FURTHER, FASTER IN WEST WALES

Developing a Health and Care System for Older People* in Carmarthenshire

* *Includes adults with physical disabilities and sensory impairment*

The 'Project' Brief

- *To develop a plan (building on a range of initiatives including 'Home First' and a range of 'step up' and 'step down' care options) that sets out a model for community health and care provision for older adults and adults with physical disabilities that allows them to remain well and independent in their own home and community (including safe alternatives to hospital admission or extended stay). This model will include the provision of beds, equipment and functional aids, therapies, social care, clinical care and support to meet the complex needs of our frail and elderly patients both now and in the future.*

- *This plan must address the complex and multiple needs of the patients rather than the capabilities of the current provider landscape. It must consider both immediate impacts that changes can make as well as setting out a model to meet medium and long term demand of the frail and elderly.*

- *The initial draft of the plan must be available by 28th February 2023 for presentation to the Chief Executive Sponsors at which time the plan must be capable of being implemented from 1st April, 2023 and fully implemented by 30th November 2023 with a clear view on how it can be progressively scaled up to meet longer term population demand.*

Context

THE WHY?

- System Sustainability
- Optimal Management of Frailty
- Population and Organisational Improved Outcomes ***– PROVEN MODEL LOCALLY and NATIONAL EXEMPLAR***

THE WHEN ?

- 'The time is now – we are currently managing the demographic tsunami' & it will get worse
- Frailty Policy Statement; provides framework for :
- Ministerial mandate – integrate 'Further, Faster' & development of Community Integrated Care Service for Wales (CICSW)

THE HOW?

- Section 33 & 'track record' of integrated working / management structure
- Part 9 Social Services and Wellbeing (Wales) Act
- Joint Committee ? Other Models Exist
- Whole System / Population Approach NOT organisational!

Project Alignment with 'Further Faster' and its Development

Policy statement/outcome framework for Frailty

Five Priority Population Groups (Regional Integrated Fund)

1	2	3	4	5
Older People including people living with dementia	Children and young people with complex needs	People with learning disabilities and neurodevelopmental conditions	Unpaid carers	People with emotional and mental heath wellbeing needs

Community Integrated Care Service for Wales (CICSW)

A Population Health Outcome Approach

Not all older people or those living with frailty will need the Community Integrated Care Service for Wales (CICSW)

Fit and Independent Adults

Older people who are:

1. Very Fit: People who are robust, active, energetic and motivated. They tend to exercise regularly and are among the fittest for their age

2. Fit: People who have no active disease symptoms but are less fit than category 1. Often, they exercise or are very active occasionally, e.g. seasonally.

3. Managing Well: People whose medical problems are well controlled, even if occasionally symptomatic, but often not regularly active beyond routine walking.

Mildly Frail

Older people who are:

4. Living with very mild frailty: Previously 'vulnerable' in CFS v1.0, this category marks early transition from complete independence. While not dependent on others for daily help, often symptoms limit activities. A common complaint is being 'slowed up' and/or being tired during the day

5. Living with mild frailty: People often have more evident slowing and need help with high order instrumental activities of daily living (finances, transportation, heavy housework). Typically, mild frailty impairs shopping and walking outside alone, meal preparation, medications, and begins to restrict light housework.

Moderately Frail

Older people who are:

CICSW

6. Living with moderate frailty: People who need help with all outside activities and keeping house. Inside, they often have problems with stairs and need help with bathing and might need minimal assistance (cuing, standby) with dressing.

Very to Severely Frail

Older people who are:

7. Living with severe frailty: Completely dependent for personal care, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~6months).

8. Living with very severe frailty: Completely dependent for personal care and approaching end of life. Typically, they could not recover even from a minor illness.

9. Terminally ill: Approaching the end of life. This category applies to people with life expectancy < 6 months, who are not otherwise living with frailty (many terminally ill people can still exercise until very close to death)

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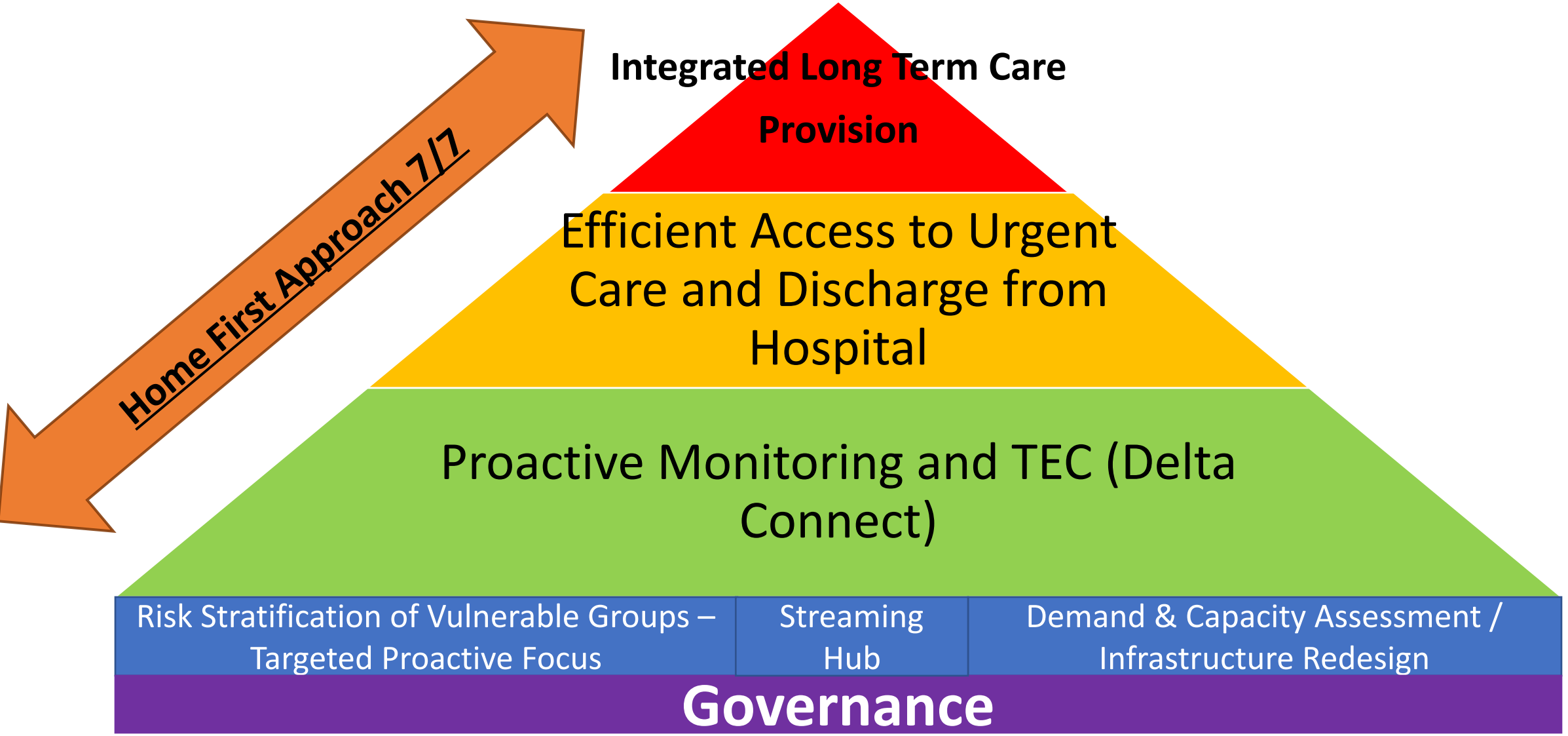
Complicated needs, becoming complex

Complex needs

NB …. Management of this population proactively is AS IMPORTANT as Integrated Care Service

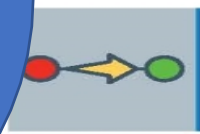
Building Blocks for Health & Care System for Older People in Carmarthenshire



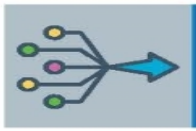
Service Infrastructure – community nursing, therapy, Delta, social care, 3rd Sector, Specialty Doctors, 1' Care Contractors

'Home' is usual place of residence and any long term care that may be in place

homefirst



Discharge to Recover & Assess (Red to Green)



Proactive Case Management & TEC (virtual ward)

SPOC & Clinical Streaming to 'Right Place'

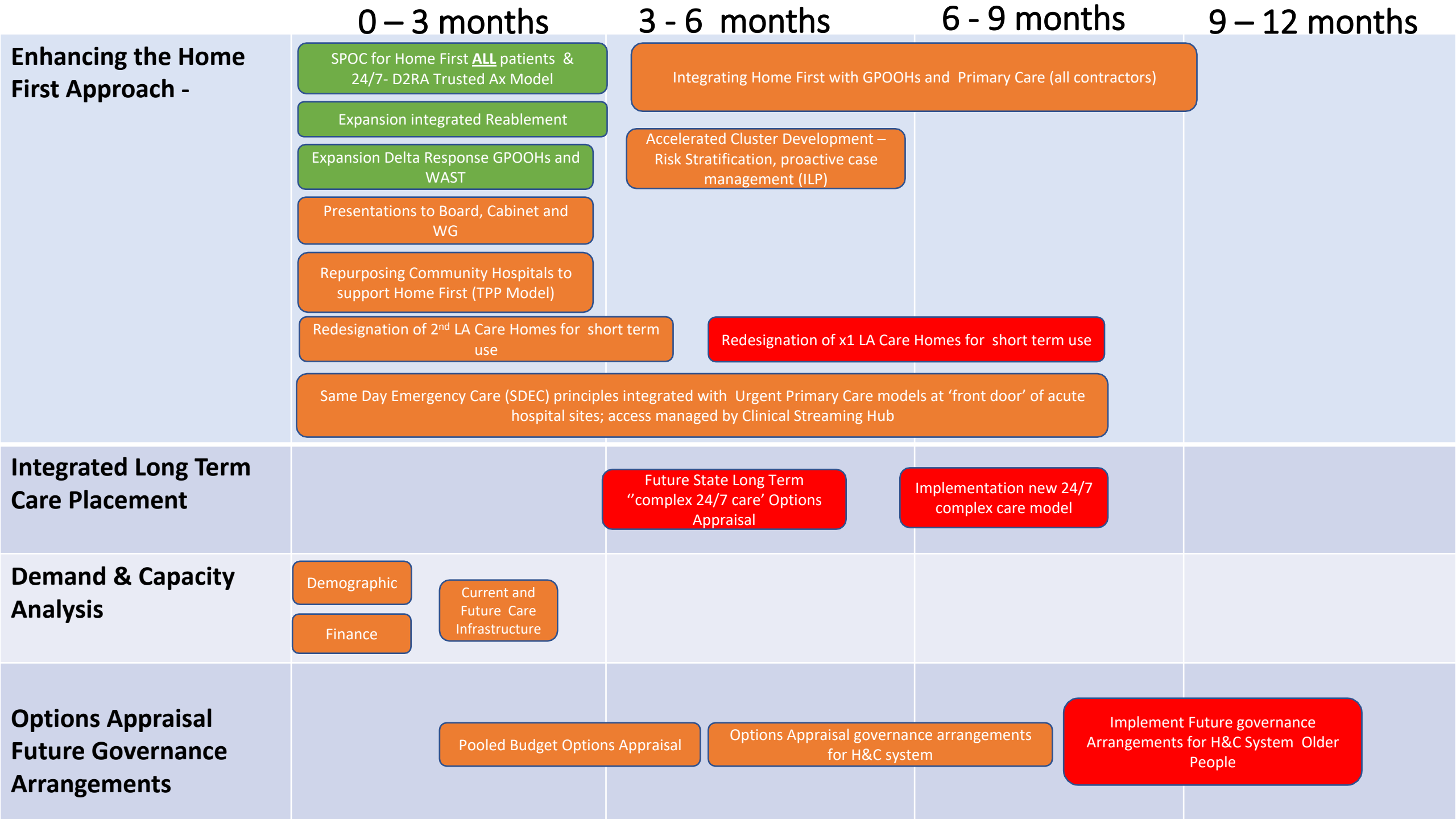
Short Term Reablement Beds

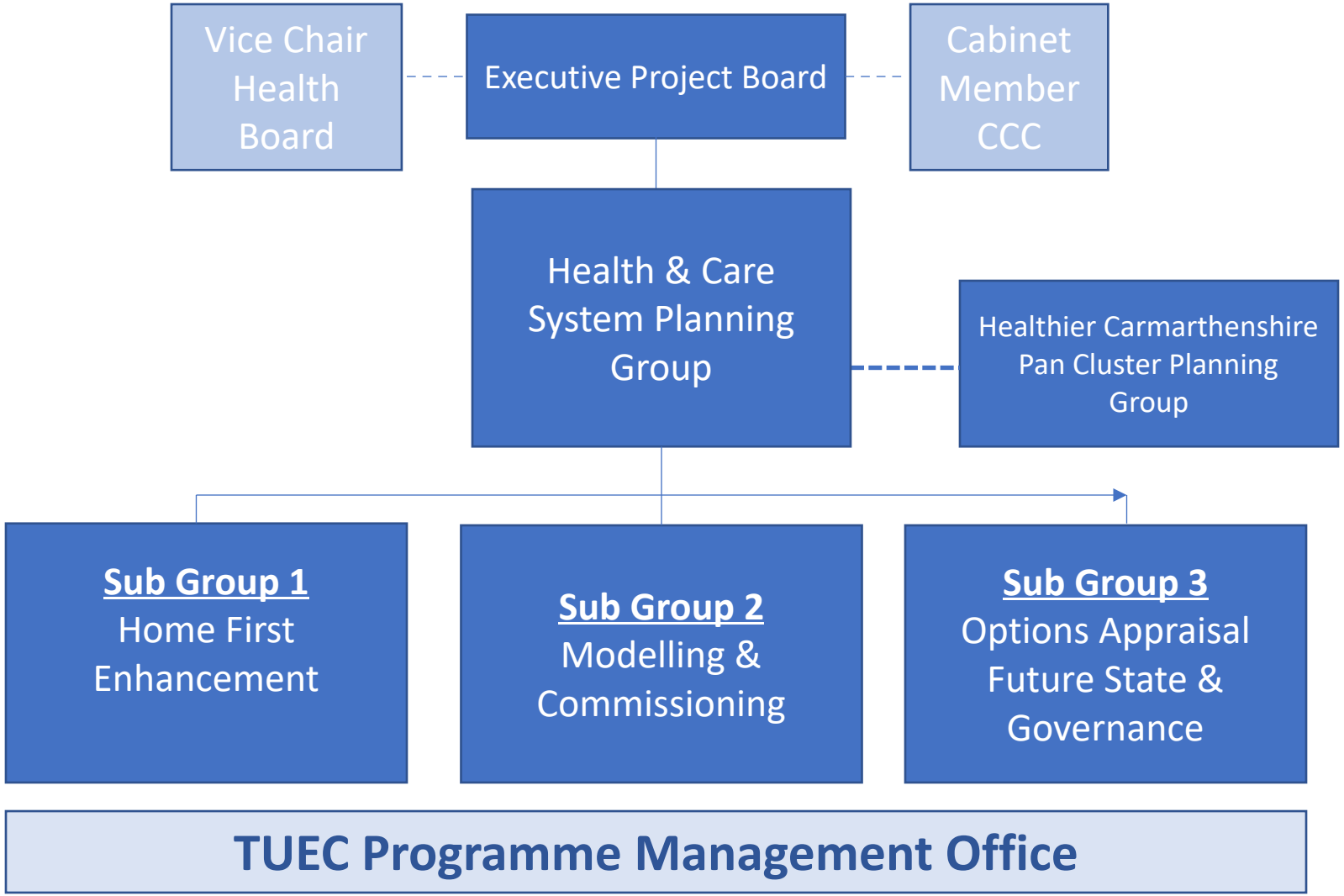
Rapid Response to Crisis (1-2 hours)

Integrated Reablement & Intermediate Care (72 hours)

<u>NOT A SERVICE –</u>

It's an approach that focuses on prevention / asset based / proportionate commissioning & best practice for frail


0 – 3 months
3 - 6 months
6 - 9 months
9 – 12 months
Enhancing the Home First Approach -
SPOC for Home First ALL patients & 24/7- D2RA Trusted Ax Model
Integrating Home First with GPOOHs and Primary Care (all contractors)
Expansion integrated Reablement
Accelerated Cluster Development – Risk Stratification, proactive case management (ILP)
Expansion Delta Response GPOOHs and WAST
Presentations to Board, Cabinet and WG
Repurposing Community Hospitals to support Home First (TPP Model)
Redesignation of 2nd LA Care Homes for short term use
Redesignation of x1 LA Care Homes for short term use
Same Day Emergency Care (SDEC) principles integrated with Urgent Primary Care models at 'front door' of acute hospital sites; access managed by Clinical Streaming Hub
Integrated Long Term Care Placement
Future State Long Term ''complex 24/7 care' Options Appraisal
Implementation new 24/7 complex care model
Demand & Capacity Analysis
Demographic
Finance
Current and Future Care Infrastructure
Options Appraisal Future Governance Arrangements
Pooled Budget Options Appraisal
Options Appraisal governance arrangements for H&C system
Implement Future governance Arrangements for H&C System Older People



Proposed Project Governance Structure

Y gofal iawn, yn y lle iawn, y tro cyntaf
Chwe Nod ar gyfer Gofal Brys a Gofal mewn Argyfwng
Right care, right place, first time
Six Goals for Urgent and Emergency Care

Outcomes Framework for Older People (and UEC)

wwcp
Partneriaeth Gofal Gorllewin Cymru
West Wales Care Partnership

'Ends'

- **Patient / Service User feedback Measures:**
  - *'My care is provided in the most appropriate setting to meet my health and care needs'* i.e. What Matters
  - *'How likely are you to recommend our services to your friends or family should they need similar care or treatment'*
- **Population Outcome**
  - Increased number of **healthy days at home** (overarching Outcome for Population)
- **Older People (UEC) High Level Outcome Indicators**
  - Reducing the number of bed days > 21 – measure of impact on discharge effectiveness / efficiency on the 'back door'
  - Number of [illegible] days' (recorded through faculty) (measure of acute hospital discharge productivity)
  - Reduction in proportion commissioned care hours / placements following in patient stay

PG1 Performance Metrics ('Means')

- TBC % of population risk stratified as vulnerable and who have stay well plans in place
- Number and proportion of vulnerable patients Managed by 'Home First'
- Number of service users receiving domiciliary care
- Total Number of commissioned domiciliary care hours

PG2 Performance Metrics ('Means')

- No. of direct referrals to SDEC
- Number of GP referrals streamed through CSH and % directed to SDEC or alternatives
- Conveyance Rate (Target 60%)
- Ambulance lost hours (Target 0)

PG3 Performance Metrics ('Means')

- 30% of acute medical take assessed in SDEC. 90% of which go home for >75 year olds, >55 year olds and rest of population
- Number Admissions
- Number of Occupied Beds
- 0-1 day LoS
- 0-3 day LoS
- Re-admission rates (balance)
- Conversion rate (balance)
- Number of patients referred to Home First
- Number and % patients Provided with crisis response

PG4 Performance Metrics ('Means')

- ED attendances (all)
- ED attendances (WAST)
- 4 hour wait
- >12hr Performance
- % of patients with clinical frailty score recorded (pre morbid and on presentation)
- TBC re EDQDF

PG5 Performance Metrics ('Means')

- % of patients have discharge criteria defined by the clinician **and** MDT within 14 hours from 'point of admission'
- 10-14 days LoS
- Number of patients with LoS > 21 days
- Occupied beds rate

PG6 Performance Metrics ('Means')

- **Average length of time to commission domiciliary care**
- **Average length of time to place into residential and nursing sector**
- **Number of people reported as clinically optimised**
- **Number of domiciliary care hours lost (handed back) due to LOS > 7 days**
- **Number of care hours commissioned following hospital inpatient stay**
- **Number of residential placements requiring increase to general or EMI nursing following hospital stay**

NB Dementia / EoL metrics here

Quality metrics: staff sickness and improved retention levels across all disciplines, reduced incidents, staff feedback

‘End’ – Outcome Indicators

- Bed day reduction > 21 days (Length of Stay)
- Reduction in Conveyance
- Reduction in Admission Rates

‘Means’ – Performance Metrics (highlights)

- 31 – 45% reduction in community social care demand (means)
- 65% reduction in social care requirement following Home First (means)
- 85% Admission avoidance with UPC / IC crisis (6994 referrals)
- 70% conveyance reduction with SPOC Home First (including APP navigator)
- 94% of all Delta ‘faller’ responses remained at home (6% conveyance rate @ 10,324 calls)
- Average 40 Discharges per week with Home First support (40 New complex patients per week)

How Far? How Fast?