Regional Integration Fund - Two-page profile

Regional Reablement Programme (PR010)

This profile shows the high-level details relates to the annual proposal, monitoring and evaluation, including indicators, performance measures, expenditure and the impact for service users.

Overview/summary of the programme

The Programme offers a specialised intervention aimed at facilitating hospital discharge and supporting individuals with complex needs, including dementia or early clinical indicators. Initially serving the Rhondda and Taff areas, the programme has expanded to include the Merthyr Tydfil region, ensuring broader accessibility. This tailored programme provides short-term enabling and rehabilitative care to enhance people's independence following hospitalisation. It features goal-oriented support from an integrated workforce, with over 90% of participants consistently achieving their rehabilitation goals. By focusing on older individuals with complex needs, including dementia, as well as people with learning or physical disabilities, the programme addresses diverse healthcare challenges.

The initiative aims to maintain patient flow during peak demand periods by increasing support through intermediate care and reablement services. It emphasises personalised care to help people regain or maintain skills affected by illness. Overall, the programme emphasises the commitment to promoting independence and improving quality of life for individuals transitioning from hospital to home.

RIF deliverables:

Primary model of care:

Home from hospital

Enablers:

Technology enabled care

Workforce development and integration

Priority population group/s:

Older people

Regional approach:

The programme is delivered CTM UHB and is currently operating in RCT and Merthyr Tydfil only.

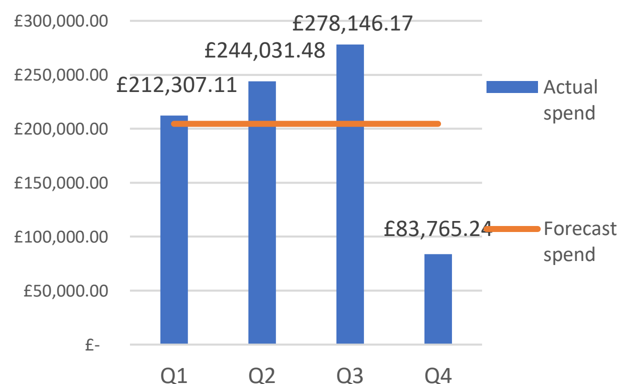
Priority (Linked to Area Plan)

Older people and people with dementia will enjoy good health and wellbeing and supported to live independently for longer.

Older people and people with dementia will receive the support they need to remain in their home for as long as possible, or to move back home as quick as possible following a hospital admission.

People with dementia and their families will have access to the information, advice and guidance that they need.

Project expenditure – £129,767 (2023/24 FY)



Projects/partners supporting delivery:

CTM UHB
RCT CBC
MT CBC
Vision products
Care and repair
Community wellbeing teams

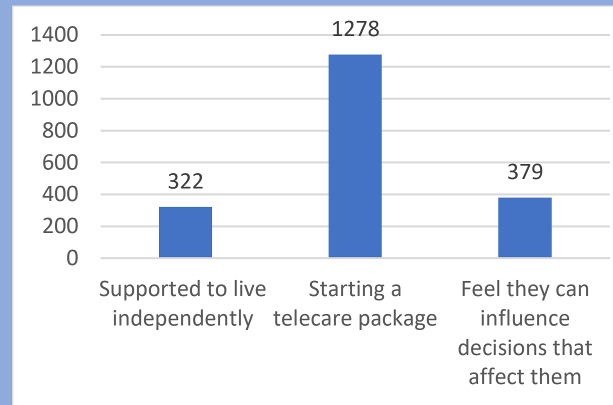
Summary of expenditure:

The funding received from RIF is a contribution towards the delivery of a larger range rehabilitation support services operating across the whole region. The funding provided during 2023/24 was fully utilised during the year.

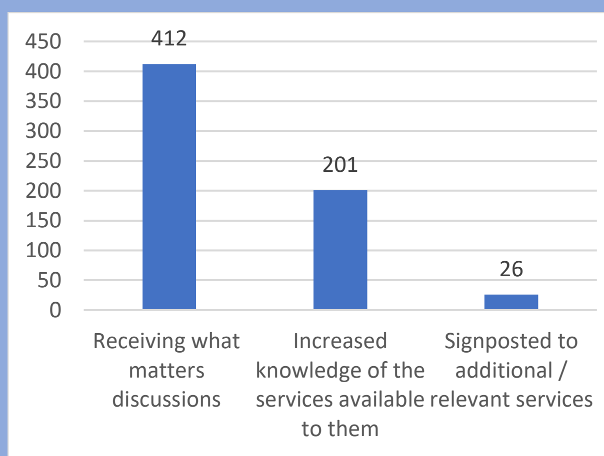
Programme outputs (annual figures):
(includes additional outcome measures)

No of referrals	668
Referrals to memory reablement	146
Referrals to community specific memory reablement	124
Referrals to memory intermediate care	100
People supported following discharge from hospital	247
No of packages of care provided	318
No of hours of direct support provided	20960

Programme outcomes: (primary measures)
(Numbers)



Programme outcomes: (primary measures)



Performance overview: (summary)

The Rehabilitation Programme demonstrates robust performance in supporting adults across diverse care needs. With 668 referrals, including specialised interventions like memory reablement and telecare for 1,278 individuals, the programme highlights a proactive approach to enhancing independence and quality of life. They have facilitated 247 successful hospital discharges, providing 318 packages of care totalling 20,960 hours of direct support. Person-centred care is evident through 412 "What matters" discussions and empowering 379 individuals to influence their care decisions. The programme has increased awareness of local services among 201 individuals and effectively linked 26 people to appropriate external support. Challenges such as managing initial expectations and ensuring accurate assessments are acknowledged. Overall, the programmes performance highlights its integral role in promoting independence, preventing further hospital admissions, and delivering tailored care solutions in our community.

Impact of the programme (qualitative):

Improved Independence: By supporting 322 people to live independently and initiating telecare for 1,278 individuals, the programme enables greater autonomy and safety, fostering confidence and reducing reliance on intensive care services.

Person-Centred Care: Through 412 "What matters" discussions and empowering 379 individuals to influence their care, the programme ensures services are tailored to individual needs and preferences, promoting dignity.

Enhanced Community Integration: By increasing knowledge of local services and linking individuals to relevant supports, the programme strengthens community ties and enables support beyond immediate care needs.

Prevention of Hospital Admissions: Facilitating successful hospital discharges and providing care packages demonstrates the programme's effectiveness in reducing unnecessary hospital admissions, reducing pressure on hospital resources and promoting continuity of care at home.

Caregiver Support: Engaging with families and caregivers ensures they are informed and involved, contributing to a supportive environment.

Recommendations:

Continue funding for the Programme.
The programme has evidenced positive outcomes for the people it supports and their carers.
The reablement element of RIF will form part of future plans around the delivery of the 2 new pathways and be an integral part for supporting people out of hospital and enabling them to remain independent and safe at home.

Additional considerations:
Technology: Further investment in technology solutions such as telecare and remote monitoring systems to enhance service efficiency, improve response times, and provide proactive care management.
Increase in Capacity: Allocate funding for expanding the capacity to meet growing demand, particularly with the implementation of new hospital discharge teams.
Community Engagement and Partnerships: Allocate funding to strengthen partnerships with community organisations. This collaboration would enhance referral pathways, improves continuity of care, and maximises resources to support individuals living independently.