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ICF Proposals Carmarthenshire

DYDDIAD Y CYFARFOD: DATE OF MEETING:	**20th March 2018**
EITEM AR YR AGENDA: TITLE OF REPORT:	**Proposals for ICF Funding for 18 / 19 Carmarthenshire to Progress Intermediate Care Pathway for Older Adults**
ARWEINYDD CYFARWYDDWR: EXECUTIVE LEAD:	**Linda Williams / Jake Morgan**
SWYDDOG ADRODD: REPORTING OFFICER:	**Rhian Dawson, Head of Integrated Services (Carmarthenshire County Council, Hywel Dda University Health Board)**

Pwrpas yr Adroddiad (dilewch fel yn addas) **Purpose of the Report** (delete as appropriate)		
Ar Gyfer Penderfyniad For Decision	**Ar Gyfer Trafodaeth For Discussion**	**Er Gwybodaeth For Information**
X	X	X

ADRODDIAD SCAA SBAR REPORT

Sefyllfa / Situation

This SBAR report outlines our proposals to the West Wales Care Partnership for Integrated Care Fund 2018 – 2019. The proposals are considered as recommendations within this report to improve intermediate care pathway for older adults in Carmarthenshire. Specifically, this proposal relates to the ICF schemes known as:

- TOCALS
- Rapid Response Domiciliary Care
- Proactive Care Team

Cefndir / Background

The proposals are grounded in evidence based practice outlined in policy and research. They are also supported by practice through ICF funded 'proof of concepts' delivered and progressed over last three years.

In summary:

- Improving outcomes for older people is dependent on effective intermediate care pathways that avoid hospital admission and support efficient discharge[1][2]. Evidence suggests that effective pathways should therefore include:
  - Timely response to acute episodes in the community; 'Step Up my Care' & Conveyance Avoidance
  - 'Front door Turnaround' & Admission Avoidance
  - Early Idenfitication of Frail Inpatients who would Benefit from 'Discharge to Assess' Hospital Pathways
  - Reablement programmes of care that are therapy led

[1] Bolton, J. (2017) *Six Steps to Managing Demand in Adult Social Care.* IPC; London
[2] BGS (2014) *Fit for Frailty* British Geriatrics Society: London

An evaluation of our intermediate care pathways in Carmarthenshire in July 2016 demonstrated that:

- ❑ Broad spectrum of services existed to support intermediate care but not coordinated and generally social worker led response
- ❑ Often frail adults with 'sudden functional decline' were conveyed unnecessarily to hospital and may have been cared for at home with better outcomes
- ❑ Domiciliary care reablement (led by social care) over used
- ❑ Simple therapy led programmes could support the individual to self manage
- ❑ Many 'front doors' to the CRTs compromised consistent approach to assessment and care planning
- ❑ Many 'front doors' compromised our ability to measure demand and capacity; Workforce? Service Commissioning?

A review and realignment of our CRTs commenced in November 2016 and with ICF supported the following:

- ❑ Enhance our current 24/7 Careline service to provide an efficient integrated Information, Advice and Assistance (IAA) Service that would also support implementation of '111' and its principles.
- ❑ Enhance care pathways in relation to admission avoidance; i.e develop our intermediate care pathway and care resource to support this (rapid response and reablement domiciliary care)
- ❑ Enable timely discharge from hospital (through strengthening the Transfer of Care Advice and Liaison Service)
- ❑ Prevent longer term reliance on statutory services through improving our long term complex care pathway (includes proportionate commissioning of care and support)
- ❑ Implement effective performance measures and secure analytical capacity to better understand demand / capacity in order to inform future commissioning of services and workforce disaggregation / realignment

Following a successful bid to the Regional Partnership Board, ICF was secured for Carmarthenshire for the following resource which contributed to the realignment:

- **Proactive Care:** Additional Multidisciplinary Practitioners to Support Intermediate Care Pathway Development in the CRTs
  - x3 Social Workers, x3 Occupational Therapists, x2 Physiotherapists x2 Therapy Techs, x3 District Nurses
  - x1 Information, Advice & Assistance Nurse
- **Reablement Occupational Therapy:** Additional x3 Occupational Therapists
- **Enhanced TOCALS:** x2 Unscheduled Care Coordinators, x2 Discharge Liaison Nurses, x2 Social Workers and x3 Occupational Therapists
- **Demand & Capacity Analyst:** x1 Analyst

Assesiad / Assessment

Over the last three years, ICF contribution to intermediate care in Carmarthenshire has grown to £1, 443, 263 with a total spend to date of £1, 275, 228

The underspend is attributed to delays in recruitment of the 2017 / 2018 posts. These however, have now been recruited to.

Total budget required to sustain existing provision will be £1, 624, 923

To ensure efficient use of ICF, an assessment of impact of the investment in intermediate care on outcomes for older people and our organsiations' performance was undertaken to provide assurance against the Triple Aim[3].

Key Findings of this assessment

Completion of Community Resource Team realignment

- Integrated 24/7 Single Point of Access; Complies with SSWBA and Supports national '111' Service
- Intermediate Care Pathway; Timely Response for Frail Older Adults with Acute and Sub Acute Presentation
- Progressive and Complex Care Pathway; Person Centred Integrated & Outcome Focused Care
- Better Understanding of our Demand & Capacity for Care Commissioning and Workforce; the analyst role has been critical investment

Improved Performance

It is clear that the realigned CRT and its associated pathways has had a beneficial impact on performance of the CRT and which will contribute to improved outcomes for older adults through timely and effective intervention. Over the last year, the service has:

- Eliminated Occupational Therapy waiting list
- Reduced number of individuals requiring reablement domiciliary care
- Reduced the number of individuals in the community waiting for assessments for care and support by up to 75%
- Reduced the number of care and support reviews outstanding by 81%
- An average of 52% of all patients assessed by TOCALS at the 'front door' are discharged home within a 72 hour period with 48% of these being discharged within the same day of presentation.

Despite this improved local performance, however, there has been

- No Reduction in WAST Conveyance rates over the last 5 months
- A marginal Reduced Length of Stay in GGH for > 75s
- An Increased Length of Stay in PPH for > 75s

The disappointing impact on wider unscheduled care performance could however be attributed to the following:

[3] Berwick D.M et al (2008) *The Triple Aim: Care, health and cost.* Health Affairs 27 (3): pp 759 – 769 *The Triple Aim: Care, health and cost.*

- Recruitment of additional Occupational Therapists and Social Workers not completed until November and hence full impact of the investment may not yet have been realised
- Over the winter period (i.e immediately following completion of realignment and recruitment) there has been a considerable increase in emergency admissions
- GGH Demand Increased by 5% between November and February
- PPH Demand Increased by up to 13% between November and February
- Increased Ambulance Conveyance in January 44%

It is also pertinent to note that the GMS infrastructure locally is fragile and imploding. Demand for GP home visits often outweighs capacity for home visits and many are 'defaulted' to hospital for assessment. While the intermediate care pathway should provide an alternative or contributory assessment to mitigate demand on GPs, the evaluation demonstrates that rarely do we receive enquiries in the CRTs of acute referrals from GP / WAST / 111.

55% of all emergency admissions are attributed to frailty in Hywel Dda. Evidence suggests that up to 30% of these admissions can be avoided with effective intermediate care pathways. While it appears that TOCALS are discharging the majority of those that they assess within a 72 hour period, when compared to the total number of emergency admissions it would appear that the service does not demonstrate value for money.

- 2017 / 2018 Quarter 3 Number of Assessments Conducted by TOCALS
  - GGH 180
  - PPH 160
- 2017 / 2018 Quarter 3 Number of Emergency Admissions > 75s
  - GGH = 850
  - PPH = 750

During the first few weeks of January, TOCALS was afforded the support of a Geriatrician dedicated to supporting Comprehensive Geriatric Assessment. Rapid Response Domiciliary Care was also 'ring fenced' to ensure availability should it be required to avoid an admission. With this joined up approach TOCALS doubled the number of discharges at the 'front door'.

While the hospitals have benefited from the additional nursing capacity particularly in relation to management of the 'complex working list', in relation to implementing robust 'discharge to assess' pathways, there is no evidence to suggest improved performance, improved outcomes or value for money in relation to the additional Discharge Liaison Nurses. It is suggested that, this 'work list' could be administered by a non qualified member of staff. Moreover, with recruitment an increasing challenge within community nursing and an increasing number of vacancies in this workforce that we should reconsider this valuable resource.

Due to delays in recruitment, it has not been possible to evaluate impact of additional occupational therapists in relation to 'discharge to assess' pathways

In recognition that improved performance in unscheduled care is dependent on partner organisations collaborating effectively, Welsh Government is developing an Outcomes Framework for unscheduled care that blends a suite of measures, targets and indicators. This may be used to demonstrate improved outcomes for individuals and organisations. This work has been considered by the West Wales Care Partnership and agreement is expected to use this framework (Regional Outcomes Framework for Older People' as a planning tool which can also be used to review impact of ICF across the 'whole system'.

Argymhelliadau / Recommendations

Following the assessment outlined above, Carmarthenshire Integrated Services Board (ISB) propose that they further 'test' the impact of the intermediate care pathway over the next 12 months and measure improved outcomes utilising the Regional Outcomes Framework and its performance measures. With reference to this, the ISB will report therefore on the outcome of the 'whole' investment in the future rather than individual schemes i.e reporting on the 'ends' rather than the 'means'.

The investment requested is as follows for 'Improving Outcomes for Older People':

Proposal	Applicable Regional Framework Theme	Investment Requested
Proactive Care	Theme Two	£486,044
TOCALS	Theme Two	£982,174
Rapid Response Domiciliary Care	Theme Two and Three	£487, 000 TBC
Demand and Capacity	Themes One, Two and Three	£37,065
Reablement OTs	Theme Three	£119,640
Total Investment		**£2,111,923**

Given the areas of improvement outlined in the assessment section above. The ISB have directed the following actions are essential in order to ensure we optimise outcomes and value for money.

- Review of existing investment into intermediate care pathway with service leads and acute sector colleagues to explore opportunities to deliver efficiencies in investment while improving outcomes to include:
    - Strengthen Links with ART and Review the Role of the Proactive Care Nurse
    - Review short term domiciliary care resource e.g British Red Cross, Reablement Domiciliary Care and Rapid Response Domiciliary care and develop Joint Intermediate Care Provider Service Commissioning Framework
    - Absorb TOCALS resource into CRTs and provide daily duty rota at 'front door' of both hospitals
    - Implement Community Geriatrician Role
    - Review the roles of the DLNs and Unscheduled Care Coordinators;
        - Consider 'Inreach' Model for DLNs to work alongside GPs to support WAST conveyance avoidance and 'pull' from hospital following admission
        - Consider focusing Unscheduled Care Coordinators to the 'front door'
    - Undertake cost benefit analysis
    - Workforce review across ICF and Core funded posts
    - Place a 'freeze' on any vacant posts while review and rationalisation of workforce is undertaken
    - Develop 'Vacancy Approval' process for ICF funded posts