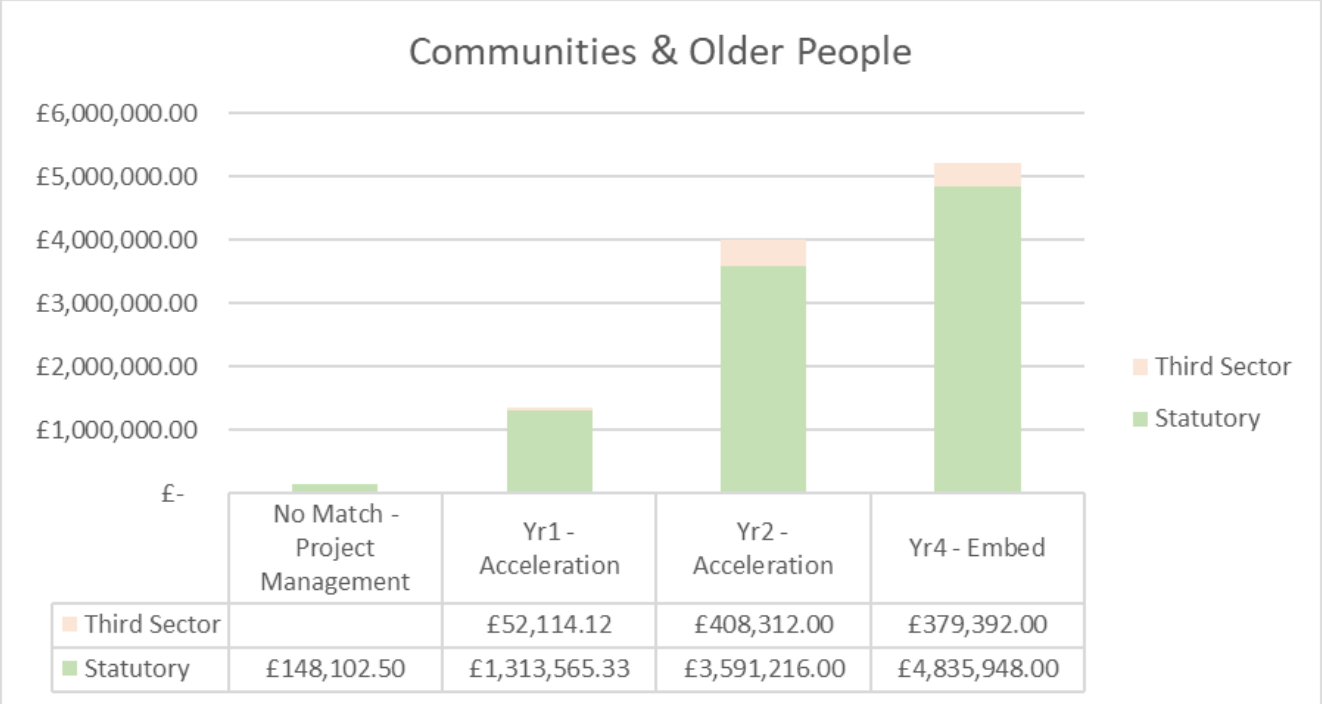
The total RIF funding allocation for the Communities and Older People Programme is £10,728,649.95

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 £6,875,836.00 although the partner contributions from core costs are significantly higher. Additionally, another £1,306,371.33 was award for step-up, step-down beds for the Health Board.

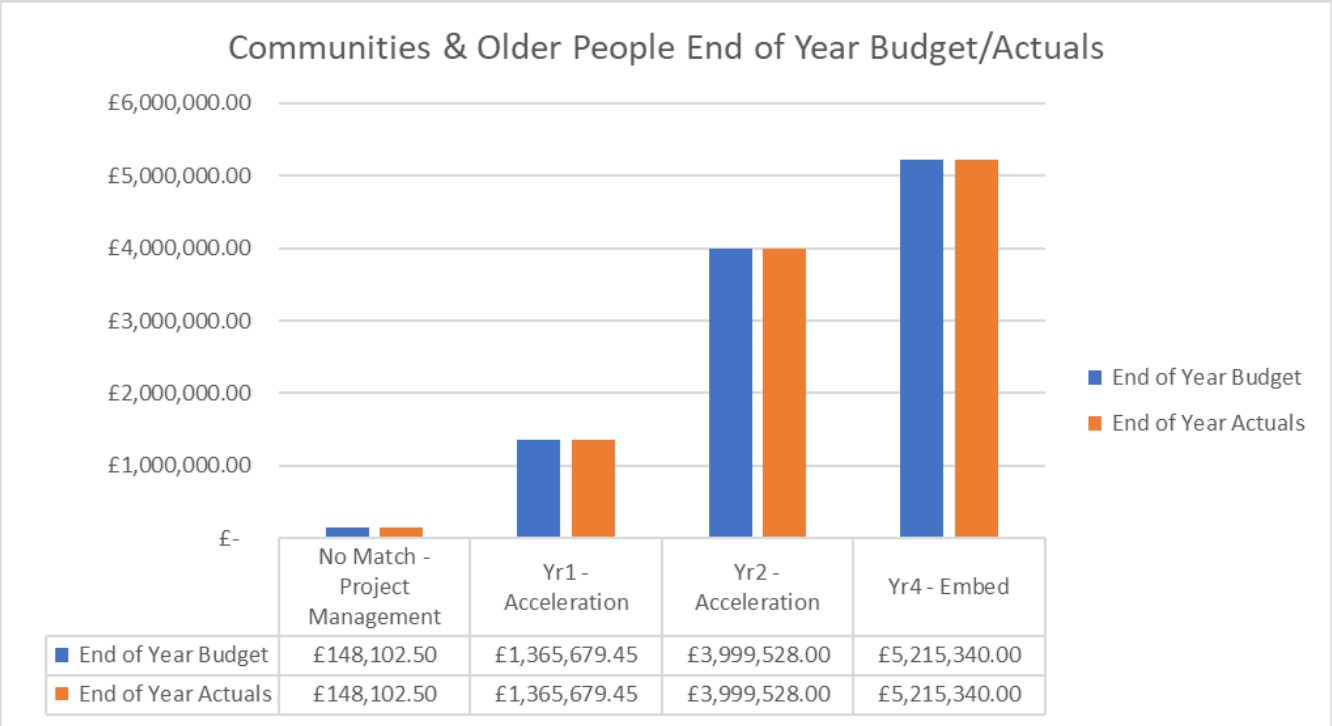
Another key area of investment is for the wider prevention and community co-ordination projects which include building community assets, of the Our Neighbourhood Approach, the volunteering project, and several third sector schemes supporting prevention. The total RIF funding is £2,240,906



Communities & Older People RIF Allocations 23-24



RIF Budget/Spend Position at end of year



	No Match - Project Management	Yr1 - Acceleration	Yr2 - Acceleration	Yr4 - Embed
End of Year Budget	£148,102.50	£1,365,679.45	£3,999,528.00	£5,215,340.00
End of Year Actuals	£148,102.50	£1,365,679.45	£3,999,528.00	£5,215,340.00

Financial and Economic Data

Measuring SROI can be challenging, especially as a lot of this work is categorised as preventative within the community.

Dance to Health has numerous benefits to the community by focussing on promoting wellbeing, fitness, balance and thereby reducing the likelihood of falls, reducing loneliness and isolation, preventing needs, and collaborating across health and care sectors to enhance overall health outcomes and reduce reliance on statutory services. Dance to Health works with individuals to tailor sessions to individual need thus helping to reduce or even prevent escalation to statutory services. By reducing the need for statutory services, this reduces the strain on resources across the health board and local authorities.

The total number of **Pathway 1** discharges was 2919, 34% of which were discharged with reablement only, 30% therapy only, 20% CVS services, 12% long-term package of care, 4% step-down long-term package of care. The reduction in unscheduled care medical admissions and the focus on safe discharges contribute to overall cost savings by optimizing hospital resources and improving service user experiences.

The Acute Clinical Team plays a crucial role in supporting patients to remain at home and avoid unnecessary hospital admissions thus enhancing community-based care. With a caseload of 3210, ACT aided **2699** avoided admissions during the period between April 2023 and March 2024 and facilitated **269** early discharges with a bed day cost saving of **£2,473,120** for the year.

Bon-Y-Maen House provides an assessment and reablement service. The service works in partnership with a range of health and social care professionals, including nurses, social workers, GPs, occupational therapists, and physiotherapists. The aim of the service is to provide short-term care and support to individuals who are experiencing a period of ill health at home or following a stay in hospital. This support helps them regain skills and confidence, enabling them to return to independent living. Between April 2023 to March 2024, there was a total of **221** discharges from hospital into Bon-Y-Maen House (pathway 2) of these **117** returned home after a period of reablement with no care.

Programme Case Studies


01 RIF - N - NPTCVS Q4 CWS Case Study


18PC Case Study West Cross Wellbeir

Digital Stories

Bonymaen House Digital Story

Westfield House - Regional Integration Fund on Vimeo

Dance To Health - Regional Integration Fund on Vimeo

How Volunteering Makes a Difference - West Glamorgan on Vimeo

West Glamorgan Volunteering Support on Vimeo / Cymorth Gwirfoddoli Gorllewin Morgannwg on Vimeo