Report of the Cabinet Member for Health and Wellbeing

Adult Services Scrutiny Performance Panel – 13th February 2018

THE ADULT SERVICES APPROACH TO INTERMEDIATE CARE

Purpose	To brief the Panel on the approach to Intermediate Care in Adult Services
Content	This report includes a summary of the approach to Intermediate Care in Adult Services, in line with the Adult Services Improvement Plan.
Councillors are being asked to	Give their views on the approach.
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1. Background

1.1 As part of the Western Bay Programme, an optimum model of intermediate care was adopted by the 3 Local Authorities and the Health Board.

1.2 The Kings Fund defines intermediate care services as those that are provided generally to older people to help them avoid going into hospital unnecessarily, to help them be as independent as possible after discharge from hospital and to prevent them having to move into residential or nursing homes until they really need to. These services tend to be time-limited, until the person has regained independence or medical stability, and are provided in people's own homes, or sometimes within local residential/nursing homes.

1.3 The aim of this optimum model was therefore to concentrate resources at the spectrum of community services which focussed on prevention and early intervention, with a view to preventing admission to and expediting discharge from hospital. The philosophy behind the model

was that targeting resources in this way would minimise and delay demand for long-term managed care. The focus was also very much on health and social care integration and wherever possible providing a seamless service to the customer.

1.4 This paper sets out how Adult Services is implementing this approach to intermediate care in line with the Adult Services Improvement Plan.

2 The Adult Services Improvement Plan

2.1 Within the Adult Services Improvement Plan, there are 10 core workstreams as follows:

- Section 33 Improvement and Implementation
- MDT Triage function within Common Access Point
- District Nursing Single Point of Access
- Anticipatory Care Regional Model
- Internal Homecare Services Restructure Implementation
- Domiciliary Care Reablement Review
- Hospital Social Work Team Intervention Process
- Community Equipment Store and Telecare Review
- Residential Care Reablement Function
- Integrated Care Fund Bid Coordination

2.2 Within the Adult Services Improvement Plan, the work surrounding Intermediate Care is most advanced as it pre-dates the Improvement Plan significantly. As a consequence, some of the workstreams are complete or nearing completion.

2.3 In addition to the above, this paper will briefly touch on the approach to DFGs as requested by the Panel.

3 Section 33 Improvement and Implementation

3.1 Following agreement of the optimum model in relation to intermediate care, the City and County of Swansea entered into what is termed as a Section 33 agreement with Abertawe Bro Morgannwg University Health Board, in order to pool the resources in relation to intermediate care.

3.2 This agreement comprised those services that delivered intermediate care, and the funding in relation to them. It also set out the governance surrounding these arrangements.

3.3 This agreement was entered into in 2014, and the world has significantly moved on particularly in relation to the level of integration in Swansea.

3.4 At the time of entering into the agreement, Swansea had a dedicated Community Resource Team responsible for delivering intermediate

care. However, in April 2015, this dedicated team was incorporated into the Integrated Hubs. It is therefore difficult to disaggregate intermediate care services from core services.

3.5 Both partners are consequently working together to revise the agreement so it covers health and social care integration across older people's services in its entirety, and the correct governance is in place to support a fully integrated management structure.

3.6 As part of this, Adult Services and the Health Board will be working together to develop the performance information. At the moment the available information is very social care driven, so having greater transparency over health information will be extremely helpful to inform service development.

3.7 Work is also ongoing to take the agreement to the next level, where the budget is truly pooled. This piece of work will start with intermediate care services with a view to being expanded further if successful.

4 MDT Triage Function within Common Access Point/District Nursing Single Point of Access

4.1 A key component of the optimum model of intermediate care was to develop a multi-disciplinary team at the Common Access Point (formerly known as Intake).

4.2 This would entail putting professionals at the front door to Adult Services to triage enquiries when they came in. The thinking behind this was that by putting professionals at the front door, demand into managed care would be minimised by wherever possible providing appropriate information and advice rather than assessing and providing a service response.

4.3 The triage function went live in the Common Access Point in January 2016, with Social Workers, Occupational Therapists, Physiotherapists and the third sector broker forming part of the multi-disciplinary team.

4.4 The performance information has shown that the number of enquiries channelled through the Common Access Point has increased month-on-month, but work is ongoing to look at the correlating data surrounding what this means in terms of those that are consequently signposted out with information and advice and those that are referred in. If the model is working correctly, the data should show an increase in those being provided with information and advice, and a decrease in referrals for assessment into the Hubs.

4.5 The triage function was originally staffed using a rota across teams. This has had varying success with difficulties in ensuring cover during all working hours. Work is therefore ongoing to look at alternative ways

of manning the cover linked to duty rotas within teams, and some progress was consequently seen in relation to cover in late 2017.

4.6 Critical to the successful implementation of the triage function has been the development of the District Nursing Single Point of Access. At the time of moving into Hubs, District Nurses were pulled out of GP surgeries and co-located with the other professionals. This decision has created some challenges in relation to communication with both patients and primary care colleagues. It was therefore agreed that to improve communication and address the various issues, a single point of access needed to be developed.

4.7 The Single Point of Access for District Nursing consequently went live in September 2017. It is co-located with the Common Access Point, and this has allowed for the District Nurses to become part of the wider multi-disciplinary team triage function. This is a huge step forward, and puts Swansea furthest ahead in terms of implementation of the optimum model in this respect.

4.8 The optimal model also includes mental health provision in the Common Access Point. A Mental Health Link Nurse and his team of Dementia Support Workers therefore work closely with Access and Information Assistants and in December 2017 work was completed to streamline the process further through the one system approach to new referrals via the Paris system.

4.9 Adult Services will continue to work with the Health Board to refine the MDT function in the Common Access Point to ensure it is fit for purpose and effectively manages demand into the service.

5 Anticipatory Care Regional Model

5.1 As part of the work surrounding intermediate care, an approach to anticipatory care was piloted.

5.2 Adult Services worked with Primary and Community Care colleagues to identify those individuals that professionals were most worried about to see whether anticipatory care plans could be put in place to better manage and coordinate their care.

5.3 Invest to Save funding was secured by the Health Board to fund dedicated staff to coordinate the process, and also provide additional administrative support to help embed the concept.

5.4 The pilot was implemented in Swansea in the West Hub with mixed success. Whilst some anticipatory care plans were put in place to support some individuals, it became clear that it would be better to target this approach as a more preventative/early intervention tool to help manage demand later on.

5.5 The project has been reviewed on a regional basis, and embedding the approach into core practice has been recommended. However, the practicalities of doing this are currently being explored.

6 Internal Homecare Services Restructure Implementation

6.1 At the time of moving into the Integrated Hubs in April 2015, the internal homecare service was organised into the 3 geographic areas.

6.2 Whilst this way of working initially saw many benefits because of the ability to have multi-disciplinary discussions and expedite support, it quickly emerged that there was an inconsistency of approach as 6 separate homecare teams had effectively been created. It was therefore agreed that the homecare service needed to be brought back together under one management structure. The new structure was consequently put in place in the Summer of last year and there is now one county-wide Reablement service and one county-wide long-term care service under the operation of a single Operational Manager.

6.3 This approach is already paying dividends surrounding consistency of approach and the ability to better manage demand.

6.4 Alongside the need to look at the management structure has been the need to address the long-standing issues surrounding working rotas and work-life balance for staff. This issue is still being addressed, but it is hoped that a rota will be piloted in both the Reablement and long-term care services during this calendar year.

7 Reablement Review

7.1 Effective Reablement support is a key component of the optimum model for intermediate care.

7.2 Initially, when the City and County of Swansea adopted the model, it was agreed that all new referrals for domiciliary care would be put through the service regardless of whether they had Reablement potential.

7.3 This approach proved problematic as capacity quickly became saturated with people who had no Reablement potential, but could not be quickly moved on to long-term services due to high levels of care needs.

7.4 The criteria was therefore reviewed for both the domiciliary care service and the residential Reablement service to only focus on those who had Reablement potential.

7.5 The outcomes of this approach has proved successful in that the majority of people who receive the service remain at home with either no care or a lower package of care.

7.6 Work is ongoing to review the criteria for the Reablement beds in Bonymaen House and Ty Waunarlwydd to ensure that the beds are used to capacity.

8 Hospital Social Work Team Intervention Process

8.1 At the time of integration into the Hubs, a decision was taken to pull out the hospital social work team from the hospital and provide the function within the Common Access Point.

8.2 This approach did not prove successful, and it became clear quickly that on-site social work support was critical on both the Singleton and Morriston sites.

8.3 The teams were therefore reinstated and work was undertaken to look at the pathways through the hospital, to ensure that discharges were expedited wherever possible and delayed transfers of care were minimised.

8.4 This work has proved successful with delayed transfers of care rarely being due to social work assessment issues.

8.5 There is also now a dedicated social worker aligned to A&E in Morriston to prevent unnecessary admissions to hospital. This approach has worked well, not only for patients but also in helping improve relationships with hospital colleagues as well as the profile of social work in the hospital.

8.6 Aligned to the work of the Hospital Social Work Team is the Acute Clinical Response Service.

8.7 The team was established in 2015 and comprises Advanced Nurse Practitioners and Chronic Condition nursing to offer short term health interventions in the community including residential homes, with a particular focus on reducing hospital admissions.

8.8 The team is based at Bonymaen Clinic and provide one of point of access across the City and County of Swansea with consistent referral criteria.

8.9 The service has assisted with the prevention of hospital admissions through the provision of health interventions in the community setting and facilitated quicker discharges from hospital by following that support home.

8.10 The team provide medical assessments by Advanced Practitioners and

where appropriate GP and/or consultant intervention either at home or in rapid assessment hot clinic.

8.11 Since the establishment of the team, work has continued to monitor and refine performance measures. The outcome of this has been a clear link to the team's work in the community and hospital admission avoidance and the facilitation of expedited discharge.

8.12 Work will continue with the team to expand upon existing links with the Hospital Social Work Team and Reablement service to ensure all opportunities to maximise our community resources is achieved.

9 Community Equipment Store and Telecare Review

9.1 A complete review has been undertaken of both the front facing and back office functions relating to the Community Equipment Store and Community Alarm Service.

9.2 The City and County of Swansea hosts the Community Equipment Store at the Suresprung premises in Morriston on behalf of Swansea, Neath Port Talbot and the Health Board. In 2015/16 a complete review was undertaken of the operational working of the store to ensure it was fit for purpose and update the governance arrangements surrounding it. This work is now complete and a new formal agreement will shortly be signed by all parties.

9.3 The support infrastructure for the service also supports the Community Alarm Service, so a review is currently being undertaken to ensure that the business support infrastructure is fit for purpose.

9.4 Alongside this, a Telecare Strategy is in the process of being developed so there is clarity surrounding the City and County of Swansea's offer in relation to telecare. To date, the Authority has concentrated on low-level community alarms which is a non-assessed for service which can be provided by other organisations often more cost-effectively. Developing technology means there are other ways that technology can be used as a more preventative/early intervention service and the we are considering where best to invest our resources in this respect.

10 Integrated Care Fund Bid Coordination

10.1 Each year the Welsh Government releases a certain degree of funding to concentrate on integrated services, with a particular focus on prevention/early intervention, intermediate care and services for Learning Disabilities.

10.2 As part of this, there is a core grant invested in mainstream intermediate care services year on year as part of the Section 33. However, on top of this there is some additional one-off capital and

revenue funding that can be invested as pump-priming/proof of concept funding.

10.3 These bids are coordinated by the Improvement Plan team who also undertake the necessary returns to Welsh Government.

10.4 In 2017/18, Adult Services was successful in gaining funding for the following projects:

Revenue (Regional bid structure)

Western Bay Domiciliary Care Capacity (Swansea, NPT & Bridgend).
Continuation of roll out of recruitment & retention strategy for external domiciliary care provision for the whole of Western Bay (£35,000).

Resource to support 7-day working pilot of community teams (Swansea only).
To maximise the presence and effectiveness of community resource 7 days a week ensuring that service users and their carers have support for assessment and reablement activity alongside hospital discharge (£29,582).

MDT resource within Common Access Point (Swansea & NPT)
To maximise the presence and effectiveness of the full MDT within the Common Access Point in Swansea and NPT by bolstering the staffing resource to facilitate increased triage and challenge at the 'front door' (Swansea: £153, 304).

Capital (Locality Bid Structure)

Enhanced Reablement Facilities in Ty Waunarlwydd
To undertake modifications / adaptions to existing facilities (8 bedded unit) in Ty Waunarlwydd, to provide a non-residential reablement/assessment unit alongside the residential assessment unit, increasing the range of assessments and reablement that can be undertaken to prepare for safe return home. The facility will complement the Bonymaen House Reablement facility (£42,500).

Closer to Home Project
Closer to Home is a strategy to develop in partnership, joint commissioning of a range of accommodation services within each locality and across the ABMU area that will support the needs of adults with a learning disability and complex behavioural and mental health needs. The proposal is to purchase and refurbish a property for 4 people (£354,164).

11 Disabled Facilities Grants

11.1 Work surrounding Disabled Facilities Grants complements the intermediate care workstreams. At the time of moving into the Hubs, the Occupational Therapist resource was divided up against the 3 geographical areas, and there was an expectation that all staff would be responsible for all elements of the work.

11.2 In reality, this meant that inevitably crisis work dominated and planned long-term work was de-prioritised. Due to the critical input of Occupational Therapists within the Disabled Facilities Grant (DFG) process, concerns were raised on the impact that this was having on DFG performance and timeliness of processing of DFG applications.

11.3 A complete review was undertaken and it was decided that the Occupational Therapy service needed to be brought back together as a County wide service and three new teams created, one to focus on Rapid Response, one to focus on Reablement and one to focus on planned work included DFGs. The restructure was implemented in the summer of 2017, but initial feedback has demonstrated that this change in approach is allowing us to prioritise all workstreams effectively. This, alongside the employment of 3.5 OTs by Housing who work within, and are supervised by, the Occupational Therapy service has meant that there have been improvements to timeliness of processing of DFGs.

11.4 Whilst Delayed Transfer of Care figures did peak in Swansea in September 2017, this was down to availability of packages of care, not adaptation delays. Discharge delays due to adaptations is not something that tends to be an issue in Swansea.

11.5 Progress and performance in relation to DFGs is continually reviewed jointly by Housing and Social Services.

11.6 Funding has also been secured via the Welsh Government ENABLE grant to focus on low level adaptations to facilitate hospital discharges. This funding is being managed by Care and Repair on behalf of the Local Authority.

12 Financial Implications

12.1 All of the above intermediate care work streams are critical to helping Adult Services manage its resources effectively and manage demand into the service.

13 Legal implications

13.1 All of the above intermediate care workstreams must be delivered in line with relevant legislation including the Social Services and Wellbeing (Wales) Act.

14 Equality and Engagement Implications

14.1 All of the above intermediate care workstream activities must be undertaken in line with the Equalities Act and relevant EIA screening and EIAs undertaken where applicable.

15 Appendices

- None

16 Background Papers

- None