Regional Integration Fund - Two-page profile

Stay Well at Home (PR012)

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

SW@H is an CT initiative designed to support adults facing acute changes in function or crises. It primarily assists frail elderly individuals with complex health issues, frequent unexplained falls, polypharmacy challenges, and other non-malignant conditions. The programme emphasises holistic wellness and personalised care plans to enhance patient stability and recovery at home.

The **Health @ Home Service** provides proactive nursing assessments, IV antibiotics, subcutaneous fluid administration, and advance care planning to prevent health crises and manage chronic conditions.

The **Supporting Medication @ Home Service** focuses on training domiciliary care workers in medication administration, managing patient referrals, and implementing comprehensive Medicines Support @ Home packages.

Hospital-Based Teams operate on a "discharge to assess" model, with trusted assessors working closely with community services to prevent unnecessary hospital admissions and ensure timely patient discharges.

The **Support @ Home Service** includes regular home visits, medication management, rehabilitation exercises, and coordination with other healthcare providers.

Delivered by a multidisciplinary team from health, social care, and the third sector, the programme also collaborates with specialised services. This integrated approach ensures comprehensive, high-quality care, enabling patients to maintain their health and

RIF deliverables:

Primary model of care:

Prevention & Community Co-ordination

Priority population group/s:

Older people

Enablers:

Integrated planning and commissioning

Promoting the social value sector

Workforce development and integration

Regional approach:

The programme is delivered by CTM UHB, RCT and MT CBCs and third sector partners and is currently operating in RCT and Merthyr Tydfil only.

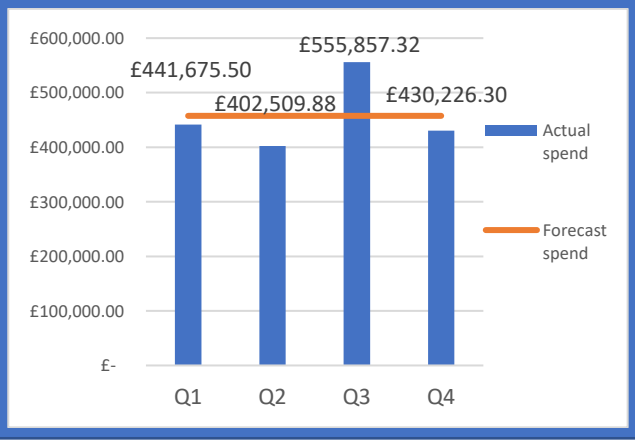
Priority (Linked to Area Plan)

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 – £1,830,269 (2023/24 FY)



Projects/partners supporting delivery:

CTM UHB
RCT CBC
MT CBC
Interlink
VAMT
Voluntary sector

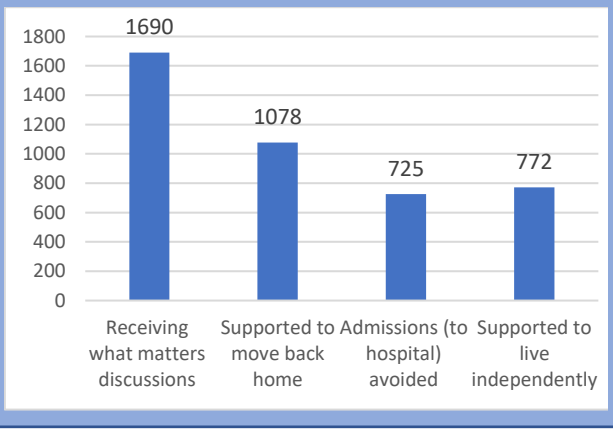
Summary of expenditure:

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.

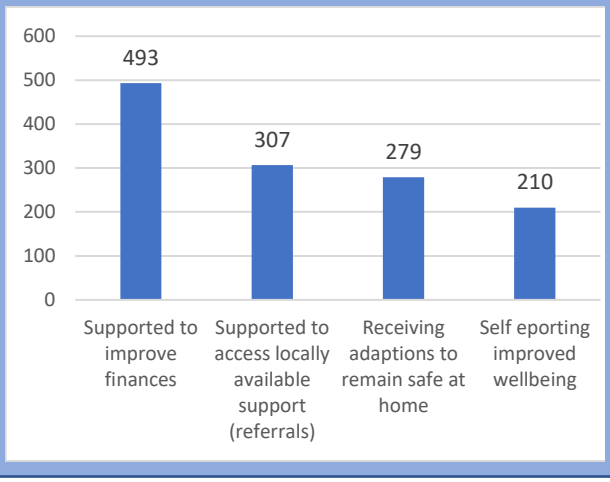
Programme outputs (annual figures):
(includes additional outcome measures)

No of referrals	3262
No of people supported	2512
No of therapy intervention hours delivered	3873
No of social worker intervention hours delivered	4544
No of appointments with people	1449
No of care home placements made	196
No of packages of care / support provided	117

Programme outcomes: (primary measures)
(Numbers)



Programme outcomes: (primary measures)



Performance overview: (summary)

The programme has demonstrated significant impact across multiple fronts. With 3,262 referrals and support provided to 2,512 individuals, interventions such as therapy and social worker hours have facilitated multiple positive outcomes. Notably, 725 hospital admissions were avoided, with 1,078 individuals supported to return home from hospital. Support also enabled 772 individuals to live independently with 279 receiving aides and adaptions. Additionally, 307 referrals to other services emphasise the comprehensive support offered. Other positive outcomes are evident in 1,690 "What Matters" discussions and 210 reporting improvements in wellbeing. This holistic approach not only supports immediate health needs but also fosters long-term independence and quality of life, reflecting effectiveness in community-based care and support services.

Impact of the programme (qualitative):

Reduced hospital admissions: By supporting individuals to manage their health at home effectively, the programme contributes to reducing unnecessary hospital conveyances and admissions, which in turn improves continuity of care and overall health outcomes.

Collaborative community impact: Partnerships with social services and other support networks enhance the programme's effectiveness, ensuring comprehensive and coordinated care that meets the diverse needs of participants.

Improved patient empowerment: Through "What Matters" discussions, the programme empowers individuals to articulate their preferences and goals in healthcare, fostering a sense of control and dignity in decision-making.

Positive feedback and testimonials: Feedback from people consistently highlights satisfaction with the programme's support.

Enhanced quality of life: People report improved wellbeing as a result of tailored support, including interventions aimed at promoting independence, financial stability, and home safety. This holistic approach addresses both physical and wellbeing needs.

Recommendations:

Continue funding for the Programme.
The programme has evidenced positive outcomes for the people it supports and their carers/family's.
The whole programme is a key element of RIF and will form part of future plans around the delivery of the 2 new pathways. It will be an integral part for supporting people to remain independent, safe at home and home from hospital following an admission.

Additional considerations:
Sustained investment: Continued funding for core services such as multidisciplinary assessments, home-based interventions, and support for independent living.
Technology: Invest in technology infrastructure for integrated health records and data sharing across services. This improves coordination, efficiency, and data-driven decision-making to optimise care delivery.
Expansion of outreach and referral networks: Expand outreach efforts and strengthen referral networks with community partners. This enhances the programme's reach and ability to meet increasing demand.