HEALTH & SOCIAL SERVICES SCRUTINY COMMITTEE

25TH JANUARY 2024

INTEGRATION IN CARMARTHENSHIRE – POSITION UPDATE ON DELIVERY AGAINST PRIORITIES

1. BACKGROUND AND INTRODUCTION

This paper provides members of the Health & Social Care Scrutiny Committee with a position statement on Integration of Health & Social Care in Carmarthenshire and specifically, an update with regards to specific priorities which were set out to deliver on a community care system for Carmarthenshire.

Following a presentation by Rhian Matthews to Scrutiny Committee at its June 2023 meeting, members agreed to support the below:

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.

Members should note that work in Integration between Health and Social Care has been focussed on delivery on the frontline of seamless services to the public. Progress on wider strategic integration has not been what was envisaged last year. Significant financial pressures, changes at Chief Executive level and a reorganisation within Health make further progress in strategically integrating the Local Authority and the Health Board unlikely in the short to medium term.

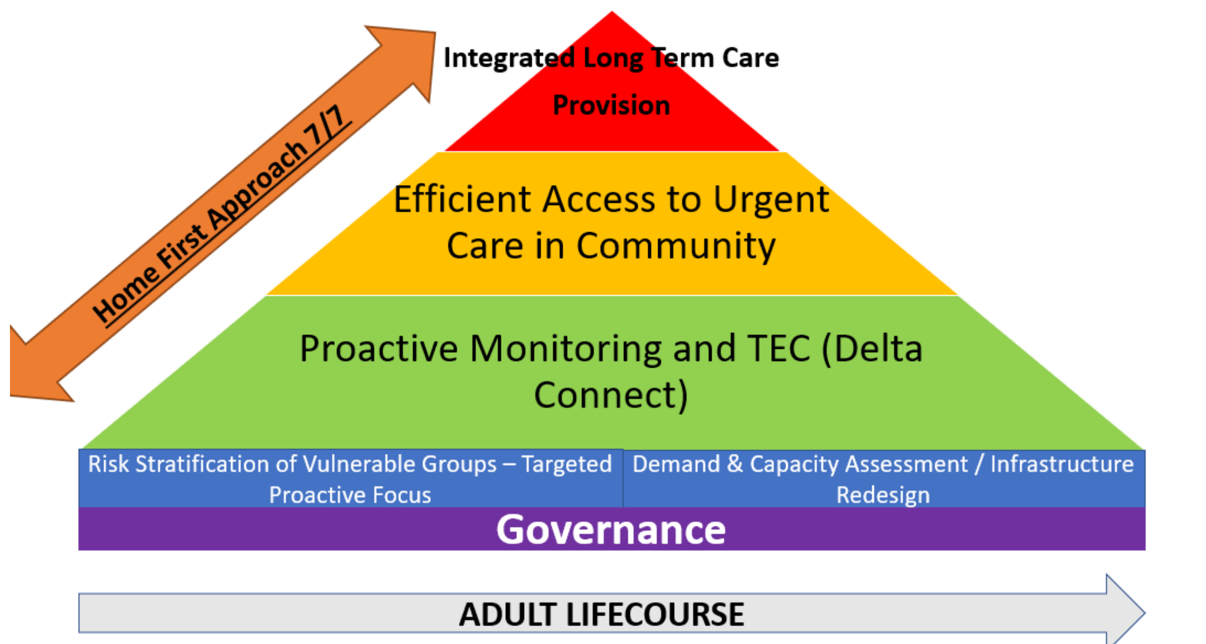
1.1 Priorities that were agreed during 2023

Following presentations of the plan to further Integration and develop a Community Care Integrated System for Carmarthenshire, the following priorities were endorsed by scrutiny committee, full council & both CEO’s of Carmarthenshire County Council & Hywel Dda UHB:

1. Development of a single point of access for Home First for all people & 24/7
2. Integration of Home First with GP out of hours/ Primary Care
3. Expansion of Integrated Reablement
4. Expansion of Delta Response to support GP Out of Hours & WAST
5. Repurpose Community Hospitals to support Home First (TPP model)
6. Re-design of an LA Care Home for short term use
7. Future state long term complex 24/7 options appraisal & implementation of the complex care model
8. Pooled Funds options appraisal / governance arrangements/ implementation

This paper will focus on progress against the above priorities and cover some of the performance metrics that we are monitoring in order to know whether the initiatives we have been implementing is making a difference to people and also to both the Health Board and Local Authority.

Figure 1 below illustrates how the Home First approach in Carmarthenshire cuts across all pathways of care, with the objective being to manage the majority of our population in the Proactive space, with efficient access to urgent care as required. Our aim is to ensure that Long term care is only prescribed following opportunities to access preventative services to reinstate previous independence and to ensure any commissioned care is right sized and proportionate to assessed care and support needs.



2. ASSESSMENT OF PROGRESS MADE

2.1 Development of a single point of access for Home First for all people & 24/7

A Home First approach across all service pathways has been developed over the course of the last 2 and a half years, however, some fundamental transformation has been progressed at the front door of community services and with broader integration across our Urgent & Intermediate Care pathway. This encompasses our Social Workers, GP's, Nurses, Community Allied Health Professionals (AHP's), Delta Connect, WAST, Third Sector Services, Reablement & Domiciliary Care Services

All working together, prioritising proactive and preventative approaches through to crisis response approaches to optimise healthier days at home for the population, avoid unnecessary hospital admissions and facilitate their discharges home from hospital as soon as possible.

Home First Services are streamlined through a single point of access that provides access to all crisis and short term urgent/ intermediate care in the County which aims to achieve three main outcomes for the population:

- Prevent admission to hospital: People who are medically suitable for treatment in the community are supported in their own home by the multidisciplinary response;
- Facilitate discharge from hospital: People are discharged from hospital as soon as clinically optimised for a period of assessment and rehab at home, or in one of our bed-based facilities;
- Triage out of statutory services and to consider a strengths based approach looking at the individuals assets and those of family & friends as a starting point rather than going directly to commissioned care as a solution.

Social Care sits at the heart of the single point of access with a strong social work focus on driving a preventative focus for people who are triaged, together with Reablement and Delta Wellbeing. An Intake & Assessment model for social work was introduced on the 6th November which builds upon a pilot that ran from March 2023 to October 23. This pilot demonstrated a 50% reduction in the number of assessments that were passed onto long term social work teams following assessment at the front door. Furthermore, the waiting list for IAA has reduced by 25% since this introduction of this way of working.

This is significant and allows our staffing resources to be cohorted so that people who require urgent assessment get a timely response and people who are in receipt of long term care get the focus they require. It also allows staff to better manage their caseloads with the unprecedented demand.

Since October, a proportionate assessment to support hospital discharge has been rolled out which introduces a trusted assessor approach into Carmarthenshire. The Community Gateway process has allowed Therapists, Nurses and Delta ward based officers to proportionately assess for preventative services to support discharge. Early indications from data being tracked demonstrate a positive picture in terms of this approach increasing the number of individuals discharged for assessment at home and a reduction in those who receive a social work assessment for long term care in a hospital setting.

2.2 Integration of GP Out of Hours with Home First & Primary Care

Following a trial in November of Home First Advanced Nurse Practitioners working alongside GP Out of Hours, this practice is going to be rolled out on a regular basis from January 2024 with ANP's working weekend shifts on a rota to support GP out of hours. It is anticipated that this will present many opportunities to offer alternative pathways to people, other than hospital. ANP's will have the full knowledge of community services, together with the support of the broader urgent care pathway in order to think creatively about safe clinical alternatives to keep people safe in their own homes.

The GP lead for Urgent & Intermediate Care, Dr Sioned Richards is in the process of engaging with each individual GP practice in the County around opportunities to access the Home First offer and specifically, urgent and intermediate care services when people go to them in crisis. It is well known that GP's will often direct people to the Emergency Department when they are unable to manage them on their own. Engagement with GP's has highlighted that often this is due to the fact that people will not present with a medical problem in isolation of a social or functional one. The benefits of Primary Care GP's having access to the Home First MDT is that medical, social and functional issues can all be dealt with by one team.

Early indications are positive, with GP's benefiting from access to this multi professional single point of access and hugely beneficial for the person needing services as they are provided with an alternative to hospital. We are tracking the outcomes on this specific element of the pathway and once there is more data, this will be reported on a regular basis.

With access to a community based multi-disciplinary team to support in a crisis/urgent situation, this should reduce the number of people directed to an emergency department. For our older, frail population, this could mean the difference between an admission to hospital and staying at home. As members will be aware, if a frail, older person is admitted to hospital, they are likely to have a long length of stay with associated deconditioning and result in the requirement either for a social care package for discharge or an enhanced level of care to what was previously in place.

2.3 Expansion of Integrated Reablement Support Workers

During the latter end of 2022, a WG programme driving building community capacity afforded Carmarthenshire the opportunity to work with Hywel Dda UHB and trial a new support worker role within the Health & Care Sector. With investment from both CCC and Hywel Dda, a project team was established and worked on a job description for a support worker who could be employed by either Health or Social Care, was able to carry out personal care but had a rehabilitation and reablement focus.

The benefit of embedding this role within the Home First pathway enabled the roles to be created on a Home Carer JD but could support delegated tasks from Physiotherapists and Occupational Therapists as well as the Registered Manager for Reablement.

There are currently 13 individuals in post (equating to 18 WTE) who are in joint posts and contracted with either the LA or the Health Board. All staff are required to be registered with Social Care Wales and this is a mandatory requirement of their employment.

The team currently deliver between 100 – 120 hours of direct care per week and hold a caseload of 12 to 15 people per week (140-200 visits per week).

In terms of outcomes, since January 2023, 91 people supported (2,549 visits/ 1502 hours of care delivered). The team predominantly support individuals from hospital to home, but increasingly are supporting admission avoidance in the community.

2.4 Expansion of Delta response to support GP out of hours & WAST

Whilst the plans to support GP out of hours have not come to fruition as at the time of writing this update, there are significant opportunities for Delta to support GP out of hours that can be developed. This area of work being progressed is dependent on continuation funding being agreed by the Health Board that is currently at risk post March 24. This funding currently pays for 6 full time Delta Response Officers, without which, working within GP out of hours will not be possible with staffing capacity.

GP out of hours within the Hywel Dda region as a whole is very fragile with there being regular uncovered shifts. Carmarthenshire are working closely with the GP Lead and Service Delivery Manager for out of hours to test new and innovative ways of supporting the service to ensure the Carmarthenshire population have access to this service.

2.5 Re-purpose Community Hospitals to support Home First (Ty Pili Pala Model)

Carmarthenshire has two Community Hospitals in County, Amman Valley Hospital which has a total of 28 beds and Llandovery Cottage Hospital which has a total of 15 beds. Both hospitals predominantly support people to ‘step

down' from an acute hospital bed where they require further rehabilitation or assessment that requires support with overnight needs. These are nurse led facilities and require medical acceptance pre-transfer either from a Consultant in Acute or a GP (commissioned via an SLA/ Intermediate Care). Length of stay on average at both sites has been in the high 80's (80 days) and the biggest issue in terms of delays in discharge are due to people waiting for packages of care through social care.

Ty Pili Pala is a 14 bedded Intermediate Care unit based at Llys y Bryn Care Home in Llanelli. The unit is run by Carmarthenshire County Council and staffed with care staff. Medical, Therapy & Social input into the unit is provided by the Home First pathway and they determine who is eligible to be admitted (with a final confirmation required by the RI/Senior Carer for the Unit). The unit is reablement led with all staff having received the same reablement training, the focus is on regaining independence and function. Length of stay on average is 30 days. 87% of people who are supported via TPP leave with no ongoing support.

Hywel Dda Health Board has embarked on a regional review of all its bed based care with a vision to develop alternative care models that are fit for purpose and focus on outcomes for individuals. The Head of Integrated Services, together with Senior therapy and Nursing staff, is in the process of reviewing the models of care provided at Llandovery and Amman Valley. Proposals will consider the benefits of having more step up opportunities to manage our frail elderly population who present at the 'front door' of our hospitals who may require a period of assessment that does not have to happen in the acute sites.

2.6 Re-design of a care home for short term use

This work has not yet been commenced. Initial discussions with the RI for LA Care Homes has resulted in some options being discussed for developing another bed based intermediate care facility in the County. Geographical locations available will make it difficult to develop with no further revenue investment to ensure the Home First resource is available to make it a success.

2.7 Future state of long term complex 24/7 options appraisal & implementation of the complex care model

The West Wales region is currently exploring the feasibility of the public sector running a nursing home. Initial legal advice has indicated that there is no legal barrier to doing this, and we are currently scoping what the delivery options might be. From a Carmarthenshire perspective, there is scope to explore options around the former Plas Y Bryn Care Home in Cwmgwilli which the Local Authority has recently purchased as well as Zone 2 of the Pentre Awel development.

Critically, what is needed is a facility that can meet the fluctuating care and support needs of an individual, between residential and nursing, without requiring them to move from their home. A ‘home for life’ model.

Delivering a public sector nursing home would support the objective of delivering a home for life for residents.

2.8 Pooled Funds options appraisal / governance arrangements/ implementation

There is an overarching s.33 agreement in place between the Health Board and the Local Authority which is the governance around the Integrated Management structure. This agreement has been in place since 2009 and is extant.

The Head of Integrated Services is currently reviewing the agreement and this will include the development of detailed service level schedules that will sit beneath the legal agreement to provide a level of detail on the services being delivered operationally. This will include service priorities, workforce and financial detail.

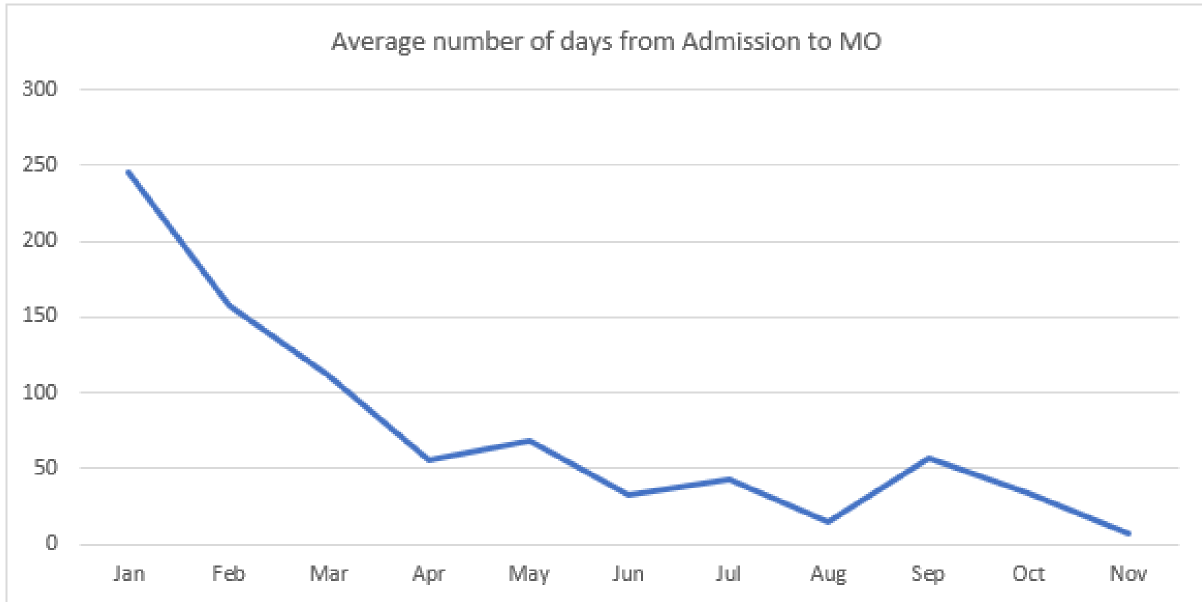
3. WHAT IS THE DATA TELLING US – IMPACT OF HOME FIRST ON THE WIDER HEALTH & CARE SYSTEM IN CARMARTHENSHIRE

There are a number of metrics tracked that are demonstrating that our Home First approach is having a positive impact both in terms of people receiving services and on organisations themselves.

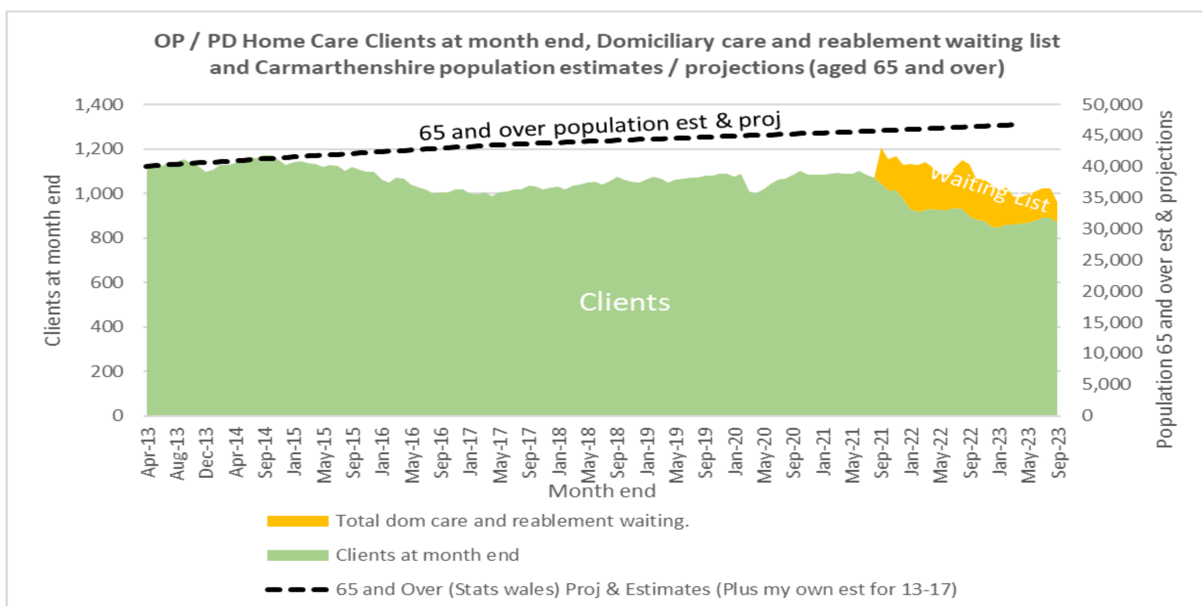
In terms of Hospital services, we know that over 78% of our acute hospital bed base is taken up by frail older adults over the age of 75. Once admitted, a frail older adult faces a length of stay of an average of 21 days and over that time, significant deterioration and de-conditioning occurs, meaning it is very challenging to get a person back to their previous baseline. Furthermore, we know our greatest opportunity to avoid admission and subsequent long lengths of stay and the associated de-conditioning, is to prevent admission in the first place.

Population level indicators being tracked include emergency admission rates, ambulance attends, occupied beds and turnaround in 72 hours (the golden timeline to avoid admission for the frail older adult). December 23 data demonstrates a significant increase in the number of emergency admissions at both Glangwili and Prince Philip sites, with a corresponding reduction in occupied beds per 10k of the population. Length of stay over 21 days is also reducing, demonstrating that the home first focus is having a positive impact in terms of reducing long lengths of stay & discharging people within 72 hours of presentation at an emergency dept.

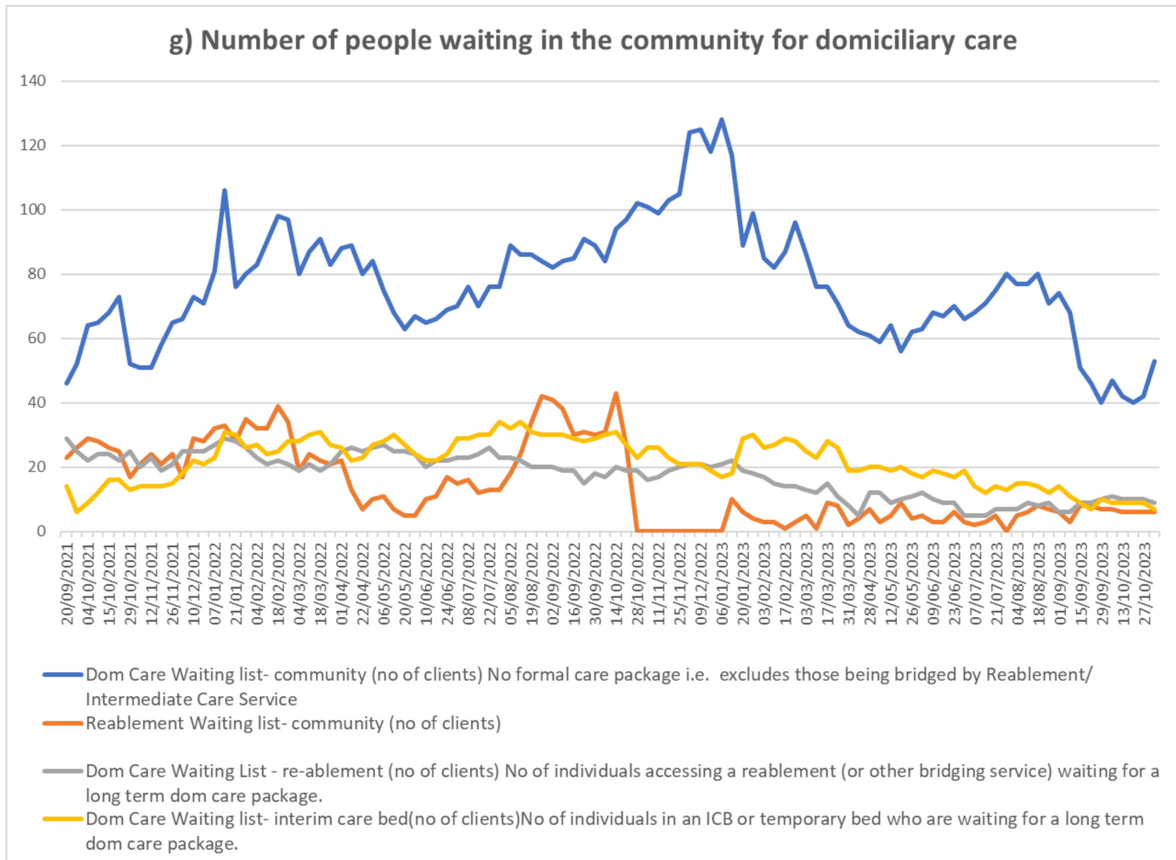
Furthermore, we are seeing a continuous improvement in the reduction in the number of days between a person being admitted into hospital to them being deemed clinically optimised, this is when their acute episode of care is complete and they are ready to move to the next stage of their care & support journey.

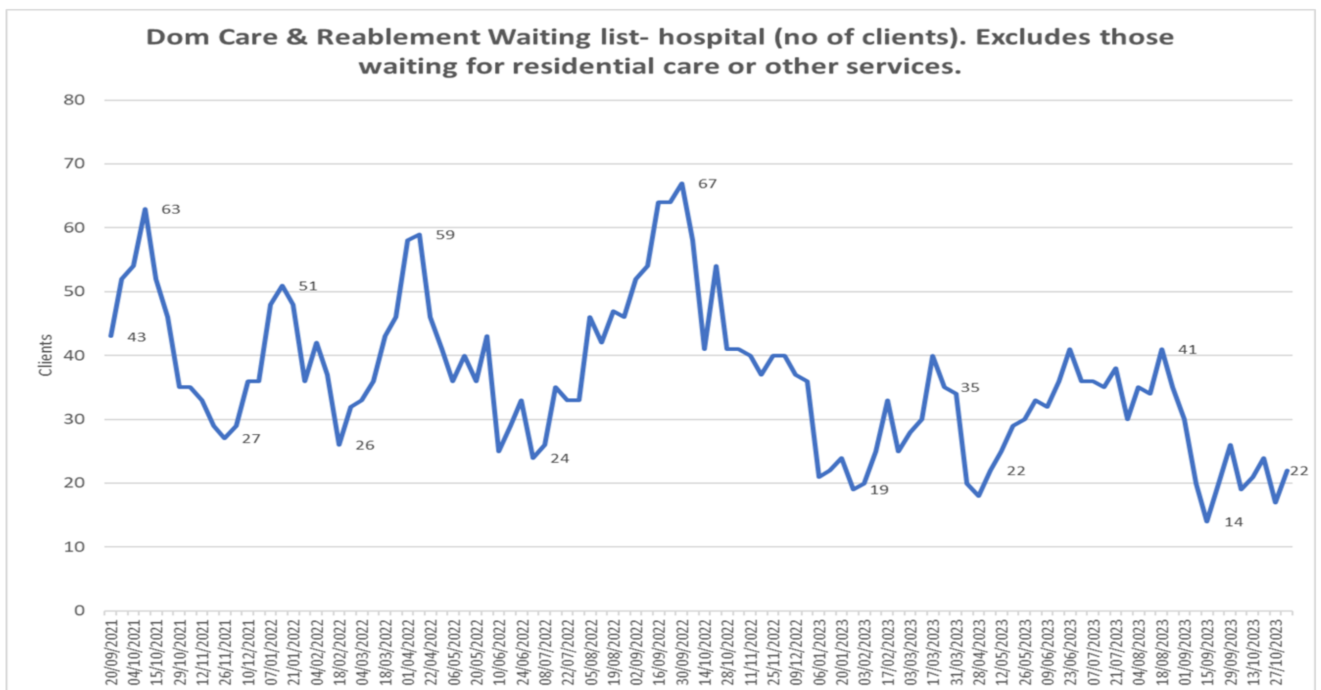


In terms of Social Care data, the below graph is a really clear illustration of our continued population growth in those over 65, 3% year on year average growth. Despite this, we are continuing to manage the demand in terms of domiciliary care and reablement and even beginning to see a reducing trend in terms of the waiting list. Another very positive indication that our overall home first approach is having a positive impact.



This is further affirmed in the below two graphs which are waits in terms of domiciliary care from both hospital and the community:





The trend mirrors the issues that have been seen with availability of domiciliary care capacity, and the downward trend of those waiting since September 2022 mirrors the overall reduction of those waiting for domiciliary care. Post August 2023, the overall number waiting in hospital significantly reduced as more care hours became available across the sector and the numbers waiting from that point onwards overall reduced.

Numbers waiting for domiciliary care in hospital between Q1 23/24 (April – June) and Q2 (July – September) have halved which provides further evidence that the Home First approach is having the positive impact in that more people are being discharged for assessment via preventative Intermediate Care services rather than waiting for assessment & commissioning of long term care in hospital.

4. CHALLENGES IN DELIVERING HOME FIRST

4.1 Financial Challenges

Both the Health Board and Local Authority are under significant pressures with regards to core budget. This position is set to worsen over the next two years. Furthermore, grant funding which is all temporary, funds a significant amount of front line services, particularly Home First, which is a significant risk as the majority of this is core service. For example, Carmarthenshire attracts £3.5 million of RIF funding into Home First services.

All grants have been frozen, so in real terms, this presents a reduction in funding year on year when you account for inflation and pay awards for staff. All the while, our demographics are increasing and we have more complex older adults to manage in the Community and in Hospital.

4.2 Workforce

Whilst recruitment hasn't posed an issue within Home First, recent recruitment of Therapists proved successful and Delta Wellbeing never have an issue in recruiting. The challenge lies in the number of temporary posts that are within this structure that are grant funded that poses the problem.

In terms of Social Work, there are only 4 vacancies in Older Adults as a whole, which is the lowest vacancy factor there has been in a long time.

Retention of staff isn't an issue within Home First, however, development of new roles and career progression opportunities such as 'grow your own' operate within Social work, Therapy & Nursing prove successful in retaining staff in the Carmarthenshire system.

4.3 Complexity & Demand

As members will be aware, Carmarthenshire has an ageing population, with 3% year on year growth in our over 65 years population. Combined with the post pandemic hangover, the impact of people not accessing services during the pandemic, delays in terms of accessing planned operations such as knee replacements/hip replacements and lack of access to GP's all contributes to increasing complexity and demand on urgent care & crisis response services in both the community and the hospital.

Whilst the Home First model is making a significant impact in terms of managing demand in the Carmarthenshire system, there is a large amount of unmet need in terms of capacity in preventative services to manage everything. With the future financial challenges ahead, it is unlikely that there will be growth in the workforce, so the message is very much to do more with less. This will result at some point in reduced service delivery or further delays for services as our workforce continues to manage with unprecedented challenges.