Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

CYFARFOD BWRDD PRIFYSGOL IECHYD
UNIVERSITY HEALTH BOARD MEETING

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	27 July 2023
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Developing a Health and Care System for Older People: Further, Faster
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Andrew Carruthers, Executive Director of Operations
SWYDDOG ADRODD: **REPORTING OFFICER:**	Rhian Matthews, Integrated System Director Carmarthenshire / Programme Director, Transforming Urgent and Emergency Care

Pwrpas yr Adroddiad (dewiswch fel yn addas)
Purpose of the Report (select as appropriate)

Ar Gyfer Penderfyniad/For Decision

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

A Statement of Intent (SOI) was issued to Local Health Boards and Local Authorities from Welsh Government in March 2023 outlining the need to go 'further, faster, together to strengthen community capacity by developing an integrated community care system for Wales' that will 'fully deliver outstanding placed based care with and for people'. A subsequent announcement was made by the Minister for Health and Social Services to the Senedd on 6 June 2023.

This report outlines Hywel Dda University Health Board's (HDdUHB) considered response and current position in relation to developing an integrated health and care system for older people in West Wales, further and faster. The Board is asked to acknowledge this position and approve further exploration of formal integration of health and social care with Local Authority partners.

Cefndir / Background

Across Wales, the urgent and emergency care system was subject to unprecedented demand last winter, which has been described as the most challenging on record for both the NHS and social care. There was some evidence of success in building community care capacity to better support our older adult population in the community and expedite their discharge home from hospital. It has been acknowledged, nationally and locally, however, that to avoid similar circumstances this winter and to mitigate against further harm to our population, that a focused effort across health and social care is required to provide greater resilience in community care.

Furthermore, the ageing demographic is set to grow incrementally year on year over the next decade and beyond, necessitating consideration of sustainable and effective growth in community care for this population.

Asesiad / Assessment

The health and care system has increasingly struggled to adapt to the multiple and interacting health and social care circumstances of this population. However, it is not age per se that presents the challenge; rather it is the prevalence of frailty and its associated complexity that underpins this challenge.

Frailty is a long term condition, and is complex in nature. Even though frailty cannot be prevented, its impact can be reduced and its progression slowed down. Frailty management requires a focus on prevention and proactive monitoring and management of an individual's needs, to avoid a loss of independence and subsequent requirement on formal care and support.

The current system, however, is weighted towards reactive crisis management and acute hospital care which is well known to be detrimental to this population, particularly if intervention results in long lengths of stay. This is important because 'what matters' to older people is to remain at home, as well and independent as possible, for as long as possible. Most older people advise that they would prefer to avoid admission where it is safe and appropriate to do so.

Achieving 'what matters' to older people and adults living with frailty to enhance quality of later life requires fundamental change to ensure that preventative and proactive management processes that delay progression of the condition, prevent crisis and reduce avoidable loss of independence. The Health Board is not able to deliver this change independently of its partners in the Local Authorities.

Following discussions at the Integrated Executive Group (IEG), 'Building Blocks' for an evidence-based health and care system for older people and adults living with frailty have been agreed, along with the associated standards of care we should collectively aspire to implement across the system. IEG has also acknowledged the requirement to integrate those older people and complex needs initiatives that are funded by Regional Integrated Fund (RIF) with initiatives funded by Urgent and Emergency Care (UEC) funding. This recognises that if we improve outcomes for older people and people living with frailty through the development of a community health and care system, this will contribute to improved outcomes for the wider population requiring access to UEC.

An Integrated Home First Group (IHFG) has been established, which will initially be Chaired by the Health Board's Executive Director of Operations and Vice Chaired by the Director of Social Services of Carmarthenshire County Council (representing the three Local Authorities). The IHFG will oversee implementation of the integrated health and care systems for older people across all three Counties. Each County System has agreed plans and programme structures in place to take this work forward. From a governance perspective, IHFG reports into the TUEC Programme Board, which in turn feeds into the Operational Planning and Delivery Programme Group (OPDPG). The OPDPG reports formally to Exec Team on a monthly basis and will take any issues requiring Executive decision to that forum.

While it is recognised that the infrastructure in each County system differs, it is anticipated that the agreed care system standards for West Wales will ensure equitable outcomes for the population. An outcomes framework has been agreed which includes high level outcome indicators and process measures that will be reviewed by IHFG. This will encourage cross County learning and contribute to business intelligence and collective determination of investments going forward.

Argymhelliad / Recommendation

The Board is requested to:

- Acknowledge the national expectation in relation to 'Further, Faster, Together'
- Acknowledge the current position locally in developing and implementing an 'outstanding place based system of health and care' for older people and people living with frailty in West Wales
- Approve the exploration of formal integration of health and social care with Local Authority partners

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not applicable
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	7. All apply
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	5. Whole systems persepctive
Amcanion Strategol y BIP: UHB Strategic Objectives:	4. The best health and wellbeing for our individuals, families and communities 5. Safe sustainable, accessible and kind care 6. Sustainable use of resources
Amcanion Cynllunio Planning Objectives	7b Integrated Localities 7a Population Health 3a Transforming Urgent and Emergency Care programme
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	4. Improve Population Health through prevention and early intervention, supporting people to live happy and healthy lives

Gwybodaeth Ychwanegol: **Further Information:**	
Ar sail tystiolaeth: Evidence Base:	British Geriatric Society, NICE guidance intermediate care, Social Care Wales, Kings Fund
Rhestr Termau:	Contained within the body of the report

Glossary of Terms:	
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	No immediate impact on finance however demographic growth and implementing the model will require community care increase
Ansawdd / Gofal Claf: Quality / Patient Care:	Implementing a health and care system that is based on evidence based practice for frailty as a long term condition will improve outcomes for this population i.e functional health and independence
Gweithlu: Workforce:	Adopting a frailty approach and implementing the standards associated with a health and care system for older people will require staff education and a focus away from acute hospital care and towards community care.
Risg: Risk:	No risks specifically with model implementation however are actions to mitigate risks outlined in Risk 1027 (Urgent and Emergency care)
Cyfreithiol: Legal:	Not applicable
Enw Da: Reputational:	Not applicable
Gyfrinachedd: Privacy:	Not applicable
Cydraddoldeb: Equality:	Not applicable

Public Board

27 July 2023

Developing a Health and Care System for Older People: Further and Faster

‘Further, Faster’ – Building an Integrated Community Care Service for Wales

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

- Discussion Paper (Jan 2023)
- Outlines imbalance in health and social care that is affecting people’s outcomes
- Significant hospital capacity is occupied by people whose needs would be better met in their own home, whilst many people in the community struggle to access a range of care and support from preventative through to acute interventions.
- Recognises that our System infrastructure not ‘fit for purpose’ to correct this imbalance and / or complex needs of our society
- Proposes the need to evolve faster, further, together, creating an integrated community care service – integration which includes roles of the Regional Partnership Boards
- Amendments to SSWBA (particularly Part 9) to enable
- Statement of Intent (March 2023) to Health Boards:
  - A frailty policy statement will set the direction for further whole system service development,
  - Agree a service specification for an ‘outstanding whole-system place-based care enables that enables older people and people living with frailty to live their best life in their community’
- Ministerial Announcement June 6th

‘Further, Faster: A Population Perspective

- Ageing Population that is projected to increase from 9.9% of the population n 2021 to 13.8% in 2041.
- Health and care system has increasingly struggled to adapt to the multiple and interacting health and social care circumstances of this population.
- Not age per se that underpins this challenge, rather it is the increasing prevalence of frailty
- Frailty is a long term condition which renders the individual less able to manage relatively minor stressors such as infection and changes in social and psychological situations
- When this happens people living with frailty lose the ability to function as physically and mentally well as they are usually able to do. Without timely and effective intervention their ability to ‘bounce back’ is affected which results in a loss of independence
- What matters to this population is that they are able to live fulfilled, independent and happy lives at home in the community for as long as possible.

Further, Faster: Population Perspective cont'd

- **Frailty is not an inevitable consequence of ageing**, for example, 20% of those aged 90 and over remain fit. The incidence and prevalence of frailty however increase with age and can be impacted by other factors such as social deprivation.
- **Frailty is not a static state and is a better predictor of health outcomes than age alone.** The greater the level of frailty the less likely they are to achieve levels of independence without help.
- For people affected their needs quickly escalate to crisis they can go from coping to not coping very quickly and when this is missed
- **Frailty has a significant impact on society** because of the number of people affected and the physical and mental impact of mismanagement of the condition in terms of achieving quality of later life
- **Mismanagement of frailty** as well as the societal and personal impact can also create a very large health and care burden for the NHS and Local Authorities

‘Further, Faster’ – Commissioning and Planning Considerations

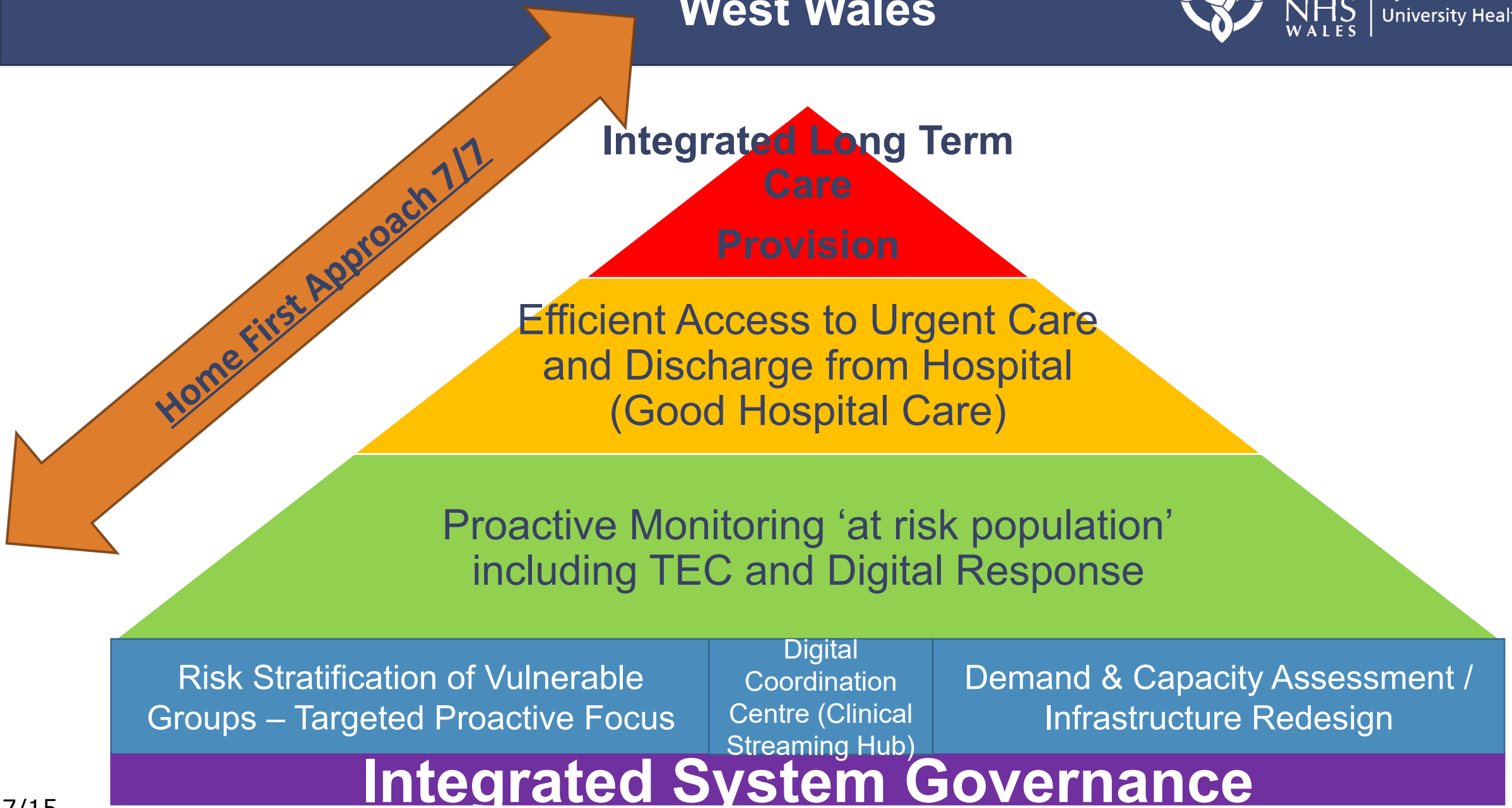
- Even though Frailty cannot be prevented, its impact can be reduced and its progression slowed down
- Our current health and care system is not conducive to doing this and does not contribute to optimal outcomes for this population
- Current System weighted towards reactive crisis management and acute hospital care which is well known to be detrimental to this population particularly if intervention results in long lengths of stay
- Most older people advise they would prefer to avoid admission where safe and appropriate to do so
- National Evidence suggests 20 – 30% admissions could have been prevented
- The fluctuating needs of our frail population presents a level of complexity that does not neatly ‘fit’ with our existing health and social care commissioning arrangements
- Achieving ‘what matters’ to older people and adults living with frailty requires fundamental change to ensure that preventative and proactive management processes that delay progression of the condition, prevent crisis and reduce avoidable loss of independence, and
- Enhance Quality of Later Life

Building Blocks H&C System Older People: What should good look like - One size does not fit all!

Severely Frail

Fit & Well	Mildly Frail	Moderately Frail	Very / Severely Frail
Enable me to age well	*Enable me to stay well and support myself*	*Enable me to live my best life at home*	*Enable me to live my best life towards the end of my life*
Prevention Offer to Delay Onset of Frailty. Ageing well in Society and its enablers	Digital self assessment and self care offer to slow down progression of frailty with TEC enabled proactive monitoring	Streamlined, responsive offer to proactively monitor (TEC) and slow down progression of frailty through early intervention (urgent primary care / intermediate care)	High quality care and treatment plans for those at high risk of decompensation and reduce conveyance and conversion through anticipated crisis intervention

Building Blocks for UEC and Health & Care System for Older People in West Wales



Service Infrastructure – community nursing, therapy, TEC, 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)

NOT A SERVICE – *It's an approach that focuses on 'What matters' Prevention / asset based / proportionate commissioning & best practice for frail*

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)
- **High Level Outcome Indicators**
  - Reducing Conveyanace rates to hospital (and self presentation as balance measure)
  - Reducing Conversion rates to inpatient beds
  - Reducing the number of bed days > 21 – measure of impact on discharge effectiveness / efficiency on the 'back door'
  - Number of 'green 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 handover delays
- 4 hour wait
- >12hr Performance
- % of patients with clinical frailty score recorded in ED (pre morbid and on presentation)

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
- Number of Trusted Assessors
- % with Clinical Criteria for Discharge
- % with EDD and D2RA Pathway allocated

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

‘Further, Faster’ – Current State in West Wales

- CEO Discussions around ‘doing differently’ had commenced prior to ‘Further Faster’ CEO to CEO in each County
- Acknowledgement of need for transformation and ‘further integration
- Integrated Executive Group agreement on ‘Building Blocks’ as Framework for developing consistent System across the Counties
- Jointly Agreed Standards associated with each ‘Building Block’
- Jointly Agreed Outcomes Framework and Process Measures across System
- Integrated Home First Group under Executive Leadership to provide oversight of implementation and impact (aligns to Transforming Urgent and Emergency Care)

‘Further, Faster’ – Current State in Carmarthenshire

- Joint Statement of Intent by CEO Hywel Dda University Health Board and CEO Carmarthenshire County Council:
- *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 population 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.*
- Approved through Democratic Processes in Carmarthenshire County Council 19th June, 2023
- Plan is in place and progressing with reporting arrangements agreed into both organisations to update on Risks, Issues, Decisions Required.

‘Further, Faster’ – Current State in Pembrokeshire

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

- Joint & Integrated programme of work by CEO Hywel Dda University Health Board and CEO Pembrokeshire County Council:
- *Improving Together and Further, Faster Strategic Oversight group leading three distinct co-chaired work streams:*
  - *Integration and Home First - to agree the vision, objectives and priorities which will make the most significant improvements. Agree plans for PCC & HDUHB to work more closely together and how these arrangements will be delivered. To build on the success of the Co-ordination Centre and agree the development areas for increasing the scale and scope of virtual wards/ managing patients at home.*
  - *Hospital Patient Flow - The development of a patient flow improvement plan, incl. a robust plan for winter to unlock blockages that lead to undue delays in care. Agree actions which include what investment and pathway changes are required to improve supply, manage demand and identify pressures. This will include consideration of proportionality of assessments and trusted assessments.*
  - *Commissioning & Partnerships - Working in partnership to determine how we may be able to change our commissioning practices to further increase community capacity within the provider market. Options to explore include therapeutic in-reach into care homes, revisiting statement of purpose for step down reablement provision. I think this is a necessary addition as availability of commissioned provision is a key part of community capacity.*
- Trusted assessor working group to agree a way forward to optimise the potential for patient assessment within a sustainable MDT model.

‘Further, Faster’ – Current State in Ceredigion

- Building upon the momentum gained over the last years
- The concepts of "Further Faster" are well embedded into Ceredigion's Integrated Plan
- Incorporated into the Governance structure of Integrated Health and Social Care - Healthier Ceredigion Strategic Group
- Additionally, three new workstreams developed to accelerate Trusted Assessor:
  - Equipment trusted assessor - refresh & expansion
  - Upskilling of Targeted Care and Enablement staff
  - Social Care assessments from other professionals

Recommendations:

- Acknowledge the national expectation in relation to ‘Further, Faster, Together’
- Acknowledge the current position locally in developing and implementing an ‘outstanding place based system of health and care’ for older people and people living with frailty in West Wales
- Approve the exploration of formal integration of health and social care with Local Authority partners

DIOGEL | CYNALIADWY | HYGYRCH | CAREDIG

SAFE | SUSTAINABLE | ACCESSIBLE | KIND

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