Pecyn Dogfennau

Mark James LLM, DPA, DCA
Prif Weithredwr,
Chief Executive,
Neuadd y Sir, Caerfyrddin. SA31 1JP
County Hall, Carmarthen. SA31 1JP

DYDD GWENER, 8FED EBRILL, 2016

AT: HOLL AELODAU'R **PWYLLGOR CRAFFU GOFAL CYMDEITHASOL AC IECHYD**

YR WYF DRWY HYN YN EICH GALW I FYNYCHU CYFARFOD O'R **PWYLLGOR CRAFFU GOFAL CYMDEITHASOL AC IECHYD** SYDD I'W GYNNAL YN **Y SIAMBR, NEUADD Y SIR, CAERFYRDDIN** AM **10.00 A.M.** AR **DDYDD LLUN, 18FED EBRILL, 2016** ER MWYN CYFLAWNI'R MATERION A AMLINELLIR AR YR AGENDA ATODEDIG.

Mark James

PRIF WEITHREDWR

AILGYLCHWCH OS GWELWCH YN DDA

Swyddog Democrataidd:	**Matthew Hughes**
Ffôn (Llinell Uniongyrchol):	**(01267) 224029**
Ffacs:	**01267 224911**
E-bost:	**MaHughes@sirgar.gov.uk**
Cyf:	**AD016-001**

PWYLLGOR CRAFFU
GOFAL CYMDEITHASOL AC IECHYD
14 AELOD

GRŴP PLAID CYMRU – 5 AELOD

1.	Cynghorydd	T.T. Defis
2.	Cynghorydd	W.T. Evans
3.	Cynghorydd	D.J.R. Llewellyn
4.	Cynghorydd	G. Thomas (Cadeirydd)
5.	Cynghorydd	J.S. Williams

GRŴP ANNIBYNNOL – 4 AELOD

1.	Cynghorydd	S.M. Allen (Is-Gadeirydd)
2.	Cynghorydd	I.W. Davies
3.	Cynghorydd	E.G. Thomas
4.	Cynghorydd	H.I. Jones

GRŴP LLAFUR – 4 AELOD

1.	Cynghorydd	K. Madge
2.	Cynghorydd	E. Morgan
3.	Cynghorydd	B.A.L. Roberts
4.	Cynghorydd	J. Williams

POBL YN GYNTAF (SIR GAERFYRDDIN) – 1 AELOD

1.	Cynghorydd	S.M. Caiach

AGENDA

Mae’r dudalen hon yn wag yn fwriadol

SOCIAL CARE & HEALTH SCRUTINY COMMITTEE
18th APRIL 2016

Forthcoming items for next meeting – Monday 16th May 2016

** Please note that the following agenda items are subject to change as the Committee's Forward Work Programme for the 2016/17 municipal year is still being developed.*

Discussion Topic	Background
Welsh in Social Care Services for Older People	At its meeting on the 20th January 2016, the Committee received an update on the Communities Department's progress with regards to the Welsh Government's Strategic Document "More than Just Words", which sets out the importance of the Welsh language when caring for older people. This second update will include a corporate response in relation to the training and 'up-skilling' of staff with regards to the Welsh language.
Mental Health Services	This update will enable the Committee to monitor the progress being made in relation to supporting people with mental health needs in the County.
Social Care & Health Scrutiny Committee Forward Work Programme 2016/17	The County Council's Constitution requires Scrutiny Committees to develop and publish annual forward work programmes that identify issues and reports to be considered during the course of the municipal year. This report will enable the Committee to confirm its Forward Work Programme for 2016/17.
Social Care & Health Scrutiny Committee Annual Report 2015/16	In accordance with Article 6.2 of the County Council's Constitution, each Scrutiny Committee must prepare an annual report giving an account of its activities over the previous year. This report will provide members with an overview of the Committee's work during the 2015/16 municipal year.

Mae’r dudalen hon yn wag yn fwriadol

Y PWYLLGOR CRAFFU GOFAL CYMDEITHASOL AC IECHYD

18FED EBRILL, 2016

CYDWEITHREDFA IECHYD A GOFAL CYMDEITHASOL CANOLBARTH A GORLLEWIN CYMRU: Y WYBODAETH DDIWEDDARAF

Y Pwrpas:

Rhoi'r wybodaeth ddiweddaraf i'r Pwyllgor ynghylch y gweithgareddau a'r canlyniadau sydd wedi deillio o waith Cydweithredfa Iechyd a Gofal Cymdeithasol Canolbarth a Gorllewin Cymru a rhoi gwybod am drefniadau partneriaeth rhanbarthol newydd i fodloni gofynion Deddf Gwasanaethau Cymdeithasol a Llesiant (Cymru) 2014.

Ystyried y materion canlynol a chyflwyno sylwadau arnynt:

- Gweithgaredd y Gydweithredfa a'r camau sydd wedi eu cymryd mewn perthynas â rhoi Cynllun Gweithredu Rhanbarthol 2015-16 ar waith.
- Bydd trefniadau partneriaeth newydd ar waith o Ebrill 2016.

Y Rhesymau:

Yn ei gyfarfod ar 22ain Mai 2015 penderfynodd y Pwyllgor yn unfrydol y dylid darparu adroddiad diweddaru arall ynghylch Cydweithredfa Iechyd a Gofal Cymdeithasol Canolbarth a Gorllewin Cymru yn ystod 2015/16. Mae'r adroddiad hwn yn rhoi'r wybodaeth ddiweddaraf i'r Pwyllgor fel y gofynnwyd amdani.

Angen cyfeirio'r mater at y Bwrdd Gweithredol / Cyngor er mwyn gwneud penderfyniad:
NAC OES

YR AELOD O'R BWRDD GWEITHREDOL SY'N GYFRIFOL AM Y PORTFFOLIO:-

Y Cynghorydd J. Tremlett (Y Portffolio Gofal Cymdeithasol ac Iechyd)

Y Gyfarwyddiaeth:		
Gwasanaethau Cymunedol	**Swyddi:**	**Rhifau ffôn:**
Enw Pennaeth y Gwasanaeth:	**Pennaeth Cydweithredu Rhanbarthol**	**01267 228978**
Martyn Palfreman		**Cyfeiriadau e-bost:**
Awdur yr Adroddiad: Martyn Palfreman		MJPalfreman@sirgar.gov.uk

EXECUTIVE SUMMARY

SOCIAL CARE & HEALTH SCRUTINY COMMITTEE

18TH APRIL 2016

MID AND WEST WALES HEALTH AND SOCIAL CARE COLLABORATIVE: UPDATE

To update the Committee on activities of the MWWHSCC, delivery of the Regional Implementation Plan and successor arrangements in place from April 2016.

DETAILED REPORT ATTACHED ?	YES

IMPLICATIONS

I confirm that other than those implications which have been agreed with the appropriate Directors / Heads of Service and are referred to in detail below, there are no other implications associated with this report :

Signed: **Martyn Palfreman** **Head of Regional Collaboration**

Policy, Crime & Disorder and Equalities	Legal	Finance	ICT	Risk Management Issues	Staffing Implications	Physical Assets
NONE	**NONE**	**NONE**	**NONE**	**NONE**	**NONE**	**NONE**

CONSULTATIONS

I confirm that the appropriate consultations have taken in place and the outcomes are as detailed below

Signed: **Martyn Palfreman, Head of Regional Collaboration**

1.Local Member(s)

N/A

2.Community / Town Council

N/A

3.Relevant Partners

Mid and West Wales Health and Social Care Collaborative

4.Staff Side Representatives and other Organisations

N/A

Section 100D Local Government Act, 1972 – Access to Information
List of Background Papers used in the preparation of this report:

THESE ARE LISTED BELOW.

Title of Document	File Ref No.	Locations that the papers are available for public inspection
Mid and West Wales Regional Implementation Plan	RCU-RIP	Appended to report
Services and Wellbeing (Wales) Act 2014: Part 9 Statutory Guidance (Partnership Arrangements)	RCU - SSWBWA	http://gov.wales/docs/dhss/publications/151218part9en.pdf

Mae’r dudalen hon yn wag yn fwriadol

REPORT OF THE DIRECTOR OF COMMUNITY SERVICES

SOCIAL CARE AND HEALTH SCRUTINY COMMITTEE

18TH APRIL 2016

MID AND WEST WALES HEALTH AND SOCIAL CARE COLLABORATIVE: UPDATE

Head of Service/Report Author & Designation/	Directorate	Telephone No.
Martyn Palfreman, Head of Regional Collaboration	Community Services	01267 228978

1. BRIEF SUMMARY OF PURPOSE OF REPORT.

The report provides the Committee with an update on the activities and outcomes from the work of the Mid and West Wales Health and Social Care Collaborative (MWWHSCC) and advises on new regional partnership arrangements being established to meet the requirements of the Social Services and Wellbeing (Wales) Act 2014.

2. KEY DECISIONS REQUIRED, IF ANY

None.

3. RECOMMENDATION(S)

That the Committee notes the contents of the report.

4. REASON(S)

At its meeting on 22nd May 2015 the Committee unanimously resolved that a further update on the Mid and West Wales Health and Social Care Collaborative should be provided during 2015/16. This report provides the Committee with the requested update.

5. BACKGROUND AND EXPLANATION OF ISSUES

The MWWHSCC is one of 6 strategic partnerships in place across Wales, established to oversee the transformation and further integration of health, social care and wellbeing services and to coordinate readiness activity in relation to the Social Services and Wellbeing (Wales) Act 2014. It spans the Hywel Dda and Powys LHB footprints and comprises senior representatives from the 4 local authorities, 2 LHBs, Pembrokeshire Association of Voluntary Services (on behalf of the 3 CVCs in the Hywel Dda area), Powys Association of Voluntary Organisations and Care Forum Wales, representing care providers. Executive and non-executive/ political leadership is provided by a regional Leadership Board and Partnership Board respectively.

Along with the other regional collaboratives in Wales, the MWWHSCC was required to develop a Regional Implementation Plan for 2015-16 setting out its planned activities and anticipated outcomes. The Plan is appended to this report. Funding to support the regional implementation plans is available via the Welsh Government's Delivering Transformation Grant, Intermediate Care Fund and Regional Collaboration Fund.

Carmarthenshire County Council is the Lead Local Authority for the Collaborative, hosting a small coordinating unit and managing the regional grants.

The MWW Regional Implementation Plan was submitted to Welsh Government in September 2015. Delivery has been monitored by a series of regional programme boards, with exception reporting on progress to the Leadership Board and Partnership Forum. Key achievements to date include:

- External evaluation of Information, Advice and Assistance arrangements across the region and development of a regional delivery plan to drive the further enhancement of services
- Development of detailed practice guidance for assessment and care management, reflecting new duties within Parts 3 and 4 of the Act and provided for adoption by local agencies
- Delivery of a range of intermediate care services as part of the continued Intermediate Care Fund (ICF) programme (a separate report will be made to the Committee on the independent evaluation of selected initiatives within Carmarthenshire)
- Development of a preventative service model for adults in West Wales, building on the ICF-funded PIVOT initiative in Pembrokeshire
- Progress in the development of an implementation plan for the transformation of learning disability services based on the regional Statement of Intent
- Completion of regional Market Position Statements for older people and children's complex needs services
- External review of CYSUR, the regional children's safeguarding board, and establishment of a shadow adult safeguarding board
- Creation of a regional programme board for implementation of the Welsh Community Care Information Solution (WCCIS)
- Completion of a comprehensive 'readiness review' to inform new Part 9 partnership arrangements and the forward regional plan
- Implementation of awareness raising and core training modules on the Social Services and Wellbeing (Wales) Act
- Regional coordination of Welsh Government communications programme to support implementation of the Act

The Social Services and Wellbeing (Wales) Act comes into force on 6 April 2016. Part 9 of the Act focuses on cooperation and partnership between local authorities, LHBs and other key partners. A core requirement under Part 9 is the creation of Regional Partnership Boards (RPBs) to drive partnership working. Separate arrangements will be required for each LHB area, meaning that a West Wales RPB will be established for the Hywel Dda LHB footprint and that the existing Mid and West Wales region will be dissolved. Shadow arrangements are in place and the inaugural meeting of the West Wales RPB will take place on 15 April 2016.

Statutory Guidance specifies minimal membership for RPBs, which must include Directors of Social Services in the region, at least one elected Member, executive and non-executive members of the LHB, user and carer representatives and nominated representatives from the

third and independent sectors. The full membership of the West Wales Board is currently being finalised.

The Act places specific statutory duties on the RPBs, including responding to the Population Assessment required under Part 14 of the Act, through which local authorities, LHBs and other partners will need to assess levels of need for care and support, the extent to which these are currently being met and the range of services required to meet identified need in the future. The Population Assessments will need to consider preventative as well as core services and be undertaken initially at local authority level, with findings aggregated into a regional Assessment. The first Assessment must be undertaken by April 2017 and the exercise will be repeated thereafter once every local government electoral cycle.

Other responsibilities of the RPBs will include:

- Ensuring the partnership bodies provide sufficient resources for the partnership arrangements in accordance with their powers under section 167 of the Act
- Promoting the establishment of pooled funds where appropriate
- Ensuring that services and resources are used in the most effective and efficient way to improve outcomes for people in their region
- Preparing an annual report for Welsh Ministers on the extent to which the board's objectives have been achieved
- Providing strategic leadership to ensure that information is shared and used effectively to improve the delivery of services, care and support, using technology and common systems to underpin this
- Prioritising the integration of services in relation to:
    - Older people with complex needs and long term conditions, including dementia
    - People with learning disabilities
    - Carers, including young carers
    - Integrated Family Support Services
    - Children with complex needs due to disability or illness
- Delivery of a pooled budget arrangement for care homes by April 2018

An early imperative for the West Wales RPB will be to establish robust links with new Public Service Boards in each local authority area, thereby facilitating strategic alignment between the corporate and health, social care and wellbeing agendas and joined up activity where appropriate, for example in relation to the Population Assessment and the Wellbeing Assessment required under the Wellbeing of Future Generations (Wales) Act 2015.

Mae’r dudalen hon yn wag yn fwriadol

Regional Implementation Plan 2015-16

Programme/ Activity	Deliverables	Key milestones	Footprint	Governance	Resources	Link to SSWBWA
Strengthen governance arrangements for Collaborative	• New arrangements in place • Arrangements reviewed	Apr 2015 Jan 2016	MWW	MWWLB	DTG	Part 9
Implement Shadow arrangements for Regional Partnership Board	• Shadow arrangements in place	Mar 2016	MWW	MWWLB	DTG	Part 9
Strategic coordination of Regional Implementation Plan	• Plan agreed and ongoing monitoring of delivery	Sep 2015 onwards	Hywel Dda/ Powys	MWWLB PHASCILB PCYPP	DTG ICF RCF	Whole Act Part 9
Develop regional performance/ outcomes framework linked to National Outcomes Framework and relevant performance regimes	• Framework in place	Mar 2016	MWW	MWWLB	DTG	Part 2: Section 8
Establish citizen engagement arrangements	• Arrangements in place forming a virtual panel via existing mechanisms for engagement	Dec 2015	MWW	MWWRPF MWWLB	DTG	Whole Act
Communications Strategy	• Develop and implement communications strategy for implementation of the Act across partner agencies	Mar 2016	MWW	MWWRPF MWWLB	DTG	Whole Act

Programme/ Activity	Deliverables	Key milestones	Footprint	Governance	Resources	Link to SSWBWA
Self assessment of readiness for SSWBWA	• Initial self assessments refreshed • Forward planning for RIP 2016-17 • Compliance Action Plan	Nov 2015 Dec 2015 Mar 2016	MWW MWW Powys	All All PHASCILB/ PCYPP	DTG DTG DTG	Whole Act
Strategic leadership development	• Delivery of national SSIA leadership modules on SSWBWA	Mar 2016	MWW	MWWRPF MWWLB	DTG	Whole Act
Wellbeing of Future Generations	• Ensure alignment of governance and RIP with local arrangements for Wellbeing of Future Generations (Wales) Act	Mar 2016	MWW	MWWLB MWWRPF	DTG	Part 2
Integrating Assessment, care management and review for older people	• Common assessment and care management frameworks in place across the Hywel Dda footprint, consistent with national requirements • IT systems support consistent approach • Development/ improvement programmes in place across agencies to deliver common framework • Appropriate links identified with the Powys footprint	Nov 2015 Mar 2017 Mar 2016	Hywel Dda	HDISPB	DTG	Part 2: Section 14
Information, Advice and Assistance for Adults	• Scoping of current arrangements for information and advice on health, social care and	Oct 2015	Hywel Dda	HDISPB	DTG	Part 2: Section 17

Programme/ Activity	Deliverables	Key milestones	Footprint	Governance	Resources	Link to SSWBWA
	wellbeing services across the Hywel Dda footprint, assessment of their compliance with SSWBWA and identification of gaps • Assess feasibility of Dewis Cymru Portal to support service in the region • Development of regional IAA service	Oct 2015 Oct 2015-Mar 2016				
Developing preventative services for adults	• Development of regional cross-sector model of prevention taking forward the existing PIVOT initiative in Pembrokeshire • Assess and respond to results from SSIA 'Hearing the Voices of Older People in Wales' regional research	From Jul 2015 Dec 2015	Hywel Dda MWW	HDISPB HDISPB PHASCILB	DTG N/A	Part 2: Section 14 Section 15 Section 16
Development of early intervention and prevention strategy for adults	• Strategy developed	Mar 2016	Powys	PHASCILB	DTG	Part 2: Section 15 Section 16
Developing social enterprises, cooperatives, user-led services and the third sector	• Deliver awareness and initial development programme drawing on findings of regional analysis	Mar 2016	Hywel Dda	HDCPB	DTG	Part 2: Section 16

Programme/ Activity	Deliverables	Key milestones	Footprint	Governance	Resources	Link to SSWBWA
Transforming Learning Disability Services	• Regional model of service agreed based on progression principles and addressing key priorities within regional Statement of Intent • First phase of implementation • Learning Disability Day and Employment Service Review and Remodelling	April 2015 Mar 2016 Mar 2016	Hywel Dda Powys	HDISPB PHASCILB	RCF	Part 2 Part 3 Part 4 Part 9
Transforming Mental Health Services	• Review existing service model for MH for acute in-patient and community services • Enhance community services • Provide Single Point of Access for all ages	Dec 2015 Jun 2015 onwards Jun 2015 onwards	Hywel Dda	HDISPB	HDUHB	Part 2 Part 3 Part 4 Part 9
Intermediate Care Fund	• Programme finalised • Delivery of programme • Year 1 evaluation completed • Year 3 priorities identified	Mar 2015 From Mar 2015 Nov 2015 Feb 2016	MWW	HDISPB PHASCILB	ICF	Part 9
Reconfiguration of daytime opportunities	• New service specification	Mar 2016	Powys	PHASCILB	DTG	Part 2 Whole Act
Extra Care development (Bodlondeb)	• Action Plan in place	Mar 2016	Powys	PHASCILB	DTG	Whole Act
Information, advice and	• Scoping of current	Nov – Dec 2015	MWW	MWWCSPB	DTG	Part 2:

Programme/ Activity	Deliverables	Key milestones	Footprint	Governance	Resources	Link to SSWBWA
Assistance for Children and Families	arrangements for information and advice on health, social care and wellbeing services in MWW, assessment of their compliance with SSWBWA and identification of gaps • Assess feasibility of Dewis Cymru Portal and Family Point to support service in the region • Development of regional IAA service	October 2015 Jan 2016 onwards				Section 17
Adoption	• Continue to consolidate Adoption Mid and West Wales • Address the following priorities: ▪ Training ▪ Placement development ▪ Adoption support ▪ Developing wider partnerships ▪ Building on good practice ▪ Website and communications	Ongoing	MWW	HDCSPB	DTG	Part 9 Section 170
Children with Complex Needs	• Complete regional Market Position Statement • Agree priorities for regional collaboration and develop implementation plan	Dec 2015 Mar 2016	MWW	MWWCSPB	RCF	Part 2 Part 3 Part 4 Part 9
Integrated Family Support	▪ Continue to consolidate	Ongoing	MWW	MWWCSPB	LA budgets	Part 9

Programme/ Activity	Deliverables	Key milestones	Footprint	Governance	Resources	Link to SSWBWA
service	regional IFSS ▪ Undertake impact evaluation to inform service development ▪ Annual report produced	 Apr 2016				
Advocacy (children)	• Agreement of regional specification reflecting national requirements • Develop standards and outcomes • Develop performance framework • Needs analysis and cost modelling • New contract live	Mar 2016 Jul 2016	MWW	MWWCSPB	DTG	Part 10: Section 181
Establishing Regional Safeguarding arrangements for children (CYSUR)	▪ Continue to consolidate regional arrangements ▪ Independent review of CYSUR ▪ Multi-agency workforce development plan	Ongoing Jan 2016 Apr 2016	MWW	MWWLB	DTG	Part 7
Establishing Regional Safeguarding arrangements for adults	• Shadow Board in place • Regional ASB in place	Nov 2015 Mar 2016	MWW	MWWLB	DTG	Part 7
Population Needs Assessment	• Representation on national programme team and contribution to development of national framework	From Aug `15	Hywel Dda/ Powys	HDCPB PHASCILB/ PCYPP	DTG	Part 2 Section 14
Strategic joint commissioning	• Complete Older People's	Oct 2015	Hywel Dda	HDCPB	DTG	Whole Act

Programme/ Activity	Deliverables	Key milestones	Footprint	Governance	Resources	Link to SSWBWA
	Market Position Statement • Review Joint Commissioning Standards • Establish Strategic Provider Forum • Develop regional commissioning plans and identify priority areas for pooled budgets	 Mar 2016 Mar 2016 TBC				Part 9
Commissioning Care Assurance Performance System (CCAPS)	• Sign-up to phase 2 of CCAPS programme • Framework in place	Sep 2015 Mar 2016	MWW	HDCPB	N/A	Whole Act Part 9
Alignment of workforce plans with wider transformation programme	• Links identified within RIP and regional SCWDP • Regional Workforce Coordinator appointed	Mar 2015 Dec 2015	MWW	MWWWPB	SCWDP DTG SCiP	Whole Act
Delivery of training on Social Services and Wellbeing (Wales) Act	• Promote 'Getting in on the Act' hub and materials • Regional training plan in place (Social Services) • Modification of CCW core modules to reflect regional programme • Delivery of CCW core modules, where feasible in partnership with the NHS	From Jun '15 Sep 2015 Jan 2016 From Jan '16	MWW	MWWWPB	SCWDP	Whole Act
Delivery of SCiP programme	• Business plan finalised • Business plan delivered • New regional stakeholder forum established	Oct 2015 Ongoing Mar 2016	MWW	MWWWPB	SCiP (CCW)	Whole Act
CEIS	• National representative for	Sep 2015	MWW	MWWLB	DTG	Whole Act

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Programme/ Activity	Deliverables	Key milestones	Footprint	Governance	Resources	Link to SSWBWA
	project group identified • Regional governance in place • Regional implementation plan in place	 Nov 2015 Mar 2016				

Key

CCW	Care Council for Wales
DTG	Delivering Transformation Grant
HDCPB	Hywel Dda Commissioning Programme Board
HDISPB	Hywel Dda Integrated Services Programme Board
HDUHB	Hywel Dda University Health Board
ICF	Intermediate Care Fund
MWW	Mid and West Wales
MWWCSPB	Mid and West Wales Children's Services Programme Board
MWWLB	Mid and West Wales Leadership Board
MWWRPF	Mid and West Wales Regional Partnership Forum
MWWWPB	Mid and West Wales Workforce Programme Board
PCYPP	Powys Children and Young People's Partnership
PHASCILB	Powys Health and Adult Social Care Integrated Leadership Board
RCF	Regional Collaboration Fund
SCiP	Social Care in Partnership

Y PWYLLGOR CRAFFU GOFAL CYMDEITHASOL AC IECHYD

18FED EBRILL, 2016

Safonau Maeth i Bobl Hŷn

Ystyried y materion canlynol a chyflwyno sylwadau arnynt:

- Craffu ar ein hymagwedd at faeth i bobl hŷn gan gynnwys y camau sydd wedi eu cymryd mewn perthynas â'r blaenoriaethau yn y Cynllun Gweithredu Safonau Maeth i Bobl Hŷn

Y Rhesymau:

- Galluogi'r Aelodau i gyflawni eu rôl graffu mewn perthynas â monitro perfformiad.

Angen cyfeirio'r mater at y Bwrdd Gweithredol / Cyngor er mwyn gwneud penderfyniad: NAC OES

Yr Aelod o'r Bwrdd Gweithredol sy'n Gyfrifol am y Portffolio:
Y Cyng. J. Tremlett (Gofal Cymdeithasol ac Iechyd)

Y Gyfarwyddiaeth:	**Swyddi:**	**Rhifau ffôn: / Cyfeiriadau e-bost:**
Addysg a Phlant		
Enw Pennaeth y Gwasanaeth:		
David Astins	Rheolwr Datblygu Strategol	01267 246426 dastins@sirgar.gov.uk
Awdur yr Adroddiad:		
Helen Bailey	Uwch-reolwr Arlwyo	01267 246484 hbailey@sirgar.gov.uk

EXECUTIVE SUMMARY
SOCIAL CARE & HEALTH SCRUTINY COMMITTEE
18TH APRIL 2016

Nutritional Standards for Older People

This report provides an update on nutritional standards for older people, focussing principally on Local Authority care homes and day centres, following the previous update to Social Care & Health Scrutiny on 15th April 2015.

It is split into 3 parts:

- Appendix A – an update on the 8 objectives reported on and discussed at Scrutiny previously
- Appendix B – an overview of the work undertaken by the Catering Service (Department for Education & Children) in support of the Communities Department
- Appendix C – answers to the four specific questions that arose during last year's discussion at Scrutiny

This report compliments the report on Community Nutritional Standards for Carmarthenshire Integrated Services (discussed at Social Care & Health Scrutiny Committee on 16th September 2015 and Executive Board on 28th September 2015, and agreed at County Council on 14th October 2015).

DETAILED REPORT ATTACHED?	**YES (Appendices A, B & C)**

IMPLICATIONS

I confirm that other than those implications which have been agreed with the appropriate Directors / Heads of Service and are referred to in detail below, there are no other implications associated with this report :

Signed: David Astins **Designation: Strategic Development Manager**

Policy, Crime & Disorder and Equalities	Legal	Finance	ICT	Risk Management Issues	Staffing Implications	Physical Assets
YES	**NONE**	**YES**	**NONE**	**NONE**	**NONE**	**NONE**

1. Policy, Crime & Disorder and Equalities

Where appropriate we need to ensure compliance with legislation and guidance from Welsh Government.

2. Finance

The Communities Department has an internal Service Level Agreement with the Department for Education & Children for a catering consultancy service.

CONSULTATIONS

I confirm that the appropriate consultations have taken in place and the outcomes are as detailed below

Signed: David Astins **Designation: Strategic Development Manager**

1.Local Member(s) N/A

2.Community / Town Council N/A

3.Relevant Partners N/A

4.Staff Side Representatives and other Organisations N/A

Section 100D Local Government Act, 1972 – Access to Information
List of Background Papers used in the preparation of this report:

DETAILED BELOW

Title of Document	File Ref No.	Locations that the papers are available for public inspection
Community Nutritional Standards for Carmarthenshire Integrated Services	-	http://democracy.carmarthenshire.gov.wales/ieListDocuments.aspx?CId=155&MId=116&Ver=4

Mae’r dudalen hon yn wag yn fwriadol

Appendix A

Nutrition Strategy for Older People – Progress Update

	Key Objective	Catering Service Update as @ March 2016
1.	Ensure menus and recipes are suitable for all, including Community Meals, using the Nutmeg software system	Ongoing updates as and when each individual site requests a change to the menu, via Nutmeg.
2.	Deliver training sessions and support for staff, where required, to ensure objective number 1 is achieved	All menus put through the Nutmeg system, future updates also need to use this system. Nutrition training is available for all new staff.
3.	Conform to allergen legislation and provide updated product specifications on a regular basis. Ensure to cater for all special diets, needs and requirements with a range of dietary sources.	Compliant. On-going activity, with product specifications distributed as required, monitored annually, meetings held and newsletters include information to as a reminder
4.	Work in line with National Procurement Standards, legislation and continue to measure performance by comparison exercises analysing trends in food costs on a monthly basis	All existing food contracts conform to procurement rules. Monthly exercises undertaken to analyse food costs. The National procurement Service (NPS) is behind schedule in setting up food related frameworks, situation being closely monitored with corporate procurement colleagues and Head of Audit, Risk & Procurement.
5.	Maintain high scores with Environmental Health inspections	Advice given to site managers if needed when a report is received with recommendations. High scores achieved by maintaining high levels of cleanliness and excellent hygiene practices. Annual monitoring of kitchen areas and cooking practices undertaken, providing guidance to management, and information in newsletters.
6.	Oversee the development of the new high technology sites catering to include involvement in management of catering staff	No further involvement from Catering Service required.
7.	Promotion of NACC events through themed weeks and events such as hydration awareness alongside traditional events e.g. St Davids Days	Events calendar has been monitored and events planned to ensure sufficient timescales for promotion. NACC events held in November 2015 and March 2016.
8.	Continue to develop menus and recipes according to client requirements as found from consultation results	Annual resident consultations were undertaken in January & February 2016 which will inform work moving forward.

Mae’r dudalen hon yn wag yn fwriadol

Nutrition for Older People – Catering Service Update

This update provides an overview of the work undertaken by the Catering Service (Department for Education & Children) in support of the Communities Department regarding catering and nutrition for older people (this is through a Service Level Agreement between the two Departments) during 2015/16. This mainly covers catering services provided in care homes and day centres.

1. Menus

Although there is no specific legislation relating to meals for older people, a proactive approach is taken to ensure the menu is nutritionally balanced (using specialist computer software) whilst at the same time ensuring they feel like they are in a home setting, eating food they like and as they would if still in their own home. Menus are tailored to specific requirements at each site rather than a one-size-fits-all approach. We are going to pilot using some additional software to analyse Community Meals. By using this we will be able to provide better advice on correct portion sizes with additional consideration to individual requirements.

2. Support for staff

We hold meetings with catering staff and managers to update and address any concerns, this year has included requirements for Community Meals, staff training, updates from the National Association of Care Caterers, promotional information, and information regarding eating well with dementia.

3. Labelling & food allergens

As a result of new legislation on food allergens brought in at the end of 2014, new labelling regulations were introduced. We are exploring whether this will have any impact within the service (we believe not but need to confirm).

It is important that staff follow the set recipes and menus so that we are confident which allergens are contained in each meal plan. Following on from training and information packs provided to staff, this message is reiterated regularly through meetings and newsletters Training sessions were arranged for Catering staff to reiterate this message, and information packs distributed accordingly.

4. Procurement

When procuring food, we have to ensure our suppliers meet certain standards, with full traceability, particularly important to ensure food safety.

The way in which most food products are procured by public sector organisations is due to change in the foreseeable future with contracts awarded under frameworks established by the National Procurement Service for Wales (NPS). This is intended to deliver better value, although some concerns exist in light of experience with other NPS arrangements.

We are monitoring the situation closely with colleagues in the corporate Procurement Team.

5. Food Hygiene Ratings

We continue to see positive results from the Food Hygiene Rating Scheme, with nearly all homes and centres scoring the highest level 5 (Very Good) and none below 4 (Good). More information can be found at http://www.food.gov.uk/business-industry/hygieneratings.

6. Promotional Activities

In addition to traditional occasions we promoted the Nutrition and Hydration week (14th – 20th March 2015), encouraging the use of jelly (free samples provided) and being creative to increase fluid intake.

Two new leaflets were produced and distributed to the cooks: 'A Food Texture Guide for Caterers' and 'Eating Well: Providing Support for Older People'.

It is noteworthy that the Cook in Charge at Y Plas has made it to the UK Care Cook of the Year 2016 finals, which takes place on 8th June.

7. How is the service viewed?

Every year we undertake surveys with residents in order to gain valuable feedback on the service. The following questions are asked:

- How satisfied are you with the catering service?
- How would you rate the quality of food?
- Do you feel there is sufficient choice and variety at meal times?
- Are the portion sizes adequate for your needs?
- Do you have any special diets? How do you rate they are catered for?
- What meal do you enjoy the most?
- What meal do you least enjoy?
- Is there anything you would like to see on the menu?
- Do you have any suggestions as to how to imporve your eating experience?

The most recent results from a sample of some 60 residents across 9 settings early in 2016 were very positive, with average scores across all sites for each question ranging from 8 out of 10, to 10 out of 10. Some of the feedback included:

- Very happy with everything
- Staff are helpful & caring
- Plenty of choice

Appendix C

Response to questions raised by Social Care & Health Scrutiny on 16th April 2015

1. How does the service identify the nutritional requirements of an individual during the initial assessment process?

- Via the Malnutrition Universal Screening Tool (MUST) process.

2. How does the service ensure these needs are met?

- Monitoring / recording weights at least on a monthly basis (more frequently if individuals are identified in medium to high risk categories).
- Food first approach – enriching foods to increase calorific value.
- Referrals via GP to dietician, dentist or Speech and Language Therapy (SALT – commonly used to help people with language or communication difficulties, although it can also be used to help individuals with difficulty swallowing, eating or drinking) to identify the possible cause of weight loss.

3. What information is provided to families so that they can ensure the individual's needs are being met?

- Quality Assurance questionnaire, contacted and updated / informed of any concerns or referrals made to professionals.
- Open door policy families are welcome to call at any time, with a daily menu board displayed.
- Discussing with families of known food preferences for individuals.

4. How is the quality of meals provided within residential care establishments?

- Menus are prepared using the Nutmeg software to ensure a healthy, nutritional, balanced diet.
- Catering staff have attended Nutritional Guidance training.
- Managers from the Catering Service (Department for Education & Children) undertake routine monitoring of our service.
- Environmental Health undertake annual inspections.
- Individuals are given the opportunity to discuss menus at residents meetings and an annual survey is undertaken by the Catering Service (Department for Education & Children).
- Quality Assurance also involves questions around menus and meal times.

Gail Jones
Senior Manager – Service Provision
Communities Department
April 2016

Mae’r dudalen hon yn wag yn fwriadol

Y PWYLLGOR CRAFFU GOFAL CYMDEITHASOL AC IECHYD

18FED EBRILL, 2016

Y PWNC:

GWERTHUSO PROSIECT CRONFA GOFAL CANOLRADDOL

Y Pwrpas:

Rhoi golwg gyffredinol, diweddariad a gwerthusiad mewn perthynas â gwasanaethau sy'n cael cyllid o'r Gronfa Gofal Canolraddol - Gwasanaeth Cynghori a Chydgysylltu ynghylch Trosglwyddo Gofal (TOCALS) a'r gwasanaeth Gofal Cartref Ymateb Cyflym.

Ystyried y materion canlynol a chyflwyno sylwadau arnynt:

Gwasanaethau sy'n cael cyllid o'r Gronfa Gofal Canolraddol fel y nodir uchod

Y Rhesymau:

Er gwybodaeth i'r Pwyllgor

Angen cyfeirio'r mater at y Bwrdd Gweithredol / Cyngor er mwyn gwneud penderfyniad:
NAC OES

YR AELOD O'R BWRDD GWEITHREDOL SY'N GYFRIFOL AM Y PORTFFOLIO:-

Y Cynghorydd J. Tremlett (Y Portffolio Gofal Cymdeithasol ac Iechyd)

Y Gyfarwyddiaeth Cymunedau	**Swyddi:**	**Rhifau Ffôn: (01267) 228900**
Enw Pennaeth y Gwasanaeth: Rhian Dawson	**Pennaeth y Gwasanaethau Integredig**	**Cyfeiriadau e-bost: rhian.dawson@wales.nhs.uk**
Awdur yr Adroddiad: Rhian Dawson		

EXECUTIVE SUMMARY

SOCIAL CARE & HEALTH SCRUTINY COMMITTEE

21ST APRIL, 2016

SUBJECT:

ICF PROJECT EVALUATION

1. BRIEF SUMMARY OF PURPOSE OF REPORT

To provide an overview, evaluation and update regarding ICF funded services specifically in relation to the Transfer of Care Advice and Liaison Service (TOCALS) and Rapid Response Domiciliary Care service.

The Intermediate Care Fund was awarded initially in 2014 / 2015 and provides the opportunity to assist in the development and testing of new models to deliver sustainable integrated services that maintain and increase individuals' well being and independence, promoting improved care co-ordination across social services health and housing working with other partners to support people to remain safely at home or in a community setting.

One of the objectives of the fund is to:

- Improve preventative care and avoid unnecessary hospital admissions and delayed discharge of older people, particularly the frail elderly.

Carmarthenshire received just over £2 million in revenue and £1 million in capital to progress a portfolio of projects to achieve these objectives.

Following continuation of the ICF funding into 2015/16, the criteria was around continuation of those projects that could demonstrate impact and outcomes around the initial objectives and Carmarthenshire received £1.63 million in revenue only funds to progress this. The main initiatives include:

- **Transfer of Care Advice & Liaison Service (TOCALS) -** Dedicated Multi-disciplinary teams (MDT) are based at both acute hospital sites and who support the rapid assessment, care & discharge planning for people who are at increased risk of long term reduced level of function as a result of a hospital admission. TOCALS operates on both hospital sites within the County and in terms of Prince Phillip Hospital Llanelli between its inception in November 2014 to November 2015, TOCALS can demonstrate a 40% reduction in delayed transfers of care compared with the previous 12 months figure.

- **Rapid Response Domiciliary Care -** 24 Rapid Response staff in post, two staff on duty throughout the day in each of the three localities between 7am and 10pm working to ensure that frail adults who are functionally compromised, following acute episodes of illness or trauma are able to recover at home. The Rapid Response service also supports admission avoidance where appropriate at the 'front door' of the hospitals. . Between September 2014 & March 2015, which was the first year of service implementation & delivery, the Rapid Response Service has prevented 167 hospital admissions and facilitated 51 early discharges from hospital.

Both these services have contributed to improved performance in unscheduled care and DToC and have received positive evaluation (attached to this report). TOCALS has also been commended by the Health Board's 'Best of Health Awards' and won the Chief Executive Prize.

Moreover, WG have recently confirmed that Intermediate Care Funding will be recurrent which provides the opportunity to sustain and enhance these services and improve outcomes incrementally year on year.

DETAILED REPORT ATTACHED ?	**YES**

IMPLICATIONS

I confirm that other than those implications which have been agreed with the appropriate Directors / Heads of Service and are referred to in detail below, there are no other implications associated with this report :

Signed: Rhian Dawson **Head of Integrated Services**

Policy, Crime & Disorder and Equalities	Legal	Finance	ICT	Risk Management Issues	Staffing Implications	Physical Assets
NONE	**NONE**	**NONE**	**NONE**	**NONE**	**NONE**	**NONE**

CONSULTATIONS

I confirm that the appropriate consultations have taken in place and the outcomes are as detailed below

Signed: Rhian Dawson **Head of Integrated Services**

1.Local Member(s) - N/A

2.Community / Town Council – N/A

3.Relevant Partners - N/A

4.Staff Side Representatives and other Organisations - N/A

Section 100D Local Government Act, 1972 – Access to Information
List of Background Papers used in the preparation of this report:

THERE ARE NONE

Title of Document	File Ref No.	Locations that the papers are available for public inspection

PACEC

Public and Corporate Economic Consultants

In Collaboration with Dr Susan Carnes-Chichlowska

Carmarthenshire County Council - Mid and West Wales Health & Social Care Collaborative

Evaluation of Transfer of Care Initiative

April 2016

Table of Contents

Appendices

1 EXECUTIVE SUMMARY

1.1 Introduction

In July 2015 PACEC was commissioned by the Mid and West Wales Health & Social Care Collaborative (HSCC) to undertake an evaluation of the Intermediate Care Fund (ICF or the Fund) and six selected projects of the eighty-six in total. The aim of the Intermediate Care Fund (as detailed in the guidance issued by Welsh Government) is 'to develop services that help to 'avoid unnecessary hospital admissions, or inappropriate admission to residential care, as well as preventing delayed discharges from hospital'. Funding is targeted at supporting older people, particularly the frail elderly, to maintain their independence and to be cared for in their own home. This report evaluates the Transfer of Care Advice and Liaison Service (TOCALS) project in Carmarthenshire. Background / Project Summary

TOCALS was awarded £260,000[1] from the ICF under the 1st phase of funding from the ICF via the Mid and West Wales Health and Social Care Collaborative from June 2014 to March 2015 (operational in the Prince Philip Hospital (PPH) from September 2014 and Glangwili General Hospital (GGH) from December 2014.[2] TOCALS was established with the main aim of: 'facilitating the active development and implementation of an effective frailty pathway, acknowledging the significant risk of permanent loss of function associated with frail elderly people being admitted to an acute general hospital.'

1.2 Methodology

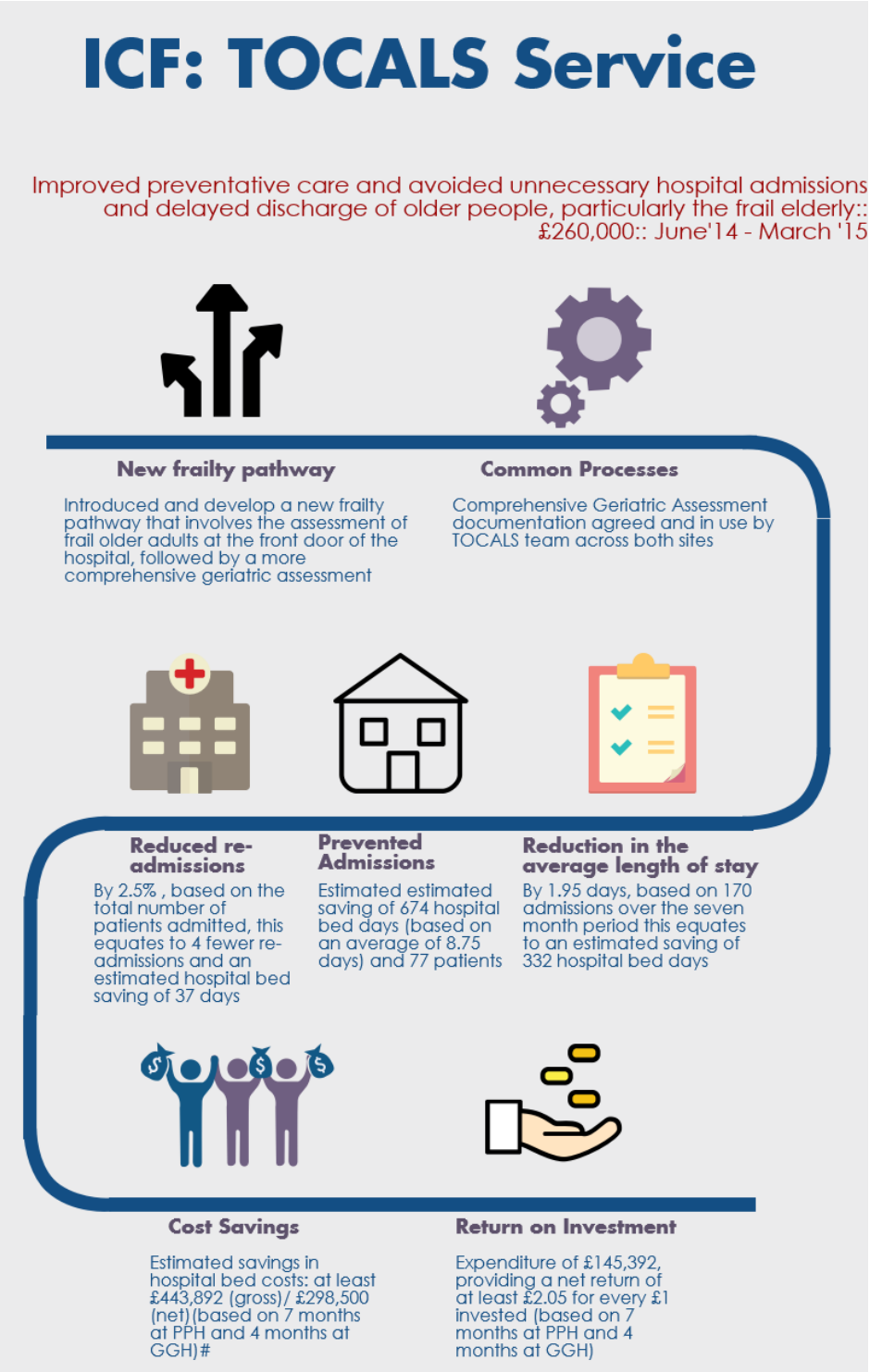
Methodological Element	Summary
Project Initiation and Initial Evidence Review:	A desk-based review of policy and literature regarding health and social care provision in Wales, including the integrated care context (project level reports) A review and analysis of internal monitoring data, including financial data A desk based benchmarking exercise to identify and compare (to the extent possible) inputs, outputs and outcomes delivered by the projects
Primary Research	A workshop and internal consultation with project managers across all six ICF projects involved in the evaluation, including group exercises to define pre and post service user pathways and service level logic models; and Online surveys of staff members (17 of 17 staff[3] – 100% response rate). However, the project promoters felt it was inappropriate for PACEC to survey service users on the grounds of confidentiality and data protection.
Economic Assessment	Assessment of: Value for Money (economy, efficiency and effectiveness); and Estimation of cost savings and return on investment
Analysis & Synthesis	Synthesis of qualitative and quantitative data; Identification of key lessons; Development of recommendations; and Analysis of desk based / survey data.

[1] Information provided to PACEC by accounting officer for TOCALS (October 2015) / ICF Spend by Workstream Document
[2] TOCALS Project Report 2 (November 2014)
[3] The TOCALS staff survey was issued by the current project manager

1.3 Evaluation Summary

The following infographic summarises the background, ambitions, and a number of evaluation findings from the TOCALS project.

* Please view Section 7 for a breakdown of the cost savings/return on investment.



The cost to deliver the project does not include the in-kind support from staff that were in post prior to TOCALS

1.4 Recommendations

This report sets out four thematic sets of recommendations regarding integration, project monitoring and outcomes, economic assessment and benchmarking, and future prospects the service with consideration of performance to date. The points below reflect the headline recommendations; a full depiction is set out in Section 8 of the main report.

1.4.1 Integration

TOCALS was overseen by an Integrated Project Board that involved senior representatives from Council, the Health Board and the Third Sector who worked together to influence the structure and delivery of the project. Structure and systems (i.e. monitoring reports) were put in place to govern the project and the Project Board also reported progress against ICF objectives to the Health and Social Care Board Staff who provided feedback noted improved levels communication with staff from other agencies and disciplines as a result of the project, therefore the project supported increased levels of integration between health board staff and council staff.

Recommendation:

TOCALS should ensure that they maintain strong working relationships with staff in the community (e.g. Community Resource Teams) so that those who are not admitted to hospital continue to have an appropriate form of alternative provision to be signposted to.

1.4.2 Outcome Measures

A number of measures were used to record the performance of the service against the reduction of bed days, hospital admissions avoided and readmissions within 30 days.

Recommendations:

- Baseline data should be collected and reported against in relation to the average length of stay prior to the TOCALS intervention or the re-admittance rates for older or frail, old patients[4].
- There is a strong body of evidence noting that the collection of feedback from service users is best practice in the evaluation of intermediate care services,[5] this includes patient satisfaction, health and well-being improvements[6] and patient quality of life.[7] TOCALS should therefore collect data on the impact of the service on patients. We recognise that this may be difficult to implement given that the TOCALS service blends with other hospital services and patients may not necessarily be aware that they have gone through

[4] Whilst it is recognised that the Project made us of generic hospital statistics on admissions and average length of stay for those aged over 65 it is not clear how directly comparable this population group is with the TOCALS target population.

[5] For example see Kings Fund (2002) Developing Intermediate Care. A Guide For Health And Social Services Professionals.

[6] Kings Fund (2002) Developing Intermediate Care A Guide For Health And Social Services Professionals

[7] Kings Fund (2014) Community services How they can transform care. Nigel Edwards

a TOCALS process. However, it is important to understand the impact of the service on patients and to collect data that can also be used to compare patients' outcomes with those from other services.

1.4.3 Performance

The TOCALS project had a number of significant achievements within a short period of time, including:

- The development and implementation of processes and procedures to facilitate the enhanced assessment of frail old patients attending A&E departments;
- Establishment of multi-disciplinary teams;
- 77 patients avoided admission;
- Reduction in the average length of stay of older patients; and
- Improved discharge planning.

Recommendations:

- An area for further consideration is **whether more patients could be assessed by TOCALS staff within the two relevant hospitals.** Further research and data collection is needed to confirm that all frail, older, people presenting in A&E are being referred for Comprehensive Geriatric Assessment, this would then determine if the potential benefits of TOCALS are being maximised. **In doing so any notable barriers to assessment under TOCALS should also be considered and minimised.**
- We recommend that targets should be developed for each objective going forward; and
- We recommend that future reporting templates detail quarterly and cumulative progress against all the objectives and targets details in the PID.

1.4.4 Economic Assessment

The project was assessed against its economy, efficiency, effectiveness and cost effectiveness and it demonstrated that gross savings for the health service amounting to £443,892. Minus the ICF monies of £145,392 the net savings achieved are in the region of £298,500. This equates to net return on investment of £2.05 for every £1 invested. However, it must be noted that, these figures are only illustrative as the costs did not include an allocation for staff involved in the project outside of the ICF core funded posts.

Recommendation:

To further inform economic assessment in the future, more detailed financial data on staffing costs should be collected, this would include time spent by all staff on TOCALS activities in addition to those who have been funded through ICF.

2 TERMS OF REFERENCE AND METHODOLOGY

2.1 Background

In July 2015, PACEC was commissioned by the Mid and West Wales Health and Social Care Collaborative (MWWHSCC) to undertake an evaluation of the Intermediate Care Fund (ICF). The table below details the terms of reference for the evaluation.

Table 2:1: Terms of Reference

Terms of Reference
To examine the process and benefits of integrating health and social care services within the region with a view to assessing (as set out in analysis and reporting): • Whether the process of integration has worked as expected and what aspects have worked well or less well; • If and how processes of integration have contributed to or retarded progress towards outcomes; and • What practical lessons can be learned for the continuing integration of services within the region and more widely.
Assess, to the extent possible, the outcomes of a selection of the region's ICF projects (through evidence review and primary research): • Characterise and categorise the range of outcomes expected from the region's projects, distinguishing service-related outcomes from service user outcomes and intermediate from final outcomes; • Gather evidence from a sub-set of the region's projects to explore if, how and to what extent these outcomes have been realised; and • Comment, as far as possible, on future prospects for realising outcomes, given the progress made to date
Conduct, to the extent possible, an economic assessment (see section 7), focusing on: • The cost-effectiveness of the region's integrated service models, vis-à-vis non-integrated ways of delivering services; • The extent to which integrated care is more efficient than non-integrated care; and • The potential for cost avoidance/negated costs contributed by preventative approaches
Provide commentary on the future prospects for care integration within the region by (as set out in conclusions and recommendations): • Identifying approaches with potential for replication or scaling up (within the context of the Social Services and Wellbeing (Wales) Act); • Discussing options for sustaining approaches following the cessation of WG funding; • Recommending components of an outcomes-based performance framework for the future • Discussing the likelihood of outcomes being realised in future; and • Discussing the trade-offs between investing further in integrating care and continuing to invest in other forms of care.

2.2 Methodology

To achieve the requirements within the Terms of Reference following methodological approach was deployed:

Table 2:2: Methodology

Methodological Element	Summary
Project Initiation and Initial Evidence Review:	• Review of Project Initiation Document (PID) and Policy Context to outline what the project had set out to achieve / rationale for the project • A desk-based review of policy and literature regarding health and social care provision in Wales, including the integrated care context • Review of relevant literature (to outline the existing and new service user pathways and to develop an evaluation / logic model for the project in relation to outputs[8] and outcomes[9]) • A review and analysis of internal TOCALS monitoring data, including financial data and progress reports • A desk based benchmarking exercise to identify and compare (to the extent possible) inputs, outputs and outcomes delivered by TOCALS and other similar interventions
Primary Research	• A workshop and internal consultation with project managers across all six ICF projects involved in the evaluation, including group exercises to define pre and post service user pathways and service level logic models • An online survey of all 17 staff members, agreed with and issued by the project manager) (see appendix C) • Interviews with project manager and members of the project board (see appendix D)
Economic Assessment	Assessment of Value for Money (economy, efficiency and effectiveness) and estimation of cost savings and return on investment
Analysis & Synthesis	• Synthesis of qualitative and quantitative data • Identification of key lessons • Development of recommendations • Analysis of desk based and survey data.

[8] Outputs are the measureable components of service delivery that can be quantified (e.g. number of patients supported per week) (http://info.wirral.nhs.uk/document_uploads/evidence-factsheets/12%20Logic%20Modelling%20factsheet%20Feb%202014.pdf)

[9] Outcomes are the effects of activities and resulting outputs. These can be divided into short, medium and long term (e.g. short – increased knowledge and skills; medium – improved patient independence; long – reduced health inequalities

3 Background

This evaluation involves a review of the overall ICF programme in Mid and West Wales and a review of six of the ICF funded projects. This report evaluates the Transfer of Care Advice and Liaison Service (TOCALS) project.

3.1 Intermediate Care Fund (ICF)

The ICF was announced by the Welsh Government in December 2013 and provided one year of funding (£50m across Wales) in 2014/15. The purpose of the fund was to:

- Encourage integrated working between local authorities, health and housing; and
- Support older people, particularly the frail old, to maintain their independence and remain in their own home.

The total funding for the Mid and West Wales Collaborative of £8.4 million[10] was shared between the four local authority areas as follows:

Table 3.3:1: Breakdown of ICF Funding 2014 / 15

Area	Revenue		Capital		Total	
Powys	£1,500,000	26.7%	£749,000	26.6%	£2,249,000	26.7%
Ceredigion	£801,000	14.2%	£400,000	14.2%	£1,201,000	14.2%
Pembrokeshire	£1,268,000	22.5%	£634,000	22.5%	£1,902,000	22.5%
Carmarthenshire	£2,058,000	36.6%	£1,029,000	36.6%	£3,087,000	36.6%
Total	**£5,627,000**	**100.0%**	**£2,812,000**	**100.0%**	**£8,439,000**	**100.0%**

Source: Intermediate Care Fund Mid and West Wales – Half Yearly Report – November 2014

ICF was welcomed as an opportunity to build on existing service arrangements and test out new approaches to intermediate care that would:

- Ensure a citizen focused approach to service planning and delivery;
- Promote independence among older individuals;
- Encourage further integration across health, social care and the wider sector;
- Foster direct engagement with key partners within local government (for example housing and the third sector in developing and delivering an ambitious programme of change in the region); and
- Make a key contribution to the delivery of commitments within the Hywel Dda and Powys area.

[10]Intermediate Care Fund Mid and West Wales – Half Yearly Report – November 2014

Over 70 individual projects were funded[11] in mid and west Wales delivering against two themes: "Investing to Go Further" and "Investing to Join Up". Investing to Go Further aims to increase integrated intermediate care capacity in order to prevent hospital admissions and maximise people's independence following a crisis. Investing to Join Up aims to build community resilience, creating environments receptive to intermediate care and contributing to its sustained success.

3.2 Background and Rationale for the TOCALS Project

TOCALS was established with the main aim of 'facilitating the active development and implementation of an effective frailty pathway, acknowledging the significant risk of permanent loss of function associated with frail elderly people being admitted to an acute general hospital' [12]. The rationale for this work was the recognition that:

- Seventy per cent of all hospital admissions are attributed to frailty (this includes frailty syndrome, delirium, dementia and depression) and frailty contributes to the longest lengths of stay and the highest readmission rates[13]
- In Hywel Dda, people over 65 years old utilise 78% of the bed days relating to A&E / GP Emergency admissions
- Facilitating efficient discharge for the frail older population improves health outcomes at micro and macro level, specifically it:
  - Supports effective patient flow and maximised use of acute hospital beds;
  - Reduces the risk and level of functional decompensation to the individual from long hospital stays; and
  - Reduces the need for prolonged rehabilitation and / or long-term care.

The reason for multi-disciplinary teams was also set out in the PID, which showed that effective discharge planning involves the skills and knowledge of professionals across the acute and community settings, given the heterogenetic needs of frail older people.

3.3 Transfer of Care Advice and Liaison Service (TOCALS) – Funding, Aims and Objectives

TOCALS was awarded £260,000[14] from the ICF under the 1st phase of funding from the ICF via the Mid and West Wales Health and Social Care Collaborative from June 2014 to March 2015 (operational in the Prince Philip Hospital (PPH) from September 2014 and Glangwili General Hospital (GGH) from December 2014.[15]

[11] Intermediate Care Fund Mid and West Wales – Half Yearly Report – November 2014
[12] Transfer of Care Initiative – Project Initiation Document, Rhian Dawson (August 2014)
[13] https://www.rcplondon.ac.uk/sites/default/files/acute-care-toolkit-3.pdf
[14] Information provided to PACEC by accounting officer for TOCALS (October 2015) / ICF Spend by Workstream Document
[15] TOCALS Project Report 2 (November 2014)

Objectives under the ICF phase 1 funding, were to:

- Embed a frailty pathway of care within both hospitals which would
- Prevent hospital admission at the front door for frail older people who require rapid MDT (multi-disciplinary team) assessment and community support to mitigate immediate risk and longer term problem solving of their co-morbidity and functional decline
- Reduce length of stay by adopting a co-ordinated approach to problem solving, and care co-ordination
- Support a minimalist (prudent) approach to admission, acknowledging that for some people admission may not lead to a change in long term medical management, but can pose significant risk of long term reduction in functional ability (i.e. increased dependency)
- Identify potential systems change and role redesign that would improve the effectiveness and efficiency of primary care, community and acute hospital services for the frail older persons.

The expected deliverables for TOCALS were identified as:

- Decreased length of stay against baseline at project initiation
- Reduced readmissions for frail older individuals who are supported by the team
- The MDT will contribute to the development of an acute hospital frailty pathway
- Support the development of a realistic Date of Discharge prediction for the frail old

In order to assess the achievement of these outcomes, the following KPIs were set[16]:

- Number of people assessed by the service
- Reduction of inpatient bed days as a result of the service
- Hospital admissions avoided from A&E/CDU[17]
- % of readmissions within 30 days against reported baseline.

3.4 How the TOCALS Operates[18]

TOCALS was set up to:

- Support front line staff to undertake a 'Front door' assessment
  - Frailty screening at presentation in order to trigger detailed comprehensive geriatric assessment (CGA)
  - CGA for those people who may benefit from a co-ordinated and integrated plan for treatment and long-term follow up initiated through a multidimensional interdisciplinary diagnostic process.
  - Geriatricians to carry out early assessment (within 24hrs) for people who are frail.
  - Organised specialist multidisciplinary team (MDT) working to support rapid assessment, care planning and discharge of frail old (reduces length of stay and risk of readmission).

[16] Carmarthenshire Detailed PIs, (July 2015)
[17] Accident and Emergency and Clinical Decisions Unit
[18] Transfer of Care Advice and Liaison Service – Evaluation, Recommendations and Strategy (March 2015),

- Encourage a 'pull' approach to acute discharges
  - Work with community MDT and the patient and their families / carers to develop a shared approach to rapid discharge.
  - Early identification of patients at risk of potentially long stays using a suitable risk tool
  - Utilise lessons learnt from emergency readmissions and people with prolonged length of stay to change the way the service works
- Proactively Approach Prolonged Lengths of Stay
  - Review prolonged hospital stays above a defined level (e.g. 14 / 21 days)
  - Regular progress meetings should take place at least twice weekly to review prolonged stays

Multi-disciplinary TOCALS teams were set up in PPH and GGH. The project was first established in PPH at the end of September 2014 and ran as a proof of concept before it was implemented in GGH in December 2014. The service operated five days a week between the hours of 9am and 5pm.

The teams consisted of 12 staff, seven of whom were funded by the ICF and five were from existing hospital staff. The teams included social workers, district nurses, physiotherapists and staff nurses (see staff detail by hospital and team structure in section 4.3).

3.5 User Pathways

The TOCALS service involves the following key steps:

- The team supports front line staff at the 'front door; to screen all older adults presenting at the front door of PPH & GGH (at A&E or Clinical Decisions Units) for the presence of 'frailty syndrome' or sudden functional decline using the CSHA Frailty Scale[19];
- TOCALS (in conjunction with hospital staff) initiated a Comprehensive Geriatric Assessment (CGA)[20] on frail adults presenting with 'frailty syndrome' or sudden functional decline;
- Based on this assessment the patient was either admitted to hospital or discharged with/ without support from other services, as needed.
- If admission was required:
  - The TOCALS team support hospital staff make recommendations regarding appropriate interventions;

[19] The Clinical Frailty Scale is a widely used tool within the health service and rates an older patient's frailty on a nine stage scale going from 1 – very fit to 9 – terminally ill.

[20] The gold standard for the management of frailty in older people is the process of care known as Comprehensive Geriatric Assessment (CGA). It involves a holistic, multidimensional, interdisciplinary assessment of an individual by a number of specialists of many disciplines in older people's health and has been demonstrated to be associated with improved outcomes in a variety of settings. It was developed by a team from the British Geriatrics Society. (http://www.bgs.org.uk/index.php/cga-managing)

  - Discharge Liaison Nurses, work to ensure that patients are provided with the care required, and establish realistic discharge dates with any support that is needed.

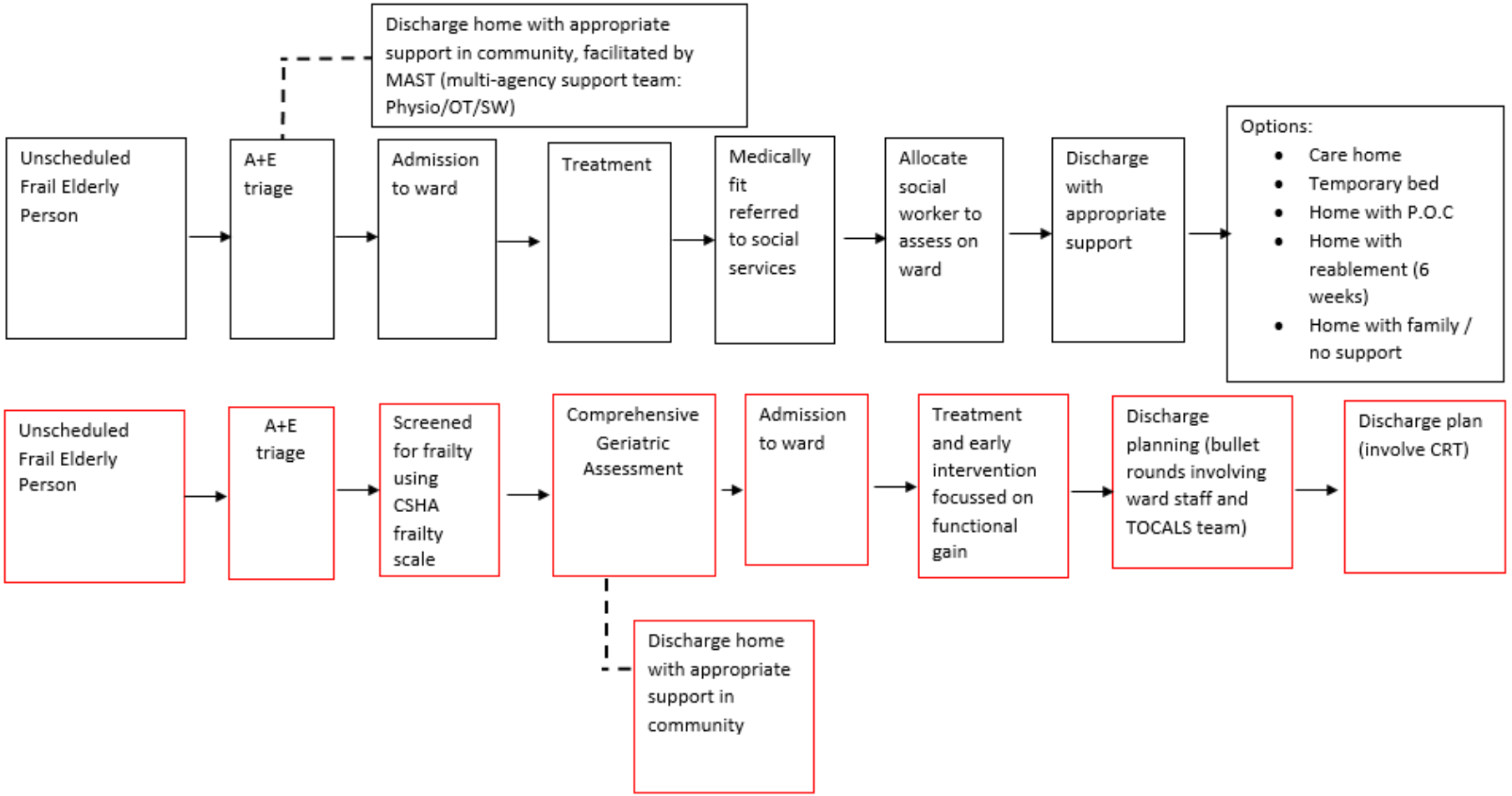
- If discharged after assessment:
  - TOCALS staff will work with Community Resource Teams (CRTs) to ensure any additional community services are provided to facilitate safe discharge. This may also have included a referral to the ICF funded Rapid Response Service, which can facilitate the implementation of a domiciliary care package within two days of an urgent referral. The total number of referrals to Rapid Response from TOCALS is not known.

The before and after ICF patient pathways were drafted by the evaluation team and agreed with the project manager. The following diagram shows the new TOCALS patient pathways (in red) alongside the old pathways (in blue).

The specific duties of the TOCALS team that were not carried out before are:

- early identification on admission of patients presenting with complex needs who may be predisposed to a long stay in hospital i.e. frail older adults using Clinical Frailty Scale (CSHA), (by working across Emergency Departments (EDs), Clinical Decision Units (CDUs), Acute Medical Units (AMUs), Orthopaedic and Rehabilitation wards; also by working in partnership with Discharge Liaison Nurses (DLNs), ward staff, mental health services, continuing health care (CHC), family and carers, General Practitioners (GPs) and their key workers in the CRTs);
- contributing to the completion of early Comprehensive Geriatric Assessment (CGA) for those presenting with Frailty Syndrome;
- developing and supporting the delivery of integrated care plans for patients; and
- reviewing patients at home/place of residence 24 hours after discharge.

Figure 3.1: Care Pathway – TOCALS



Source: Care Pathway Developed by PACEC in consultation with TOCAL (September 2015).

Summary

TOCALS was awarded funding of £260,000[21] from the ICF over the period June 2014 to March 2015, with operational delivery in PPH from September 2014 and GGH from December 2014. TOCALS was designed to provide a multi-disciplinary approach to address the needs of older people either in, or seeking to attend, hospital and especially those who are assessed as frail. It was recognised that there are older people in hospital at risk of functional decompensation and whose needs could be better and more cost effectively met in a community setting while also avoiding unnecessary hospital admissions / delayed discharge of older people, particularly the frail old.[22]

[21] Information provided to PACEC by accounting officer for TOCALS (October 2015) / ICF Spend by Workstream Document
[22] Transfer of Care Initiative – Project Initiation Document (June 2014)

4 CONTEXT, LITERATURE REVIEW & LOGIC MODEL

4.1 Introduction

This section sets out the context in which the TOCALS operates in Carmarthenshire as well as a brief summary of the literature relating to benefits and the outcomes that can be expected from such services.

4.2 Socio-economic context

4.2.1 Carmarthenshire Population

People over 65 in Carmarthenshire account for 22% of the total population.[23] As shown in table 4.1, these numbers are expected to grow by 11% (n=4,433) by 2020.

Table 4.4:1 Carmarthenshire Population Projections for People Aged 65 and Over[24]

Year	Males Aged 65 and Over	Females Aged 65 and Over	Total Population Aged 65 and Over
2014	19,307	22,368	41,676
2015	19,729	22,684	42,413
2016	20,100	23,015	43,115
2017	20,486	23,364	43,850
2018	20,859	23,758	44,616
2019	21,259	24,097	45,356
2020	21,641	24,468	46,109

Source: Stats Wales[25]

This highlights a growing level of demand for health and social services. However given the reduction in public sector budgets it also demonstrates the need for innovative solutions / models of delivery that can provide the supports needed but much more cost efficiently and effectively to the public purse.

[23] Carmarthenshire County Council: http://www.carmarthenshire.gov.wales/media/824482/county_profile.pdf.
[24] This change relates to the increase of older persons in Wales under the definition solely that these people are over 65. It is anticipated that in future years healthy life expectancy years will improve; and hence service demand for this age bracket will not necessarily increase in line with the growth in size of the number of people over the age of 65. Sourced via: Kings Fund (2014) *Making our health and care systems fit for an ageing population*
[25] StatsWales (2011). Available at: https://statswales.wales.gov.uk/Catalogue/Population-and-Migration/Population/Projections/Local-Authority/2011-Based/PopulationProjections-by-LocalAuthority-Year

4.3 Evidence Review – TOCALS

The literature suggests that services which provide early assessments as well as rapid assessments and care & discharge planning include the following outputs and outcomes:

Service Level Outputs / Outcomes:

- **Reduction in unscheduled hospital admissions**: Most studies suggest that admissions can be avoided in 20-30% of over 75 year old frail persons, with one report noting that 'avoiding admissions in this group of older people depended on high quality decision making around the time of admission, either by GPs or hospital doctors. Crucially it also depended on sufficient appropriate capacity in alternative community services (notably intermediate care) so that a person's needs can be met outside hospital, so avoiding 'defaulting' into acute beds as the only solution to problems in the community.[26] Having specialists trained in recognising and managing frailty at the front door can reduce admissions and a study in the United States[27] found that a service for older persons located in the emergency department reduced admissions by 3% provided there are easy to access, timely, credible alternatives to admission.
- **Facilitation of early discharge**: A Kings Fund report[28] noted that Health Trusts with proactive approaches to discharge and staff with close links / understanding of what services are available in the community (including high degrees of multi-disciplinary working) can reduce the length of time that older patients stay in hospital.[29] Specifically this report notes that the number of extended stays can be reduced by between 14% and 40% (including bed days avoided by reducing admissions) if a proactive, multidisciplinary approach is taken to discharge planning, that also involves the community.
- **Cost savings - a Swedish intervention:**[30] 'Continuum of care for frail older people: from emergency ward to living at home' found that such interventions increase participant's independence as well as saving money for the health service. The intervention involves collaboration between a nurse with geriatric competence at the emergency department, the hospital wards and a multi-professional team for care and rehabilitation of the older people in the municipality with a case manager as the hub. The multi-professional team includes professionals in nursing, occupational therapy, physiotherapy and social work. Together they create a continuum of care for the frail older person from the emergency department, through the hospital ward to their own homes. Information is immediately transferred from emergency department to the wards and the municipality. Discharge planning starts the same day as the older frail person is admitted to the hospital and all planning is coordinated by the case manager. The intervention has a person-centred approach with shared decision-making throughout the care chain. The frailty screening includes five questions concerning endurance, tiredness, falls, needing support shopping and more than three visits at the emergency department within the most recent twelve months. When the screening indicates more than two frailty indicators they are screened for

[26] Mytton et al. British Journal of Healthcare Management 2012 Vol. 18 No 11
[27] Keyes D, Singal B, Kropf CW and Fisk A (2014) 'Impact of a new senior emergency department on emergency department recidivism, rate of hospital admission, and hospital length of stay', Annals of Emergency Medicine 63(5), 517–524.
[28] Kings Fund (2014) Community services: How they can transform care
[29] Kings Fund (2014) Community services: How they can transform care
[30] Best Practice: Continuum of care for frail older people: from emergency ward to living at home (2013) http://www.projectaida.eu/wp-content/themes/thunderbolt/docs/Swedish_Skora.pdf

frailty as part of the program. All persons 75 years of age or older who are screened for frailty within the continuum of care process are target users. Results published in 2013 found that the randomised control study had evidenced positive results for the users. Specifically, participants in the integrated care program were significantly more satisfied with the care planning and their own possibility of participating in the care planning compared to the control group. It also notes that unpublished material shows promising effects on the participant's independence in activities of daily living up to twelve months and indications that the municipality saves money. Identified strengths from the programme are:

- the emergency department recognises and treats the frail older person as a VIP;
- information is immediately transferred from emergency department to the wards and the municipality;
- discharge planning starts the same day as the older frail person is admitted to the hospital;
- all planning is coordinated by the case manager;
- a case manager is available for the frail older person and her/his relatives during daytime in weekdays;
- a rehabilitation team is placed in the direct vicinity with the case manager;
- care planning at home which emphasises the older person's participation;
- those persons that are identified as frail older persons but not admitted to the hospital ward are also offered care planning at home; and
- continuous follow-ups by the case manager.

TOCALS type services also deliver service user / patient outcomes. Examples include:

- **Increased independence**: a study[31] on the effects of delays in transfer on independence outcomes for older people found that the time window for between-service transfers to intermediate care that optimises clinical outcomes for frail older people recovering from an acute illness is small. In this study, it was found that a delay of more than two days was sufficient for detrimental effects on an independence outcome to be observed. Other studies from the Health Foundation and Kings Fund also demonstrate that delayed discharge can lead to a deterioration in the condition of patients and the loss of independence/functionality[32,33]. For example, a Health Foundation report[34] found that delays in getting specialist geriatric medicine assessment meant that many frail older people had to stay in hospital overnight unnecessarily. In addition, during the initial tests of change, a limited audit of ward rounds showed that 20% of these patients had their diagnosis or care fundamentally changed by a geriatric medicine specialist if they were seen at an early stage compared to 20 hours after admission.
- Improved quality of life - a study on the Costs and Outcomes of Intermediate Care for Older People[35] where quality of life was assessed before and after intermediate care using the using

[31] Effects of delays in transfer on independence outcomes for older people requiring postacute care in community hospitals in England Young, John et al. *Journal of Clinical Gerontology and Geriatrics* , Volume 1, Issue 2 , 48 - 52
[32] Kings Fund (2002) Developing Intermediate Care. A Guide for Health and Social Care Professionals.
[33] There is a body of evidence demonstrating that the condition of older patients can deteriorate if they are not discharged from hospital once they are fit to do so, for example, see The Health Foundation. Improving the Flow of older people (2013).
[34] The Health Foundation (2013) Improving the Flow of older people
[35] Intermediate Care National Evaluation Team (ICNET) (2006) A National Evaluation of the Costs and Outcomes of Intermediate Care for Older People

the EuroQol EQ-5D instrument and found that the largest gains in quality of life were seen for admission avoidance schemes (compared to supported discharge).

In addition, a Cochrane Review[36] identified that it was the lack of a comprehensive assessment of the medical, social, functional or psychological needs that led to a high rate of admission to hospital and / or permanent residential care within the frail older people population. A report[37] on the assessment and management of the clinically frail in Nova Scotia, Canada notes that there are various models of service provision for older people: needs related, age defined and integrated. However all share the same strategic aim to ensure that older people have a multi-disciplinary assessment and access to Comprehensive Geriatric Assessment (CGA). The CGA is defined as 'multidimensional interdisciplinary diagnostic process focused on determining a frail older person's medical, psychological and functional capability in order to develop a co-ordinated and integrated plan for treatment and long term follow up'. Moreover, it is noted by this research that the CGA has proven efficacy in maximising independence, reducing hospital admission and maintaining optimal cognitive and physical function and incorporates multi-disciplinary assessment as well as the client's living environment.

This report recommends the screening of all older adults for frailty syndrome at the 'front door' of the hospital and a CGA as appropriate.

4.4 Logic Model

Based on established evidence, Logic Models set out the inputs and outputs needed to deliver the expected outcomes. The following logic model has been developed using the evidence noted in Section 3 and provides evidence of the KPIs used to measure the performance of similar intermediate care services, including service related outcomes[38] and the user related outcomes.[39]

[36] Cochrane Review (2010) *Comprehensive Geriatric Assessment for Older Adults Admitted to Hospital*
[37] Dawson, Rhian; Jenkins, Lesley (2014) *Are We Failing our Frail: Lessons from International Evidence*
[38] These are outcomes that benefit the hospital or the health care system (e.g. improved patient flow)
[39] These are outcomes that benefit the user of the service (e.g. improved health and well-being, greater functionality etc.)

Figure 4.1: Logic Framework for TOCALS

Inputs	Activities	Outputs	Outcomes
Funding Resources Facilities IT	• Multi-disciplinary teams developed at each hospital site. • Buy in appropriate stakeholders in the hospital and community • Development of a functional 'medical fit' list and glossary of terminology to be used across health and social care • Set targets for outputs and outcomes. • Monitor performance against outputs and outcomes. • Communication Activities: Highlight Meetings[40] on a weekly basis to ensure all staff up to date on patients. • Bullet rounds[41] to support and guide Comprehensive Geriatric Assessment	• Number of referrals from relevant hospital staff • Number of patients assessed under the (CGA)[42] within target times. • Number of patients supported through the service/ referred to other more relevant supports (i.e. there link to Rapid Response service) • Number of staff involved / trained in the geriatric assessment process and specific needs of older, frail patients. • Development of Geriatric Assessment Process and supporting documentation.	Service Related Outcomes • Reduction in unscheduled hospital admissions[43] • Reduction in the length of stay • Facilitation of early discharge[44] • Cost savings to the health service[45] Service User Outcomes • Increased independence[46] • Improved quality of life.[47] • Increased patient satisfaction

[40] Highlight meetings were held with staff involved in TOCALS delivery and other hospital staff to discuss communication challenges and issues in order to facilitate closer working relations. These sessions supported learning, service development and improved outcomes from patients.

[41] Bullet rounds are quick fire multidisciplinary discussions on all patients in order to share current patient status and any interventions required.

[42] The gold standard for the management of frailty in older people is the process of care known as Comprehensive Geriatric Assessment (CGA). It involves a holistic, multidimensional, interdisciplinary assessment of an individual by a number of specialists of many disciplines in older people's health and has been demonstrated to be associated with improved outcomes in a variety of settings. It was developed by a team from the British Geriatrics Society. (http://www.bgs.org.uk/index.php/cga-managing)

[43] Mytton et al. British Journal of Healthcare Management 2012 Vol. 18 No 11

[44] Kings Fund (2014) Community services: How they can transform care

[45] Best Practice: Continuum of care for frail older people: from emergency ward to living at home (2013) http://www.projectaida.eu/wp-content/themes/thunderbolt/docs/Swedish_Skora.pdf

[46] Effects of delays in transfer on independence outcomes for older people requiring post-acute care in community hospitals in England Young, John et al. *Journal of Clinical Gerontology and Geriatrics* , Volume 1, Issue 2 , 48 - 52

Inputs	Activities	Outputs	Outcomes
	• Bi-monthly newsletters, outlining case studies which support learning and development of staff and cultural change.		

As shown in the logic model there is a range of KPIs needed at output and outcome level to measure performance. To date TOCALS has focused mainly on output measures and to a lesser extent outcome measures (see section 5.1). While a focus on output measures was appropriate for a pilot stage intervention, there is now an opportunity to develop further outcome KPIs in order to demonstrate the achievements of the service at both output and outcome level.

The research shows that similar intermediate care services provide a wide range of outcomes and these should be measured to provide a full picture of the impact the service provides. Patient surveys can be used to collect this evidence as well as tools such as the Older People's Quality of Life Questionnaire. The Office of Research Ethics Committee Wales note that is ethical to speak to patients in receipt of care services as part of an evaluation providing they have sufficient competence to understand what they are agreeing to and that they understand they can opt out. Looking ahead to any future evaluation of the service, patient feedback should be gathered to help develop the evidence base.

Key Findings

The number of older people in Carmarthenshire is projected to grow significantly over the next five years, which will lead to increased pressure on the health and social care system. The literature review shows that models of care focusing on early assessment of older patients at the "front door" of the hospital and planning patient discharge as soon as patients are admitted have a number of positive impacts on the health service (including a reduction in unnecessary admissions and a delayed discharge). In addition patients have better health and well-being outcomes and report higher levels of satisfaction with the care they have received. ICF monies for the TOCALS service were used to develop this approach by providing a service that implements decision making at the 'front door' of the hospital and discharge planning on the ward, in order to ensure the timely and efficient 'transfer of care' of frail older adults back to their community.

The TOCALS project has focused on a number of output measures such as number of patients assessed or decreased length of stay, however there is an opportunity for the service to also measure the patient experience and how quality of life is improved for those who use its services.

5 INTEGRATION

The following section details the level of integration of stakeholders at strategic and operational levels with regard to TOCALS.

5.1 Strategic Level Integration

5.1.1 Project Board

The Project is overseen by a Project Board which consists of senior staff from Carmarthenshire County Council and Hywel University Dda Health Board; including the Head of Primary, Community and Social Care; the Locality Manager and TOCALS Project Lead; the clinical lead physiotherapist; the Directorate Lead Nurse for Unscheduled Care; the clinical lead occupational therapist; the Professional Lead for Social Work; the Assistant Locality Manager for Llanelli, the Directorate Lead Nurse for Scheduled Care; and the Scheduled Care General Manager.[48]

Therefore the project board includes representation from senior members of staff from Health and Local Government, therefore ensuring that they are involved in the leadership and governance of the project.

Project Board meetings were held every month from October 2014 – March 2015, in order to:

- Review the performance of the service and advise on changes and alterations to the delivery model;
- Report issues and develop solutions for the service (e.g. the inability to recruit certain team members, especially Occupational and Physio therapists);
- Approve any changes to project objectives, constraints, products and timescales of the initiatives; and
- Oversee the implementation of new processes and protocols associated with the service, including the Frailty Assessment Process and 'bullet rounds'.

Whilst many members would have been familiar with each other prior to meeting on the Board, feedback from project staff highlighted that it provided a new forum for the professionals to focus on working more closely together and specifically on the needs of older frailer patients.

The Project Board has worked together to engage staff at both hospitals and to develop protocols and processes, including the patient assessment processes and bullet rounds[49] and to garner support and input from other existing teams including Multi-disciplinary teams (MDTs) and CRTS.

[48] TOCALS Project Board Meeting 15th December

[49] Bullet rounds are quick fire multidisciplinary discussions on all patients in order to share current patient status and any interventions required.

5.2 Operational Level Integration

The operational level integration involved different disciplines and required staff involved in the hospitals to be aware and knowledgeable regarding the capacity and support in the community. Specific examples of operational level integration are:

- TOCALS team staff worked with existing hospital staff including Discharge Liaison Nurses (DLNs), Physiotherapists, and Occupational Therapists to support patients (either in the hospital or in the community);
- Systems and processes were established to facilitate partnership working between TOCALS and staff in Emergency Departments (ED) and Clinical Decision Units (CDU) to ensure that all frail older adults attending the 2 hospitals were referred to TOCALS for a Comprehensive Geriatric Assessment;
- Highlight meetings were held with staff involved in TOCALS delivery and other hospital staff to discuss how communication could be improved between TOCALS staff, hospital and community staff and to address any potential issues in order to facilitate closer working relations. Feedback from staff suggests that these sessions supported learning, service development and improved outcomes from patients;
- 'Bullet rounds' were introduced on the hospital wards; these were quick fire multidisciplinary discussions on all patients in order to share current patient status and any interventions required. This was a very successful in keeping everyone fully updated on the status of individual patients
- Ward handover sheets were developed to support multidisciplinary discussion on patient progress and discharge planning; and
- Teaching sessions on Frailty / Delirium led by consultant Geriatrician were held; and
- TOCALS was also supported by Geriatrician staff who provided clinical advice when needed and helped communicate the 'frailty approach' to nursing and physician staff.

5.2.1 Project Management and Integrated Working

The Project Manager is employed jointly by Hywel Dda University Health Board and Carmarthenshire County Council.[50] This provides the project with a strategic overview of both health board and council processes and procedures and a clear understanding of how the project contributes to the aims and objectives of both organisations.

The Project Manager is responsible for overseeing the progress of the project and reports to the Board throughout the year. The role also requires the manager to liaise with other health service professionals in the planning and implementation of the service. This included the development of protocols and processes for the frailty assessment and discharge planning.

The Project Manager established relationships and referral processes with community based staff such as those on the Community Response Teams (CRTs) (evidenced by referrals to the community). Therefore, the pre-existing relationships with community based staff and a detailed understanding of community based health and social services helped to contribute towards the successful implementation of the project.

[50] Transfer of Care Initiative – Project Initiation Document, Rhian Dawson (June 2014)

Two TOCALS teams were put in place for the delivery of the project, one based at Prince Phillip Hospital (PPH) and the other at Glangwili General Hospital (GGH). As shown in the following table the ICF funded staff included social workers, physiotherapists and nurses who worked alongside existing (non ICF funded) staff (including Discharge Liaison Nurses, Physiotherapist and OTs in both hospitals).

Table 5.5:1: Staff involved in the TOCALS service at each hospital site

Hospital	Staff Involved	
	ICF Funded Staff	Existing Staff
PPH	• 1x Social Worker • 1x Physiotherapist • 1X Discharge Liaison Nurse	• 1 x Occupational Therapist (OT)
GGH	• 1x Social Worker • 2x Nurse • 1x Discharge Liaison Nurse	• 1x Physiotherapist • 1X OT Technician • 1x Discharge Liaison Nurse • 1 x Social Worker

The project manager noted that the TOCALS team members were experienced individuals who had professional, clinical and leadership skills that allowed for constructive and positive discussions with clinicians and multi-disciplinary staff within the hospitals.

In Glangwili Hospital the TOCALS team worked in partnership with the Clinical Decisions Unit (CDU) staff to ensure that all frail older adults received CGA at the 'front door'. The TOCALS staff also worked closely with the DLN to enhance and support existing discharge facilitation at ward level. Feedback from the Project Manager and service delivery staff indicates that the TOCALS team in Prince Phillip Hospital also worked closely with hospital staff and were supported and endorsed by clinicians, geriatricians and multi-disciplinary staff within the hospital.

5.2.3 Staff Feedback on Integrated Working[51]

TOCALS staff were surveyed as part of the evaluation to get their views on how well the project had worked.[52] 100% (n=18) of those who responded noted that there is effective inter-agency team working on the TOCALS service; and 94% of respondents (n=17) believed that the TOCALS project provided the opportunity to share knowledge and expertise with other staff from other agencies.

Furthermore, 94% of respondents either 'agreed' or 'strongly agreed' that there was effective multi-disciplinary working within the TOCALS service. Some of the additional responses in relation to this question include:

> *"As a member of the team we discuss patients in a holistic way with everyone inputting their specialised knowledge" (GGH)*
>
> *"Excellent communication between all staff groups. Work closely together and see referred patients together." (PPH)*
>
> *"Every team member had an understanding of each other's role and had the same work passion and enthusiasm towards patient care." (PPH)*

A key element to the successful implementation of the TOCALS project was hospital staff working with and referring patients to community services, 88% (n=16) of respondents to the staff survey believed that hospital staff were 'a lot more' or 'somewhat more' confident about discharging patients to the community safely as a result of TOCALS.

5.2.4 Risk Management

A risk management plan was developed and included in the PID in August 2014. The majority of risks identified for TOCALS related to the potential failure to integrate the new processes into the existing care pathways; lack of communication between team members and confusion on roles / responsibilities. The actions taken against identified risks is outlined below:

- **Integration of new processes into existing Care Pathways**: This was actioned early on in the project, through the development of the CGA and the training of relevant staff.
- **Communication:** There was on-going communication to ensure that the team were kept up to date throughout for example: the highlight meetings held weekly between staff on the multi-disciplinary team and the introduction of the 'bullet rounds' (i.e. brief daily information sessions on patients including all those responsible for care e.g. consultant, nurse, discharge liaison nurse, physio etc.) helped demonstrate to those involved the benefits of the service. Feedback from staff survey, highlighted 72% (n=13) of staff survey respondents agreed or strongly agreed that there was good communication with staff across the different professions within the hospital while 22% (n=4) indicated neither / nor and 6% (n=1) disagreed. Moreover, 100% agreed or strongly agreed that there was effective multi-disciplinary team working within the TOCALS service. Comments included:

[51] Transfer of Care Advice and Liaison Service – Evaluation, Recommendations and Strategy (March 20 15),
[52] In total 18 staff completed an online survey: 8 from PPH, 6 from GGH and 4 community based staff.

> *"Excellent communication between all staff groups. Work closely together and see referred patients together"*
>
> *"There is good communication with staff from other agencies/organisations"*

Furthermore, case studies were used to support learning at practitioner level through newsletters distributed to clinicians, nursing staff and acute sector managers.

- **Confusion on Roles and Responsibilities**: There is no evidence from the consultations or staff survey that this risk materialised. For example 94% of respondents to the staff survey noted that they were very satisfied or satisfied that Staff were working together and knowing what each other was doing.

Key Findings

The project has demonstrated integration at a strategic level as a Project Management Board was developed which created new, inter-agency working relationships and met on a monthly basis throughout the implementation phase of the project. Furthermore, new processes (i.e. Frailty Assessment) and protocols (i.e. Bullet Rounds with MDT members) were implemented and integrated into the care systems quickly and seamlessly.

Feedback from staff involved at all levels (i.e. project manager, project board and delivery staff) has indicated that the project led to improved communication and increased integration among staff from the different agencies and different professions. Significantly, staff reported increased levels of confidence in referring patients to community services.

One of the key risks for the project, which was noted as the implementation stage was lack of inter-agency communication. This risk does not appear to have materialised, as the majority of staff who responded to the survey provided positive feedback on inter-agency and multi-disciplinary communication, which may be partly due to the processes that were put in place.

6 PROJECT MONITORING AND OUTCOMES

This section provides an assessment of the extent to which outcomes have been realised from June 2014 to March 2015 and how they have been monitored and reported on.

6.1 Monitoring and Reporting

6.1.1 Monthly Data Collection and Reporting

The Assistant Locality Manager collates data on the project and reports to the Project Board on a monthly basis, including details of performance in relation to the following:

- Number of referrals to the service (output)
- Number of patients admitted (output);
- Average length of stay in PPH and GGH (outcome);
- Number of re-admissions (output);
- Number of avoided admissions (outcome); and
- Patient case studies.

The data provided monthly reports against the set KPIs. Table 6.1 reviews the performance against the objectives that were set out in the PID. However, as there were no formal outcome targets set for the project, evidence against indicative outcomes has been examined, and potential KPIs for future consideration are listed below. The Logic Model in section 4 highlights the expected outputs and outcomes. The reporting system should be developed to cover those not currently measured, specifically:

- Patient health and well-being evidence: The National Audit of Intermediate Care recommends the use of the Barthel Index on admission and discharge from intermediate care services to assess changes in functionality. This would be appropriate for patients who have been admitted to hospital and those who have been transferred to community based services;
- Improvement in the quality of life of patients should also be recorded and reported this would also apply to patients who have been admitted to hospital and those who have been transferred to community based services.[53] While it is noted that the TOCALS service plans to collect this through case studies during 2015/16, it is suggested that KPIs are set for these areas and evidence should be collected against using robust tools such as the Older Peoples Quality of Life Questionnaire (OPQOL).[54]
- Patient satisfaction data should be collected consistently and routinely across all localities.

[53] There are a number of quality of life scales that are specifically designed for use with Older people, for example the Older Peoples Quality of Life Questionnaire (OPQOL)

[54] Bowling, A. and Stenner, P. Journal of Epidemiology and Community Health 2011;**65**:273-280

6.2 TOCALS Performance over the Evaluation Period

In total 247 people were referred to the TOCALS service during its seven months of operation in PPH and 3 months of operation in GGH. An overview of the number of people assessed is detailed in table 6.1.

Table 6:1: Performance against expected deliverables-June 2014 – March 2015 (PID August 2014)

Expected Deliverables from both Acute Hospital Sites[55]	Performance September 2014 - March 2015[56]			Details
	PPH (September 2014 – March 2015)	GGH (December 2014 – March 2015)	Total / Overall	
Decreased length of stay against baseline at project initiation	Average length of stay of TOCALS Patients 6.2 days	Average length of stay of TOCALS patients 11.3 days	170 patients were admitted to hospital and the average length of was 9 days.	No baseline of average length of stay for frail, elderly patients was collected prior to TOCALS was provided.
Reduced readmissions for frail older individuals who are supported by the team	4	3	7 re-admissions (4%) of total discharged.	Re-admission rates prior to TOCALS not provided. A report by StatsWales reported average re-admittance rates of 6.5%[57]
The MDT will contribute to the development of an acute hospital frailty pathway	N/A	N/A	TOCALS staff formed part of a multi-disciplinary team that worked to design and implement a new frailty pathway into the 2 hospitals. The pathway involves the assessment of frail older adults at the front door of the hospital, followed by a more	The acute hospital frailty pathway was developed and implemented by September 2014 in PPH and December 2014 in GGH.

[55] Outcomes taken from the Transfer of Care PID – August 2014 – Final Version

[56] Performance information taken from: Information on patients provided by the project manager to PACEC (October 2015); and The End of Programme Evaluation Paper prepared by the Project Manager (March 2015)

[57] StatsWales (2015) – Available at: https://statswales.wales.gov.uk/catalogue/Health-and-Social-care.

Expected Deliverables from both Acute Hospital Sites[55]	Performance September 2014 - March 2015[56]			Details
	PPH (September 2014 – March 2015)	GGH (December 2014 – March 2015)	Total / Overall	
			comprehensive geriatric assessment.	
Support the development of a realistic date of discharge prediction for the frail old	N/A	N/A	Feedback from staff indicates that the new pathway led to the development of a more realistic date of discharge prediction for frail older patients.	Bullet rounds were used to discuss current patient status and any interventions required in order to support discharge. Feedback from staff indicates that this led to the development of a more realistic date of discharge prediction for frail older patients.

Therefore the project has performed well against the deliverables in the PID both in terms of decreasing length of hospital stay and reducing hospital readmissions as well as successfully implementing new processes and procedures.

6.3 Outcomes

In addition to the deliverables noted in the PID the monthly reports covered progress on the following key outcomes.

Table 6:2: Performance against Key Outcomes (PPH: September 2014 – March 2015 and GGH: December- March 2015

Outcome Measure	Evidence
Reduced in-patient bed days (time)	Average length of stay: 10.7[58] days across all of Hywel Dda-University Health Board (for all patients aged 65 years and over). TOCALS average length of stay (ALOS) = 8.75 days: • PPH 6.2 days • GGH 11.3 days The overall ALOS for TOCALS patients was 1.95 days fewer than the Health Board average for all patients aged 75 years and over. Moreover, this is in line with research on interventions to reduce length of stay in hospital[59] that states early discharge planning programmes can reduce average length of stay by less than 1 day.[60] The Project Manager noted that the GGH tends to have patients with more serious/complex conditions and that would expect longer stays than in PPH.
Hospital admission avoided from A+E/CDU	Number of patients avoided admission from the project: 19 in PPH[61] (25% of total avoided admissions due to TOCALS). Number of patients avoided admission from the project: 58 in GGH[62] (75% of total admissions due to TOCALS). **Total avoided admissions: 77** The Project Manager noted that PPH is a smaller hospital with fewer emergency admissions, which mainly accounts for the difference in the number of referrals in the two hospitals.
Hospital readmissions after 30 days %	4% of patients were readmitted after 30 days

Source: TOCALS Project Monitoring Reports (September 2014 – March 2015)

Therefore TOCALS has:

- **Supported a reduction in the average length of stay by 1.95 days**, based on 170 admissions over the seven month period (September 2014 – March 2015) this equates to an estimated saving of 331.5 hospital bed days;

[58] Data on average length of stay across of Hywel Dda University Health Board as provided by project administrative support

[59] Miani C, Ball S, Pitchforth E, Exley J, King S, Roland M, et al. Organisational interventions to reduce length of stay in hospital: a rapid evidence assessment. Health Serv Deliv Res 2014;2(52)

[60] Shepperd S, McClaran J, Phillips CO, Lannin NA, Clemson LM, McCluskey A, et al. Discharge planning from hospital to home. Cochrane Database Syst Rev 2010

[61] TOCALS Project Monthly reports

[62] TOCALS Project Monthly reports

- **77 patients avoided admissions, this equates to an estimated saving of 673.75 hospital bed days** (based on an average 8.75 days x 77 patients). This relates to seven months in PPH (September 2014 - March 2015) and 4 months in GGH (December – March 2015);
- **Reduced re-admissions by 2.5%,** based on the total number of patients admitted, this equates to 4 fewer re-admissions over the seven months, an estimated hospital bed saving of 37.2 days. (based on: 2.5% of 170 admissions = 4.25 x 8.75 (ALOS) = 37.2 days).

Therefore from the 247 patients who were referred to TOCALS an estimated 1,042 hospital bed days have been saved (an average of just over 4 days per patient).

Additionality is a key concept when assessing the impact of any intervention as it assesses the extent to which the outcomes delivered would have happened anyway. A Staff survey and interviews were used to obtain this information. Staff feedback indicates that they believed that patients would have been more likely to be admitted to the emergency department / CDU or stay longer in hospital (89% respectively) without the TOCALS project. In addition, 100% of staff respondents believed that patients received support sooner as a result of TOCALS and 94% believed that patients achieved 'greater benefits' as a result of this support.

6.3.1 Staff feedback on Outcomes Delivered

An online staff survey was issued to all staff involved in the TOCALS project to gather feedback on the service (as set out in appendix C). Eighteen staff completed the survey from the following:

- Community (health manager) – 3
- Glangwili General Hospital – 7
- Prince Philip Hospital – 8

Respondents were asked to rate the impact of the service on a high to low assessment scale and the responses received are displayed in table 6.3.

Table 6:3: Please indicate your opinion of the level of impact achieved by TOCALS

Area of Impact	Low	Medium	High	Total Responses
Patient's ability to regain independence / functionality	1 (5%)	6 (33%)	11 (61%)	18
Patient's ability to access appropriate health and social care services	0	6 (33%)	11 (61%)	17
Patient's ability to access suitable voluntary sector services in the community	1 (5%)	12 (67%)	5 (28%)	18

Area of Impact	Low	Medium	High	Total Responses
Patients' satisfaction with the services and advice received	1 (5%)	7 (39%)	9 (50%)	17[63]

Source: PACEC- TOCALS Staff survey (October 2015)

The majority of staff believed TOCALS had a medium to high impact on a range of patient outcomes including their ability to re-gain independence or functionality and their level of satisfaction with the service. Whilst this is a positive view of the service, robust data collected routinely would be required to fully understand the impact of the TOCALS services on patients.

Survey results also demonstrate the positive impact of the project on staff, for example 100% (n=18) of respondents agreed that TOCALS provided hospital staff with more support when considering the alternatives to admitting patients. One respondent highlighted that the service was well thought off amongst staff and that A&E staff saw it has a valuable tool for them to refer older, frail adults to.

"This has been a valuable asset to the hospital and has had noticeable results on patient flow. The knowledge of the MDT members has made access to information easier and has allowed patients to be discharged home safely with community services which previously wouldn't have been so accessible." (PPH)

6.3.2 Patient Case Studies

While it was not possible through this evaluation to collect primary data from service users to understand the impact of the TOCALS service on them, the project Manager provided case studies to provide qualitative examples of the outcomes achieved, as illustrated below.

Patient Case Study 1:

Mrs J is 87 years old and lives alone while her daughter lives locally and supports her with shopping and banking.

When Mrs J's daughter was on holiday she suffered a fall and presented in the Emergency Department with a swollen right knee. While there was no bone injury, due to poor mobility Mrs J. was admitted to hospital until arrangements could be made for temporary social care support.

On the ward, the nurses observed and recorded that Mrs J had episodes of confusion and disorientation, and while at times she was compliant with nursing care there was also occasions when she resisted any support and exhibited challenging and difficult behaviour.

[63] One respondent did not provide an answer to this question.

Mrs J was also incontinent of urine and faeces and it had been suggested that Mrs J's needs would be best met with EMI Residential Placement.

Collateral information was sought from Mrs J's daughter who advised that her mother's physical and cognitive status prior to admission was significantly different to how she was presenting on the ward. A clinical assessment was undertaken using a validated tool 'Confusion Assessment Method' (short CAM) which was positive and indicative of delirium. Causes for the sudden change in mental status were considered and Mrs J was treated for Intravenous antibiotics and encouraged to mobilise when able. Mrs J was discharged home with reablement providing minimal support.

Patient Case Study 2:

Mrs M is an 81 year old lady who refused any support when she first became known to the Community Resource Team. She had severe cellulitis of the lower limbs at risk of infection. She lives alone, remaining on the ground floor of her house. She has a level access shower, profile bed and rise and recline chair.

She was admitted to CDU after falling at home and being unable to call for help until being found 3 days later. After assessment on CDU, she was moved to a ward for treatment of a chest infection. TOCALS assessed her transfers and mobility and identified that transfers were difficult and she was unable to stand for any length of time. The advice of the CRT senior OT was sought to identify suitable equipment to assist with toileting. Although the patient was progressing well towards returning home, there were some delays caused by scheduling MDT meetings and there was some duplication of therapy input. Mrs M developed two hospital acquired infections, which further set back a timely discharge. However she has now recovered and has been discharged.

Lessons learned: Scheduled MDT meetings are valuable but should not take the place of daily inter-disciplinary conversations on a daily basis that are recorded. Robustly communicated daily progress reports from the multi-disciplinary team ensure that actions identified have been undertaken and support the avoidance of unnecessary delays and facilitate timely discharge.

Patient Case Study 3:

102 year old patient attended ED 48 hours after discharge from the hospital's rehabilitation unit with reduced mobility. The patient had been discharged with one carer attending to support identified needs four times a day.

TOCALS assessed function and gained collateral from family. It was identified that the patient had increased anxiety about falling and did not feel that one carer was sufficient to support her. It was identified that the patient's functional performance improved significantly with the assistance of two for transfers and mobility. There were no medical concerns identified by either TOCALS or the clinician involved.

The TOCALS OT liaised with the patient's social worker in the community and discussed options for increasing support on discharge. The Social Worker was able to support temporary increase in support with two carers using the ICF funded Rapid Response Domiciliary Care service on a temporary basis while further assessment on the individual's progress was made by the community based therapists. Lessons learned: The patient's overall presentation was affected by anxiety due to a history of falls. The nursing staffs in the ED were reluctant to mobilise client due to her frail appearance. TOCALS were able to complete a full Comprehensive Geriatric Assessment and identify that her functional needs could be met in the community. Working with the Social Worker allowed the exploration of all options including the use of Rapid Response Domiciliary service and the development of a contingency plan. As a result, a hospital admission was avoided.

Key Findings

The TOCALS has had a number of notable successes during the 7 (PPH) and 4 (GGH) months of delivery including:

- Reduced hospital admissions, with 77 of the 247 patients referred to the service avoiding admission, over the 7 months of the pilot.
- Supported early discharge, as on average TOCAL patients who were admitted experienced shorter lengths of stay at 9 days compared to a Health Board average of 10.7 days;
- A lower than average re-admission rate after discharge from hospital (only 4% of those discharged under TOCALS were re-admitted, compared to an overall average of 6.5%);
- Increased integrated health care provision through the development and training of a multi-disciplinary team of experts (Introduction of highlight reports and bullet rounds led to a new way of working with both care staff within the hospital and community care staff coming together to deliver the TOCALS service). Respondents to the staff survey reported effective working with staff from other agencies; and

- Improved patient pathways for those classified as frail old (introduction of new frailty assessment for patients entering the hospital and a comprehensive geriatric assessment has led to improved care for frail, older adults).

Feedback from staff also indicated that without the service patients would have been admitted to the emergency department / CDU or remained in hospital for longer.

It is a strength of the TOCALS programme that it is focused on measuring its contribution to the ICF outcomes, namely reduced admissions and decreased length of stay. Research shows that it is likely to be delivering positively in other areas that are a benefit to the health and social care system, however in order to assess the full impact of the project further data should be collected focusing on service user related outcomes. This would include data such as:

- Improvement in the quality of life of patients (those who have been admitted to hospital and those who have been transferred to community based services, for example through the use of a quality of life tools such as the Older People's Quality of Life Questionnaire).
- Patient experience of the new processes (patient satisfaction / feedback on TOCALS should be collected consistently and routinely across all localities).

7 ECONOMIC ASSESSMENT

7.1 Introduction

This section sets out the economy, efficiency and effectiveness of the TOCALS service as well as the cost savings it has generated.

7.2 Economy [64]

The service was awarded £260,000 from the ICF and ran from June 2014-March 2015. A breakdown of the budget and expenditure is set out in the following table below.

Table 7.7:1: TOCALS- Breakdown of Costs against ICF monies June 2014 – March 2015

Area of Spend	Budget[65]		Actual[66]		Variance[67]	
	£	% of total budget	£	% of spend	£	% of spend vs. budget
Staffing						
Salaries and Staff Costs	£208,108	80%	£125,456.50	86.3%	-£82,651.50	60%
Administration and Equipment						
Admin, Operational & Office Equipment	£51,892	20%	£19,006.47	13.1%	-£31,956.27	37%
Computer Hardware	-	--	£929.26	0.6%	-	-
Total	**£260,000**	**100%**	**£145,392.23**	**100%**	**£114,607.77**	**56%**

Source: Information provided to PACEC by accounting officer for TOCALS (October 2015) / ICF Spend by Workstream Document

Overall the project has an underspend of £114,608 (44%) under the budget. This was primarily due to the inability to recruit staff, (including Occupational Therapists and one of the two Physiotherapists as set out in the PID, therefore arrangements were made to access existing staff (who were not funded through ICF) as needed.

[64] Economy considers the extent to which activities were delivered at minimum cost-
[65] Carmarthenshire County Council Finance Department
[66] Carmarthenshire County Council Finance Department
[67] Refers to how much an actual expense deviates from the budgeted or forecast amount

The majority of spend (86%) was on staff salaries. As noted in section 5, the ICF funded staff included:

- 2 Discharge Liaison Nurses,
- 2 Social Workers,
- 1 Physiotherapist; and
- 1 Nurses

In addition to the clinical staff noted above a small amount of funding (£1,811) was allocated to administration. Expenditure on hardware and equipment included expenditure on Patient Status at a Glance (PSAG) boards and IT equipment.

7.2.1 Other in-kind contributions

As summarised in section 5, the TOCALS project staff worked within the hospital and community teams in both localities and relied upon input from a number of staff who were already in post prior to TOCALS (such as Nurses Occupational Therapists and Physiotherapists). During September 2014 to March 2015 a total of 12 staff were involved in the delivery of the service, seven of whom were funded through ICF and five were not. Therefore the project received in-kind support from Carmarthenshire County Council and Hywel Dda University Health Board via five additional staff. The actual time spent on the TOCALS project and the value of their time was not available for this evaluation.

The project also received support during the implementation phase from Integrated Services. This equated to approximately 20% of the Project Managers time, equating to around £11,718 over the 10 month period. Furthermore, during the project implementation and piloting phase TOCALS was overseen by a Senior Staff member, with approximately 80% of their time was spent on TOCALS during its operation, equating to approximately £46,872 over the 10 month period.

7.3 Efficiency [68]

Efficiency is measured by comparing the performance of the TOCALS service with other similar services (where comparable data is available). Research[69] notes that the average length of stay in hospital is frequently used as an indicator of efficiency[70], and measures to reduce length of stay can be seen to enhance both operational and allocative efficiency. Specifically, this research notes that a shorter stay reduces the cost per discharge and may shift care from the inpatient setting to alternative settings for the delivery of continued care after discharge that tend to be less expensive. The average length of stay for TOCALS patients was 9 days, 1.7 days fewer that the Hywel Dda University Health Board average for patients aged 75 or over[71]. Furthermore, re-admission rates are also regarded as a part of

[68] **Efficiency:** considers the benefits (the net outputs or outcomes) compared to the intervention costs
[69] Miani C, Ball S, Pitchforth E, Exley J, King S, Roland M, et al. Organisational interventions to reduce length of stay in hospital: a rapid evidence assessment. Health Serv Deliv Res 2014;2(52)
[70] Organisation for Economic Co-operation and Development (OECD). Health at a Glance 2012: OECD Indicators. Paris: OECD; 2012
[71] Data on average length of stay provided by project administration staff

an overall measurement of hospital performance and efficiency[72], re-admission rates for TOCALS patients are 2.5% less than the Welsh national average at 4% compared to 6.5%.

The evaluation team identified a similar service in Cardiff and Vale as a useful comparator for the TOCALS project. The Frail Older Persons Assessment and Liaison service (FOPAL) at University Hospital of Llandough (UHL) was noted as having similar aims, objectives and processes as TOCALS. It also identifies frail older patients presenting at A&E who can be returned directly to the community with or without support from community services and those who would benefit from being admitted to an appropriate in-patients ward for assessment treatment with a discharge plan. The project was also funded under the ICF and was established in July 2014, further details on FOPALS are set out in appendix C).

The FOPALs project received 95 referrals in one month and has a multi-disciplinary team with seven staff, if multiplied to seven months (the length of time TOCALS operated) this would equate to 95 patients per member of staff, compared to 35 patients per ICF funded staff member for TOCALS[73]. As costs for the FOPAL service were not provided it is not possible to provide a cost per patient comparison. Therefore, whilst the TOCALS project was efficient in making use of existing staff and resources and reducing the average length of stay for patients to below average, it does not compare well to other projects on number of staff per patient referred. It should also be noted that UHL has significantly more people presenting A&E than either PPH or GGH, for example in March 2015 10,960 patients attended UHL in Cardiff compared to a total of 6,023 for both GGH and PPH in Carmarthenshire[74]. The attendance rates suggest that there are likely to be more, frail, elderly patients who could be referred to the service in Cardiff and Vale than in Carmarthenshire.

7.4 Effectiveness[75]

Effectiveness considers how well the project delivered against the objectives and targets that were set for it and the outcomes achieved. No specific targets were set for the number of patients to be treated through the service, the rate of hospital admissions prevented or days saved, therefore it is not possible to comment on the project's effectiveness in this regard.

However, as set out in Section 6.2, the project manager provided data on progress against the project's deliverables, these primarily related to the establishment of services and have been achieved.

Feedback provided by staff also noted that the TOCALS project was also effective in achieving positive outcomes for patients, for example staff noted that the TOCALS was effective in helping patients regain their independence and functional ability and they believed that there was high levels of patient satisfaction. Therefore, overall the project is effective as

[72] NHS Institute: (2008) Performance Management: Available at: http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/performance_management.html
[73] 247 patients / 15 staff members = 16.47 ~ 16
[74] http://www.infoandstats.wales.nhs.uk/page.cfm?orgid=869&pid=62956
[75] **Effectiveness:** involves considering whether an intervention's objectives have been met.

it has achieved the deliverables set out in its Project Initiation Document and has increased communication and cooperation between hospital and community staff and feedback from staff also indicates that the project also had a positive impact on the health and well-being of patients.

7.4.1 Cost Effectiveness / Cost Savings

From the September to March 2015 the project prevented 19 hospital admissions in PPH and 58 in GGH and reduced the average length of stay in hospital to 6.5 days in PPH and 11.3 days in GGH. Furthermore, the rate of re-admission for TOCALS patients was lower than would have been expected at 4% (rather 6.5%). In totals these actions resulted in an estimated saving of 1,042 bed days over the seven months from September 2014 to March 2015. Data from NHS Wales[76] indicates that the cost of an acute hospital bed day is £426. The following table provides an overview of the estimated savings in hospital bed days generated by the project.

Table 7.7:2: Estimated Savings as a Result of the TOCALS project

Key Outcomes	Output	Calculations	Savings achieved @ £426 per hospital bed day
Reduced in-patient bed days (time)	Average length of stay: TOCALS = 8.75 days. Health Board = 10.7 days Difference = 1.95 days	170 patients x 1.95 days = 331.5 bed days	£141,219
Hospital admission avoided from A&E/CDU	77 avoided admissions	77 x 8.75 days = 673.75 bed days	£287,018
Hospital readmissions after 30 days %	4% patients were readmitted after 30 days, = 4 less than would have been expected for the 170 patients who were admitted.	4.25 x 8.75 days = 37.2 bed days	£15,842
Total		= ~ 1,042 bed days	**£443,892* (due to rounding)**

The table above shows that based on the 247 referred to TOCALS, it is estimated that gross savings for the health service amount to £443,892. Minus the ICF monies of £145,392 the

[76] Welsh Government | *Health statistics Wales. Finance. 2012/13*. Available at: http://gov.wales/statistics-and-research/health-statistics-wales/?lang=en.

net savings achieved are in the region of £298,500. This equates to net saving of £2.05 for every £1 invested. However, it must be noted that, these figures are only illustrative as the costs did not include the in-kind support provided by Carmarthenshire Council and Hywel Dda Health Board in the form of staff who were involved in TOCALS activities but, were outside of the ICF core funded posts.

Furthermore, this analysis does not take into account the benefits to patients such as improved health and well-being and/or quality of life, nor does the analysis account for potential benefits achieved to other part of the health service, for example through a reduction in delayed discharges. Due to a lack of data these additional savings cannot be measured at this point in time.

7.5 Future

It is projected that by 2020 there will be 46,109 people in Carmarthenshire who are 65 years or older compared to 41,676 in 2014 (an increase of 10.6%). This will place significant pressure on the health and social care system as data from NHS Wales indicates that health and social care provision for older people is proportionately higher that the population size (specifically those aged over 74 account for 8% of the population, yet receive 24% of the procedures in NHS Wales).[77] The financial analysis set out above indicates that the TOCALS project can deliver a net return of approximately £2.05 for every £1 invested. This service can therefore help deliver significant savings to the health and social care system.

Discussions with the Project Manager and members of the Project Board have highlighted that the services and processes developed under the TOCALS project have now been mainstreamed, are being developed further and embedded within the core health and social care system. Feedback from staff and key stakeholders suggests that the processes and procedures that were implemented under the TOCALS project have created a cultural change amongst hospital staff in how they think about frail patients and has helped them to have increased confidence in referring patients on to community based services. Therefore TOCALS services are being reviewed and developed within Carmarthenshire and are likely to continue to do so in the near future.

Key Findings: The project was delivered under budget with a total expenditure of £145,392 and 93% of expenditure was focused on service delivery. However it is likely that the service could be more efficient as the service operated at just over 35 patients per member of staff compared to 95 patients per staff member in the comparable benchmark service. It is also noted that the levels of referrals from PPH were significantly less than those in GGH, which would indicate that there is scope to increase the referral rate there and also increase the efficiency of the project.

No SMART targets were set for the project and therefore it is not possible to conclude on whether it delivered on expectations, however it has delivered effectively against the

[77] Patient Episode Database for Wales (2015) (August 2015) Available at: Http://www.infoandstats.wales.nhs.uk/Documents/869/ExcelTables10P_2014_Wales.xlsx

objectives that were set for it. However evidence on effectiveness could be strengthen by the routine collection of data relating service user impacts.

Key Findings

The TOCALS service has generated considerable health savings as based on the average length of stay for patients in Carmarthenshire it is estimated that the service saved approximately 1,042 hospital bed days through preventing admissions, supporting early discharge and reducing re-admissions. **This equates to estimated net savings of £298,500 and associated return on investment of £2.05 per £1 invested.**

8 CONCLUSIONS AND RECOMMENDATIONS

8.1 Introduction

The TOCALS project was designed to 'improve preventative care and avoid unnecessary hospital admissions and delayed discharge of older people, particularly the frail old'.[78] The key aim for the TOCALS service as set out in the PID[79] was ***"to facilitate the active development and implementation of an effective frailty pathway, acknowledging the significant risk of permanent loss of function associated with frail old people being admitted to an acute general hospital[80]."***

8.2 Outcome Measures

A number of measures were developed and used to record the performance of the service with regard to reduction of bed days, hospital admissions avoided and readmissions within 30 days.

8.2.1 Recommendations

- Baseline data should be collected and reported against in relation to the average length of stay prior to the TOCALS intervention or the re-admittance rates for older or frail, old patients[81].
- There is a strong body of evidence noting that the collection of feedback from service users is best practice in the evaluation of intermediate care services,[82] this includes patient satisfaction, health and well-being improvements[83] and patient quality of life.[84] TOCALS should therefore collect data on the impact of the service on patients. We recognise that this may be difficult to implement given that the TOCALS service blends with other hospital services and patients may not necessarily be aware that they have gone through a TOCALS process. However, it is important to understand the impact of the service on patients and to collect data that can also be used to compare patients' outcomes with those from other services.

8.3 Performance

Performance against activities detailed in the PID is outlined in the table below. The evidence was collected from monitoring reports, interviews with staff and case study information collected by staff.

[78] Transfer of Care Initiative – Project Initiation Document, Rhian Dawson (June 2014)
[79] ibid
[80] Ibid.
[81] Whilst it is recognised that the Project made us of generic hospital statistics on admissions and average length of stay for those aged over 65 it is not clear how directly comparable this population group is with the TOCALS target population.
[82] For example see Kings Fund (2002) Developing Intermediate Care. A Guide For Health And Social Services Professionals.
[83] Kings Fund (2002) Developing Intermediate Care A Guide For Health And Social Services Professionals
[84] Kings Fund (2014) Community services How they can transform care. Nigel Edwards

Table 8:1: Summary of TOCALS Project Performance (June 2014 – March 2015)

Expected Deliverables[85]	Performance September 2014 - March 2015[86]	Details
Decreased length of stay against baseline at project initiation	170 patients were admitted to hospital, the average length of stay decreased to 9 days.	Average length of stay decreased by 6.2 days in PPH and 11.3 days in GGH. No baseline of average length of stay prior to TOCALS was provided. **No specific targets were developed for this deliverable.**
Reduced readmissions for frail older individuals who are supported by the team	Only 7 re-admissions (4%) of total discharged.	Re-admission rates prior to TOCALS not provided. **No specific targets were developed for this deliverable.**
The MDT will contribute to the development of an acute hospital frailty pathway	TOCALS staff have formed part of a multi-disciplinary team which have worked proactively to introduce and develop a new frailty pathway into the hospitals which have participated. The pathway involves the assessment of frail older adults at the front door of the hospital, followed by a more comprehensive geriatric assessment.	The Project Manager noted that this new care pathway for this group lead to better assignment of the next stage of care (i.e. hospital admission or discharge with appropriate support).
Support the development of a realistic date of discharge prediction for the frail old	Discharge Liaison Nurses, working in partnership TOCALS team members have developed an enhanced discharge process by ensuring that patient needs, identified in the CGA carried out before admissions is acknowledged and acted upon on the wards.	Bullet rounds to share current patient status and any interventions required. Feedback from staff indicates that all of this has led to the development of a more realistic date of discharge prediction for frail older patients.

Data sourced on performance and detailed in the table above has been sourced from Project Monitoring reports.

[85] Outcomes taken from the Transfer of Care PID – August 2014 – 'Final Version' – Internal document
[86] Performance information taken from: Information on patients provided by the project manager to PACEC (October 2015); and The End of Programme Evaluation Paper prepared by the Project Manager (March 2015)

Therefore, as summarised in the above table, the TOCALS project had a number of significant achievements within a short period of time, including:

- The development and implementation of processes and procedures to facilitate the enhanced assessment of frail older patients attending A&E departments;
- Establishment of multi-disciplinary teams;
- 77 patients avoided admission;
- Reduction in the average length of stay of older patients; and
- Improved discharge planning.

However an area for further consideration is whether more patients could be referred to TOCALS within the two relevant hospitals.

8.3.1 Recommendations

- Further research and data collection is needed to confirm that all frail, older, people presenting in A&E are being referred for Comprehensive Geriatric Assessment, this would then determine if the potential benefits of TOCALS are being maximised.
- We recommend that targets should be developed for each objective going forward; and
- We recommend that future reporting templates detail quarterly and cumulative progress against all the objectives and targets details in the PID.

8.4 Integration

TOCALS was overseen by an Integrated Project Board that involved senior representatives from Council, the Health Board and the Third Sector who worked together to influence the structure and delivery of the project. The structure and systems (i.e. monitoring reports) were put in place to govern the project.

The service was delivered by Health Board staff who worked closely with staff in the community (i.e. Council staff), as well as staff within the hospitals and Primary Care Teams (Health Board Staff). The TOCALS project staff also worked with closely with established staff in the hospitals such as the Discharge Liaison Nurses and the integrated Community Response Teams. In addition, new processes and procedures were put in place to support joint working such as highlight meetings and bullet rounds.

Staff who provided feedback noted improved levels communication with staff from other agencies and disciplines as a result of the project, therefore the project supported increased levels of integration between health board staff and council staff.

8.4.1 Recommendation

TOCALS should ensure that they maintain strong working relationships with staff in the community (e.g. Community Resource Teams) so that those who are not admitted to hospital continue to have an appropriate form of alternative provision to be signposted to.

8.5 Economic Assessment

The project was assessed with regard to its economy, efficiency, effectiveness and cost effectiveness and it demonstrated that:

- **Economy**: Overall expenditure for the project was under budget by £114,608 (44%). This was primarily due to the inability to recruit staff as it was not possible to recruit the additional OTs and a Physiotherapist therefore the TOCALS project made use of existing staff (who were not funded through ICF). In addition to the ICF funding the Carmarthenshire Council and Hywel Dda University Health Board also invested at least £80,398 into the project, in particular during the implementation phase. The TOCALS project was highly focused on service delivery with 93% spent on staff to deliver the service. The project also made use of existing resources and support in-kind from the Hywel Dda University Health Board.
- **Efficiency:** The cost per patient using the TOCALS service equates to £588 per patient. Overall the project received 49 referrals per month compared to a similar project in Cardiff (FOPALS) which received 95 per month and while this project had one staff member per 95 patients the TOCALS project had one staff member per 46 patients. Overall, this would suggest that the project could be more efficient.
- **Effectiveness**: The service prevented admissions and supported early discharge for 247 patients, resulting in a total estimated saving of 1,042 bed days.
- Based on the 247 referred to TOCALS it is estimated that gross savings for the health service amount to £443,892. Minus the ICF monies of £145,392 **the net savings achieved are in the region of £298,500**. This equates to net saving of £2.05 for every £1 invested. **However, it must be noted that, these figures are only illustrative as the costs did not include an allocation for staff involved in the project outside of the ICF core funded posts.**

8.5.1 Recommendation

To further inform economic assessment in the future, more detailed financial data on staffing costs should be collected, this would include time spent by all staff on TOCALS activities in addition to those who have been funded through ICF.

APPENDIX A – POLICY CONTEXT

Policy Context

There are a number of Welsh Government policies and strategies that are directly relevant to the implementation and delivery of the Rapid Response services as summarised in the following table.

Table 1 Relevant National Policies and Strategies

Policy	Relevance
The National Service Framework (NSF) for Older people in Wales[87] (2008)	This document sets out to improve health and social care services and equity of access for older people by setting national evidence-based standards for health and social care services. Specific aims of relevance include: 'Challenging Dependency- methods should be put in place to help the old retain their independence'
Social Service Wellbeing Act (2014)[88]	This act provides a single statutory framework covering local authorities responsibilities in relation to all those who need care and support, of all ages, and including their carers. It specifically impacts the delivery of integrated care in Wales as it reforms and integrates social service law and makes provision for: • A duty to assess the needs of an adult for care and support, particularly through the provision of preventative measures put in place to meet individual needs • Co-ordination and partnership by public authorities with a view to improving the well-being of people
A Framework for Delivering Integrated Health and Social Care for Older People with Complex Needs (2014)[89]	The purpose of this Framework is to focus on older people with complex needs and ensure they have a strong voice and control over their care and support. It places a strong focus on preventative services and support to maintain well-being. It is about ensuring services, care and support are designed, co-ordinated and delivered effectively, to meet the outcomes that are important to people and their carers. The Statement of Intent in this framework sets out the need for an integrated approach to targeted preventative services e.g. reablement & intermediate care.

[87] Welsh Government. (2006) National Service Framework for Older People in Wales. Available at: http://www.wales.nhs.uk/sites3/Documents/439/NSFforOlderPeopleInWalesEnglish.pdf
[88] HM Government [Legislation] (2014). 'Social Services and Well-Being Act (Wales) 2014. Available at: http://www.legislation.gov.uk/anaw/2014/4/pdfs/anaw_20140004_en.pdf
[89] Welsh Government (2014) 'A Framework for Delivering Integrated Health and Social Care for Older People with Complex Needs'. Available at: http://gov.wales/docs/dhss/publications/140319integrationen.pdf

Policy	Relevance
Setting the Direction (Feb 2010)	'Setting the Direction' recognises the commitment to delivering world-class integrated health care in Wales which requires a change in the approach to developing both policy and service delivery models for primary and community care. The key underlying Principles for improvement include: • Universal population registration and open access to effectively organised services within the community • First contact with generalist physicians that deal with undifferentiated problems supported by an integrated community team • Localised primary care team-working serving discrete populations • Focus on prevention, early intervention and improving public health not just treatment • Co-ordinated care where generalists work closely with specialists and wider support in the community to prevent ill-health, reduce dependency and effectively treat illness • A highly skilled and integrated workforce • Health and social care working together across the entire patient journey ensuring that services are accessible and easily navigated • Robust information and communication systems to support effective decision-making and public engagement • Active involvement of citizens and their carers in decisions about their care and well-being.
Sustainable Social Services (Feb 2011)	The documents sets out the commitment to reshaping social services on the basis of the following: • Prioritise integrated services esp. for families with complex needs, looked after children, transition to adulthood, frail older people • Need to build services around people • Integrated care one of the 8 priorities for action, led to reshaping services in reablement and family support through integration with health services
Delivering Local Healthcare (July 2013)	This document sets out; • Deliver more healthcare closer to home to reduce hospital use • Increase ability of local services to support people being healthier and facilitate easier access • Greater integration with single system of care planning and service delivery

Table 2 Relevant Local Policies and Strategies

Policy	Relevance
Carmarthenshire County Council Annual Report 2014/15 & Improvement Plan 2015/16[90]	The report sets out the aim to 'transform service delivery that reduces dependency and promotes independence. It aims to secure greater independence and choice for local people, with preventative strategies at the heart of service delivery in adult services.' A key area of focus is to reduce the delayed transfer of care through: • Improve the links between the community and acute sector • A Rapid Response domiciliary care service • Key models established to reduce the number of hospital admissions as well as put in place preventative measures.
Strategy for the care of older people in Carmarthenshire[91]	The areas within this theme are intermediate care, delayed transfers of care, aids and equipment and rehabilitation. Aims include: • Ensure that older people will have access to a range of high quality services, including rehabilitation and intermediate care services to enhance their ability to live as independently as possible in their own home or other care settings. • Resolve the problems of delayed transfers of care

[90] http://www.carmarthenshire.gov.wales/media/846036/Full_ARIP_Report_15-16.pdf
[91] http://online.carmarthenshire.gov.uk/agendas/eng/SHEW20040331/REP04_01.HTM

APPENDIX B – BENCHMARKING

Benchmarking

Introduction

As part of the Evaluation the services provided by TOCALS have been benchmarked against the Frail Older Persons Assessments and Liaison Service (FOPAL) Cardiff and Vale of Glamorgan.

In gathering the information on the benchmarks, only used robust, credible sources of information such as programme data and statistics has been utilised.

Frail Older Persons Assessment and Liaison Service (FOPAL) Cardiff and Vale of Glamorgan

Rationale for Frail Older Persons Assessment and Liaison Service (FOPAL)[92]

FOPAL was created to deliver targeted Comprehensive Geriatric Assessment (CGA) to frail older people presenting at A&E or the Medical Emergency Assessment Unit (MEAU) at University Hospital Wales Cardiff. The vision for the development of the service was to realise the full benefit of investing in a front of house frailty model and achieve the maximum gains of having one.

As the TOCALS being evaluated in this report worked specifically in relation to discharge pathways for frail old patients, FOPAL was deemed to be an appropriate benchmark service.

Background to Frail Older Persons Assessment and Liaison Service (FOPAL)[93]

FOPAL is part of a range of existing and developing specialist older people care services within the Older Persons Acute and Intermediate Care Services which operate alongside integrated community resource teams (CRTs) across three localities. The aim of the service is to work across the boundaries between hospital and community, and health and social care.

As no new resources became available to support service development, FOPAL occurred in a succession of stages, with the early phase predominantly dedicated to exploring feasibility of the concept and providing accurate information on which to base further developments. Subsequent stages involved the establishment of the FOPAL service, as well as a Frailty Clinical Decisions Unit (FCDU) and Acute Geriatric Medicine beds which allow direct admission to a single ward area without requiring further moves and give immediate access to a Geriatrician-led multi-disciplinary team. The Service also required the development of an Emergency Frailty Unit (EFU) within A&E where patients stay for no more than 36 hours.

The FOPALS team is based within A&E and/or MEAU. The team is comprised of a consultant geriatrician, a senior geriatric assessment liaison nurse, senior nurse sessions specifically linked with the CRTs, a part-time social worker and physiotherapy, occupational therapy and mental health links.

[92] FOPAL Proposal OPSD (Older People's Service Delivery Group)
[93] FOPAL Proposal OPSD (Older People's Service Delivery Group)

The FOPAL teams complete CGAs before agreeing a plan for the patient which is discussed with the relevant team to agree its implementation. This could include discharge home with or without community interventions, or to a community hospital or an acute ward. In a small proportion of cases, discussions may be had over end of life planning. Patients may also be referred to a myriad of other available community services such as Palliative Care, Day Hospitals and CRTs. Key requirements of the successful functioning of this system are maintaining the link with primary care and timely transfers of good quality information.

Objectives and Targets

The purpose of this service was to deliver targeted Comprehensive Geriatric Assessment (CGA) to frail older people presenting as emergencies (A&E and MEAU) at University Hospital Wales. A number of targets were set for Stage 2 of the service, which would provide measures of success[94]. These were:

- Reduced emergency admissions for over 65s.
- Reduced bed utilisation for over 65s.
- Increased discharge to usual place of residence.

Outcomes

Performance information is available for the one month period from 01 July 2014 – 31 July 2014[95].

Outcomes

KPI	Outcome
Increase the rate of timely discharge	FOPALS received 95 referrals – 56 of these (58.9%) avoided admission, 2 (2.1%) due to frailty and 37 who (38.9%) received therapy only 66 (69.5%) were discharged within the same month of referral
Avoid unnecessary hospital admissions	Of the 95 referrals received, 56 (58.9%) were able to avoid hospital admission. Of the 92 patients seen, 17 were admitted to University Hospital of Wales within the same month as referral and 3 were admitted to Llandough Hospital. This brings total number admitted to 20 (21.7%) of total seen.
Discharge to community care facilities	Of the 86 patients which were referred and discharged in the same month: One was admitted to a nursing home; • 39 recovered and returned to their own homes; • Three were discharged to a care home;

[94] The Wyn Campaign Milestone Report – February 2013 (Available at: http://www.cardiffandvaleuhb.wales.nhs.uk/sitesplus/documents/1143/Wyn%20Campaign%20Milestone%20Report%20February%202013%20final.pdf)
[95] FOCAL Performance Report July 2014

KPI	Outcome
	• Three are functioning independently of support; • Three were referred to social service care package; Four were referred to community MDT; Five were referred to community physio; Seven were referred to CRT; and One refused further intervention.

Benefits Delivered

Unfortunately, an evaluation of FOPALS had not been undertaken at the time this report was written. However, a 2010 study of another older person's assessment and liaison team (OPAL) in the acute admissions areas of a general hospital found that OPAL was effective as a medium for timely review and intervention of frail older patients in an acute medical setting, and as a mechanism for reducing length of stay[96]. The performance information for FOPALS that is discussed above would suggest that similar benefits will be delivered by this service.

Conclusions and Summary

TOCALS and FOPAL appear to be very similar services, with similar aims and objectives: both aim to avoid unnecessary hospital admissions and delayed discharge of frail older patients; both have established frailty/discharge pathways; and both are multi-disciplinary teams which operate at the 'front door' of the hospital. However, the two services operate in very different contexts. Carmarthenshire, where TOCALS operates is a rural region of Mid and West Wales; whereas FOPAL operates in the capital city of Cardiff. This may somewhat explain the difference in referral numbers as compared below. As described in Section 1 of this report the TOCALS is targeted at frail, older people in Carmarthenshire with the aim of reducing the length of their hospital stay and boosting the rate of timely discharge back into the community. The benchmarked example described above has similar aims and appears to have similar outcomes.

Comparing FOPAL to the TOCALS Programme shows a number of key findings:

Comparison of services

	TOCALS	FOPAL
Average number of referrals	247 (over two hospitals in a 10 month period)	95 (in one hospital over a 1 month period)
% Avoided admissions	31% (over 10 month period)	58.9% over 1 month period

[96] Allen, S., Bartlett, T.,Ventham, J., McCubbin, C., and Williams, A. (2010).'Benefits of an older persons' assessment and liaison team in acute admissions areas of a general hospital', *Pragmatic and Observational Research, 1,* pp. 1-6: http://www.dementiapartnerships.org.uk/archive/wp-content/uploads/may-ooi.pdf

APPENDIX C – STAFF SURVEY TEMPLATE

Welsh Intermediate Care fund – staff Survey – TOCALS Project

As you may be aware PACEC (Public and Corporate Economic Consultants) have been appointed by the Mid and West Wales Health and Social Collaborative to evaluate services and projects delivered under the Intermediate Care Fund (ICF).

As part of this evaluation we are required to gather feedback from staff involved in the TOCALS (Transfer of Care) project on their experience of delivering the services and working collaboratively, the effectiveness of the service, the impacts of service and how additional the service is.

It should take no more than 15 minutes to complete and your responses will be completely confidential and you will not be identifiable in any report.

The response date for this survey is Friday 4th December 2015.

This survey can also be completed online using the following link:

http://www.smartsurvey.co.uk/s/TOCALSSTAFF/

1 - Your job role

Q1 What is your title? *(Please tick one)*

Hospital Ward Manager	
Emergency Department Sister	
TOCALS Team Member	
Consultant	
Hospital Doctor	
Health Manager (Community)	
Local Authority Manager	
Professional Lead	
Other *(Please specify below)*	

Q2 In which setting do you work? *(Please tick one)*

Prince Philip Hospital	
Glangwili Hospital	
Community Response Team	
Other community based team	
Other *(please specify below)*	

Q3 How does your role interface with TOCALS? *(Please provide details below)*

2 – The Effectiveness of the TOCALS Service

Q4 To what extent do you agree or disagree with the following statements relating to the TOCALS service? *(Please tick one per row)*

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly Disagree	Don't know
It is clear what type of patient is likely to benefit from TOCALS support						
The service is patient focused						
Level of staffing resource is adequate						
In the Emergency Department TOCALS helps to avoid unnecessary admissions						
TOCALS helps support discharging planning in the wards						
There is good communication with staff across the different professions within the hospital						
There is good communication with staff from other agencies/organisations (e.g. hospital and community staff)						
The service provides Value for Money for the level of resources in TOCALS						
The service has provided hospital staff with a knowledge of the support that is available to patients in the community						

Q5 Please indicate your opinion of the level of impact achieved by the service. *(Please tick one per row)*

	High	Medium	Low
Reduction in the number of patient bed days			
Reduction in the number of older people who are admitted to hospital			
Improved patient flow			
Patient's ability to regain independence / functionality			
Patient's ability to access appropriate health and social care services			
Patient's ability to access suitable voluntary sector services in the community			
Patients' satisfaction with the services and advice received			
Increased confidence in hospital staff in discharging patients to the community			

Q6 How satisfied were you with the following aspects of the services provided? *(Please tick one per row)*

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly Disagree	Don't know
Staff working together and knowing what each other was doing						

The speed of the service delivery once a patient has been referred						
The knowledge of all staff involved of patients' needs and their ability to provide me with what I needed						
The information given to patients about their care						
The overall level of care provided by the service						

Q7 Do you think the service could be improved? *(Please tick one)*

Yes	No

If yes, how? (Please provide details below)

3 - Additionality of the support from the Intermediate Care Services

We are interested to find out if the benefits to patients and hospital staff would have happened anyway without the services provided under the TOCALS project.

Q8 In your opinion, did TOCALS make an impact on the support patients received whilst in the Emergency Department or, as an in-patient? *(Please tick one)*

Very positive impact	
Positive impact	
No impact	
Negative impact	
Very negative impact	

Q9 In your opinion did TOCALS make a difference to the timeliness of the support patients received? *(Please tick one)*

Sooner	
Later	
About the same	

Q10 In your opinion did TOCALS make a difference to the scale of the benefits achieved? *(Please tick one)*

Greater benefit	
Smaller benefit	
About the same	

Q11 In your opinion did TOCALS make a difference to the support for hospital staff in feeling confident about discharging patients into the community safely? *(Please tick one)*

A lot more confident	
Somewhat more confident	
No change	
Less confident	
A lot less confident	

Q12 In your opinion did TOCALS make a difference to the support for hospital staff in considering the alternatives to admitting patients? *(Please tick one)*

A lot more support	
Some more support	
No change	
Less support	
A lot less support	

Q13 In the absence of TOCALS do you think that your patients would have been more or less likely to: *(Please tick one per row)*

	More likely	Neither	Less likely
Be admitted to hospitals from the Emergency Department / CDU			

Stay longer in hospital			
Receive the appropriate support in the community after discharge			

4 - Multi-disciplinary working

Q14 To what extent do you agree there is effective multi-disciplinary team working within the TOCALS service? *(Please tick one)*

Strongly Agree	
Agree	
Not sure	
Disagree	
Strongly Disagree	

Please state the reason for your answer below:

Q15 Has multi-disciplinary working improved as a result of the TOCALS project? *(Please tick one)*

Yes	
No	
Not sure	

Please state the reason for your answer below:

Q16 To what extent has the TOCALS project provided the opportunity to share knowledge and expertise with other staff from other disciplines? *(Please tick one)*

A lot	
A little	
Not at all	
Not sure	

5 - Inter-agency working

Q17 To what extent do you agree there is effective multi-agency team working in the TOCALS service? *(Please tick one)*

Strongly Agree	
Agree	
Not sure	
Disagree	
Strongly Disagree	

If you disagree or strongly disagree, please explain why:

Q18 To what extent has the TOCALS project provided the opportunity to share knowledge and expertise with other staff from other agencies? *(Please tick one)*

A lot	
A little	
Not at all	
Not sure	

Other issues

Q19 To what extent do you agree with the following statements? *(Please tick one per row)*

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly Disagree	Don't know
The aims and objectives of this service have been well communicated through the TOCALS newsletters and other means						
The service has the potential to positively contribute to patient flow						
The service has the right mix of skills and expertise to work as efficiently as possible						

Q20 Is there anything else that you feel is important about the project that we should take into account as evaluators? *(Please provide details below)*

Thank you for taking the time to complete the survey – the information that you have provided will greatly assist in evaluating the TOCALS Project and the ICF in Mid & West Wales

APPENDIX D – CONSULTEES

Consultee	Role
Debra Llewellyn	Project Manager
Rhian Dawson	Project Director
Linda Williams	Chair of the Project Board

PACEC

Public and Corporate Economic Consultants

In collaboration with Dr Susan Carnes-Chichlowska

Carmarthenshire County Council - Mid and West Wales Health & Social Care Collaborative

Evaluation of Rapid Response Service

April 2016

TABLE OF CONTENTS

Appendices

1 EXECUTIVE SUMMARY

1.1 Introduction

In July 2015 PACEC was commissioned by the Mid and West Wales Health & Social Care Collaborative (HSCC) to undertake an evaluation of the Intermediate Care Fund (ICF or the Fund). The work involved evaluating six of the 86 projects funded through the ICF. This report evaluates the Rapid Response project. There are five other evaluation reports and an overall programme report completed as part of the evaluation.

1.2 Background

The ICF was introduced by the Welsh Government in April 2014 to assist in the development of new models of delivering sustainable integrated services that maintain and increase people's wellbeing and independence, and promote improved care coordination across social services, health, housing and other sectors. A one off allocation of £50 million within the devolved Welsh Government budget was made available in 2014/15 across Wales via ICF, comprising £35 million revenue funding and £15 million capital.

The Carmarthenshire Rapid Response service was awarded funding of £311,550 which aimed to:

- reduce the number of people admitted into hospital and deliver more timely discharges of patients back in to the community;
- further help people in their goal to remain healthy and independent;
- enhance the quality of life for people with care and support needs;
- delay and reduce the need for care and support; and
- ensure that people have a positive experience of care and support.

The Carmarthenshire Rapid Response service is delivered throughout Carmarthenshire from 7am to 10pm and is targeted towards patients who otherwise would have been admitted to hospital or would not have been discharged. The service is focused on the rehabilitation of patients and provides intensive support for short periods (e.g. up to 6 weeks), however in some cases the service facilitates discharge from hospital until a long term care package can be put in place.

The core Rapid Response Team consists of 24 Domiciliary Care workers (including supervisors and managers) and a Support and Development Manager who are responsible for providing personal care to patients referred to them.

1.3 Methodology

Methodological Element	Summary
Project Initiation and Initial Evidence Review	• Review of Project Initiation Document (PID) and Policy Context to outline what the project had set out to achieve / rationale for the project • A desk-based review of policy and literature regarding health and social care provision in Wales, including the integrated care context • Review of relevant literature (to outline the existing and new service user pathways and to develop an evaluation / logic model for the project in relation to outputs[1] and outcomes[2]) • A review and analysis of internal Rapid Response monitoring data, including financial data and progress reports • A desk based benchmarking exercise to identify and compare (to the extent possible) inputs, outputs and outcomes delivered by Rapid Response and other similar interventions
Primary Research	• A workshop and internal consultation with project managers across all six ICF projects involved in the evaluation, including group exercises to define pre and post service user pathways and service level logic models • An on-line survey of 12 staff members (50% of 24 staff)
Economic Assessment	Assessment of: • Value for Money (economy, efficiency and effectiveness) • Consideration of additionality, displacement and spillover effects • Estimation of cost savings and return on investment
Analysis & Synthesis	• Synthesis of qualitative and quantitative data • Identification of key lessons • Development of recommendations • Analysis of desk based and survey data.

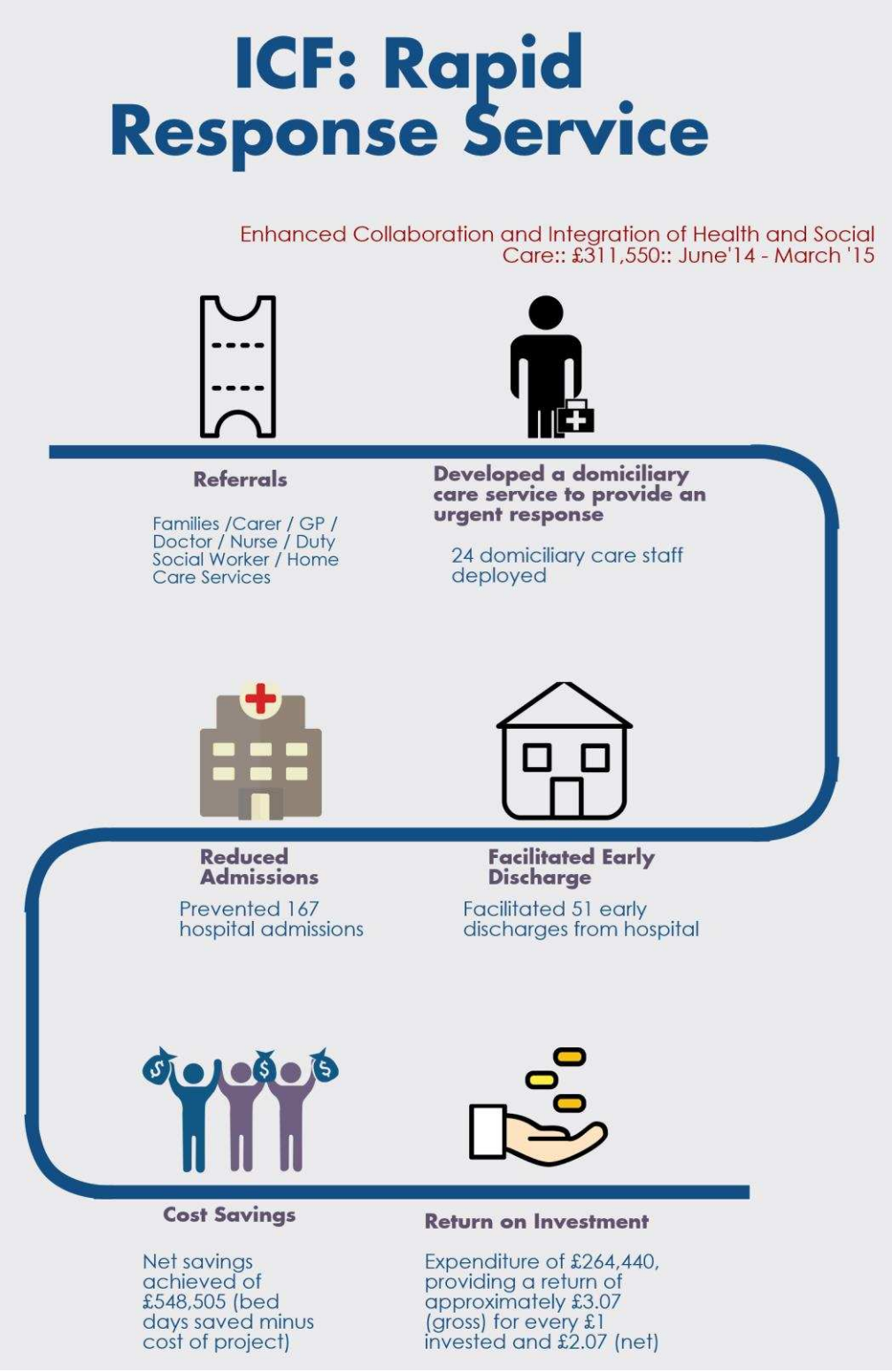
This report reflects an evaluation of the Rapid Response Service that was part of the ICF pilot schemes. The PACEC remit has been to evaluate progress within a set timeframe of six pilot projects representative of 86 projects that received ICFs. The TOR recommended the use of the Integrated Care Evaluation Framework (ICE-F)[3] which will give structure to the following evaluations. The evaluations all need to establish the difference between the outcomes of delivering integrated care services compared to the pre-existing services within a limited time frame.

[1] Outputs are the measureable components of service delivery that can be quantified (e.g. number of patients supported per week) (http://info.wirral.nhs.uk/document_uploads/evidence-factsheets/12%20Logic%20Modelling%20factsheet%20Feb%202014.pdf)

[2] Outcomes are the effects of activities and resulting outputs. These can be divided into short, medium and long term (e.g. short – increased knowledge and skills; medium – improved patient independence; long – reduced health inequalities)

1.4 Evaluation Summary

The following infographic sets out the background, ambitions, and a number of evaluation findings from the Rapid Response Service.



1.5 Key Findings

The key findings from the evaluation are listed below. These refer to the economic assessment of the project, what worked well, and what could be improved in the future via means of recommendations.

Cost Savings:

Total ICF expenditure for the Rapid Response Service was £264,440 and it is estimated that the project has generated net savings of £548,505 over the seven months that it was operational (October 2014 - March 2015). As such, for every £1 invested the Rapid Response service has provided a net return of £2.07. However, the cost savings noted above do not take into account other potential savings associated with the service, such as a potential reduction in the number of patients entering long term domiciliary care, avoided admissions to nursing or care homes, or avoided ambulance journeys. Furthermore, the analysis does not take into account the benefits to patients such as increased or re-gained functional ability. Due to a lack of data these savings cannot be measured at this point.

What worked well:

- Feedback from staff indicates that the project integrated well with other services and agencies. Staff in supervisory or managerial roles reported having more contact with staff from other agencies and professions as a result of the service.
- Project monitoring data indicates that the service prevented 167 admissions and supported 51 early discharges during its seven months of service delivery.
- Feedback from staff also indicates that without the service patients would have remained in hospital for longer and patient case studies demonstrate the positive impacts of the service on the health and well-being of patients.
- Staff survey feedback (100% of 12 responses) indicates that they felt the project had increased communication between social services and hospital staff, and that this in turn had helped to improve the patient handover process.

What could be improved:

- Staff reported limited awareness of the service by GPs, suggesting there is a need to raise the profile of the service (and the benefits it can bring to the Health Service and the patients), possibly through a handbook for GPs of the local care services they can directly refer to.
- While the Rapid Response project had a clear focus on early discharge and reducing the number of people admitted to hospital, no targets were set regarding integration / collaboration, meaning it is not possible to conclude on whether the process worked as expected.
- The service focused on measuring benefits at service level however the outcomes for service users should be also measured, including patient's experience and the extent to which their quality of life has improved, alongside those measuring gains to health / social care services in order to provide a holistic view of the benefits being achieved.

1.6 Recommendations

This report sets out four thematic sets of recommendations regarding integration, outputs and outcomes, economic assessment and future prospects / sustainability. The points below reflect the headline recommendations; a full depiction is set out in Section 8 of the main report.

1.6.1 Integration

The project adopted an integrated approach at a strategic level as it was overseen by an integrated project board. Qualitative feedback from the staff survey[4] indicated the project had **increased communication between social services and hospital staff** and that this in turn had helped to improve the patient handover process. It was also noted that the **referral process from integrated Community Resource Teams (CRTs) worked well** and that the **project had helped improve communications and relationships** between the staff involved. However, while the Rapid Response service had a clear focus on early discharge and reducing the number of people admitted to hospital, no targets were set regarding integration / collaboration, meaning it is not possible to conclude on whether the process worked as expected.

Recommendations:

- **Objectives and targets should be set with regard to what effective integration and collaboration looks like for the service**. Research[5] by the Nuffield Trust states that this should include impact on health outcomes, but also improved quality of care, service user satisfaction, and effective relationships and systems.
- **Referral data should be examined to consider the specific numbers being referred by GPs and Primary Care Teams and whether there are opportunities to increase these**. The project should consider ways in which the profile of the service (and the benefits it can bring to the Health Service and the patients) can be raised with other health care teams such as GPs and OTs (e.g. through community nurses) in order to maximise referrals. In addition, in any future service it would be useful to pilot work with a number of GP practices in order to project the potential numbers or % of GP case load that could be referred.
- We recommend that an **up to date handbook of care service**s is available to all care agencies to sustain integration, to allow for direct communication between professionals, and to build confidence in care provision.
- **Research is needed to confirm that all of the target audience are being reached**. Further work is required to assess whether there are a number of patients that could be utilising this service, but who are not and the reasons for this. This could be done through reviewing the records in a number of wards for a period of time. This would

[4] An on-line survey of 12 staff members (50% of 24 staff)
[5] Nuffield Trust (2011) *What is Integrated Care?*

provide information on whether the service is being referred to appropriately, and the projected numbers to come through should there be more numbers identified**.**

- **The capacity of the Rapid Response service should be sufficient** to ensure that a tight turn around target of all those being referred are supported within two days.

1.6.2 Outputs / Outcomes

Outcome Measures

Project monitoring reports provided information on service level 'outcomes', specifically the prevention of hospital admissions and facilitating early discharge. These were key to ensuring that service was demonstrating a contribution to reducing the pressure for beds within hospitals. However, it should also measure the patient experience and how quality of life is improved for those who use its services. In addition, a number of areas that were detailed in the PID were not monitored. Specifically, there was no data collected against the following aims / service user outcomes:

- People will be further helped in their goal to remain healthy and independent;
- To delay and reduce the need for care and support;
- Enhance the quality of life for people with care and support needs; and
- Ensure that people have a positive experience of care and support.

Evidence on all of the above can be collected through surveys or interviews with service users. There is a strong body of evidence noting that the collection of feedback from service users is best practice in the evaluation of intermediate care services,[6] including patient satisfaction, health and well-being improvements (reablement)[7] and patient quality of life.[8]

Performance

The key areas of strength within the existing service were the:

- Development of domiciliary care capacity and systems within the council in a short period of time;
- Achievement of 167 people avoiding hospital and 51 people discharged sooner as a result of this service; and
- Delivery of the service on time and within budget, and ability to respond to short turnaround times for helping clients.

Areas for development include:

- SMART targets should have been established for the Rapid Response service at the outset (based on performance against a baseline / linked to an evidence based logic model) and in line with ICE-F guidance, which states outputs and outcomes should be

[6] For example see Kings Fund (2002) Developing Intermediate Care. A Guide For Health and Social Services Professionals.
[7] Kings Fund (2002) Developing Intermediate Care: A Guide For Health And Social Services Professionals
[8] Kings Fund (2014) Community services How they can transform care

defined at national, local and individual / personal level. In the absence of SMART targets, it has not been possible to effectively conclude on the success or effectiveness of the Carmarthenshire Rapid Response service.

- Only 10% of referrals came from the Primary Care teams. Targets are needed for referrals from those working in primary care. These should be set after a review of the numbers of people being referred to hospital by them that could be helped at home. Targets are also needed for the number of in-hospital referrals.

Recommendations:

- **Include measures relating to individual and personal objectives**. For example, this would include patients' quality of life, improvements in health and well-being and levels of satisfaction with the services provided. The data collected should be in line with national standards for reablement services[9] and ICE-F guidance.
- **Baseline and distance travelled data is required** to provide evidence of how the service has contributed to individual outcomes (for example, rating wellbeing at beginning of service, middle and at discharge or referral).
- **SMART targets should be developed for each objective**; and
- **Future reporting templates should detail quarterly and cumulative progress** against all the objectives and targets details in the PID.

1.6.3 Economic Assessment

The Rapid Response service was under budget by £47,109 which was mainly due to the lead in time required to establish the project, attract and appoint staff, and acquire the equipment necessary to run the service. However, the service prevented admissions for 167 patients (43% of all referrals) and facilitated the early discharge of 51 patients. This resulted in a gross cost saving of £812,945 / net cost saving of £548,505. Therefore, every £1 invest in the Carmarthenshire Rapid Response service provided a return of £3.07 (gross) and £2.07 (net). However, this approach only captures cost saving due to hospital bed days saved, as data on the number of days saved in relation to residential care were not collected in the monitoring reports and therefore this does not reflect the full cost savings to the health and social care system.

Recommendations:

- **We recommend that any future project collects detailed quantitative data relating to early discharge**, for example the number of days saved through each early discharge (not just the number of patients who have been discharged early), which would enable the project to make a more accurate assessment of its impact.
- **We recommend that data is collected that shows the reduced cost to residential and nursing home care services**.

[9] Reablement Gold Standards & Toolkit. Developed in partnership between WSP and the Social Services Improvement Agency during 2009/10 through the development of an action learning set involving Welsh LAs.

1.6.4 Sustainability and Future Prospects

Further research should be undertaken on the need and capacity in other council areas before the service is rolled out across Mid and West Wales. Specifically, an assessment of need should be completed to determine if there is a need to provide an urgent response to referrals for domiciliary care to prevent delayed discharges and help to avoid unnecessary admissions.

There is a need to determine if there is existing capacity within domiciliary care/reablement services in other Councils within Mid and West to continue to provide this urgent response service or is there a need for additional resources. Any research or review in this area should take a whole systems approach and therefore consider the level of potential referrals from hospitals and other relevant staff in the community (e.g. GPs / community organisations), as well as the capacity to deliver the service.

It is noted that the Carmarthenshire Reablement Service Structures are currently review under and it is understood that the Rapid Response service will be more closely aligned in order to facilitate closer links to hospital staff, higher levels of referrals and a reduction in inappropriate referrals (for example fewer referrals for patients who require long term care).

2 TERMS OF REFERENCE AND METHODOLOGY

2.1 Terms of Reference

The table below details the terms of reference for the overall evaluation.

Table 2:1: Terms of Reference

Terms of Reference
To examine the process and benefits of integrating health and social care services within the region with a view to assessing (as set out in analysis and reporting): • Whether the process of integration has worked as expected and what aspects have worked well or less well; • If and how processes of integration have contributed to or retarded progress towards outcomes; and • What practical lessons can be learned for the continuing integration of services within the region and more widely.
Assess, to the extent possible, the outcomes of a selection of the region's ICF projects (through evidence review and primary research): • Characterise and categorise the range of outcomes expected from the region's projects, distinguishing service-related outcomes from service user outcomes and intermediate from final outcomes; • Gather evidence from a sub-set of the region's projects to explore if, how and to what extent these outcomes have been realised; and • Comment, as far as possible, on future prospects for realising outcomes, given the progress made to date
Conduct, to the extent possible, an economic assessment (see section 7), focusing on: • The cost-effectiveness of the region's integrated service models, vis-à-vis non-integrated ways of delivering services; • The extent to which integrated care is more efficient than non-integrated care; and • The potential for cost avoidance/negated costs contributed by preventative approaches
Provide commentary on the future prospects for care integration within the region by (as set out in conclusions and recommendations): • Identifying approaches with potential for replication or scaling up (within the context of the Social Services and Wellbeing (Wales) Act); • Discussing options for sustaining approaches following the cessation of WG funding; • Recommending components of an outcomes-based performance framework for the future • Discussing the likelihood of outcomes being realised in future; and • Discussing the trade-offs between investing further in integrating care and continuing to invest in other forms of care.

2.2 Methodology

To achieve the requirements within the Terms of Reference the following methodological approach was used:

Table 2:2: Methodology

Methodological Element	Summary
Project Initiation and Initial Evidence Review	• Review of Project Initiation Document (PID) and Policy Context to outline what the project had set out to achieve / rationale for the project • A desk-based review of policy and literature regarding health and social care provision in Wales, including the integrated care context • Review of relevant literature (to outline the existing and new service user pathways and to develop an evaluation / logic model for the project in relation to outputs[10] and outcomes[11]) • A review and analysis of internal Rapid Response monitoring data, including financial data and progress reports • A desk based benchmarking exercise to identify and compare (to the extent possible) inputs, outputs and outcomes delivered by Rapid Response and other similar interventions
Primary Research	• A workshop and internal consultation with project managers across all six ICF projects involved in the evaluation, including group exercises to define pre and post service user pathways and service level logic models • An on-line survey of 12 staff members (50% of 24 staff)
Economic Assessment	Assessment of: • Value for Money (economy, efficiency and effectiveness) • Consideration of additionality, displacement and spillover effects • Estimation of cost savings and return on investment
Analysis & Synthesis	• Synthesis of qualitative and quantitative data • Identification of key lessons • Development of recommendations • Analysis of desk based and survey data.

This report reflects an evaluation of the Rapid Response Service that was part of the ICF pilot schemes. The PACEC remit has been to evaluate progress within a set timeframe of six pilot projects representative of 86 projects that received ICFs.

[10] Outputs are the measureable components of service delivery that can be quantified (e.g. number of patients supported per week) (http://info.wirral.nhs.uk/document_uploads/evidence-factsheets/12%20Logic%20Modelling%20factsheet%20Feb%202014.pdf)

[11] Outcomes are the effects of activities and resulting outputs. These can be divided into short, medium and long term (e.g. short – increased knowledge and skills; medium – improved patient independence; long – reduced health inequalities)

2.3 Evaluation Challenges

In conducting this evaluation there were a number of main challenges:

Availability of data: data had not been collected / reported on in project monitoring reports against each of the activities / objectives stated in the project PID, meaning it was not possible to conclude on performance.

Limitations of the methodology: while the Integrated Care Evaluation Framework (ICE-F) states that in order to evaluate and understand an integrated service it is necessary to measure performance indicators, service outputs and personal outcomes achieved by the individual using the service, the evaluation team were not permitted to gather feedback from service users which meant there is limited evidence on the individual outcomes being achieved.

Cost savings: This evaluation was requested to identify potential cost savings to the Health and Social Care sector in Wales and to therefore provide an initial indication of potential savings which could be obtained from rolling out comparable schemes on a wider basis. This evaluation has identified the reduction in use of hospital (NHS) bed days as a proxy indicator for cost savings i.e. the unit cost of an NHS bed day is estimated at £426[12]; any identification of number of days saved per beneficiary due to intermediate care allows for a calculation of gross cost savings. The evaluation challenge is that this only reflects the use of one indicator, and for a number of projects dealing with preventative care services, there will be other 'non-captured' cost savings, for example, the cost of a handrail installation (c. £100-200) may serve to actually prevent a serious fall in the home, and these benefits may not be captured in the short-term. This means that there is a challenge in identifying cost savings in their entirety, due to the use of one indicator in the context of other service benefits over time. This does not allow for a full reflection of the actual cost saving potential of some intermediate care schemes.

[12] Welsh Government | *Health statistics Wales. Finance. 2012/13*. Available at: http://gov.wales/statistics-and-research/health-statistics-wales/?lang=en.

3 BACKGROUND

In July 2015 PACEC was commissioned by the Mid and West Wales Health & Social Care Collaborative (HSCC) to undertake an evaluation of the Intermediate Care Fund (ICF or the Fund). The evaluation involves a review of the overall programme and six of the ICF funded projects. This report evaluates the Rapid Response project.

3.1 Intermediate Care Fund (ICF)

The ICF was introduced by the Welsh Government in April 2014 to assist in the development of new models of delivering sustainable integrated services that maintain and increase people's wellbeing and independence, and promote improved care coordination across social services, health, housing and other sectors. A one off allocation of £50 million within the devolved Welsh Government budget was made available in 2014/15 across Wales via ICF, comprising £35 million revenue funding and £15 million capital.

The purpose of the Fund was to:

- Encourage integrated working between local authorities, health and housing; and
- Support older people, particularly the frail elderly, to maintain their independence and remain in their own home.

The total Fund is £8.4 million[13] which was shared between the four local authority areas as follows:

Table 3:1: Breakdown of ICF Funding 2014 / 15

Area	Revenue		Capital		Total	
Powys	£1,500,000	26.7%	£749,000	26.6%	£2,249,000	26.7%
Ceredigion	£801,000	14.2%	£400,000	14.2%	£1,201,000	14.2%
Pembrokeshire	£1,268,000	22.5%	£634,000	22.5%	£1,902,000	22.5%
Carmarthenshire	£2,058,000	36.6%	£1,029,000	36.6%	£3,087,000	36.6%
Total	**£5,627,000**	**100.0%**	**£2,812,000**	**100.0%**	**£8,439,000**	**100.0%**

Source: Intermediate Care Fund Mid and West Wales – Half Yearly Report – November 2014

[13]Intermediate Care Fund Mid and West Wales (November 2014) Half Yearly Report

ICF was intended to build on existing service arrangements and test out new approaches to intermediate care that would:

- Ensure a citizen focused approach to service planning and delivery;
- Promote independence among elderly individuals;
- Encourage further integration across health, social care and the wider sector;
- Foster direct engagement with key partners within local government (for example housing and the third sector in developing and delivering an ambitious programme of change in the region); and
- Make a key contribution to the delivery of commitments within the Hywel Dda and Powys area.

Over 70 individual projects were funded[14] delivering against two themes: "Investing to Go Further" and "Investing to Join Up". Investing to Go Further aims to increase integrated intermediate care capacity in order to prevent hospital admissions and maximise people's independence following a crisis. Investing to Join Up has the aim of building community resilience, creating environments receptive to intermediate care and contributing to its sustained success.

3.2 Rationale for the Rapid Response Project

The rationale for the Carmarthenshire Rapid Response service was set out in the Project Initiation Document (PID)[15] and is based on research from the National Institute of Health Research (NIHR) into the effectiveness of prevention services in adult social care[16]. This found that reablement services improved outcomes for 50–90% of the older people who used them, as demonstrated through their need for less or no support than when they initially contacted the service. Moreover, a report from the Centre for Workforce and Intelligence[17] identified a number of key benefits from Rapid Response services operating across England, as summarised in table 3.2.

[14] Intermediate Care Fund Mid and West Wales – Half Yearly Report – November 2014
[15] Domiciliary Rapid Response – Project Initiation Document (June 2014)
[16] http://blogs.lse.ac.uk/socialcareevidenceinpractice/2013/02/21/prevention-services-in-adult-social-care-reablement/
[17] http://www.cardiffandvaleuhb.wales.nhs.uk/sitesplus/documents/864/updated_integrated-care-for-older-people%5B1%5D.pdf

Table 3:2: Identified benefits of a Rapid Response Service

Benefit identified	Explanation
Quality of care	Rapid Response services have high patient satisfaction because patients have the ability to choose whether they want their care to be delivered at home. Patients are also typically assessed within a few hours of referral.
Productivity and efficiency benefits	Data from the Salford Rapid Response team showed that the model avoided 3% of total A&E admissions which resulted in estimated net savings of £137million/year in Salford.
Workforce	A literature review conducted by the CfBT Education Trust[18] found that multi-agency working had a number of positive impacts on professionals such as increased knowledge and understanding of other agencies, as well as improved relationships and communication between agencies.

Source: Centre for Workforce Intelligence

3.3 Rapid Response Service – Funding, Aims and Objectives

The Carmarthenshire Rapid Response service was awarded £311,550 from the ICF via the Mid and West Wales Health and Social Care Collaborative from June 2014 to March 2015. The service was established with the main aim of further enhancing collaboration and integration of Carmarthenshire health and social care services and delivering 'Care Closer to Home'.[19] Other key aims for the Carmarthenshire Rapid Response service as set out in the PID[20] were:

- To strengthen the domiciliary team to be able to provide a model of anticipatory care to the frail elderly as well as to those with chronic conditions and palliative care needs whose needs can ebb and flow (rise and fall) overtime;
- To successfully reduce the number of people admitted into hospital and deliver more timely discharges of patients back in to the community;
- To further help people in their goal to remain healthy and independent;
- To enhance the quality of life for people with care and support needs;
- To delay and reduce the need for care and support; and

[18] http://www.nfer.ac.uk/publications/MAD01/MAD01.pdf
[19] This is part of a multi-million pound investment by the Welsh Government in local health services across Wales to help the NHS deliver more care closer to people's homes and reduce pressure on hospital services. This is part of the Welsh NHS Primary Care Fund aimed to improve primary care in Wales. For more information see: http://gov.wales/newsroom/healthandsocialcare/2014/141106primary-care/?lang=en
[20] Source: Domiciliary Rapid Response – Project Initiation Document (June 2014)

- To ensure that people have a positive experience of care and support.

The PID notes that in meeting these objectives the service was to:

- Respond to GPs and District Nurses who would identify service users in the community that would benefit from hospital avoidance and be able to remain safely at home;
- In-reach to referrals from the acute hospital departments of Accident and Emergency and CDU to remove people who are medically fit and ready for discharge out of the hospital setting, and return them safely to the community;
- Enhance access for service users requiring domiciliary rapid response support in order to prevent hospital admissions;
- Develop a domiciliary care service to provide an urgent response to the needs of people who are experiencing a crisis due to an acute or chronic condition; and
- Provide a rapid response to the telecare community alarm system when activated for assistance.

3.4 How the Rapid Response Service Operates

The Carmarthenshire Rapid Response service is delivered throughout Carmarthenshire from three bases which are co-terminous with the other Health and Social Care structures in the area (they are Llanelli, Amman Gwendraeth and 3 Ts). Each of these three localities also has Community Resource Teams (CRTs) and GP lead Multidisciplinary Teams (MDTs).

The service operates from 7am to 10pm and is targeted towards patients who otherwise would have been admitted to hospital or would not have been discharged. The service is focused on the rehabilitation of patients and provides intensive support for short periods (e.g. up to 6 weeks), however in some cases the service facilitates discharge from hospital until a long term care package can be put in place.

The core Rapid Response Team consists of 24 Domiciliary Care workers (including supervisors and managers) and a Support and Development Manager who are responsible for providing personal care to patients referred to them. The team works alongside other health and social services staff who are also responsible for providing care in the home, including Social Workers, District Nurses and Occupational Therapists (OTs). The service accepts referrals from a wide range of sources and aims to get domiciliary care packages in place within 2 days (where appropriate), as detailed in table 3.3.

Table 3:3: Source of Referrals to the Rapid Response Service (June 2014 - March 2015)

Source of Referrals	Number	%
Careline (telecare)	214	54.3%
Staff within Community Resource Teams	79	20.1%
Staff within Primary Care Teams	40	10.2%
Llanelli Central MDT	16	4.1%
Llanelli West MDT	14	3.6%
Llanelli East MDT	12	3.0%
Convalescence	3	0.8%
Meals On Wheels	1	0.3%
Other	15	3.8%

Source: Rapid Response Patient Data provided to PACEC – October 2015

Table 3.3 shows that the majority of referrals (up to October 2015) came from the telecare service, Careline (54.3%). The other most common sources of referral were from staff from within the CRTs (20.1%) and staff within the primary care teams. The referrals from CRTs may also include those who are also in Primary Care Teams, such as District Nurses and other professionals linked to GPs. The Support and Development Manager noted that the team (such as Domiciliary Team Managers and Supervisors) were in regular contact with Primary Care Teams through the CRTs. The table below sets out the response times for the service.

Table 3:4: Rapid Response Service Response times (June 2014 – March 2015)

Response time from referral	%
Same day	75.6
1 day	8.9
2 days	2.8
3 days	1.8
4 days	1.3
5+	6.9
Unknown	2.8
Total	100

A high proportion of patients referred were seen within the target time of 2 days (87%) while a small proportion (6.9%) took 5 days or more. Feedback provided by the Project Manager indicates that almost half of those that took more than 5 days relate to patients were Rapid Response was used as an interim arrangement until a long term care package could be established. Therefore, these referrals may not have been entirely appropriate and may make the service appear less effective.

3.4.1 User Pathways

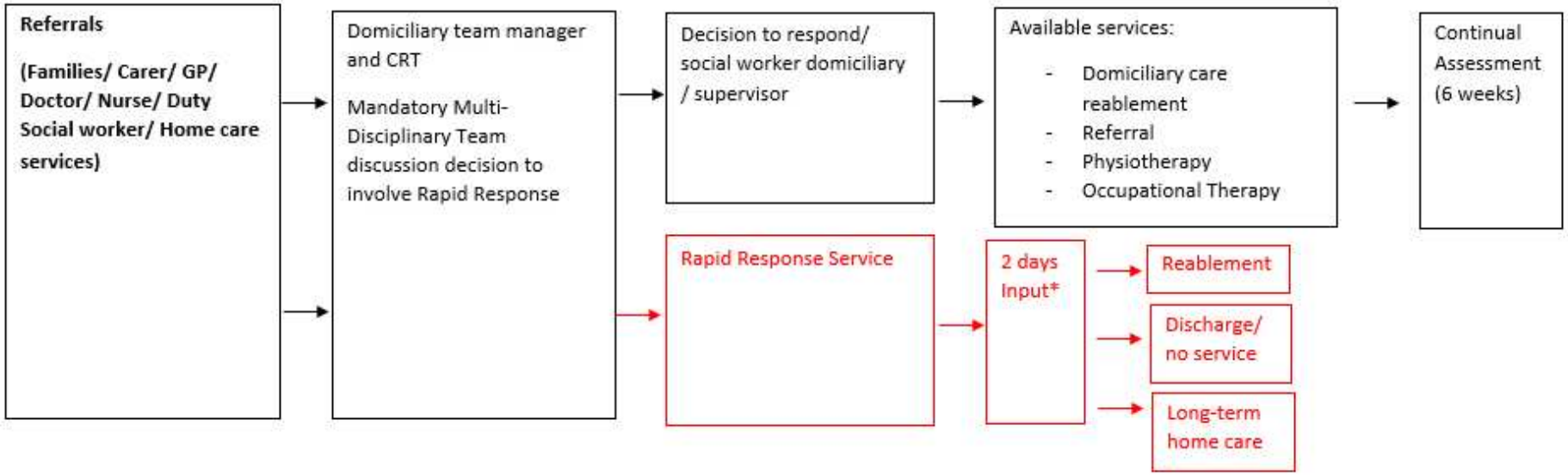
The evaluation team met with the Support and Development Manager to understand how the service developed as result of the ICF funding and how it differed from the service that was provided before.

The before and after ICF funding patient pathways were drafted by the evaluation team and agreed with the project manager. The figure overleaf shows the new Carmarthenshire Rapid Response service within the wider Domiciliary Care service as the red pathway.

As illustrated the process for the Rapid Response service is: patients are assessed by the Multi-disciplinary team (MDT) within Social Services. If the needs of the patient are deemed to be urgent or, the patient is in crisis, the MDT will refer the case to Carmarthenshire Rapid Response and there is a target these will be responded to within 2 days.

It should be noted that there are no specific referral criteria for the service, however referrers are asked to use their professional judgement and their assessment of patient's needs. Prior to the implementation of Carmarthenshire Rapid Response social workers would have made an assessment and if domiciliary care was required the patient would then go onto a waiting list which could be up to 6 weeks. Furthermore, the care packages provided under the Carmarthenshire Rapid Response service were likely to be more intensive (i.e. more hours provided each day and be more focused on regaining functionality), and provided for a much shorter period of time (up to six weeks).

Figure 3:1: Care Pathways before and after the ICF funding for Rapid Response (2014/15)



The following case study provides an example of the activities provided by the Carmarthenshire Rapid Response service under this process.

Table 3:5: Case study illustrating how Rapid Response operates in Carmarthenshire

Case Study- Mrs P Enhanced Hospital Discharge	
Background	Mrs P's recent hospital admission was due to a fall which caused a fractured hip. Mrs P's medical history is of a previous CVA, dementia and she is partially sighted. Whilst in hospital Mrs P continued to fall when trying to get in and out of bed and was regularly muddled, confused with poor orientation to time and place, and had been verbally and physically aggressive to the staff on the ward. Mrs P prior to admission lived at home with her daughter and family. To plan for a safe return home the Carmarthenshire Rapid Response service was commissioned until capacity was available within Reablement in two weeks' time.
Rapid Response Intervention	Initial Care package - 4 calls per day x 2 Domiciliary Support Workers to work towards gaining skills and independence with personal care, dressing, undressing and toileting.
Outcome	Within the first few days it was evident that Mrs P could weight bear and was able to mobilise slowly with minimal assistance. Mrs P, in her home environment, was calm, content and happy to be back with her family. On transfer to Reablement two weeks later the care package was for one worker three times per day. Without the initial input of the Carmarthenshire Rapid Response Team this return home would have been delayed for another 2 weeks.

Source: ICF RR 14-15 Year End project report

Summary

The Carmarthenshire Rapid Response service was provided with £311,550 funding from ICF over the period June 2014 to March 2015. It was designed under a reablement model to address an identified need for additional capacity within domiciliary care in order to respond urgently to referrals from a wide range of agencies including hospitals, GPs and telecare providers. It was recognised that the provision of this type of service can facilitate early discharge and prevent unnecessary hospital admissions for older patients, with research noting that benefits of a Rapid Response service include improved quality of care, reduced hospital admissions and increased knowledge and understanding within multidisciplinary teams.

4 CONTEXT, LITERATURE REVIEW & LOGIC MODEL

4.1 Introduction

This section sets out the context in which the Rapid Response service operated in Carmarthenshire as well a brief summary of the literature relating to benefits and the outcomes that can be expected from such services.

4.2 Socio-economic context

4.2.1 Carmarthenshire Population

People over 65 in Carmarthenshire account for 22% of the total population.[21] As shown in table 4.1, these numbers are expected to grow by 11% (n=4,433) by 2020.

Table 4:1 Carmarthenshire Population Projections for People Aged 65 and Over[22]

Year	Males Aged 65 and Over	Females Aged 65 and Over	Total Population Aged 65 and Over
2014	19,307	22,368	41,676
2015	19,729	22,684	42,413
2016	20,100	23,015	43,115
2017	20,486	23,364	43,850
2018	20,859	23,758	44,616
2019	21,259	24,097	45,356
2020	21,641	24,468	46,109

Source: Stats Wales https://statswales.wales.gov.uk/Catalogue/Population-and-Migration/Population/Projections/Local-Authority/2011-Based/PopulationProjections-by-LocalAuthority-Year

This highlights a growing level of demand for health and social services as well as the need for innovative solutions / models of delivery that can provide the supports needed more cost efficiently and effectively to the public purse.

[21] Carmarthenshire County Council: http://www.carmarthenshire.gov.wales/media/824482/county_profile.pdf.

[22] This change relates to the increase of older persons in Wales under the definition solely that these people are over 65. It is anticipated that in future years healthy life expectancy years will improve; and hence service demand for this age bracket will not necessarily increase in line with the growth in size of the number of people over the age of 65. Sourced via: Kings Fund (2014) *Making our health and care systems fit for an ageing population*

4.2.2 Rural Areas and Need for Health and Social Care Support

The Carmarthenshire Rapid Response service covers a geographically large area and many parts of the county are very remote and sparsely populated. Research suggests that the costs of rural services are higher because of the geography of rural areas and the smaller dispersed populations within them. Specifically, a comprehensive review[23] of evidence on the additional costs of service provision in rural areas concluded that there was a clear cost premium in order to achieve a similar standard of service to that in urban areas.

Furthermore, people who live at exceptionally rural parts of the county may experience particular difficulties accessing domiciliary support should they require it urgently to prevent hospital admissions, convalescence bed or residential care. The Carmarthenshire Rapid Response service covers the whole county, responds to urgent referrals and supports clients until the crisis is resolved or, another agency is able to accommodate, although this can often be for some time.

4.3 Evidence Review - Rapid Response

There is a wide range of evidence demonstrating that community based, intermediate care services are effective in reducing hospital admissions, supporting early discharge and delivering a higher quality patient experience.[24] The literature suggests that effective Rapid Response services include the following measures:

Service Outputs / Outcomes:

- Reduction in unscheduled admissions - the reduction of inappropriate admissions to acute or residential care has been identified as part of the role of intermediate care[25].[26].[27]. Small-scale studies of rapid response teams suggest that their provision of health and social care services in the community has an important role in supporting people to remain in their own homes. In the Brooks' study referenced of a new intermediate care rapid assessment support service, just four (5%) of all the older people using the service were admitted to an acute hospital.
- Reduced hospital admissions - an analysis of community based intermediate care showed that care provided at home and effective discharge planning can reduce hospital admissions by 15%[28];

[23] Hindle, T., Spollen, M., and Dixon, P. (2004) Review of the evidence on additional costs of delivering services to rural communities

[24] Imison, C, Thompson, J, Poteliakhoff, E (2012). *Older people and emergency bed use*. London: The King's Fund

[25] Beech, R. et al. (2004) 'An evaluation of a multidisciplinary team for intermediate care at home', *International Journal of Integrated Care*, no 4 (October−December).

[26] Brooks, N. (2002) 'Intermediate care rapid assessment support service: an evaluation', *British Journal of Community Nursing*, vol 7, no 12, pp 623−633.

[27] Kaambwa, B. et al. (2008) 'Costs and health outcomes intermediare care: results from five UK cases sites', *Health & Social Care inthe Community*, vol 16, no 6, pp 573−581.

[28] Shepperd, S. et al. (2009) 'Avoiding hospital admission through provision of hospital care at home: a systematic review and

- Reduced delayed discharges - a Health Foundation study found that hospitals can reduce delayed discharges if they have access to services that can react to patients needs quickly[29]; and
- Reduced dependency on services - a study by the RCN on a Scottish Rapid Response service found that a reablement focused, Rapid Response service is likely to be more efficient than other forms of care in the community as they are focused on regaining independence and therefore reduce dependency on other services[30].

Service user / patient outcomes include:

- Increased independence - the Kings Fund notes that intermediate care is effective with regard to helping users regain independence[31];
- Improved access to other health and social care services[32]; a Centre for workforce intelligence report noted that due to the range of professionals that are involved in intermediate care, patients' access to a wider range of services is increased[33]; and
- Improved experience / quality of life - for example a review of Bristol Rapid Response service found significant improvements in patients' experience. Furthermore, other studies have found that patients who accessed reablement services demonstrated a significant short-term improvement in perceived health and quality of life.[34]

4.4 Logic Model

Logic models set out, based on evidence, the inputs and outputs needed to deliver on the expected outputs. The following logic model has been developed using the evidence noted in section 4.3 regarding other Rapid Response Services. It provides evidence of the KPIs used to measure performance of other Rapid Response programmes and allows a comparison with the measures used in the Carmarthenshire Rapid Response service.

meta-analysis of individual patient data'. Canadian Medical Association Journal, vol 180, no 2 pp 175-82.

[29] Health Foundation (2013). Improving patient flow: how two trusts focused on flow to improve the quality of care and use available capacity effectively. London: Health Foundation.

[30] Http://www.rcn.org.uk/__data/assets/pdf_file/0005/592601/Gail_Meier_Short_term_augmented_response_service_STARS.pdf

[31] Kings Fund (2002) Developing Intermediate Care. A Guide for Health and Social Care Professionals.

[32] http://www.cardiffandvaleuhb.wales.nhs.uk/sitesplus/documents/864/updated_integrated-care-for-older-people%5B1%5D.pdf

[33] Kings Fund (2002) Developing Intermediate Care. A Guide for Health and Social Care Professionals.

[34] Kings Fund (2014) Community services How they can transform care. Nigel Edwards

Table 4:2: Illustrative Rapid Response Logic Model

Inputs	Activities	Outputs	Outcomes
Salaries Admin and Equipment Travel costs.	Appointment of team Awareness raising across primary, acute and community sector stakeholders Assessments Development of Processes Response to referrals within time lines Signposting to other services (as appropriate to patients' needs) Personal care provision.	Number of Referrals / by source Number of users seen / supported in line with target waiting times / response times Number diverted from hospital admission/Number of people discharged early/Improved patient flow in hospital and community services[35]	**Service Related Outcomes** • Reduction in the number of unscheduled hospital admissions of over 65 yr. olds [36] • Reduction in the length of hospital stay for patients over 65 / Reduction in delayed discharge[37] • Community and hospital resources used more efficiently[38] • Reduce pressure on other parts of community & hospital services[39] **Service user Outcomes[40]** • Quality of life of service users is improved [41] • Service users regain or maintain independence / functionality[42]; • Improved access to services for patients[43]/ Speedier and more appropriate referral of the patient[44]

[35] Health Foundation (2013) Improving patient flow
[36] Health Foundation (2013) Improving patient flow
[37] Kings Fund (2014) Community services: How they can transform care. Nigel Edwards.
[38] http://www.rcn.org.uk/__data/assets/pdf_file/0005/592601/Gail_Meier_Short_term_augmented_response_service_STARS.pdf
[39] Health Foundation (2013) Improving patient flow.
[40] The service user outcomes should be monitored by user profile to ensure equality and build understanding of the service i.e. gender, age, source of referral, user needs etc.
[41] Kings Fund (2014) Community Services: How they can transform care. Nigel Edwards.
[42] Kings Fund (2002) Developing Intermediate Care A Guide For Health and Social Services Professionals
[43] Centre for Workforce Intelligence Older People Care Pathway Team June 2011
[44] Centre for Workforce Intelligence Older People Care Pathway Team June 2011

Key Findings

Research shows that older people may be admitted to hospital or kept in hospital longer than required due to a lack of support / help at home, resulting in a significant cost to the health and social care system and a poorer experience for patients. ICF monies for the Carmarthenshire Rapid Response service were used to address this need by providing a domiciliary care service that provides an urgent response to prevent unnecessary hospital admissions and to facilitate early discharge from acute hospitals.

5 INTEGRATION

5.1 Introduction

The following section details integration[45] of stakeholders at strategic and operational levels.

5.2 Pre ICF Integration Levels

The Whole Systems Partnership Report issued in March 2014 set out the current situation at that time with regard to integration between health, social care and housing. It stated that:

- *'There is no **common language** for intermediate care in the Mid and West Wales area;*
- *Whilst there had been some progress there were **variable levels of integration** between health and social care and there had been little integration with the third sector or housing services.*
- *No consistent or robust **information base** on levels of need or housing services*
- *No consistent or robust basis for **constructing proposals or evaluating costs and benefits** for further development of intermediate care services'.*

A mixed methods approach was used to measure the distance travelled with regard to the integration between these services (e.g. using surveys and interviews to ask staff and stakeholders regarding change in integration, use of language and systems and use of consistent processes throughout the funding period).

This section reviews the extent to which ICF has progressed in each of these areas based on the feedback provided.

5.3 Strategic Level Integration

5.3.1 Project Board

The project is overseen by an Integrated Project Board, which includes Carmarthenshire County Council Social Services Directors, Hywel Dda University Health Board Heads of Service and a third sector representative (Pembrokeshire Association for Voluntary Action (PAVS)). Therefore relevant organisations are represented on the Project Board and at a sufficiently senior level to make decisions and to influence the structure and delivery of the project. The project board met monthly from June 2014 to March 2015 and reviewed progress against the Projection Initiation Document (PID).

Therefore, the Project Board brought together representatives from different sectors, however there is insufficient evidence to conclude on the effectiveness of this structure.

[45] By integration this refers to in principal "a single system of needs assessment, service commissioning and/or service provision" to deliver health outcomes (Health and Well-being Best Practice and Innovation Board (2013) *The Determinants of Effective Integration of Health and Social Care*)

5.4 Operational level integration

5.4.1 Project Management, Structure and Resources

There is a dedicated Support and Development Manager (SDM) for service provision who is employed by Carmarthenshire County Council and reports to the Senior Service Manager. The SDM represents the Senior Manager at Regional Project Board meetings. This structure allows the Support and Development manager access to all the organisations who are key to the delivery of the project.

Table 5:1: Staff Structure for the Rapid Response Service

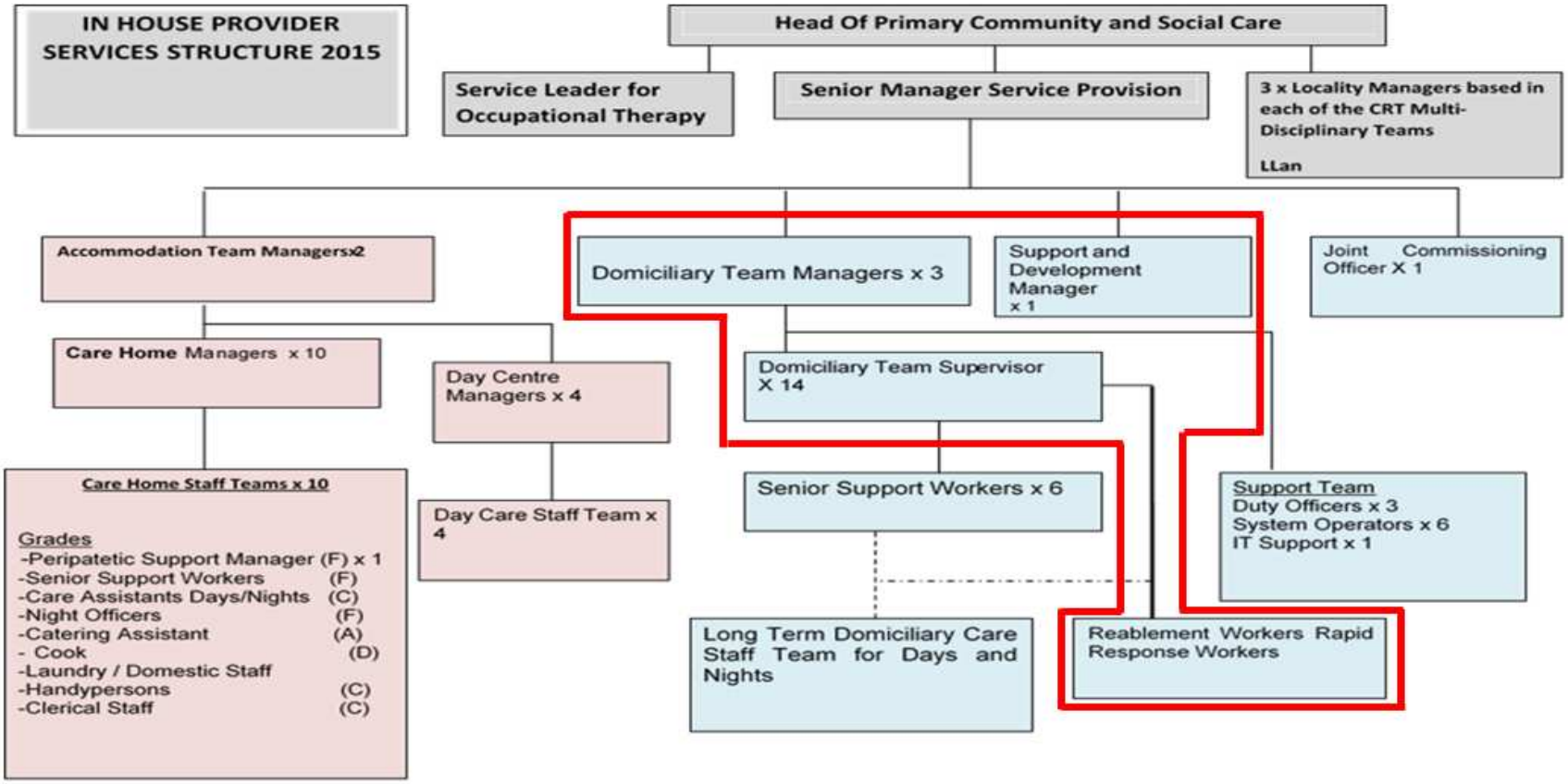
Role	Details / Purpose
Support and Development Manager (x1)	Oversees implementation of the Rapid Response Service
Domiciliary Support Workers (x24)	Provision of care and support to service users 24 @ 261/4 hours per week- 2 shifts: Early Shift 7am-3pm Late Shift 2pm – 10pm

Source: Project Initiation Document – June 2014

The Support and Development Manager is based within the Provider Service Team and works from a centralised location in Carmarthenshire to manage the service. This post supports service development and Team Managers.

The following figure shows the current connections between Rapid Response, domiciliary care and other social services teams including the multi-disciplinary CRTs and long term domiciliary care services.

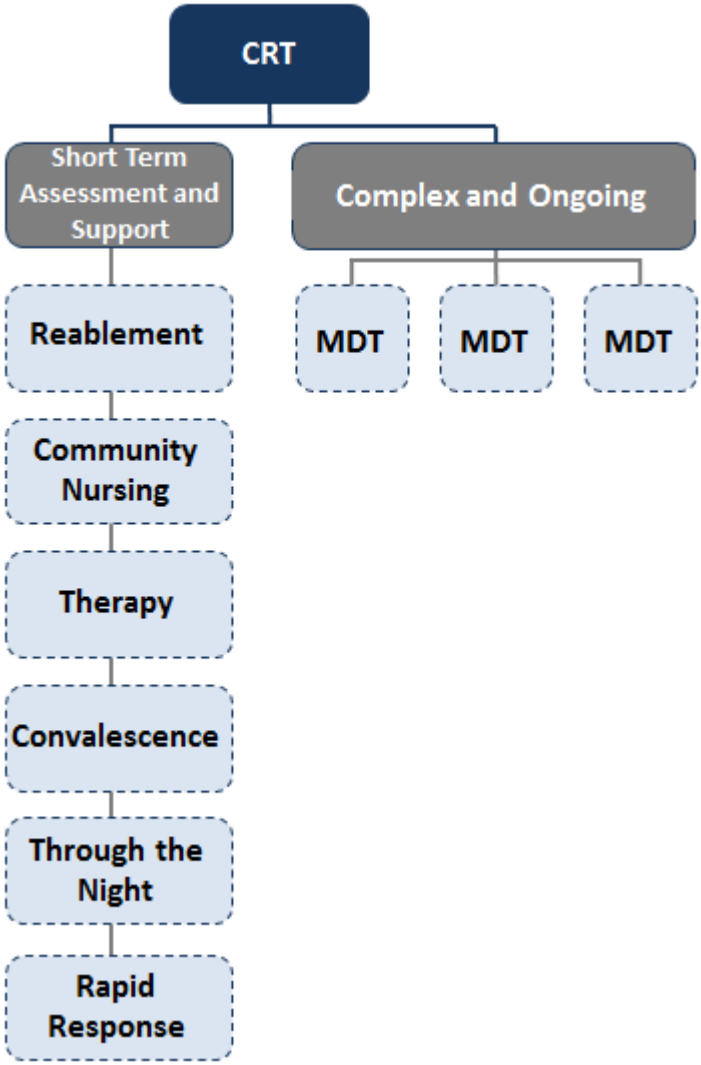
Figure 5:1: Overview of how Rapid Response currently sits within the overall Domiciliary Care Service



Source: Rapid Response- Reablement - Staffing June14

It is noted that there is currently a review underway of all short term intervention services, it is envisaged that the Rapid Response service will be more closely aligned in order to facilitate closer links to hospital staff, higher levels of referrals and a reduction in inappropriate referrals (for example fewer referrals for patients who require long term care). An outline of the proposed new structure is in figure 5.2.

Figure 5:2: Proposed New Structure



Source: Support and Development Manager

5.4.2 Staff Feedback on Integration

As part of the evaluation staff were surveyed (see appendix B) about their views on the Carmarthenshire Rapid Response service and their experiences of working as part of an integrated team. Twelve members of 24 staff (50% response rate) provided feedback and a summary of this is provided below.

Staff in supervisory or managerial roles reported having more contact with staff from other agencies and professions as a result of the service. For example, they noted that hospital staff were now more likely to contact them and ask for advice on who to refer and / or make referrals to the service. 100% of staff who responded to the survey agreed or strongly agreed that that there was effective multi-disciplinary team working in the service and two respondents specifically noted that the service had improved patient handover procedures. However, a small number of staff also **suggested areas for improvement**:

- **Communication**: one respondent felt that communication between the service and hospital staff could be improved. Two respondents also noted that there should be increased levels of communication with OTs and another two felt communication with the Primary Care teams could be improved. These respondents believed that there was a low level of awareness of the service amongst GPs, particularly with the Out Of Hours (OOH) service.
- **Standards**: one interviewee noted different competencies and standards for staff from different agencies, which made working as part of a multi-disciplinary, multi-agency team more difficult. For example, District Nurses work to Health Standards[46] while Care Workers work to standards set out by the Care Council Wales (CCW).[47] This interviewee believed that the service would be more effective and streamlined if the same standards/competencies could be used. Whilst these reflect different lines of work, there may be scope to explore the use of common standards and associated competencies.

5.5 Risk Management

An initial risk assessment[48] was undertaken at the project planning stage. The risk plan developed as a result of this assessment highlighted risks regarding: getting staff recruited on time; ensuring that there was sufficient capacity within Domiciliary Care to meet demand; inappropriate referrals to the service; and funding not being available to deliver the service in the future.

The lack of integrated working was not noted as a risk, however it was partially mitigated through the appointment of experienced domiciliary care staff, who already had relationships

[46] http://www.qni.org.uk/docs/DN_Standards_Web.pdf
[47] http://www.ccwales.org.uk/national-occupational-standards/

[48] Domiciliary Rapid Response – Project Initiation Document (June 2014)

developed with hospital staff, and therefore able to get referrals. However, there was a need to develop closer working relationships with more GPs.

Key Findings

The project adopted an integrated approach at a strategic level as it was overseen by an integrated project board. Qualitative feedback from staff indicated the project had increased communication between social services and hospital staff and that this in turn had helped to improve the patient handover process. It was also noted that the referral process from integrated CRTs worked well and that the project had helped improve communications and relationships between staff from the various agencies.

Whilst the services are delivered solely by Carmarthenshire County Council Social Services staff, the project has provided the opportunity for them to work more closely with staff from other organisations including Hywel Dda Health Board and the integrated CRTs.

Staff survey feedback indicates that they felt the project had increased communication between social services and hospital staff and that this in turn had helped to improve the patient handover process. It was also noted that the referral process from integrated CRTs worked well and that the project had helped improve communications and relationships between staff from the various agencies.

Areas for Development

While the Rapid Response project had a clear focus on early discharge and reducing the number of people admitted to hospital, no targets were set regarding integration / collaboration, meaning it is not possible to conclude on whether the process worked as expected. Research[49] by the Nuffield Trust states that this should include impact on health outcomes, but also improved quality of care, service user satisfaction, and effective relationships and systems.

Going forward, the project should consider ways in which the profile of the service (and the benefits it can bring to the Health Service and the patients) can be raised with other health care teams such as GPs and OTs, possibly through e.g. community nurses, in order to maximise referrals.

[49] Nuffield Trust (2011) *What is Integrated Care?*

6 PROJECT MONITORING AND OUTCOMES

6.1 Introduction

The following section provides an assessment of the extent to which any service related and service user outcomes[50] have been realised from June 2014 to March 2015 and how outcomes have been monitored.

6.2 Monitoring and Reporting

6.2.1 Data Collection and Reporting

The Support and Development Manager collates data from Service Managers and Supervisors. Quarterly reports were submitted to the Project Board. These reported on:

- Total funding allocation / spend for each quarter / total spend to date and any underspend;
- Number of referrals / people who accessed the service;
- Number of potential hospital admissions diverted / avoided;
- Number of patients that have been discharged early; and
- Qualitative examples of the services in the form of short case studies.

An end of year report followed the same format and provided information on achievements from June 2014 to March 2015.

The quarterly and end of year reports primarily provide information on the following three objectives:

- Increased integrated Rapid Response capacity will reduce unscheduled admissions to hospital;
- To achieve increased Rapid Response Capacity, working towards the achievement of an optimised function in which 15% of potential unscheduled over 65 medical admissions are to be avoided through provision of alternative support; and
- Provide a rapid response to the telecare community alarm system when activated for assistance.

[50] Outcomes for integrated care are centred on the impact services have on a person's life. The Social Policy Research Unit split outcomes into four separate categories Quality of life outcomes/personal outcomes – daily living and acceptable quality of life; Process outcomes – individual experience of support; Change outcomes – improvements to physical, mental or emotional functioning; and Maintenance outcomes – no change in condition (Glendinning, C., Clarke, S., Hare, P., Kotchetkova, I., Maddison, J. and Newbronner, L. (2006) Outcomes-focused Services for Older People, SCIE Knowledge Review, 13)

Monitoring and Reporting – Areas for Development

There are areas included in the PID which are not monitoring or reported on. These are:

- To further help people in their goal to remain healthy and independent;
- To enhance the quality of life for people with care and support needs; and
- To ensure that people have a positive experience of care and support.

Given that there are set as objectives for Rapid Response, it is important that there is evidence that the service is delivering on these.

Furthermore, data is collected on response times for referrals, however this data is not reported to the project board. This is a key indicator as the Carmarthenshire Rapid Response service was established to provide a faster service than the service that had existed previously. Reports should therefore measure performance in these areas.

There is currently no process in place to collect satisfaction data, quality of life or feedback on their experience of the service. It is suggested that KPIs are set for these areas such in line with those suggested in the logic model (see section 3; i.e. service user satisfaction and quality of life) and evidence should be collected against these using robust tools such as the Older Peoples Quality of Life Questionnaire (OPQOL).[51]

ICE-F guidance[52] states that the assessment of the impact of delivering integrated care needs to be considered at three levels; national, local and individual:

- National Objectives: For example, the number of over 65s length of stays in hospital will be reduced; a reduction in A&E call outs and emergency admissions for over 65s
- Local, service or organisational objectives: For example, output measures concerned with service efficiency and performance could monitor avoidable admissions, unnecessary length of stays, number of planned care admissions against emergency admissions for over 65s. Costs can be calculated according to service use; and
- Individual or personal objectives for the individual for the service users: Social Cost benefit / outcomes measures: For example, individuals and their carers can maintain contact with a key health or social care professional with whom they can discuss their care needs and can plan and refer care as necessary. The individual's wellbeing, independence and capability can be measured against their desired outcomes from receiving the service delivered.

The Carmarthenshire Rapid Response service has KPIs at national and local level, however KPIs should be developed at individual level. In addition, baseline or distance travelled data is required to provide evidence of how the service has contributed to individual outcomes (for example, rating wellbeing at beginning of service, middle and at discharge or referral).

[51] Bowling, A. an Stenner, P. Journal of Epidemiology and Community Health 2011;**65**:273-280
[52] Dr Carnes-Chichlowska, Susan; Professor Burholt, Vanessa & Dr Rea, David (2015) The Integrated Care Evaluation Framework (ICE-F): *A Realistic Evaluation of Integrated Health and Social Care Services in Wales*

6.3 Performance over the Evaluation Period

The Rapid Response PID sets out a number of activities that were required to take place in order to meet the objectives. These were reported on quarterly, as summarised in the table below:

Table 6:1: Performance against Objectives (June 2014[53] – March 2015)

Activities [54]	Performance
Respond to GPs and District Nurses who identify service users in the community that would benefit from hospital avoidance and be able to remain safely at home	**Activity Completed:** Consultations with key stakeholders and staff suggested there was a low level of awareness of the service amongst GPs and in particular the GP OoH service. This point of view is further validated by the low level of referrals to the service from Primary Care teams (10%). However, GPs were not consulted as part of this evaluation and therefore their reasons for low referrals is not known. **No specific targets were developed for this activity / objective. In any future service, it would be useful to pilot work with a number of GP practices in order to project the potential numbers or % of GP case load that could be referred. These %s could then be applied to other GP practices.**
In-reach to referrals from the acute hospital departments of Accident and Emergency and CDU to remove people who are medically fit and ready for discharge out of the hospital setting and return them safely to the community	**Activity Completed:** The project monitoring reports state that the service has been able to reach 51 people who were medically fit but in hospital and to facilitate their discharge. This will have contributed to service level outcomes including improved patient flow, freeing up of vital hospital resources and produced costs savings. It is not possible to calculate the cost savings (due to those who are medically fit but in hospital) as the number of days saved for each patient is not collected. **No specific targets were developed it is unclear as to whether all the potential patients that could have been referred where referred. Further work is required again to assess whether there are a number of patients that could be utilising this service, but who are not and the reasons for this.**

[53] Recruitment of existing internal staff for the Rapid Response Service commenced in June 2014, staffing resource was in place to introduce the service from September 2014
[54] Rapid Response Project Initiation Document

Activities [54]	Performance
Enhance access for service users requiring domiciliary rapid response support in order to prevent hospital admissions	**Activity Completed:** 75% of referrals were responded to within the same day (based on project monitoring data). **No specific targets were developed for this activity / objective.**
Develop a domiciliary care service to provide an urgent response to the needs of people who are experiencing a crisis due to an acute or chronic condition	**Activity Completed:** 24 domiciliary care support staff were deployed in provide an urgent response service (since October 2014). **No specific targets were developed for this activity / objective.**
Provide a rapid response to the telecare community alarm system when activated for assistance	**Activity Completed:** 113 people who used telecare alarms were referred to the Rapid Response service (based on project monitoring data). **No specific targets were developed for this activity / objective.**
To increase the use of rapid response by primary care	Only 10% of the referrals (as detailed in section 2) came from Primary Care Teams. As no baseline data or specific targets were set, it is not possible to say if this objective has been achieved. **No specific targets were developed for this activity / objective.**

Data sourced on performance and detailed in the table above has been sourced from Project Monitoring reports.

Overall, it is not possible to determine the extent to which the project met all of its stated objectives as while there is evidence of activities, there were no associated targets set.

6.4 Outcomes

The Carmarthenshire Rapid Response service set the following 'key outcomes' at service level (as defined in the project end of year report).

Table 6:2: Patient outcomes

Project Outcomes	Patient Numbers	%
Potential hospital admissions diverted to RR	167	43%
Early Hospital Discharge	51	13%
Total number of responses to Telecare Alarms during the day	113	30%
Service User numbers held by RR awaiting Reablement/ Long Term Domiciliary	39	10%
Other	15	4%
Total	385	100%

Source: Project End of Year Report March 2015

Table 6.2 shows that of the 385 patients who accessed the service 43% of them avoided hospital admission. This contributes towards the objective of providing 'an optimised function in which 15% of potential unscheduled over 65 medical admissions are to be avoided through provision of alternative support'. However, as the total number of hospital admissions for those aged 65 has not been specified, it is not clear if the objective has been fully achieved.[55] Cost savings are considered in the economic assessment section (section 6).

Additionality is a key concept when assessing the impact of any intervention as it assesses the extent to which the outcomes delivered would have happened anyway. Patient feedback is generally used to get this information; however, it was not possible to complete such a survey in this evaluation. Staff survey feedback indicated they felt that patients would definitely not have achieved the same benefits and would have had to spend a longer time in hospital.

Patient Case studies

Whilst it was not possible through this evaluation to collect primary data from service users to understand the impact of the Carmarthenshire Rapid Response service for service users, the following case studies were included in the Project End of Year report dated March 2015.

[55] Data from Hywel Dda University Health Board shows that in 2014/15 there were 36,526 emergency admissions to Glangwili and Prince Philips Hospitals, however, the proportion of these who were aged over 65 years has not as yet been provided.

Case Study 1 – Mrs A Enhanced Hospital Discharge

Mrs A was admitted into hospital via A& E on the 20th of November, 2014 due to a general deterioration in health and confusion. Whilst on the ward staff and the service users' husband raised concerns that Mrs A's health and mobility had deteriorated in the months prior to admission resulting in oedema and ulcers on both legs. District Nurses had been visiting daily. Being unable to undertake personal care resulted in tissue viability issues which was exacerbated by Mrs A sleeping on a reclining chair for the last 12 months. On admission Mrs A was non weight bearing and was therefore hoisted for all transfers.

Rapid Response Intervention

Whilst considerable therapeutic and nursing support was input by the hospital staff the care package to go home was for 2 Domiciliary Support Workers four times per day to support with personal care, dressing, undressing, toileting and all transfers

Outcome

Mrs A's husband was supported by ensuring that his wife's nutritional needs were met by providing meals, snacks and drinks. In the first few week RR staff worked closely with Mr and Mrs A. Progress was made and the care package was reduced from four visits a day to two visits per day. Following the transfer to Reablement continual progress was made to Mrs A's mobility and only one carer was required twice per day to assist with personal care.

Case Study 2 – Mrs Y Avoiding Hospital Admission

Mrs Y was taken to A&E after falling on a shop escalator and suffering a sprained ankle, broken knuckles, and bruising to her ribs and left side of her face. Mrs Y lives with her husband who has chronic heart failure and hearing problems. Mrs Y is her husband's main carer. After assessment in A&E, Mrs Y was discharged to the Rapid Response Team via the Out of Hours Domiciliary Care Manager, thus avoiding hospital admission. Prior to this accident Mrs Y was independent and no social service input had ever been in place. When discussing what was important to Mrs Y she explained that she would like to regain her independence as soon as possible.

Rapid Response Intervention

It was identified that three calls per day by a single staff member was required for assistance with personal care tasks and meal preparation. The Rapid Response Team supported Mrs Y for four days, after which the care package was transferred to the Reablement Team.

Outcome

During this time, Mrs Y improved and within three to four weeks visits were decreased and eventually ceased due to full independence being achieved. Mrs Y was so grateful for the input of the service that she sent a letter to compliment and thank the staff teams.

Key Findings

The Carmarthenshire Rapid Response Project has prevented 167 admissions and supported 51 early discharges over the evaluation period, which related to 7 months of service delivery, given the time needed to get the service up and running Feedback from staff also indicates that without the service patients would have remained in hospital for longer and patient case studies demonstrate the positive impacts of the service on the health and well-being of patients.

Areas for Development

Carmarthenshire Rapid Response has focused on benefits at service level, as shown by the information reported on to the Project Board monthly. Further information is required in order to fully evidence the total impact of the service. In particular, the outcomes for service users should be measured, including patient's experience and the extent to which their quality of life has improved alongside those measuring gains to health / social care services in order to provide a holistic view of the benefits being achieved. Specifically, data should be collected in relation to the following:

- **Reduction in the length of hospital stay for patients over 65 / Reduction in delayed discharge**: data should be collected on the number of days saved through early discharge which would facilitate a more accurate analysis of hospital bed days saved.
- **Improved patient flow**: as noted in the logic model (section 3) Rapid Response services should have a positive impact on patient flow. This could be measured using data such as length of stay in hospital, length of engagement with Rapid Response and information on where patients are discharged to following Rapid Response.
- **Patient satisfaction/patient experience:** whilst it is recognised that qualitative case studies have been collected to describe the patient journey, there has been no systematic approach to collecting data on patients' experience with the service. Staff should issue brief surveys to all those who have been supported through the service and the results should be reported on a quarterly basis.
- **Increased independence/functionality/quality of life:** the improvement in health and well-being of patients is core to the delivery of intermediate care services. The National Audit of Intermediate Care[56] recommends the use of the Barthel Index[57] on admission to and discharge from intermediate care services to assess the extent to which patients have regained their day-to-day functioning.

[56] NHS (2015) National Audit of Intermediate Care
[57] Ordinal scale used to measure performance in activities of daily living (ADL) – measures function & quality of life

7 ECONOMIC ASSESSMENT

7.1 Introduction

This section sets out the economy, efficiency and effectiveness of the Rapid Response service, as well as the saving it has generated within health or social services.

7.2 Economy[58]

The funding received for this project was £311,550 for over the period June 2014[59] to March 2015.

Table 7:1: Budget vs. Expenditure for the Rapid Response Project (June 2014 – March 2015)

	Budget	Expenditure	Variance[60]
Quarter 1 (June 2014)	£77,887.50	£0.00	£77,887.50
Quarter 2 (July – Sept 2014)	£77,887.50	£9,627.55	£68,259.95
Quarter 3 (Oct – Dec 2014)	£77,887.50	£112,665.43	-£34,777.93
Quarter 4 (Jan – Mar 2015)	£77,887.50	£142,147.52	-£64,260.02
Total	**£311,550**	**£264,440.50**	**-£47,109.5**

Source: Rapid Response Project Manager (October 2015) – ICF Claim Form

Overall the programme recorded an underspend of almost £50,000. This was largely due to the lead in time required to establish the service, attract and appoint staff, and acquire the necessary equipment. The service became operational on the 15 September 2014 and while spend in the next quarter increased significantly, there was insufficient time left to meet the overall spend targets for the year.

[58] Economy considers the extent to which activities were delivered at minimum cost
[59] Recruitment of existing internal staff for the Rapid Response Service commenced in June 2014, staffing resource was in place to introduce the service from September 2014
[60] Refers to how much an actual expense deviates from the budgeted or forecast amount

Table 7:2: Analysis of Spend (June 2014 – March 2015)

Area of Spend	Budget[61]		Actual[62]		Variance	
	£	% of total budget	£	% of spend	£	% of spend vs. budget
Staffing						
Salaries and Staff Costs	£265,976	85.4%	£248,196	93.9%	-£17,780	93.3%
Staff Travel Expenses	£43,590	14.0%	£14,493	5.5%	-£29,097	33.2%
Administration and Equipment						
Admin, Operational & Office Equipment	£1,984	0.6%	£146	0.1%	-£1,838	7.4%
Computer Hardware	-	--	£1,600	0.6%	+£1,600	-
Subsistence						
Subsistence	-	-	£6.80	0.003%	+£6.80	
Grand Total	**£311,550**	**100%**	**£264,441**	**100%**	**£47,109**	**84.9%**

As set out in the above table the majority of spend was on staff salaries, which accounted for 93.9% (£248,196) of the total spend. Other staffing related costs including travel expenses accounted for 5.5% of the total spend (and accounted for over half of the under spend). Less than 1% was spent on administration and equipment.

It should also be noted that the project received in-kind support from Carmarthenshire County Council. In-kind contributions included support from a Social Services Manager (20% of her time which equates to approximately £11,718 over the 10-month period) and other indirect costs such as HR, IT and accommodation, the value of which would be in the region of £39,667 based on 15% of the project costs.[63] Therefore the total value of the Council's in-

[61] Carmarthenshire County Council Finance
[62] Carmarthenshire County Council Finance
[63] Indirect costs usually include resources such as Human Resources, Finance and IT services and are also allocated to projects based on estimates. We have used an estimated overhead figure of 15% that is normally applied to project work as this is sighted as best practice by the Wales European Funding Office.

kind contribution is in the region of £51,385.

The Carmarthenshire Rapid Response service has been delivered economically as it was able to use Council services to establish and manage the project. The ICF funding was therefore mainly used for additional domiciliary care staff delivering front line services.

7.3 Efficiency[64]

Efficiency is measured through comparing the average cost per patient for the Carmarthenshire Rapid Response service with two other schemes which were also focused on reducing hospital admissions. Note, it was not possible to access robust evaluation data on other Rapid Response services based on a social care model and this information would have been preferred. Ideally, social care model comparators will be found for any future evaluation. The two comparators (Advanced Prevention and Facilitated Discharge and Lincoln Rapid Response Teams) are health led and are mainly delivered by clinical staff (including GPs and nurse clinicians), they are focused on getting packages of care into patient's homes to facilitate early discharge and reduce hospital admissions. Therefore, it is important to consider the differences in how the schemes are delivered when comparing outputs. Details on the benchmarks are included in Appendix C.

Table 7:3: Comparison of Services

	Carmarthenshire Rapid Response	APFD	Lincoln RRT
Cost	£264,440.50 (ten months from June 2014 to March 2015[65])	£93,658.49 (Feb 2011-January 2012[66])	£989,218[67] (November 2013 to March 2014)
Cost per patient	£687[68]	£306[69]	£1,910
Average number of referrals per month	39[70]	28[71]	124[72]

[64] Efficiency: considers the benefits (the net outputs or outcomes) compared to the intervention costs
[65] Service delivery was September 2014 – March 2015
[66] Proposal for the future commissioning of the admissions prevention service (29th November 2011)
[67] This figure does not include the staff salaries of operational workers who were already in post. If these salaries are included, the set-up and operational costs of the RRT rise to £1,185,940. This figure is also for four RRTs.
[68] Cost to deliver the service over a 10 month period £264,440.50 / 385 patients who accessed the service over the period = £686.86 per patient
[69] Cost of the service over a 12 month period £102,172.90 (Cost for 11 months (February 2011 – January 2012) £93,658.49 / 11 = £8,514.41 (costs per month) * 12 (months) = £102,172.90) / /334 =£305.91
[70] Based on 385 patients accessing the service over the 10-month period / 10 = 39 per month
[71] Based on 334 referrals in the first full year / 12 months = 28 per month
[72] Based on 621 referrals to four teams from November 2013 to March 2014.

Table 7.3 shows that the Rapid Response service compares very favorably with Lincoln RRT in terms of cost per patient and overall cost (and this could be due to the involvement of GPs and nurses not involved in Carmarthenshire Rapid Response). The Lincoln service is similar to the Carmarthenshire Rapid Response service as it accepts referrals from a range of stakeholders and delivers care in the home following a multi-disciplinary assessment. The Carmarthenshire Rapid Response service cost per patient is significantly less than the Lincolnshire service at £687 compared to £1,091.

The other service that was identified as a benchmark (APFD) appears less expensive per patient than the Carmarthenshire Rapid Response service (at £306 per patient). However, the APFD service primarily accepts referrals, undertakes assessments and then refers the patient on to other appropriate services. Unlike the Carmarthenshire Rapid Response service and the Lincolnshire RRT it does not provide the care (while the Carmarthenshire Rapid Response service may intervene to support people at crisis, it also maintains domiciliary support until another agency can provide support if longer term needs are identified). APDF was included as a benchmark as the structures and processes that were established to respond quickly and make patient assessments are similar.

It should also be recognised that the Carmarthenshire Rapid Response service was a pilot and there have been costs involved in set up (i.e. developing new processes; training staff in new processes and building new relationships with referral bodies etc.) which have impacted on the costs; therefore further efficiencies may be possible in the future.

7.4 Effectiveness[73]

Effectiveness considers how well the project delivered against the objectives that were set for it. No specific targets were set for the number of patients to be treated by the service, the rate of hospital admissions prevented or bed days saved.

7.5 Cost Savings

The service prevented admissions for 167 patients (43% of all referrals).[74] Data from local hospitals[75] indicates that the average length of stay in hospital for patients over 75 years in Carmarthenshire is 10.7 days. Therefore, if it was assumed that each of the 167 patients were saved from staying in hospital for this period it results in an estimated saving of 1,786.9 days. However further information is needed on the nature of the conditions in order to more accurately predict the number of bed days saved.

Furthermore, the project facilitated the early discharge of 51 patients, however it is not known how many hospital bed days were saved as a result of the service, nor is it known how long patients stayed in hospital prior to their discharge. However, if it is assumed that the

[73] Effectiveness: involves considering whether an intervention's objectives have been met.
[74] Data source from project reports
[75] Hospital patient data provided via the project manager

Carmarthenshire Rapid Response service saved at least 1 hospital bed day per patient that would equate to an additional 51 bed days saved. If it is assumed that the facilitation of early discharge would save half of the average hospital stay of 10.7 days this would equate to a total saving of 272.8 bed days. Therefore, it is estimated that the Rapid Response service delivered a saving of between 51 and 272.8 bed days through the facilitation of early discharge

Data from NHS Wales[76] indicates that the cost of an acute hospital bed day is £426. The following table provides an overview of the estimated savings in hospital bed days generated by the Carmarthenshire Rapid Response service, based on the assumptions detailed above.

Table 7:4: Estimated Savings from Hospital bed days saved

	No. of patients	Estimated bed days saved	Estimated Costs Saved
Prevented Hospital Admission	167	1,786.9	£791,219
Early Discharge from Hospital (1 day) – 51 patients	51	51	£21,726
Early Discharge from Hospital (5.35 days) –51 patients	51	272.8	£115,148

As set out in the above table, the estimated gross savings in hospital bed costs is £812,945 (£791,219 + £21,726), based on a saving of 1 day per patient early discharge. If it is assumed that the service could generate up to 5.3 days hospital beds days for early discharge patients, the total estimated gross savings could increase to £906,367 (based on 51 patients).[77]

Total ICF expenditure was £264,440, therefore the project has generated net savings of £548,505 over the seven months that it was operational (October 2014 - March 2015). If it is assumed that patients who were discharged early saved on average 5.3 days the net saving would increase to £641,927. However, these figures should be treated with caution based on the assumptions made. The cost savings noted above do not take into account other potential savings associated with the service, such as a potential reduction in the number of patients entering long term domiciliary care, avoided admissions to nursing or care homes, or avoided ambulance journeys. Furthermore, the analysis does not take into account the benefits to patients such as increased or re-gained functional ability or quality of life. Due to a lack of data these additional savings cannot be measured at this point in time.

[76] NHS Wales
[77] 51 patients x 5.3 bed days x £426 (cost of a bed day) = £115,148 + £791,219 (avoided admissions) = £906,367.

7.6 Sustainability and Future Prospects

Further research should be undertaken on the need and capacity in other council areas before the service is rolled out across Mid and West Wales. Specifically, an assessment of need should be completed to determine if there is a need to provide an urgent response to referrals for domiciliary care to prevent delayed discharges and help to avoid unnecessary admissions. There is a need to determine if there is existing capacity within domiciliary care/reablement services in other Councils within Mid and West to continue to provide this urgent response service or is there a need for additional resources. Any research or review in this area should take a whole systems approach and therefore consider the level of potential referrals from hospitals and other relevant staff in the community (e.g. GPs / community organisations), as well as the capacity to deliver the service. It is noted that the Carmarthenshire Reablement Service Structures are currently review under and it is understood that the Rapid Response service will be more closely aligned in order to facilitate closer links to hospital staff, a higher levels of referrals and a reduction in inappropriate referrals (for example fewer referrals for patients who require long term care).

Key Findings

The project can be considered to be economic as it was delivered within budget and also 93% of expenditure was on front line services. Overall the Rapid Response service was under budget by £47,109 which was mainly due to the lead in time required to establish the project, attract and appoint staff, and acquire the equipment necessary to run the service. However the service effectively prevented admissions for 167 patients (43% of all referrals) and facilitated the early discharge of 51 patients. This resulted in a gross cost saving of £812,945 / net cost saving of £548,505. Therefore, every £1 invest in the Carmarthenshire Rapid Response service provided a return of £3.07 (gross) and £2.07 (net).

Areas for Development

Targets were not set for the Carmarthenshire Rapid Response service and therefore it is not possible to definitely conclude on whether it effectively delivered on expectations.

However, cost saving calculations only reflect those due to hospital bed days saved and there is potential for further outcomes and cost savings to be evidenced through more robust monitoring and data collection of service user outcomes and data on the discharge location of service users (e.g. to another secondary care setting).

8 CONCLUSIONS AND RECOMMENDATIONS

8.1 Introduction

The Carmarthenshire Rapid Response service was designed to enhance collaboration and integration through a multi-disciplinary, coordinated care approach. It was devised to support the provision of increased care closer to home as part of the integrated community locality model. The key aims for the Carmarthenshire Rapid Response service as set out in the PID[78] were:

- To strengthen the domiciliary team to be able to provide a model of anticipatory care to the frail elderly as well as to those with chronic conditions and palliative care needs whose needs can ebb and flow (rise and fall) overtime;
- To successfully reduce the number of people admitted into hospital and deliver more timely discharges of patients back into the community;
- To further help people in their goal to remain healthy and independent;
- To enhance the quality of life for people with care and support needs;
- To delay and reduce the need for care and support; and
- To ensure that people have a positive experience of care and support.

8.2 Integration

The project adopted an integrated approach at a strategic level as it was overseen by an integrated project board. Qualitative feedback from the staff survey[79] indicated the project had **increased communication between social services and hospital staff** and that this in turn had helped to improve the patient handover process. It was also noted that the **referral process from integrated Community Resource Teams (CRTs) worked well** and that the **project had helped improve communications and relationships** between the staff involved. However, while the Rapid Response service had a clear focus on early discharge and reducing the number of people admitted to hospital, no targets were set regarding integration / collaboration, meaning it is not possible to conclude on whether the process worked as expected.

Recommendations:

- **Objectives and targets should be set with regard to what effective integration and collaboration looks like for the service**. Research[80] by the Nuffield Trust states that this should include impact on health outcomes, but also improved quality of care, service user satisfaction, and effective relationships and systems.
- **Referral data should be examined to consider the specific numbers being referred by GPs and Primary Care Teams and whether there are opportunities to**

[78] Source: Domiciliary Rapid Response – Project Initiation Document (June 2014)
[79] An on-line survey of 12 staff members (50% of 24 staff)
[80] Nuffield Trust (2011) *What is Integrated Care?*

increase these. The project should consider ways in which the profile of the service (and the benefits it can bring to the Health Service and the patients) can be raised with other health care teams such as GPs and OTs (e.g. through community nurses) in order to maximise referrals. In addition, in any future service it would be useful to pilot work with a number of GP practices in order to project the potential numbers or % of GP case load that could be referred. These %s could then be applied to other GP practices.

- We recommend that an **up to date handbook of care service**s is available to all care agencies to sustain integration, to allow for direct communication between professionals, and to build confidence in care provision.
- **Research is needed to confirm that all of the target audience are being reached**. Further work is required to assess whether there are a number of patients that could be utilising this service, but who are not and the reasons for this. This could be done through reviewing the records in a number of wards for a period of time. This would provide information on whether the service is being referred to appropriately, and the projected numbers to come through should there be more numbers identified**.**
- **The capacity of the Rapid Response service should be sufficient** to ensure that a tight turn around target of all those being referred are supported within two days.

8.3 Outputs / Outcomes

8.3.1 Outcome Measures

Project monitoring reports provided information on service level 'outcomes', specifically the prevention of hospital admissions and facilitating early discharge. These were key to ensuring that service was demonstrating a contribution to reducing the pressure for beds within hospitals. However, it should also measure the patient experience and how quality of life is improved for those who use its services. In addition, a number of areas that were detailed in the PID were not monitored. Specifically, there was no data collected against the following aims / service user outcomes:

- People will be further helped in their goal to remain healthy and independent;
- To delay and reduce the need for care and support;
- Enhance the quality of life for people with care and support needs; and
- Ensure that people have a positive experience of care and support.

Evidence on all of the above can be collected through surveys or interviews with service users. There is a strong body of evidence noting that the collection of feedback from service users is best practice in the evaluation of intermediate care services,[81] including patient satisfaction, health and well-being improvements (reablement)[82] and patient quality of life.[83]

[81] For example see Kings Fund (2002) Developing Intermediate Care. A Guide For Health And Social Services Professionals.
[82] Kings Fund (2002) Developing Intermediate Care A Guide For Health And Social Services Professionals
[83] Kings Fund (2014) Community services How they can transform care. Nigel Edwards

8.3.2 Performance

The key areas of strength within the existing service were the:

- Development of domiciliary care capacity and systems within the council in a short period of time;
- Achievement of 167 people avoiding hospital and 51 people discharged sooner as a result of this service; and
- Delivery of the service on time and within budget, and ability to respond to short turnaround times for helping clients.

Areas for development include:

- SMART targets should have been established for the Rapid Response service at the outset (based on performance against a baseline / linked to an evidence based logic model) and in line with ICE-F guidance, which states outputs and outcomes should be defined at national, local and individual / personal level. In the absence of SMART targets, it has not been possible to effectively conclude on the success or effectiveness of the Carmarthenshire Rapid Response service.
- Only 10% of referrals came from the Primary Care teams. Targets are needed for referrals from those working in primary care. These should be set after a review of the numbers of people being referred to hospital by them that could be helped at home. Targets are also needed for the number of in-hospital referrals.

Recommendations:

- **Include measures relating to individual and personal objectives**. For example, this would include patients' quality of life, improvements in health and well-being and levels of satisfaction with the services provided. The data collected should be in line with national standards for reablement services[84] and ICE-F guidance.
- **Baseline and distance travelled data is required** to provide evidence of how the service has contributed to individual outcomes (for example, rating wellbeing at beginning of service, middle and at discharge or referral).
- **SMART targets should be developed for each objective**; and
- **Future reporting templates should detail quarterly and cumulative progress** against all the objectives and targets details in the PID.

8.4 Economic Assessment

The project was assessed with regard to its economy, efficiency, effectiveness and cost effectiveness and it demonstrated that:

[84] Reablement Gold Standards & Toolkit. Developed in partnership between WSP and the Social Services Improvement Agency during 2009/10 through the development of an action learning set involving 9 of the 22 Welsh Local Authorities.

- **Economy**: Overall expenditure for the project was under budget by £47,109. This was mainly due to the lead in time required to establish the project, attract and appoint staff, and acquire the equipment necessary to run the service. It was delivered economically as it was supported through existing Council structures and resources (i.e. HR, Finance and IT). The ICF monies were therefore focused on front line delivery.
- **Efficiency:** It is difficult to get benchmarks that are exactly the same to the Carmarthenshire Rapid Response service in terms of the support being provided and how it is delivered. However based on available information, the Lincolnshire RRT appears similar in that it accepts referrals from a range of stakeholders and delivers care in the home following a multi-disciplinary assessment. The Carmarthenshire service compares very favorably with the Lincoln RRT benchmark in terms of cost per patient and overall cost. The Rapid Response service cost per patient is significantly less than the Lincolnshire service at £687 compared to £1,910.
- **Effectiveness**: The service prevented admissions for 167 patients (43% of all referrals)[85] and facilitated the early discharge of 51 patients. This resulted in a gross cost saving of £812,945 / net cost saving of £548,505. Therefore, every £1 invest in the Carmarthenshire Rapid Response service provided a return of £3.07 (gross) and £2.07 (net). However, to calculate total savings to the health sector required data on the number of hospital bed days that were saved as a result of the early discharge, however this had not been collected.

Recommendations:

- **We recommend that any future project collects detailed quantitative data relating to early discharge**, for example the number of days saved through each early discharge (not just the number of patients who have been discharged early), which would enable the project to make a more accurate assessment of its impact; and
- **We recommend that data is collected that shows the reduced cost to residential and nursing home care services**.

8.5 Sustainability and Future Prospects

Further research should be undertaken on the need and capacity in other council areas before the service is rolled out across Mid and West Wales. Specifically, an assessment of need should be completed to determine if there is a need to provide an urgent response to referrals for domiciliary care to prevent delayed discharges and help to avoid unnecessary admissions.

There is a need to determine if there is existing capacity within domiciliary care/reablement services in other Councils within Mid and West to continue to provide this urgent response service or is there a need for additional resources. Any research or review in this area should take a whole systems approach and therefore consider the level of potential referrals from hospitals and other relevant staff in the community (e.g. GPs / community organisations), as

[85] Based on project reports

well as the capacity to deliver the service.

It is noted that the Carmarthenshire Reablement Service Structures are currently review under and it is understood that the Rapid Response service will be more closely aligned in order to facilitate closer links to hospital staff, a higher levels of referrals and a reduction in inappropriate referrals (for example fewer referrals for patients who require long term care).

APPENDIX A – REPORT TEMPLATE

Intermediate Care Fund

Project Report – Rapid Response Service

Work Stream: Rapid Response Service
Theme/ Category: Investing to do more
Lead Officer: Gail Jones
Project Detail: It is proposed that the Rapid Response Service will support the provision of increased care closer to home as part of the integrated community locality model by meeting the needs of local communities. This service design will strengthen the domiciliary team to be able to provide a model of anticipatory care to the frail elderly as well as those with chronic conditions and palliative care needs whose needs ebb and flow (rise and fall) overtime.

Allocation of Revenue Funding - £311,550	**Claim for Q1 = £0** **Claim for Q2 = £** 9,627.55 **Claim for Q3 = £** 112,665.43	**Claim for Q4** - £142,758.62 **Total Spend** -£265,051.60 Under spend - £-46,498.40

Key Objectives:

1. Increased integrated Rapid Response capacity will reduce unscheduled admissions to hospital.
2. To achieve increased Rapid Response Capacity, working towards the achievement of an optimised function in which 15% of potential unscheduled over 65 medical admissions are to be avoided through provision of alternative support.
3. To increase use of Rapid Response by primary care.

Progress against Key Objectives as at March 2015:

- There are now 24 Rapid Response staff in post, induction training has been completed and service delivery commenced on the 15/09/2014.
- Service Managers are actively working with colleagues within the Community Resource Teams MDT's to discuss individual referrals for people that would benefit from the Rapid Response service.
- Service Users within Carmarthenshire have been receiving support and care via the RR service. Activity within the Rapid Response Service has been set out in key outcomes below.

Key Outcomes:

Outcome information- From the 20/1/15 to the 24/02/2015

			Rapid Response TTT	Llanelli	A&G	Total
A	RR interventions	Total People who have accessed the RR service between the above dates.	**17**	**20**	**30**	**67**
B	Potential hospital admissions diverted to RR	Input from the RR team to avoid potential hospital admission	**17**	**5**	**7**	**51**
C	Early Hospital Discharge		**2**	**2**	**0**	**4**
D	Total number of responses to Telecare Alarms during the day		**3**	**8**	**12**	**23**
	Service User numbers held by RR awaiting Reablement/ Long Term Domiciliary	Data information as of 24/02/2015	**20**	**1**	**6**	**27**
	Other Outcomes					

Case Study examples:

Case Study 1 – Mrs P Enhanced Hospital Discharge

Mrs P's recent hospital admission was due to a fall which caused a fractured hip. Mrs P's medical history is of a previous CVA, dementia and is partially sighted. Whilst in hospital Mrs P continued to fall when trying to get in and out of bed, was regularly muddled, confused with poor orientation to time and place and, had been verbally and physically aggressive to the staff on the ward. Mrs P prior to admission lived at home with her daughter and family. To plan for a safe return home RR was commissioned until capacity was available within Reablement in two weeks time.

By MDT agreement the following was implemented:-

Rapid Response Intervention

Initial Care package; - 4 calls per day x 2 Domiciliary Support Workers to work towards gaining skills and independence with personal care, dressing, undressing and toileting.

Outcome

Within the first few days it was evident that Mrs P could weight bear and was able to mobilise slowly with minimal assistance. Mrs P, in her home environment was calm, content and happy to be back with her family, On transfer to Reablement two weeks later the care package was for one worker three times per day. Without the initial input of the RR Team this return home would have been delayed for another 2 weeks

Case Study 2 – Mrs A Enhanced Hospital Discharge

Mrs A was admitted into hospital via A and E on the 20th of November, 2014 due to a general deterioration in health and confusion. Whilst on the ward staff and the service users husband raised concerns that Mrs A's health and mobility had deteriorated in the months prior to admission resulting in oedema and ulcers on both legs District Nurses had been visiting daily. Being unable to undertake personal care resulted in tissue viability issues which was exacerbated by Mrs A sleeping on a reclining chair for the last 12 months. On admission Mrs A was non weight bearing and was therefore hoisted for all transfers.

Rapid Response Intervention

Whilst considerable therapeutic and nursing support was input by the hospital staff the care package to go home was for 2 Domiciliary Support Workers four times per day to support with personal care, dressing, undressing, toileting and all transfers

Outcome

Mrs A's husband supported by ensuring that his wife's nutritional needs were met by providing meals, snacks and drinks. In the first few week RR staff worked closely with Mr and Mrs A. Progress was made and the care package was reduced from four visits a day to two visits per day. Following the transfer to Reablement continual progress has been made to Mrs A's mobility as only one carer is now required twice per day to assist with personal care.

Case Study 3 – Mrs Y Avoiding Hospital Admission

Mrs Y lives with her husband who has chronic heart failure and hearing problems. Mrs Y is her husband's main carer, therefore, he was unable to physically support her. They have a daughter, who lives in Cardiff, and fortunately friendly and supportive neighbours.

Mrs Y fell on a shop escalator, due to the fall she sustained a sprained ankle, broke to knuckles bruised her ribs and the left side of her face. Mrs Y was taken to A and E but after assessment was discharged into the care of the Rapid Response Team via the Out of Hours Domiciliary Care Manager thus avoiding hospital admission. Prior to this accident Mrs Y was independent and no social service input had ever been in place. When discussing what was important to Mrs Y she explained that she would like to regain her independence as soon as possible.

It was indentified that 3 calls per day single staffed were required for assistance with personal care tasks and meal preparations. Rapid Response supported for 4 days and then the care package was transferred to the Reablement Team. During this time Mr Y improved and within three to four weeks visits were decreased and then stopped due to full independence being achieved. Mrs Y was so grateful for the input of the service she sent in a letter to compliment and thank the staff teams. (Letter is available)

APPENDIX B – STAFF SURVEY

Introduction

This section sets out the findings from the survey and interviews with staff and other key stakeholders involved in the development and delivery of the Rapid Response project.

An online survey developed by the evaluation team was emailed to 24 service delivery staff by the project manager. Eight members of staff completed the survey. A further four members of staff completed one to one interviews. Three GPs who refer into the service were also invited to take part in short telephone interviews, one of whom agreed to do so. Therefore, in total feedback was received from thirteen key stakeholders.

The survey and the interviews covered a number of key issues relating to the evaluation, including

- The extent of health and social care integration within the project and how well integration has worked;
- The outcomes that have been achieved, service-related and service user outcomes;
- The cost-effectiveness of the project, compared to non-integrated ways of delivering services;
- The future prospects for Rapid Response services.

Outcomes achieved

The evaluation team could not access patient contact details and therefore, it was not possible to collect primary evidence from patients on their outcomes as a result of using the service. However, feedback from staff who are involved in service delivery noted that because the service is very patient focused it has achieved a number of positive outcomes and impacts for service users. Almost all staff noted that most clients would not have got out of hospital as quickly without the service or have been able to stay in their own home without the service. It was noted that this is an important factor in maximising the service users' independence and functional ability and also improves quality of life.

The funding for the Rapid Response service provided new and additional resources within the existing Domiciliary Care services and without the ICF monies the service would not have been implemented and the patients and service outcomes would not have been achieved.

A small number of those who were interviewed (circa 25%) also noted that there are no processes in place to routinely collect data on patient outcomes and that the evidence for the effectiveness of the service would be strengthened if baseline and exit data on the patients' health and well-being was collected.

Summary

A number of key themes have emerged from the analysis of the response to the online survey and consultations with staff and other key stakeholders as summarised below:

- All felt the service facilitated a reduction in hospital admissions and supported early discharge among patients over 65. Furthermore, all of those who provided feedback also noted a range of positive service users' outcomes. These included the ability of patients to regain or, maintain independence and have an improved quality of life than would have been the case without the service.
- A small number of interviewees also noted that the evidence of the effectiveness of the service could be strengthened if information from clients was collected regarding their quality of life/ independence / confidence etc. before and after the service.

APPENDIX C – BENCHMARKING

Benchmarking

Introduction

In order to assess the effectiveness of the Rapid Response service a benchmarking exercise was undertaken to compare the outcomes and impacts achieved by Rapid Response Carmarthenshire with those elsewhere. It is difficult to find directly comparable services to benchmark, but two have been agreed with the project team. These are:

- Rapid Response Teams, Lincoln; and
- Admissions Prevention and Facilitated Discharge Service (Wirrral).

Rapid Response Teams (Lincoln) [86]

Rationale for Selecting Admission Avoidance Programme – Rapid Response Teams

The Rapid Response Teams are one of the services operating under the Admission Avoidance Programme in Lincolnshire. The teams aim to enhance community capacity to treat and support patients in their own home in order to reduce emergency hospital admissions. The vast majority of patients who are assessed by the service are over 70 years of age. The Rapid Response team is jointly managed and funded by Lincolnshire Partnership NHS Foundation Trust (LPFT) and Lincolnshire Community Health Services (LCHS).

Therefore, this service possesses similar aims and objectives and targets a similar group as the Rapid Response service in Carmarthenshire.

Background to Admission Avoidance Programme – Rapid Response Teams

The Admission Avoidance Programme Board was set up in April 2013 with the aim of reducing emergency hospital admissions across the winter pressures period (October to March). Four projects were identified and planned of which Rapid Response Teams were one.

The Rapid Response Teams (RRT) in Lincoln, Grantham, Boston and Louth were initially planned to be operational from 18 November 2013. In the project initiation documents, it was identified that each RRT should operate 24 hours across seven days a week and would encompass a range and mix of skills: an Emergency Care or Advanced Nurse practitioner (Band 7); a Mental Health Nurse (Band 6), a Nurse (Band 5) and six generic health care support workers (Band 3). However, in some areas not all envisaged staff members were recruited and other teams were forced to operate more limited hours (e.g. 9am to 5pm) due to staff capacity issues. In comparison, the Rapid Response service in Carmarthenshire is comprised of one Project Manager and 24 Domiciliary Support Workers (Grade D and recruited from existing staff). The service is also supported by 24 part-time Domiciliary Support Workers (Grade D) who were recruited to backfill the positions vacated by the

[86] Windle et al. (2014). *Admission Avoidance Programme: Final Report.* University of Lincoln: Community and Health Research Unit.

internal recruitment process. The service in Carmarthenshire operates a flexible service which is delivered between the hours of 7am to 10pm.

The four RRTs receive referrals from the Contact Centre or Lincolnshire Out-of-Hours team. Following receipt of referral, the relevant RRT will visit and assess the patient within two hours, providing treatment, support at home and onward referral as necessary. Referrals come to the Rapid Response service in Carmarthenshire from a range of different sources such as Careline, the community resource teams, and staff within the primary care team.

Objectives and Targets

The remit of the Admission Avoidance Programme was to identify and implement a range of community-based resources that could reduce emergency admissions by 5,000 finished consultant episodes, (pro-rata), across the winter pressures period (October 2013 to March 2014).

Outcomes

Over the period of implementation (November 2013 – March 2014), the total number of referrals received was 621. The majority of referrals were received from GPs. The majority of patients were managed in the community with fewer than 15% of patients admitted to acute care. From data collated by the Lincoln RRT, the mean age of the patient assessed was 82 with almost the total population (89%) aged 70 and over. Over three-quarters of patients (77%) received one day's care, with only one in ten requiring three or more days support. Table 1 details the destination of patients referred to/assessed by Lincoln RRT during the implementation period.

Table 1: Destination of patients referred to/assessed by Lincoln RRT

Disposition	Aged < 74	Aged > 75
Referral to A&E (%)	0	5
Admission (acute, respite, rehabilitation) (%)	18	35
Community Support (%)	64	51
Referral to MEAU (%)	18	9
Totals	**100% (n=33)**	**100% (n=115)**

Source: Windle et al. (2014). Admission Avoidance Programme: Final Report. University of Lincoln: Community and Health Research Unit.

Costs and Funding

The total cost from November 2013 to March 2014 of the RRT including set-up and operational costs was £1,185,940 (see table 2 for a detailed breakdown of costs). Using

these figures, the likely per annum costs were calculated as £2,493,105.

Table 2: Costs of the Rapid Response Teams (November 2013 – March 2014)

Cost item over the planning and implementation period of the RRT	Cost to date (£)	Budget from which monies were drawn
Total Project Management Costs, LPFT & LCHS (x 8 months)	93,450	LCHS/LPFT
Total Staff Costs (5 months)	940,004	RRT/LCHS
Non-pay staff expenditure	66,328	RRT
Medical, surgical and clinical equipment	18,750	RRT
IT costs	14,000	RRT
Workforce Training	12,300	OD Workforce Development
Financial administration	33,908	Finance
Recruitment (Human Resources)	7,200	HR
Total spend over implementation period		**1,185,940**

Source: Windle et al. (2014). Admission Avoidance Programme: Final Report. University of Lincoln: Community and Health Research Unit.

The cost per patient referred and attended over the period of development and implementation was £1,910. As mentioned above, the mean age of patients referred to the Lincoln RRT was 82. A total of 5,889 patients aged 80 and over were admitted to Lincoln County Hospital (LCH) between October 2013 and February 2014. Of these, 2,569 (45%) had lengths of stay of seven or more bed-days. If 51 percent of these patients (1,310) were continued to be managed in the community by RRT, a saving of £3,209,966 could be generated.

Evaluation and Benefits Delivered

An evaluation was carried out to assess the effectiveness of the Admission Avoidance Programme projects over their short-term of operation. The evaluation addressed two questions:

1. Does the scheme contribute to discernible, (real and tangible) quantifiable reduction in acute emergency admissions?

2. Does the scheme represent value for money when benchmarked against the cost of an acute admission?

A combination of methods was used in the evaluation: rapid literature reviews (where

evidence was available); semi-structured interviews with strategic and operational staff; process mapping exercises; assessment of costs; non-participant observation; statistical process control and secondary quantitative analysis across a range of datasets.

The results showed no overall demonstrable changes in the monthly emergency admissions for United Lincolnshire Hospitals NHS Trust (ULHT). However, the Rapid Response service did result in the majority of patients referred being managed in the community with fewer than 15% of patients admitted to acute care. Quantifiable reductions were also found across two other measures: numbers of bed-nights and zero lengths of stay. From November 2013 to February 2014, only 20 winter expansion beds were opened, compared to over 100 during October 2012 to February 2013.

The short-term nature of the evaluation did not enable a full cost-effectiveness analysis to be undertaken. However, each of the four services operating under the Admission Avoidance Programme, including the Rapid Response Teams, would seem to demonstrate value for money when benchmarked against the cost of an acute admission.

Conclusions

The Rapid Response Teams in Lincolnshire and the Rapid Response Teams in Carmarthenshire are similar services with similar objectives and outcomes. Both aim to reduce emergency hospital admissions and enhance community capacity for the patient to remain in their home; both utilise multi-disciplinary teams; both target mainly the older population; and both have resulted in avoided hospital admissions for the majority of patients referred to the service.

Admissions Prevention & Facilitated Discharge Service

Rationale for Selecting the Admissions Prevention & Facilitated Discharge Service

The Admissions Prevention and Facilitated Discharge (APFD) service was implemented in 2011 and is specific to Wirral. The service aims to reduce the incidence of hospital admissions and also aims to facilitate a timely supported discharge process for those that are admitted into hospital[87].

The APFD service provides interventions such as increased packages of care within a patients' home, rapid access to respite and 24 hour nursing beds, prompt access to therapies (e.g. physiotherapy, occupational therapy), the facilitation of early supported discharge from hospital into alternative community settings, and also when needed, long term care arrangements for patients. The typical user of the APFD service is an older patient over the age of 65[88].

Therefore, the service has similar aims and objectives and targets similar patients as the Rapid Response project however, the crucial difference between the two services is that the

[87] Admissions Prevention and Facilitated Discharge Service Evaluation – Final Report, February 2013
[88] Admissions Prevention and Facilitated Discharge Service Evaluation – Final Report, February 2013

Carmarthenshire Rapid Response service also delivers the care whereas the APFD projects refers on to other service providers.

Background to the Admissions Prevention & Facilitated Discharge Service[89]

The APFD service was hosted and delivered by two General Practices co-located at a medical centre in Wirral. A Senior Nurse Clinician was initially recruited to develop and deliver the project in February 2011 for 25 hours per week supported by full administrative support. The Senior Nurse Clinician worked closely with health and social care Multi-Disciplinary Teams to support case management approaches to patient care. In comparison, the Rapid Response service in Carmarthenshire is comprised of one Project Manager, 24 Domiciliary Support Workers and another 24 part-time Domiciliary Support Workers who were recruited in order to enable a flexible service operating from 7am to 10pm to be provided.

Patients are referred to the APFD service by health care professionals such as their GP, a District Nurse or a social worker. Within the first full year, the service had received 334 referrals. The most common cause of referral to the APFD service during the period of April 2011 to September 2011 was for fall, chronic obstructive pulmonary disease, and dementia, with the typical user of the APFD service being an older patient[90]. Referrals come to the Rapid Response service in Carmarthenshire from a range of different sources such as Careline, the community resource teams, and staff within the primary care team.

The APFD service provides interventions such as:

- Increased packages of care within the patient's home,
- Rapid access to respite and twenty four hour care nursing beds,
- Arranging prompt access to therapies (e.g. physiotherapy and providing necessary adaptations within an individual's home),
- Facilitating supported discharge, and
- The service also arranges long term care placements within nursing homes where necessary.

These interventions are provided with an aim to prevent acute crises from occurring that require a hospital admission; to support individuals to maintain themselves within their community for as long as they are able; and to facilitate a supported, timely discharge if individuals are admitted into hospital.

Objectives and Targets

Whilst there were no targets for the service, the objectives were:

- To increase and improve the packages of care provided to patients;
- To improve the access to therapies (e.g. physiotherapy);
- To increase the access to respite and 24 hour nursing beds;

[89] Admissions Prevention and Facilitated Discharge Service Evaluation – Final Report, February 2013
[90] Admissions Prevention and Facilitated Discharge Service Evaluation – Final Report, February 2013

- To facilitate a process of supported discharge; and
- To arrange long term care placements where required.

Outcomes

As mentioned above, in its' first full year of operation, the APFD service had received 334 referrals. In comparison, the Carmarthenshire Rapid Response service received 385 referrals across a 10 month period.

The table below presents the number and outcomes of referrals (i.e. what course of action was taken for the patient following referral to the APFD service) over a 6 month period between March and September 2011 only.

Table 3: APFD Outcomes of Referral over 6 months

Outcome	Number	%
Admission Prevented	76	46.9
Home Support/ Increased Care Package [91]	42	26.0
Hospital Admission	14	8.6
Facilitated/Supported Discharge	5	3.1
Referred to other services	2	1.2
Change from residential to nursing bed status	2	1.2
Community Equipment	2	1.2
Referred to Wirral Department of Adult Social Services (DASS)[92]	1	0.6
Inappropriate referral/ Patient declined support	18	11.1
Total	**162**	**100**

Source: Proposal for the future commissioning of the admissions prevention service (29th November 2011)

[91] Relates to 42 referrals that resulted in a patient being supported to remain in their own home rather than go into residential care / hospital, through commissioning home support services

[92] Provides access to a range of support services which will enable people to live safely and independently in either their own homes, or alternative accommodation if appropriate

Costs and Funding

The costs involved in providing the support from February 2011 to January 2012 are detailed below.

Table 4: APFD Costings

Cost Element	Cost	Detail
Staffing		
Nurse Practitioner	£37,295	25 hours per week
Admin support	£13,653	37.5 hours per week
Duty GP (rota)	£6,048	£161.89 per session (37.35 sessions)
Practice Manager	£9,505	10 hours per week
Sub total	£66,501	
On cost @ 24%	£15,960.24	
Back up Staffing		
Ad Hoc Nurse Clinician	£5,400	To cover Nurse Practitioner annual leave @ 5 session per week
Ad hoc GP Locum Costs	£4,047.25	To cover 2hr meeting based on 25 meetings per year
Sub-Total	£9,447.25	
Sundry		
Travel/Mileage Costs	£1,000	
Office / Promotional Costs	£750	
Sub-Total	£1,750	
Grand Total	**£93,658.49**	

Source: Proposal for the future commissioning of the admissions prevention service (29th November 2011)

The evaluation included a cost saving review by the NHS Wirral Performance and Intelligence Team[93] based on six months of data from April to September 2011. **The**

[93] : Proposal for the future commissioning of the admissions prevention service (29th November 2011)

estimated savings[94] from avoided hospital admissions were calculated at an average of £127,000 for the six-month period. However this does not take into consideration the potential saving from A&E attendance which could add a further £10,000 saving if patients were admitted via the A&E department[95].

Evaluation and Benefits Delivered[96]

The evaluation took into consideration the cost saving review that is detailed above, as well as collecting qualitative data via:

- Semi-structured telephone interviews with health care professionals; and
- Semi-structured case study interviews with families of patients.

The evaluation demonstrated the potential cost-effectiveness of the APFD service, as the cost to deliver the service was approximately £94'000 for the 11 month period from February 2011 to January 2012 therefore approximate costs for a six month period are £51,086.45[97] compared to potential savings from avoided hospital admissions of £127,000 that were calculated for the six month period from April to September 2011.

The main findings of the qualitative evaluation indicate a high level of user satisfaction with the APFD service. Family members of patients described experiencing strain and difficulty in accessing support services before the APFD service had intervened. The service had intervened at a critical point for many and provided a rapid response which often resulted in an avoided hospital admission for patients. Many family members described the service as crucial, and expressed dismay at the thought of not having the service.

Conclusions

Whilst the APFD service had similar aims and objectives as the Rapid Response and produced similar outcomes, it was structured differently, for example it was based within a primary care setting which is likely to increase awareness of the service amongst GPs. However, this did not appear to have an impact on the number of referrals to the service – Carmarthenshire had an average of 39 referrals per month, while APFD only had an average of 28 referrals). Furthermore, the service was focused around increasing access to existing services and creating care packages around existing services, whereas the Rapid Response project created additional care staff in the community to provide the care, therefore increasing capacity and level of provision.

[94] The potential cost savings from avoided hospital admissions as a result of the Admission Prevention team was estimated by multiplying the proportion of referrals with a known diagnosis by the lowest and highest cost of admission for that diagnosis
[95] Proposal for the future commissioning of the admissions prevention service (29th November 2011)
[96] Admissions Prevention and Facilitated Discharge Service Evaluation – Final Report, February 2013
[97] Cost for 11 months (February 2011 – January 2012) £93,658.49 / 11 = £8,514.41 (costs per month) * 6 (months) = £51,086.45

Summary

The two benchmarked examples, whilst delivered under different models, possess similar aims and outcomes. The points below compare some of the key metrics with the performance of Rapid Response:

Table 5: Comparison of services

	Carmarthenshire Rapid Response	APFD	Lincoln RRT
Cost	£264,440.50 (ten months from June 2014 to March 2015[98])	£93,658.49 (Feb 2011-January 2012[99])	£989,218[100] (November 2013 to March 2014)
Cost per patient	£686.86[101]	£305.91[102]	£1,910
Average number of referrals per month	39[103]	28[104]	124[105]

Therefore, the Rapid Response service provides similar services (such as enhancing community capacity to treat and support patients in their own home in order to reduce emergency hospital admissions) to those in Lincoln but at significantly less cost per patient (£686 compared to £1,910). It is difficult to say for certain as to why the Lincoln service costs so much more than that of the Carmarthenshire service. However, it is possible that it is due to the higher grade of staff that are recruited by the Rapid Response Teams in Lincoln (i.e. Band 7 Advanced Nurse Practitioner, Band 6 Mental Health Nurse and Band 5 nurse, compared to Grade 4 Domiciliary Support Workers in Carmarthenshire).

Whilst the Carmarthenshire service was more expensive than the APFD project, the AFPD did not actual deliver the services but referred patients on to other providers. On this basis the Carmarthenshire Rapid Response service compares well with the other services.

[98] Service delivery was September 2014 – March 2015
[99] Proposal for the future commissioning of the admissions prevention service (29th November 2011)
[100] This figure does not include the staff salaries of operational workers who were already in post. If these salaries are included, the set-up and operational costs of the RRT rise to £1,185,940. This figure is also for four RRTs.
[101] Cost to deliver the service over a 10 month period £264,440.50 / 385 patients who accessed the service over the period = £686.86 per patient
[102] Cost of the service over a 12 month period £102,172.90 (Cost for 11 months (February 2011 – January 2012) £93,658.49 / 11 = £8,514.41 (costs per month) * 12 (months) = £102,172.90) / /334 =£305.91
[103] Based on 385 patients accessing the service over the 10 month period / 10 = 39 per month
[104] Based on 334 referrals in the first full year / 12 months = 28 per month
[105] Based on 621 referrals to four teams from November 2013 to March 2014.

APPENDIX D – POLICY CONTEXT

Policy Context

There are a number of Welsh Government policies and strategies that are directly relevant to the implementation and delivery of the Rapid Response services as summarised in the following table.

Table 1 Relevant National Policies and Strategies

Policy	Relevance
The National Service Framework (NSF) for Older people in Wales[106] (2008)	This document sets out to improve health and social care services and equity of access for older people by setting national evidence-based standards for health and social care services. Specific aims of relevance include 'Challenging Dependency- methods should be put in place to help older people retain their independence'
Social Service Wellbeing Act (2014)[107]	This act provides a single statutory framework covering local authorities responsibilities in relation to all those who need care and support, of all ages, and including their carers. It specifically impacts the delivery of integrated care in Wales as it reforms and integrates social service law and makes provision for: • A duty to assess the needs of an adult for care and support, particularly through the provision of preventative measures put in place to meet individual needs • Co-ordination and partnership by public authorities with a view to improving the well-being of people
A Framework for Delivering Integrated Health and Social Care for Older People with Complex Needs (2014)[108]	The purpose of this Framework is to focus on older people with complex needs and ensure they have a strong voice and control over their care and support. It places a strong focus on preventative services and support to maintain well-being. It is about ensuring services, care and support are designed, co-ordinated and delivered effectively, to meet the outcomes that are important to people and their carers. The Statement of Intent in this framework sets out the need for an integrated approach to targeted preventative services e.g. reablement & intermediate care.
Setting the Direction	'Setting the Direction' recognises the commitment to delivering world-class integrated health care in Wales which requires a change in the

[106] http://www.wales.nhs.uk/sites3/Documents/439/NSFforOlderPeopleInWalesEnglish.pdf
[107] http://www.legislation.gov.uk/anaw/2014/4/pdfs/anaw_20140004_en.pdf
[108] http://gov.wales/docs/dhss/publications/140319integrationen.pdf

Policy	Relevance
(Feb 2010)	approach to developing both policy and service delivery models for primary and community care. The key underlying Principles for improvement include: • Universal population registration and open access to effectively organised services within the community • First contact with generalist physicians that deal with undifferentiated problems supported by an integrated community team • Localised primary care team-working serving discrete populations • Focus on prevention, early intervention and improving public health not just treatment • Co-ordinated care where generalists work closely with specialists and wider support in the community to prevent ill-health, reduce dependency and effectively treat illness • A highly skilled and integrated workforce • Health and social care working together across the entire patient journey ensuring that services are accessible and easily navigated • Robust information and communication systems to support effective decision-making and public engagement • Active involvement of citizens and their carers in decisions about their care and well-being.
Sustainable Social Services (Feb 2011)	The documents sets out the commitment to reshaping social services on the basis of the following: • Prioritise integrated services esp. for families with complex needs, looked after children, transition to adulthood, frail older people • Need to build services around people • Integrated care one of the 8 priorities for action, led to reshaping services in reablement and family support through integration with health services
Delivering Local Healthcare (July 2013)	This document sets out; • Deliver more healthcare closer to home to reduce hospital use • Increase ability of local services to support people being healthier and facilitate easier access • Greater integration with single system of care planning and service delivery

Table 2 Relevant Local Policies and Strategies

Policy	Relevance
Carmarthenshire County Council Annual Report 2014/15 & Improvement Plan 2015/16[109]	The report sets out the aim to 'transform service delivery that reduces dependency and promotes independence. It aims to secure greater independence and choice for local people, with preventative strategies at the heart of service delivery in adult services.' A key area of focus is to reduce the delayed transfer of care through: • Improve the links between the community and acute sector • A Rapid Response domiciliary care service • Key models established to reduce the number of hospital admissions as well as put in place preventative measures.
Strategy for the care of older people in Carmarthenshire[110]	The areas within this theme are intermediate care, delayed transfers of care, aids and equipment and rehabilitation. Aims include: • Ensure that older people will have access to a range of high quality services, including rehabilitation and intermediate care services to enhance their ability to live as independently as possible in their own home or other care settings. • Resolve the problems of delayed transfers of care

[109] http://www.carmarthenshire.gov.wales/media/846036/Full_ARIP_Report_15-16.pdf
[110] http://online.carmarthenshire.gov.uk/agendas/eng/SHEW20040331/REP04_01.HTM

EXPLANATION FOR NON-SUBMISSION OF SCRUTINY REPORTS

SCRUTINY COMMITTEE : **SOCIAL CARE & HEALTH**

DATE OF MEETING : **18TH APRIL, 2016**

ITEM	RESPONSIBLE OFFICER	EXPLANATION	REVISED SUBMISSION DATE
Carmarthenshire Carers Action Plan Update	Jonathan Rees	We are currently establishing a new Strategic Partnership Board for Carers with Heads of Service and as a result we would like to present a report for consideration by Scrutiny Committee which will look into the future provision of support for carers. The meeting of the Strategic Board will be held on 19th April, 2016.	To be confirmed
Mental Health Services	Avril Bracey, Head of Mental Health & Learning Disability	The scrutiny report will primarily be to report progress on the Together for Mental Health Annual Report. This report is currently out to consultation which will be concluded at the end of March. The final report will not be available until Mid-April and will therefore be presented to the Committee's meeting in May. A representative of the Health Board will also be available to attend.	16th May 2016

ITEM	RESPONSIBLE OFFICER	EXPLANATION	REVISED SUBMISSION DATE
Review of Reablement	Rhian Dawson	As previously advised, changes in the staffing structure took place in December. An evaluation of changes to the service is not yet complete. The report is therefore deferred.	15th June 2016

Y PWYLLGOR CRAFFU – GOFAL CYMDEITHASOL AC IECHYD

DYDD LLUN, 29AIN CHWEFROR, 2016

YN BRESENNOL: Y Cynghorydd G. Thomas (Cadeirydd)

Y Cynghorwyr:
S.M. Allen, I.W. Davies, T.T. Defis, W.T. Evans, H.I. Jones, D.J.R. Llewellyn, E. Morgan a J. Williams

Y Cynghorydd J.D. James yn dirprwyo ar ran y Cynghorydd B.A.L. Roberts
Y Cynghorydd M.J.A. Lewis yn dirprwyo ar ran y Cynghorydd J.S. Lewis

Hefyd yn bresennol:
Y Cynghorydd J. Tremlett - Yr Aelod o'r Bwrdd Gweithredol dros Ofal Cymdeithasol ac Iechyd

Hefyd yn bresennol fel sylwedydd:
Ms P. Owen, Cydlynydd Cymorth Partneriaeth a Chraffu ar gyfer Iechyd a Lles, Cyngor Sir Penfro

Hefyd yn bresennol ar gyfer cofnod rhif 7:
Ms S. Frewin – Uwch-reolwr Cynhwysiad Cymunedol
Ms S. Phillips – Pobl yn Gyntaf Sir Gaerfyrddin, yn ogystal â Katelyn Mathews a Darren Pollet

Roedd y swyddogion canlynol hefyd yn bresennol:

Mr J. Morgan	-	Cyfarwyddwr y Gwasanaethau Cymunedol
Ms R. Dawson	-	Pennaeth y Gwasanaethau Integredig
Mr A. Maynard	-	Pennaeth Iechyd Meddwl ac Anableddau Dysgu
Mr L. Walters	-	Uwch-reolwr Cymorth Busnes
Mrs T. Lewis	-	Rheolwr y Trysorlys
Mrs A. Thomas	-	Uwch-gyfrifydd
Mr D. Eldred	-	Cyfrifydd y Grŵp
Mrs M. Evans Thomas	-	Swyddog Gwasanaethau Democrataidd
Mrs K. Evans	-	Swyddog Cymorth Aelodau

Y Siambr, 3 Heol Spilman, Caerfyrddin : 10.00 a.m. – 12.35 p.m.

1. YMDDIHEURIADAU A MATERION ERAILL

Derbyniwyd ymddiheuriadau am absenoldeb gan y Cynghorwyr S.M. Caiach, K. Madge, B.A.L. Roberts, E.G. Thomas a J.S. Williams.

Cyfeiriwyd at y ffaith mai dyma'r cyfarfod olaf o'r Pwyllgor Craffu Gofal Cymdeithasol ac Iechyd y byddai Anthony Maynard yn bresennol ynddo gan ei fod yn ymgymryd â swydd arall yn yr Awdurdod. Diolchwyd i Mr Maynard am ei gyfraniad i'r gwasanaeth, yr adran a'r Pwyllgor dros y blynyddoedd a dymunwyd yn dda iddo yn ei swydd newydd.

2. DATGAN BUDDIANNAU PERSONOL

Cynghorydd	Rhif y Cofnod(ion)	Y Math o Fuddiant
Y Cynghorydd H.I. Jones	Eitemau 7–9	Merch-yng-nghyfraith yn gweithio i'r Gwasanaethau Cymdeithasol.
Y Cynghorydd M.J.A. Lewis	Eitemau 7–9	Aelod o'r Cyngor Iechyd Cymunedol.
Y Cynghorydd E. Morgan	Eitemau 7–9	Merch yn nyrs seiciatrig.

3. DATGAN CHWIP WAHARDDEDIG

Ni chafwyd dim datganiadau ynghylch chwip waharddedig.

4. CWESTIYNAU GAN Y CYHOEDD (NID OEDD DIM WEDI DOD I LAW)

Dywedodd y Cadeirydd nad oedd dim cwestiynau wedi dod i law gan y cyhoedd.

5. EITEMAU AR GYFER Y DYFODOL

Cyfeiriwyd at y ffaith bod saith o bynciau trafod wedi'u rhestru i'w hystyried yn y cyfarfod nesaf a theimlwyd y gellid gohirio un neu ddwy eitem hyd at y cyfarfod nesaf i ganiatáu digon o amser i drafod.

PENDERFYNWYD

5.1 gohirio'r eitemau canlynol i'w hystyried yn y cyfarfod sydd i'w gynnal ar 16eg Mai, 2016:-

- **Yr laith Gymraeg yn y Gwasanaethau Gofal Cymdeithasol ar gyfer Pobl Hŷn**
- **Safonau Maethol ar gyfer Pobl Hŷn;**

5.2 bod yr eitemau sy'n weddill i'w hystyried yn y cyfarfod a gynhelir ar ddydd Llun, 18fed Ebrill, 2016 yn cael eu nodi.

6. ADRODDIAD MONITRO YNGHYLCH CYLLIDEB REFENIW A CHYLLIDEB GYFALAF 2015/16

Rhoddodd y Pwyllgor ystyriaeth i Adroddiadau Monitro'r Gyllideb Refeniw a'r Gyllideb Gyfalaf ar gyfer y Gwasanaeth Iechyd a Gofal Cymdeithasol am y cyfnod

tan 31ain Rhagfyr 2015, ynghylch blwyddyn ariannol 2015/16.

Rhagwelid y byddai'r Gwasanaeth yn gorwario £404k o ran y Gyllideb Refeniw ddiwedd y flwyddyn ac y byddai -£231k o amrywiant net yn erbyn y Gyllideb Gyfalaf oedd wedi'i chymeradwyo ar gyfer 2015/16.

PENDERFYNWYD derbyn yr adroddiad.

7. GWERTHUSO'R "CYNLLUN MAWR "

[SYLWER: Roedd y Cynghorwyr H.I. Jones, M.J.A. Lewis ac E. Morgan oll wedi datgan buddiant yn yr eitem hon eisoes.]

Rhoddodd y Pwyllgor ystyriaeth i adroddiad a roddai fanylion gwerthusiad o effeithiolrwydd y Cynllun Mawr.

Diben y strategaeth oedd sicrhau bod pobl sydd ag anableddau dysgu yn mwynhau'r un hawliau sylfaenol ag unrhyw un arall. Golygai hyn y byddent yn cael cynnig tai addas, yn cael cymorth i ddod o hyd i waith neu alwedigaeth ystyrlon arall oedd yn addas iddynt, yn gallu mwynhau amser gyda ffrindiau a theulu a chymryd rhan yn eu cymuned leol ac yn niwylliant y sir.

Ar sail tystiolaeth yr adroddiad, mae mwyafrif yr amcanion a osodwyd yn y Cynllun Mawr wedi'u gwireddu, a mwy. Ond roedd darpariaeth y gwasanaethau yn esblygu'n barhaus, a phwysig oedd sicrhau ein bod yn ymatebol i anghenion ein cwsmeriaid, ein statws economaidd newidiol a deddfwriaeth newydd, yn ogystal ag ymdrechu i efelychu arferion gorau.

Estynnodd y Cadeirydd groeso i'r cyfarfod i Ms Sarah Phillips, Pobl yn Gyntaf Sir Gaerfyrddin, sef gwasanaeth eirioli a hyfforddi sy'n cynorthwyo oedolion sydd ag anawsterau dysgu. Yr oedd Katelyn Mathews a Darren Pollet yn bresennol gyda hi, a rhoesant gyfrif o'r gwasanaethau sy'n eu cynorthwyo. Pwysleisiasant yr hyn a weithia'n dda a'r hyn y gellid ei wella. Yn ôl Ms Phillips, gyda dyfodiad y Ddeddf Llesiant, roedd Sir Gaerfyrddin i'w llongyfarch am ei gweithdrefnau ymgysylltu a chynhwysiant, a oedd yn rhagorol.

Diolchodd y Cadeirydd i Ms Phillips a'r ddau ddefnyddiwr gwasanaeth am eu presenoldeb a'u cyfraniad a oedd yn llawn gwybodaeth ac a werthfawrogwyd yn fawr.

PENDERFYNWYD nodi'r adroddiad.

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8. PROSIECT GWEITHIWR CYMORTH IECHYD A GOFAL CYMDEITHASOL

[SYLWER: Roedd y Cynghorwyr H.I. Jones, M.J.A. Lewis ac E. Morgan oll wedi datgan buddiant yn yr eitem hon eisoes.]

Atgoffwyd y Pwyllgor y bu i Fwrdd Iechyd, Gofal Cymdeithasol a Lles Sir Gaerfyrddin, ym mis Tachwedd 2014, gymeradwyo defnyddio Cyllid Gofal Canolraddol i symud ymlaen ar Brosiect Gweithiwr Cymorth Gofal Cymdeithasol a geisiai drosglwyddo tasgau'n ymwneud â gofal iechyd i weithwyr gofal

cymdeithasol mewn cartrefi gofal i bobl hŷn. Canolbwyntiai'r prosiect ar gyfenwi gofal clwyfau anghymhleth yng Nghartref Gofal Preswyl Llys y Bryn.

Awgrymai'r dystiolaeth yn gryf yr arweiniodd y prosiect yn Llys y Bryn at enillion effeithiol ar fuddsoddiad o ran lleihau presenoldeb Nyrs Ardal. Cafwyd buddion eraill hefyd, megis gwell ansawdd bywyd i drigolion, gwell cydweithio rhwng staff Llys y Bryn a Nyrsys Ardal a gweithlu mwy hyderus.

Bu'r prosiect peilot yn arbennig o lwyddiannus, gan herio'r cysyniad traddodiadol o wahanol grwpiau o staff yn gweithio mewn seilos. Yr oedd yn profi bod gweithwyr gofal integredig wedi cyfrannu'n sylweddol tuag at hyn.

O ganlyniad i'r prawf hwn ar gam cysyniad, yr oedd yn amlwg y gallai'r model hwn gael ei ymestyn i gynnwys ymyriadau eraill megis cofnodi arwyddion hanfodol a gofal cathetr.

Argymhellwyd hefyd bod model hyfforddiant gofal clwyfau anghymhleth yn cael ei gyflwyno fesul cam i Gartrefi eraill yr Awdurdod Lleol yn Sir Gaerfyrddin. Cynghorwyd yn gryf bod gwerthusiad effaith yn cael ei gynnwys o'r cychwyn yn ogystal â dadansoddiad ariannol o ran enillion ar fuddsoddiad.

Rhoddwyd sylw i'r cwestiynau/materion canlynol wrth drafod yr adroddiad:-

- Pan ofynnwyd a fyddai'r cyfrifoldebau ychwanegol yn cael eu hadlewyrchu yng nghyflog y staff, esboniodd Pennaeth y Gwasanaethau Integredig y byddai unrhyw ddyletswyddau ychwanegol yn cael effaith ar gyflog a byddai'n rhaid cynnal ymarferiad gwerthuso swyddi;
- Pan ofynnwyd a fyddai pobl hŷn sy'n byw yn eu cartrefi eu hunain yn derbyn yr un driniaeth, esboniodd Pennaeth y Gwasanaethau Integredig ei bod yn bwysig cynnal y cynllun peilot mewn amgylchedd diogel, dan reolaeth, ac mai dyma pam y dewiswyd cartref gofal. Ond y bwriad yn y pen draw fyddai cyflwyno'r rhaglen yn y gymuned.

PENDERFYNWYD derbyn yr adroddiad.

9. DEDDF GWASANAETHAU CYMDEITHASOL A LLESIANT (CYMRU) 2014 – ADOLYGIADAU POLISÏAU A GWEITHDREFNAU YNGHYLCH CODI TÂL AR OEDOLION AM WASANAETHAU

[SYLWER: Roedd y Cynghorwyr H.I. Jones, M.J.A. Lewis ac E. Morgan oll wedi datgan buddiant yn yr eitem hon eisoes.]

Atgoffwyd y Pwyllgor bod Deddf Gwasanaethau Cymdeithasol a Llesiant (Cymru) 2014 wedi'i basio gan Lywodraeth Cymru a bod gwahanol rannau o'r Ddeddf bellach yn dod i rym. Darparai'r Ddeddf y fframwaith statudol i gyflenwi ymrwymiad Llywodraeth Cymru i ganolbwyntio ar lesiant, hawliau a chyfrifoldebau. Roedd Rhan 5 y Ddeddf yn ymwneud yn benodol â chodi tâl ar ddefnyddwyr gwasanaeth am wasanaethau a dderbyniant a byddai'r rhan hon yn dod i rym ar 6ed Ebrill, 2016.

Rhoddodd y Pwyllgor ystyriaeth i adroddiad a nodai'r prif feysydd, yn benodol mewn perthynas ag asesiadau ariannol a chodi tâl, yr oedd angen eu hystyried ar y cychwyn a chynigwyd, yn ystod y flwyddyn ariannol nesaf, y byddai polisi

diwygiedig newydd, a ddygai ynghyd elfennau o'r polisïau presennol, yn cael ei gyflwyno i'w gymeradwyo gan yr aelodau.

Rhoddwyd sylw i'r cwestiynau/materion canlynol wrth drafod yr adroddiad:-

- Mynegwyd pryder bod y gwahanol gategorïau o ofal a fframwaith o daliadau yn anodd eu dirnad. Meddai Cyfarwyddwr y Gwasanaethau Cymunedol wrth y Pwyllgor y byddai'n rhoi eglurhad o'r pwyntiau hyn yn yr adroddiad cyn iddo gael ei gyflwyno i'w ystyried gan y Bwrdd Gweithredol.

PENDERFYNWYD ARGYMELL I'R BWRDD GWEITHREDOL bod y Diwygiadau i'r Polisïau a'r Gweithdrefnau ar gyfer Codi Tâl ar Oedolion, fel a fanylir yn yr adroddiad, yn cael eu cymeradwyo.

10. Y PWYLLGOR CRAFFU - GOFAL CYMDEITHASOL AC IECHYD: Y WYBODAETH DDIWEDDARAF AM Y CAMAU A GYMERWYD AC ATGYFEIRIADAU.

PENDERFYNWYD nodi'r adroddiad.

11. EGLURHAD YNGHYLCH PEIDIO Â CHYFLWYNO ADRODDIADAU CRAFFU.

Nododd y Pwyllgor y rhesymau dros beidio â chyflwyno'r ddau adroddiad canlynol:-

- Gwerthusiad o Brosiectau Cronfa Gofal Canolraddol (ICF)
- Adolygiad o'r Gwasanaeth Ailalluogi

PENDERFYNWYD nodi'r ffaith na chyflwynwyd yr adroddiadau.

12. COFNODION – 20FED IONAWR, 2016

PENDERFYNWYD llofnodi cofnodion y cyfarfod a gynhaliwyd ar 20fed Ionawr, 2016, gan eu bod yn gofnod cywir.

_____ _____

Y CADEIRYDD **DYDDIAD**

Mae’r dudalen hon yn wag yn fwriadol