Story of Change for People and the System through the West Glamorgan Regional Partnership

Partneriaeth Ranbarthol Gorllewin Morgannwg | West Glamorgan Regional Partnership

Reporting Period: Quarter 4 Cumulative 2022-23 Financial Year

Programme Overview	
	TITLE: West Glamorgan Home First Programme
	The Home First Programme has been established to support the effective development and delivery of the Discharge to Recover and Assess (D2RA) model, incorporating all its constituent pathways, in a standardised manner, across the West Glamorgan region, as aligned to national policy requirements, using a "Home First" ethos. The main aims of the programme can be defined as: • To implement a Whole System approach across the region of West Glamorgan to avoid hospital admission and to safely discharge individuals via the Discharge to Recover Assess Model. • To implement a consistent regional Discharge to Recover and Assess model, based on a "Home First" ethos across the West Glamorgan footprint to avoid hospital admission where appropriate, and facilitate timely discharge with relevant support once all necessary clinical interventions that can only be undertaken in an acute setting are complete and an individual is considered clinically optimised. • To expedite discharges to ensure there is flow through the hospital and social care system to match the expected discharge profile, through the facilitation of safe and timely discharge, allowing for a period of recovery before any assessment of long-term care need is undertaken, therefore maximising outcomes and improving service user's experience. • To ensure that assessment and discharge processes are clear, understood by all stakeholders and all safeguards are maintained. To make sure that all service delivery within the model maximises independence, is outcome focussed and is based on each individual's specific needs.

RBA Performance Accountability	
	SECTION GUIDANCE NOTE: This section of the report focusses on the performance accountability of the RBA methodology (delivery of programmes). It should demonstrate the activities enabled by RIF funding/programmes and demonstrate how person-centred outcomes are being achieved. You can copy and paste infographics, etc. from the excel tool to add to the reporting and include person/project case studies as supporting evidence/sharing of good practice.
	Quantitative Measures
	During 2022/23 the number of unscheduled care medical admissions for patients over 65+ into hospital reduced from 10,121 to 9,301. Although the average number of acute beds days occupied by residents over 65+ for the unscheduled care medical admissions increased from 16.5 days to 17.5 days. **Discharges from Hospital** The total number of discharges facilitated by all the D2RA pathways was 3180 during 2022/23. **Pathway 0** is where preventative services delivered in collaboration with third and voluntary sector organisations aims to avoid further referral and admission - 633 discharged from hospital were facilitated via Pathway 0 against a target of 516. The Pathway 0 offer is

supported by the Third sector, providing services to enable the safe return home from hospital, E.g., decluttering the home, or low-level support, E.g., shopping/medication delivery.

Pathway 2 is initiated as soon as treatment, which can only be delivered within an acute hospital environment, is completed. Supports people to recover at home before being assessed for any ongoing need - 1609 individuals were discharged from hospital on Pathway 2 against an annual target of 2100. However, there were changes made to targets during a mid-year review as there was a perceived increase in demand that the region was possibly going to experience for the remainder of the year. Under Pathway 2, individuals are assessed and provided with short term therapeutic support and Reablement to regain as much independence as possible. This includes functional support, equipment provision and right sizing of care packages to ensure that care is adequately suited to the individual.

Pathway 3 Should only be considered where the needs of the individual rule out recovery & assessment at home. - 369 individuals were discharged from hospital into a short term bedded facility via Pathway 3, exceeding the annual target of 204. During a Pathway 3 facilitated discharge, individuals spend time receiving intensive therapeutic support in a Reablement facility, whilst being assessed/right sized for their longer-term care needs.

Pathway 4 is similar to Pathway 2 but acknowledges specific considerations to be addressed in the existing care home environment. Individuals should be allowed a period of recovery, followed by assessment in their usual environment - 569 people were discharged from hospital on Pathway 4, against a target of 672. Pathway 4 supports those individuals who require a long-term placement upon discharge to access the appropriate setting, which is coordinated with Social Work support. One of the challenges experienced by this pathway has been around securing the placement of choice and the culture change required to support individuals and their families to access an interim placement whilst awaiting a space, rather than remaining in a hospital bed.

Long Term Care and Support

The region supported 1,411 people over the age of 65 in residential or nursing care establishments in March 23. In comparison the numbers of people supported in April 2022 for the same establishments were at 1,461, thus demonstrating a reduction in long term care which is one of the main objectives of the Home First Service.

As of February 23, the number of people aged 18+ supported in domiciliary care was 1,621, compared 1,777 individuals as of February 22, which equates to an 8% reduction in long term domiciliary care.

During the year 22/23, an average number of 1,558 individuals monthly were provided a domiciliary care package to support them to live at home, Domiciliary Care has supported an average of 1,558 people per month with their support needs in their own home. This equated to 871,464 hours of care commissioned by Local Authorities over the year.

Step-Up Step-Down Bed scheme

The Regional Step-Up Step-Down scheme was introduced in December 2022 to help with the pressures being experienced by the integrated health care system.

Rationale for the introduction of the scheme was based on identified benefits such as:

- Opportunities for recovery are improved because of additional assessment and recovery provision outside of an acute setting.
- Agreement in place that the priority on brokerage would remain the same high priority for SUSD patients, to prevent a patient staying longer in SUSD than Acute site.
- Reduced Length of Stay on an acute site mitigating risk associated with prolonged hospital admission, such as deconditioning, loss of confidence, loss of independence.
- Reduced Length of Stay leading to significant bed days saved.

A Total 167 people have been transferred since December 1st (SUSD Scheme commencement date) of which 74 patients have been discharged during this period to their usual or new place of residency.

Proms and Prems

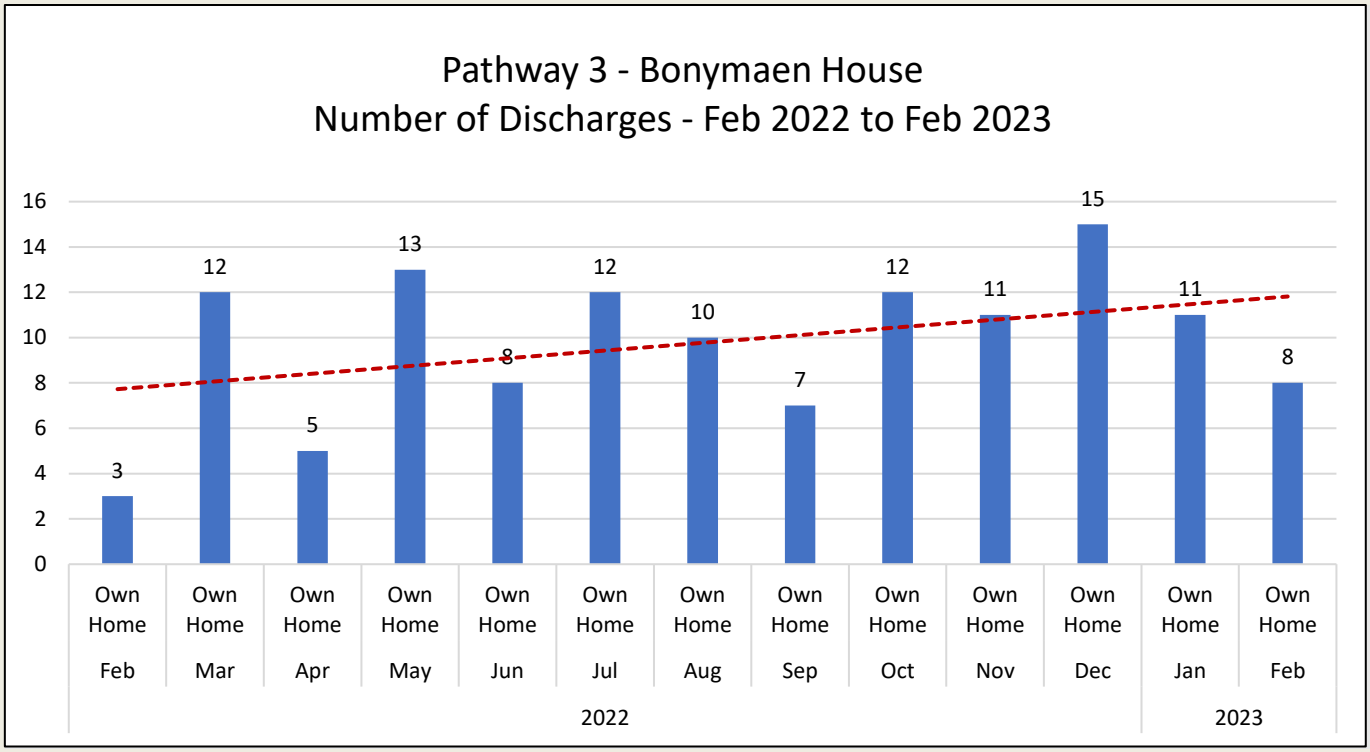
1,332 individuals have been included in the pilot with of the Proms and Prems pilot across West Glamorgan. This system was implements to review individual progress in relation to personal outcomes during and after a period of reablement in their own home. Supplementary to this we also have collected individuals' experiences of the reablement service they have received.

Community Wellbeing Service (not including discharges)

In addition to providing discharge support, the Community Wellbeing Service supported 766 people and their wellbeing assessments were undertaken. Over 83% of individuals reported an improvement in their wellbeing after receiving this service.

Qualitative Indicators

An example of the difference made can be visibly seen through the West Glamorgan Bonymaen House provision (short term bedded facility). For individuals who have been supported at Bonymaen House during the period of February 22 to February 23, the number of people who returned to their own home independently was 135 out of 214 individuals. This means that long term care needs were avoided, thanks to the intensive reablement support provided in this facility. The trend continues to see an increase in this outcome noting that during December 22, January & February 23, Residential Reablement services in Bonymaen had an overall percentage of 62% of people returning to their own homes, independently and with care packages.



Pathway 3 reablement figures for the latter part of 2022/23 show that this intervention is ensuring more people either have a reduced or no package of care in order for them to live independently in their own home.

<u>Patient-Reported Outcome Measures (Proms) and Experience Measures (Prems)</u>

Developing the opportunities and mechanisms for collecting and analysing the quality of the service provided by the Home First Model is a continuous and key consideration to inform service improvement. The introduction of software provided by ProMapp was introduced in 22/23 and has been rolled out across a controlled section of the service, with a view to incrementally broadening this scope over time. The software allows baseline and follow up feedback regarding Proms and Prems to be readily captured and easily understood/analysed. Whilst there is further work to be undertaken to fully roll out and embed the capture of Proms and Prems information, the first phase has provided useful feedback about the experience of individuals and their carers/families who are navigating through a discharge pathway. Some of the key outputs are highlighted below:

Proms and Prems Outputs (1st April 2022 – 31st March 2023)

In terms of their frailty score, 98.63% individuals were scored as vulnerable or worse at their baseline assessment prior to community intervention commencing. This improved to 89.64% at

their post-intervention assessment with 10.36% reported as managing well or better (compared with 1.37% before intervention).

The Average Health Today score increased from 52.37 prior to Home First intervention, to 60.29 post-intervention.

Results from the post-intervention patient experience questionnaire were as follows:

- 92% of respondents felt length of time waiting for their care from community team to start was reasonable.
- 93% of respondents felt the staff that cared for them at home had been given all the necessary information about their condition or illness from the person who referred them.
- 94% of respondents were aware of what they were aiming to achieve with the community team.
- 80% of respondents felt they were always involved in setting these aims and 17% felt the sometimes were.
- 82% of respondents felt they were definitely involved in discussions and decisions about the care, support, and treatment, 17% felt they were to some extent.
- 71% of respondents felt that visit times were always convenient, 24% responded that they sometimes were.
- 25% of respondents knew how to contact staff on most or all nights, 56% did not feel they had this information on any night, indicating there is significant improvement required in this particular area.
- 76% of respondents felt any important questions were answered well enough, 13% felt they sometimes were, 10% had no need to ask.
- 80% of respondents felt staff definitely gave them or someone close to them all the information they needed to help care for them, only 1% did not.
- 86% of respondents stated that their social contact had improved at least to some extent since receiving their care, 13% were not concerned about this.
- 93% of respondents always had confidence or trust in staff supporting them, whist the other 7% sometimes did.
- 94% of respondents felt involved in decisions about when their care from the community team was due to stop at least to some extent.
- 9% of respondents felt they were not given enough notice about when their care from the community team was due to stop, 17% felt they were to some extent and 74% felt they definitely were.
- 91% of respondents felt staff discussed with them whether they needed any further health or social care services once their support from the community team ended.
- 94% of respondents felt they were always treated with dignity and respect whilst receiving their care and the other 6% sometimes did.
- 74% of respondents felt there was something that could have made their experience better, 26% did not.

Individual Patient Case Studies

1 - 'Mr M'

Mr M is 87 years old and has dementia. He was living at home with his wife, but they were finding it hard to cope at home as Mr M was falling regularly.

Care and Repair had provided support by installing grab rails and other aids and adaptions over the last two years, and Mrs M had found the service *"Brilliant".*

However, on the 20th of November, Mr M got up in the night, fell over and was badly hurt. He was taken into Morriston Hospital and moved to Ward 7 a week later.
Mrs M found the nursing staff and the doctor on the ward to be very kind and helpful. The doctor took time to talk to her about her husband's medical situation and explained the outcome of the Home First assessment.
Mrs M said, *"I have nothing but admiration for the NHS and the care staff – it's wonderful what they do".*

Mrs M did not meet Alison, the Home First Discharge Liaison Nurse, as her time on the ward was restricted due to Covid-19 protocols (she could only visit for 30 mins per day). However, Mrs M was in regular contact with Andy, the Home First Social Worker, via phone. She said:

"Andy has been wonderful - he actually rang me today to check how I was doing and to answer some questions I had on the finances".

Andy helped Mrs M to understand the process of finding a care home for her husband and navigate the complex financial paperwork. Mrs M visited several care homes, but quickly decided that Brynhyfryd House in West Cross was the right home for her husband.

Mrs M has found the Pathway 4 process very smooth and swift. Her husband was only in hospital for 4 weeks before being moved to their care home of choice, and this included a delay as the care home had to shut for a short period due to a Covid-19 case.
Mrs M has been happy with the process and couldn't think of anything she would change or improve to make the service better.

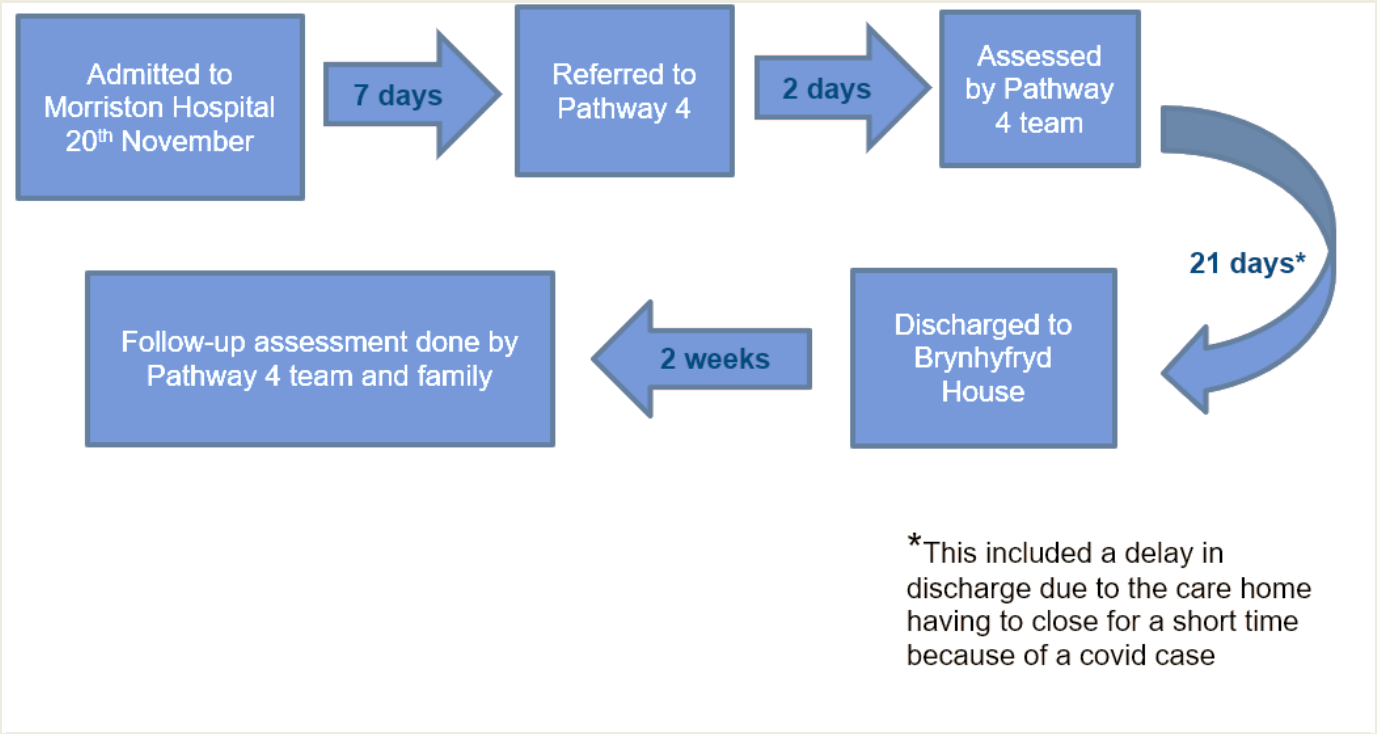
Hospital feedback on Pathway 4
The patient flow co-ordinators have reported that having access to the Pathway 4 team has been invaluable. Michelle reports *"It's really helpful to have the known points of contact".*

The co-ordinated liaison between the patient, family, social worker, discharge liaison nurses, patient flow coordinators and care home staff is what makes the Pathway 4 process work so well.

Care Home feedback on Pathway 4
Julie, the manager at Brynhyfryd House reported that working with the Pathway 4 team has been excellent. She said, *"Andy and Alison have been extremely supportive to all parties involved".* Julie did note that she would welcome more information about Pathway 4, noting that *"A simple guide would be helpful, which provides guidance on the Pathway, contact details, and expected outcomes".*

What difference did Pathway 4 make?

- Mr and Mrs M were supported by dedicated staff members from the Pathway 4 team, this ensured that they were helped throughout the process by familiar people and there was continuity throughout.
- Mr M was discharged 4 weeks after being admitted to Morriston Hospital, which his wife felt was “very quick”.
- Mr M received a follow up assessment from the Pathway 4 team once he had settled into Brynhyfryd House Care Home. This assessment enabled a detailed review of Mr M’s health and social care needs outside of an acute care setting.
- Feedback shows high levels of satisfaction from the family, hospital staff and the Care Home.



2 – ‘Mrs B’

Mrs B is 88 years old and has vascular dementia. She was admitted to Morrison hospital on the 17th of December. Mrs B was living at home, supported by domiciliary carers four times a day. Her niece Jackie, Mrs B’s only close relative, reported that she had been struggling to take care of herself, but at the time was adamant that she wanted to stay at home.

On the 17th of December, the carers found Mrs B in a delirious and agitated state. She was admitted to hospital and found to have a chest and urinary tract infection.

Jackie lives in Bournemouth and therefore had the difficult job of trying to make best interest decisions for her aunt while being over 200 miles away. Jackie expressed that the Pathway 4 team were excellent at keeping her informed about what was happening and explained the process clearly when it was decided that her aunt would receive the most appropriate care in a care home. Lloyd, the Pathway 4 social worker e-mailed Jackie information and helped her to navigate the process of choosing a care home.

Once Mrs B was well enough to leave hospital, Jackie, with the help of the Pathway 4 team made the decision for Mrs B to move to Hillside Care Home for her ongoing assessment. Jackie commented that:

"The process was so quick. I was panicking a bit, but Lloyd reassured me that if I felt the placement wasn't right for my aunt then a review would take place once she was at Hillside and changes could be made if necessary."

Mrs B went to Hillside on the 5th January and Jackie reported that her aunt had been given a lovely room with a small adjoining courtyard, so she would be able to enjoy some time outside in the summer. She was pleased to find that the staff were lovely, nothing was too much trouble, and it was a welcoming environment.

Jackie was keen to ensure that she attended the follow up assessment in person on the 14th January. Lloyd and Anne-Marie (the Pathway 4 Discharge Liaison Nurse) worked around Jackie's schedule, so they were all able to undertake the review together to assess Mrs B's ongoing care needs.

Jackie couldn't praise the team enough, saying:

"I can't fault them. I have been kept up to date throughout. I have had all the necessary information e-mailed to me and Lloyd has rung me on several occasions to follow-up and answer any of my questions. It has been a very easy process despite me living so far away. And most importantly my aunt is happy in her new home."

Hospital feedback on Pathway 4

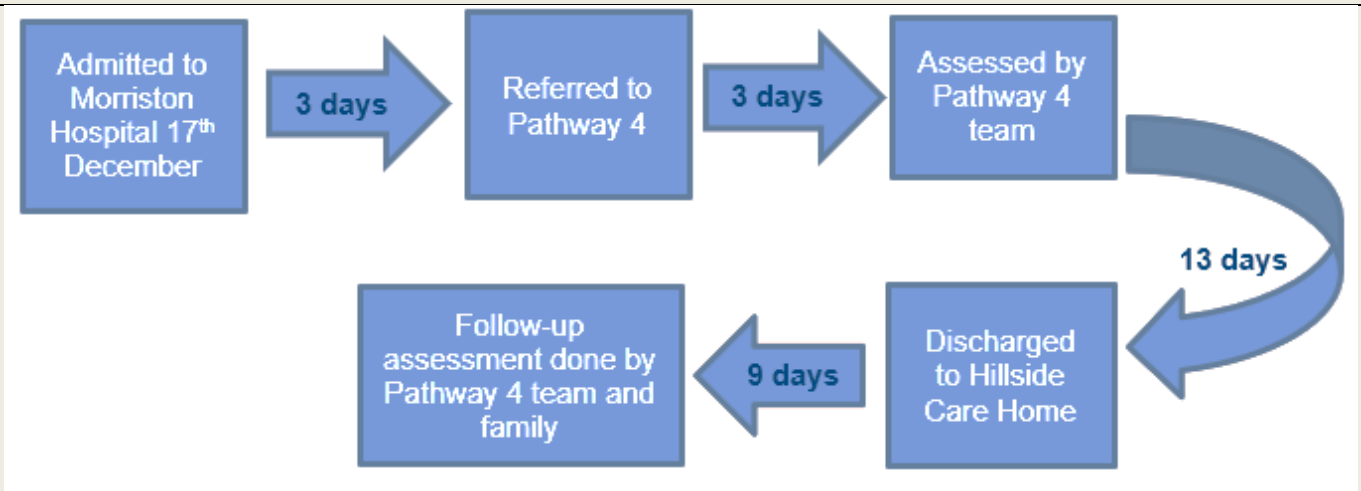
The patient flow co-ordinators have reported that having access to the Pathway 4 team has been invaluable. Michelle reports *"It's really helpful to have the known points of contact".* The co-ordinated liaison between the patient, family, social worker, discharge liaison nurses, patient flow coordinators and care home staff is what makes the Pathway 4 process work so well.

Care Home feedback on Pathway 4

Marie, the Manager at Hillside Care Home was asked for her feedback on the Pathway 4 process. Marie commented that the Social Worker and Discharge Liaison Nurse had been very approachable and helpful. She did note that it would be useful to have more information about Pathway 4. Marie suggested that a leaflet could be sent out to all Care Home Managers which could include details about Pathway 4, who the team are and how to contact them and details on the funding process.
Overall, Marie felt that Mrs B's transfer to the home had been an easy process, worked well and there were no glitches.

What difference did Pathway 4 make?

- Mrs B and her family were supported by dedicated staff from Pathway 4, this ensured that they were supported throughout the process by the same members of staff.
- Mrs B was discharged 19 days after being admitted to Morriston Hospital.
- Mrs B received a follow up assessment once she had settled into Hillside Care Home. This assessment enabled a detailed review of Mrs B's health and social care needs outside of an acute care setting.
- Feedback shows high levels of satisfaction from the family, hospital staff and the care home.



Step Up/Step Down Scheme

Patient Experience/Outcomes

Patient 1: Complex discharge solution

Patient had spent 200 days in an acute hospital, whilst complex discharge planning was undertaken. The patient was awaiting rehousing and POC. Referred to SUSD scheme 30/3 assessed 3/4/23 mapped to a bed for transfer on 4/4/23 transferred successfully to await a long-term POC. Requiring a maximum POC. Now settled well and really enjoying the environment. Patient has LD, was not coping in the hospital environment, and had a significant delay due to need for rehousing.

Patient 2: Improved function and reduced POC

Patient had spent 213 bed days waiting a LTPOC on Brokerage assessed 19/8/22 assessed 19/8/22 and mapped. During review patient had improved in function from requiring a double POC with a steady to a Single staffed POC due to the opportunity to optimise in a care residential environment

Patient 3: Choice Solution

Patient admitted to hospital from residential home referred to P4 team for nursing D2RA bed with no home of choice identified as needed no third party. Mapped to an appropriate SUSD bed and transferred when issues escalated immediately as patient not settled, With SUSD team intervention with the 24-post discharge support provided by the scheme the issues were actioned with support from the DLN at the care home supporting the patient and the care home for a successful placement. This has since become her permanent home and patient was timely discharged from the scheme to a permanent bed in the same home preventing further disruption in her ongoing care homes.

Patient 4: Assessment/admission avoidance solution

Patient deteriorating at home carer crisis where Next of Kin unable to manage admitted to emergency department 16/12 no domiciliary care capacity to support at home referred to SUSD team assessed mapped to bed and transferred the same day. Assessed in an appropriate environment returned home with a Direct payment POC and discharged from scheme.

Community Wellbeing Service (not including discharges)

In addition to providing discharge support, the Community Wellbeing Service supported 766 people and their wellbeing assessments were undertaken. Over 83% of individuals reported an improvement in their wellbeing after receiving this service.

RBA Population Accountability

SECTION GUIDANCE NOTE:
This section of the report focusses on the population accountability of the RBA methodology (delivery of system change and wider system performance enabled by the programme/regional Model of Care – demonstrating contribution and learning to inform national models).
For Q4 reporting system level indicators have not been agreed, therefore, please reference any data you consider appropriate to aid identification of population indicators/system measures as part of the intended reflection exercise, and for future testing at Q1.

Transformation: Changes to System

GUIDANCE NOTE:
There are two outcome *statements* aligned to the NMOC that have been included in the sections below. Provide an explanation as to how the project/programme activities are meeting the statements – to aid the test for Q4 please identify if any statements are measurable (please delete rows if not appropriate to your project/programme).

Home from Hospital

1. People go home from hospital in a more timely manner with the necessary support in place at discharge
2. People have a better understanding of the discharge process and are more involved in pre and post discharge planning

In order to address the challenge of a changing landscape following the impact of the pandemic, the Home First Programme realised the potential for improved service management and planning if performance data could be used intelligently to predict future demand and the capacity required to adequately support the service. Therefore, a project to deliver a capacity and demand system-wide tool that will be handed to the Partnership following project completion, which will set out 5-year capacity and demand current and future projections and specifically reflects:

- activity patterns, demographic changes, and acuity with a focus on frailty and dementia.
- demand and capacity constraints across all the D2RA pathways from the Community and acute settings
- is sensitive and accommodating to qualitative data specifically of the service users.
- will allow for new data to be included in the tool, such as data which will inform RIF funding.

A thorough report to be produced that focuses on local and national best practice prevention, early intervention, maximising community assets and third sector services to reduce demand on primary and secondary care, improved wellbeing, and independent living/ personalised care. Alongside modelling outputs, this will enable the West Glamorgan Partnership to support future commissioning/planning for the Home First Model and D2RA.

There will be a wealth of learning and experience to share once the modelling tool has been fully adopted and refined by the Partnership, which the West Glamorgan Region fully commits to sharing with colleagues across Wales to inform wider development and adoption to improve services for citizens across Wales. This will be a key piece of sharing for the IPC Communities of Practice, as well as other, relevant forums.

	West Glamorgan is currently undertaking a review of their Section 33 Agreement, which includes the Home First Service, to ensure we are able to meet the demands with the correct level of resource and capacity and ensure the service is sustainable for the future. This will very much be influenced and informed by the aforementioned Demand and Capacity Modelling Tool.

RIF Financial Accountability

Financial and Economic Data

PROMS and PREMS

The ProMapp software procured to support the capture of Proms and Prems required an initial investment of £12, 500. Based on the number of individual contacts, this cost has equated to circa £9.50 per person that was discharged from hospital into Home First via a pathway 2. Prior to the implementation of this software, there was no reliable mechanism by which West Glamorgan could measure either patient outcomes or patient experiences with any data quality integrity. Since its implementation, the system is providing valuable information to the reablement service about to review the way they deliver services and identify areas for service improvement. West Glamorgan will be looking to expand the service across all Home First Services so that the whole system can benefit from lesson learned.

Demand and Capacity Tool

An investment of £47,100 was made to develop a demand and capacity modelling tool to enable detailed service planning over the next 3-5 years and provide assurance that the programme is appropriately resourced and has a robust commissioning model. This analysis will provide the information to develop recovery/delivery trajectories across all Pathways for 2022-27. The tool was developed in line with the revised Discharge to Recover Then Assess pathways, which are being updated across Wales. By utilising current intelligence in relation to service trends and performance, the user is able to:

- Influence demand projections through changes to winter pressures, Acute Length of Stay
- Influence capacity projections through changes to reablement periods, bed numbers, bed utilisation, pathway length of stay
- Explore insights narrative
- Explore underlying assumptions and methodology
- Explore different graphical views

In addition, the model owner is able amend baseline information, thus ensuring the tool is refreshed and able to project more accurately. This offers the service an innovative solution to service management and will support with capacity planning to ensure that resources are deployed in the right place at the right time to deal with fluctuating demand in the community. Whilst the current model is predicated on community demand from hospital, there will be future development to understand how demand that starts from the community can also be better managed and improve the preventative aspect of the Home First Service. Once the tool is able to correctly predict and prevent 14 hospital admissions (based on an average regional length of stay of 17 days), it will see a return on investment.

Decluttering

£25,000 was invested into the Third Sector which led to the provision of 21 individual deep-cleans/decluttering interventions to support with safe discharges from hospital back to the individual's own home. This equates to £1,190 per intervention. 100% of these referrers

were contacted within 48 hours of the referral being made and 100% of individuals reported a reduction in clutter. This led to a reduced length of stay in hospital by ensuring that the individual's home was safe for discharge and prevented an unplanned readmission. For every additional day spent in hospital these 21 individuals would have incurred a cost of £3,990. A typical intervention would take on average 5 days (including referral, co-ordination and undertaking the clean). The regional average length of stay in hospital sits at 17 days, which would equate to £67,830 worth of bed days. Had each of these individuals therefore been discharged after 5 days, this would equate to a saving of £47,880.

Bedded Reablement

214 people received intervention at Bonymaen House from February 2022 to February 2023. The service costs £1,391,896 per year of which £579,957 is funded via RIF. Therefore, the cost of the service per person for that year would be £6,504. Of these, 135 individuals returned home with no long-term care needs. It could be hypothesized that if these 135 individuals had otherwise required an average Domiciliary Care Package of 11.5 hours weekly, at a cost of £279 weekly (£24.25 regional hourly rate), annually this could have cost the whole service £1,958,580. It should be noted that this cost avoidance is only calculated for 1 year, the cost would likely continue, and potentially grow, for the rest of the individual's life.

In addition to the financial benefits of the aforementioned schemes and the expected improvements to community services, it is pertinent to highlight the impact that such investment will have on quality of life by preventing unnecessary admissions or reducing deconditioning by facilitating earlier/safer discharges back into the community.