Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

GOLD STRATEGIC GROUP

DATE OF MEETING:	15 September 2021
TITLE OF REPORT:	Integrated Executive Group (Tactical Health and Social Care) response to the Health Board Executive / Gold request for the rapid development of Enhanced 'Bridging' Provision for Home Care
LEAD DIRECTOR:	Jill Paterson (Exec. Director Primary Care, Community and Long Term Care)
REPORTING OFFICER:	Rhian Dawson (Integrated System Director, Carmarthenshire and Integrated Bronze Chair)

Purpose of the Report (select as appropriate)
Er Sicrwydd/For Assurance

SBAR REPORT

Situation

Due to the unprecedented challenges being faced across the health and social care system, the following brief was given by the Health Board Gold Command Group on 8th September 2021 to the Health & Social Care Tactical Response Group:

With recruitment processes starting during week commencing 13th September, the HB's existing Bridging Service will be immediately extended such that it can provide transitional support to all patients awaiting domiciliary care up to the point when an appropriate package of care becomes available or the 31st March 2022 (whichever is sooner). An exit strategy from this arrangement for each individual receiving bridging support will need to be agreed prior to the commencement of that support recognising and planning for the fact that, whilst local authorities would seek prompt transfer from any temporary provision for each individual receiving bridging support, there is a risk that this would not be possible. The proposed model will aim to enhance existing integrated arrangements in each County area and its impact will be closely monitored from inception so that decisions can be made on refinement/ cessation as appropriate. The expectation is that there are no/minimal delays for patients deemed ready to leave across all HB services Arrangements will be designed to prevent negative wider system impact e.g. by avoiding recruitment directly from the existing domiciliary care capacity within the region and have a comprehensive risk register to support this. It is not anticipated that the implementation of this service extension includes the opening of Field Hospital capacity as part of the solution which would require Gold Command Group consideration before enacting.

This paper is a first response from Tactical on the implementation plan. This plan is under active discussion and development so will change and evolve quickly.

Background

It has been recognised across the Health Board and the three Local Authorities that the current fragility and paucity of domiciliary care provision in the community is contributing to increased risk to our population.

- Risk of harm to individuals waiting an ambulance in the community
- Risk of sub optimal outcomes and harm to individuals requiring assessment and care and support in the community
- Risk of sub optimal outcomes for patients delayed in hospital pending care and support availability
- Risk of sub optimal outcomes for patients pending bed availability to receive urgent planned care

The Health Board Gold Command Requirement was consequently presented to the West Wales Care Partnership's Integrated Executive Group (IEG) on Monday along with a paper outlining the following:

- Current position relating to domiciliary care compromise across Carmarthenshire, Pembrokeshire and Ceredigion and the underlying cause
- The impact on domiciliary care compromise the availability of packages of care for patients delayed in hospital or who are pending care and support following an assessment of need at home.
- Existing mitigating actions in train to support recovery and sustainability of domiciliary care across our three Counties
- Acknowledgement that Bridging Services exist across the three County 'systems' however delivery of such services varies across the Health Board area and are either Health Board or Local Authority led. As such, the IEG paper outlined a definition of 'bridging care' along with principles and standards that need to be considered in delivering such a service.
- Proposed model and response to the Health Board Executive Group / Gold brief for an Enhanced Health Board Bridging Service
- Initial assessment of risks associated with implementing an enhanced Health Board led 'bridging care' provision

As in earlier stages of the local pandemic response, IEG has become the Health & Social Care Tactical Group, constituting key Health Board Executive Directors and the three local Directors of Social Care. This tactical group will develop the implementation plan and has already established its Bronze Delivery Group to deliver the necessary actions.

The assessment section of this SBAR outlines the detail of this paper along with the noted response at IEG and next steps to implementing an enhanced 'bridging service' a per the Gold Command Requirement

Assessment

Current Position

There are multiple factors contributing to the current high level of challenge :

- Higher than ever demand on social care services – complexity and numbers.
- A high number of care homes in Covid exclusion which compromises step down opportunities when these are appropriate for patients / people waiting domiciliary care.
- Large number of handback of care packages due to workforce constraints.
- Aging population – more people over 55 than under 55 in Pembs a differential which is projected to continue to grow, additional demand but also a reduction in workforce
- Hospitality staffing shortages driving different opportunities for people which compound historical recruitment and retention challenges experienced by the sector
- Overseas staff have returned to home country
- High levels of care home embargoes leading to smaller bed numbers and choice of patients leading to lower complexity patients taking places
- Mental health services facing unprecedented demand
- Workforce fatigue
- Family fatigue and increasing concerns

This is being felt across the system and the impact on the hospital system is summarised in the table below, this is based on information in the Complex to Discharge SharePoint system on 10th September 2021:

County	Number in hospital – medical optimised on Pathway 2	Total bed days – since medically optimised date on Pathway 2	Number in hospital – Ready to Leave waiting LTPOC	Total bed days – since RTL date waiting LTPOC
Glangwili Hospital	27	425	12	136
Prince Philip Hospital	10	160	12	162
Carmarthen Community Hospitals	2	160	1	8
Bronglais Hospital	7	205	No SharePoint data	No SharePoint data
Ceredigion Community Hospital	No SharePoint data	No SharePoint data	No SharePoint data	No SharePoint data
Withybush Hospital	17	516	7	222
Pembrokeshire Community Hospitals	18	1001	16	444

The current position, delivery model and need are summarised in the table below. It is important to note that each County has slightly different pressures but there remains flow of packages, just not in the size and number to meet current demand.

	Current providers of bridging-type care	Current mitigations
Carmarthenshire : 111 on LTPOC list, 31 in hospital bed	• Delta Rapid Response • Crisis Response (through ART) • In house dom care / reablement • Community Independence Service (the original Bridging delivered by Mi Home Care)	• Family support grant • Temporary placement pathway into residential care home voids • Local recruitment campaign & enhanced pay rates to LA staff • Step down beds – Llys y Bryn, community hospital and considering Selwyn Samuel
Ceredigion : 72 on LTPOC list, 6 in hospital	• Integrated enablement team via Porth Gofal • ART – rapid response for discharge	• Utilisation of step down beds – although current limitations on capacity • Integrated enabling team
Pembrokeshire : 104 on LTPOC list, 18 in hospital	• Art / Care at Home Team • Reablement • Interim Care Beds	• 17% of market through in house team and authority has been given to recruit up to 1000 hours of care provision • Direct payments & microenterprises increasing • Seeking to optimise Shared Lives opportunities • D2RA Pathway 2 model in place for people with lower levels of need • Bridging care service scaled up, commencing 6th September – to deliver care for 16 – 20 additional people per week • Interim care beds being commissioned through health and social care

The assessed demand for care is potentially as high as 175WTE Band 2 Healthcare Support Workers with an additional need for Band 4/5 clinical and professional supervisors and administrative and management support. The final model needs further definition to confirm the total demand however the resource requirement is significant and the table below provides an initial indicative position based on the assessed brokerage list in each County.

County	Hours on List	Workforce Demand	Geographical Areas	Times of Day
Carmarthenshire	c. 1200	60 – 65 B2 HCSW Model assumptions : 1.4 RN 4 B4 Aps TBC - Admin / Co-ordinators	Garnant / Brynamman, Burry Port, Hendy/Llangennech, Hebron, Llangain Llanybri, Llanygynog, Blaenwaun, Efailwen	7.30 – 9.30am 8 – 10pm
Ceredigion	800 - 900	40 – 45 B2 HCSW Model assumptions : 1 RN 3 B4 APs TBC - Admin / Co-ordinators	Initial focus on North but to consider south to avoid destabilising	7.30 – 9.30am 8 – 10pm
Pembrokeshire	1200 - 1300	60 – 65 B2 HCSW Model assumptions : 1.4 RN 4 B4 Aps TBC - Admin / Co-ordinators	Hakin, Haverfordwest, Johnston, Kilgetty, Milford Haven, Pembroke Dock, Tenby & Saundersfoot	7 – 10.30am – Priority 1 12 – 2.30 pm 4 – 6pm 7 – 11pm – Priority 2

Definition of Bridging Care

Bridging care provides additional capacity to bolster the provision of home care and support in the short to medium term where other forms of social care are not available within a timescale that is deemed reasonable relative to the risk in the system. It enhances the community Support Worker workforce which will integrate and enhance social care provision in partnership with Local Authorities.

Care may be provided :

- for those individuals at home to prevent or reduce the risk of an urgent admission to hospital / residential care
- for those individuals in an acute or community hospital bed who require care to enable their discharge home
- for those individuals in an Interim care bed to support transfer home

Dependent on the specific local drivers of demand and need, Bridging Care can be provided in the following ways:

- Providing additional capacity to home-based care to increase social care availability
- Providing additional capacity for home based care where a long term care provider has advised they can currently only provide a proportion of the total care package
- Providing the care at home for an individual / patient where long term care provider has agreed to provide care however unable to start until a date in the future.
- Providing additional capacity to support safe staffing in step down beds in community

Furthermore, it is proposed that due to the significant risk in accessing onwards packages of long term care and therefore blocking the bridging care services, the following definition for **Interim Long Term Care** could be considered as part of the scope of this proposal :

Interim Long Term Care can be provided by the community Support Worker workforce deployed through the Local Authority registered home care service on a short-medium term basis in order to increase the total capacity of home based social care. This workforce would need to be registered with Social Care Wales which will be supported during a joint induction process. This workforce could also provide assessed Continuing Health Care and other health related packages to release capacity into social care system and Fast Track packages.

Regional Principles and Standards for Bridging Care / Interim Long Term Care

Each County has a different combination of challenges, assets and existing mitigations in place. For this model to function effectively it needs to be able to adapt to and wrap around existing models of provision. To ensure consistency of outcomes however, the following principles have been developed.

Clarity of Scope : Each Integrated Locality to define the scope of the Bridging Care and whether it will support one or more of:

- home based assessment
- bridge until long term care provision can be commissioned
- provide interim long term care – health and/or social

Access Process : Each Integrated Locality will enable a simple referral/access process through a single point of contact. The referrer should be able to make the referral electronically or by phone and the referral form should be added as an attachment to the Complex to Discharge SharePoint system.

Acceptance Criteria :

- People who need short term support, to 'bridge' position until their assessed care and support is available
- Resident of the named Integrated Locality
- Over 18 years of age
- Medically optimised/stable
- Consented to the service being delivered in the community

Exceptions :

- People who need care to be provided by the team overnight
- People with low level needs which can be met by community or third sector groups
- People whose assessment needs to happen in a bedded facility
- People who require ongoing complex medical intervention

Proactive Identification & Promotion of the Service : Clear information will be made available to the wards and discharge support teams to enable appropriate people to be identified and "pulled" through Board Rounds and local MDT or escalation meetings. **NB** the patient's care and support needs on discharged will have been assessed by the MDT i.e they are deemed 'Ready to Leave'

Joint Training : The workforce undertake the Joint Induction Framework to enable the delivery of health and social care to consistent and agreed standards. This will support later handover of care. This training will also include "Releasing Time to Care" principles.

Independence & Ability : Focus on the functional independence and wellbeing of the individual in order to right-size long term care needs. This will include managing the expectations with families and other professionals around "prescribed" levels of care.

Time Limited : Either supports delivery of an assessed care package until such a time a commissioned package can be found or can additionally support a period of assessment at home. There needs to be a strong focus on 'flow' with an exit strategy agreed prior to discharge or within the first 72 hours of the bridging care being put in place.

Local Co-ordination : Packages will be co-ordinated at an Integrated Locality level to enable the piecing together of a safe package between partner providers.

Priority should be given to placing the patient with usual providers e.g Local Authority provision or independent sector provision. Should this not be available within a 72 hour period consideration should be given to the use of 'bridging' resource either in a single entity or through single entity co-ordination to maximise shared resource and avoid handoffs and duplication.

Local Support & Supervision : Each Integrated Locality will define the alignment of this workforce to local teams to provide consistent support, supervision and advice for the workforce. The Head of Nursing will be responsible for ensuring that the care that they are provided aligns to Health Board policy and protocols. The local team needs to be constituted with appropriate staff to support the competency and development of the community Support Worker

workforce. A local base within each place-based footprint will be established where each Support Worker can meet with peers, collect supplies and receive supervision.

Registration : where staff are deployed under Local Authority in house teams and registered managers, the staff must be able to fulfil the registration requirements of the provider. The Head of Nursing however needs to ensure that neither the Health Board nor the Health Board employee is compromised in fulfilling these requirements.

Proposed Response to Gold Command Requirment for an Enhanced Bridging Service

In order to mitigate a number of the risks identified above, the model being proposed has been developed in 2 phases. **Phase 1** addresses the need for immediate action to support a compromised system in readiness for increasing winter and COVID pressures. **Phase 2** addresses the medium to longer term need to change the system and respond to the challenges faced across health and social care in the delivery of sufficient timely and high quality home based care.

Phase 1 : Increasing Healthcare Support Workers, aligned to existing Integrated Locality Teams to deliver home-based care until March 2022.

- Recruit additional Healthcare Support Workers on fixed term contracts to March 2022 – who will be aligned to existing Integrated Locality Community Teams (to be specifically agreed in each County) to deliver home based care. Commence recruitment w/c 13.09.2021. Numbers based on hours of care on the LA waiting list, 50% down time for travel, training & supervision, 42 weeks of the year to accommodate annual leave, sickness etc:
    - Carmarthenshire – maximum 65WTE
    - Ceredigion – maximum 45WTE
    - Pembrokeshire – maximum 65WTE
- Recruit additional Band 4/5 Assistant Practitioner / Registered Nurses to provide the clinical support and supervision for the HCSW. Commence recruitment w/c 13.09.2021. Numbers based on 1 RN for 45 WTE and 1 AP for 15 WTE – to be further reviewed and agreed.
    - Carmarthenshire – c.5WTE
    - Ceredigion – c.4WTE
    - Pembrokeshire – c.5WTE
- Through an expression of interest process, recruit B6/7 project manager and B4 co-ordinators in each County to support management of the enhanced caseload to maximise potential and evaluation. Support sought from employing organisations to release capacity asap. Commence recruitment w/c 20.09.2021.
    - Carmarthenshire – c. 3WTE
    - Ceredigion – c. 3WTE
    - Pembrokeshire – c. 3WTE
- Agree community based HCSW job role across the region.
- Cost of model to be developed by Finance Business Partners once workforce model agreed and partnership discussion on funding mechanisms.
- Legal framework to be agreed, partnership legal advice to be sought collectively.
- Agree the scope of the service in each County and any specific time or geographical areas to target and support recruitment.
- Agree the referral and co-ordination mechanisms in each County and the referral template which, wherever possible, should be the same template used for existing in house teams.
- Agree the HCSW team alignment of the workforce in each County.
- Establishment of an Operational Delivery Group to develop, implement and monitor this project with representation from all partners and corporate teams.

Phase 2. - Develop an integrated health and social care workforce, supported by a partnership agreement / pooled fund, to change the supply and model of community care for the population.

This phase requires a longer period of partnership development and would need to include:

- Development of various integrated health and social care job roles – this would need to address Terms and Conditions concerns
- Development of a working model which addresses the isolation, lack of team and base support for home-based care workers
- Development of a partnership agreement and pooled fund to support longer term delivery which addresses the financial risk and statutory responsibilities of each partner organisation
- Development of a single IT system to enable whole system care planning, communication and scheduling

Evaluation Measures

In order to develop an understanding of the full cost and impact of the proposed models, the following measures are proposed. These will be reported on a monthly basis by each County system team to track impact and inform learning for further phases of development.

Process Measures Bridging Service

- No. on active caseload
- Rationale for bridging e.g. D2RA assessment, reablement, LTPOC, CHC, fast track
- WTE Employed staff & staff mix
- Care package at commencement of service – No. hours, No. carers, No. calls
- Care package upon handover of the patient - No. hours, No. carers, No. calls
- Average length of stay - days

System Outcome Measures

- No. ED lodgers at 8.30am
- No. surge beds at 8.30am
- No. patients in hospital bed, medically optimised on D2RA Pathway 2 & no. days
- No. patients in hospital bed, ready to leave waiting POC / reablement & no. days
- No. people & total hours waiting on LTPOC brokerage list – in community & hospital

Balancing Measure

- No. patients readmitted within 28 days of discharge
- Reduced interest in domiciliary care adverts
- No. of applications received for HCSW who are working within social care sector (either independent or Local Authority

Initial Assessment of Risks in Implementing the Model

A risk assessment was undertaken following discussions with Heads of Adult Social Care and their Local Authority colleagues. A high level assessment of risks is included in the appendix.

IEG Considered Response to the Health Board Gold Command Requirement

On consideration of the paper, IEG noted and requested the following urgent actions :

IEG (Health & Social Care Tactical) : It was acknowledged that current position is increasing the risk of harm to our population across our system of health and care and that a collaborative solution should be implemented with urgency. Caution however was also requested by the Directors of Social Services that in mitigating domiciliary care compromise with Health Care Support Worker resource that this may further destabilise the sector and impact on medium to longer term recovery. It was noted that further discussions were scheduled between CEOs of all organisations to further consider and seek endorsement for the model / a collaboratively iterated model with a view to an agreed collective position by end of the week.

IEG members agreed to further reflect and feedback any supportive comments to better clarify definitions, scope and principles. To help clarify what the opportunities are for trialling a new model / informing a phase 2 development.

Each County System :

- Nominate an operational leadership group to take this forward for the County and include Health Board senior recruitment and workforce personnel as well as Heads of Adult Social Care and Local Authority commissioning colleagues (by Wednesday 15th September)
- To agree the scope of the bridging care model using the definition and principles outlined in IEG paper (by 17th September)
- Identify what team this additional recruitment will enhance – rather than the development of a new separate team

Job description & Recruitment Campaign :

- County operational Leads to link with Recruitment (Sally Owen) and Workforce (Tracy Walmsley) to agree, where possible, a single HCSW job description which can be used in a central advertising campaign (by Friday 17th September)
- For this campaign to be carefully constructed to encourage new capacity in the system
- To commence recruitment w/c 20th September pending approval by Integrated Executive Group
- To give clarity on ceasing the recruitment if it is deemed to just be moving existing workforce around the system
- To give clarity on options for NOT interviewing people currently within the existing care system
- To offer posts until end March 2022

Legal Advice : Assistant Director for Corporate Governance (Sian-Marie James) in liaison with the Local Authorities to seek legal advice for the defined model – informed by the County Operational Leads.

Recommendation

'Gold' is requested to take assurance that progress is being made against the Health Board Executive Group / 'Gold ' Command proposed requirement regarding the enhanced 'bridging service'.

Objectives: (must be completed)	
Datix Risk Register Reference and Score:	
Health and Care Standard(s):	Choose an item. Choose an item. Choose an item. Choose an item.
Quality Improvement Goal(s):	Choose an item. Choose an item. Choose an item. Choose an item.
UHB Strategic Objectives:	Choose an item. Choose an item. Choose an item. Choose an item.
UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Statement	Choose an item. Choose an item. Choose an item. Choose an item.

Further Information:	
Evidence Base:	
Glossary of Terms:	
Parties / Committees consulted prior to Gold Strategic Group:	

Impact: (must be completed)	
Financial / Service:	e.g. financial impact or capital requirements: (if yes, please complete relevant section of the integrated impact assessment template available via the link below) http://howis.wales.nhs.uk/sitesplus/862/opendoc/453906
Quality / Patient Care:	e.g. adverse quality and/or patient care outcomes/impacts: (if yes, please complete relevant section of the integrated impact assessment template available via the link below) http://howis.wales.nhs.uk/sitesplus/862/opendoc/453906
Workforce:	e.g. adverse existing or future staffing impacts: (if yes, please complete relevant section of the integrated impact assessment template available via the link below) http://howis.wales.nhs.uk/sitesplus/862/opendoc/453906

Risk:	e.g. risks identified and plans to mitigate risks: (if yes, please complete relevant section of the integrated impact assessment template available via the link below) http://howis.wales.nhs.uk/sitesplus/862/opendoc/453906
Legal:	e.g. legal impacts or likelihood of legal challenge: (if yes, please complete relevant section of the integrated impact assessment template available via the link below) http://howis.wales.nhs.uk/sitesplus/862/opendoc/453906
Reputational:	e.g. potential for political or media interest or public opposition: (if yes, please complete relevant section of the integrated impact assessment template available via the link below) http://howis.wales.nhs.uk/sitesplus/862/opendoc/453906
Privacy:	e.g. potential impact on individual's privacy rights or confidentiality and/or the potential for an information security risk due to the way in which information is being used/shared, etc: (if yes, please complete relevant section of the integrated impact assessment template available via the link below) http://howis.wales.nhs.uk/sitesplus/862/opendoc/453906
Equality:	e.g. potential negative/positive impacts identified in the Equality Impact Assessment (EqIA) documentation – follow link below • Has EqIA screening been undertaken? Yes/No (if yes, please supply copy, if no please state reason) • Has a full EqIA been undertaken? Yes/No (if yes please supply copy, if no please state reason) http://howis.wales.nhs.uk/sitesplus/862/opendoc/453906

Appendix One Initial Risk Assessment

Description	Initial risk score			Mitigating Actions
	Likelihood	Impact	Score	
Recruitment on NHS T&C could destabilise the existing independent sector and social care workforce by attracting existing workforce rather than adding new capacity to the system.	3	5	15	To actively seek recruit new people to sector with no experience, recruit from outside HDUHB / Wales/UK. To showcase the opportunity for a variety of career pathways to attract returners to work, college students and new people to the area. To extend flexibility of the working model – seeking people who want o work only mornings or evenings rather than long or whole days. To consider how to support double handed runs and thereby attract people who do not drive. Carefully consider the banding of posts and whether A4C B2s or 3s will attract the new staff to the sector.
Short term contracts will not provide sufficient assurance to attract new recruits and lead to instability with people leaving the sector at the end of the fixed term period	4	4	16	Phase 1 recruitment for fixed term contracts to end March 2022 Develop Phase 2 recruitment for substantive contracts and how many each Integrated Locality could appoint to given the workforce turnover to redeploy into if the model no longer needed
Care will become quickly saturated with long term care needs as limited onward care provision	4	3	12	Each Integrated system to model the "gap" for long term care and recruit accordingly Monitor the waiting list trend – a growing list will cause a blocked model, a reducing risk would suggest the need to scale back the model over time
The job role could be muddled between health and social care tasks leading to a lack of clarity of responsibility and potential harm to patient	3	3	9	Clear definition of tasks, training, education & competencies Clear line management support Clear supervision of all care packages provided
Delegated responsibility for the supervising staff of the Support Workers	3	2	6	To agree the levels of responsibility for the supervising staff To ensure sufficient capacity for supervising staff
Lack of co-ordination of care packages leading to delays, missed calls and potential harm to patient	3	4	12	Need to build in sufficient co-ordination and management support Simple IT system to manage packages and scheduling of runs Clearly define where the management and supervision will sit in each Integrated Locality
People in receipt of care through the interim team will not have a package to be moved into at end of March 2022	4	4	16	Carefully map the impact of the model on the care market and develop exit strategies and contingency plans Develop Phase 2 of the model to include substantive recruitment and a longer term integrated model
Additional pressure on fragile community services – therapies, social workers & reablement	3	3	9	Consider the additional need for community based services which the model might demand to support community assessment and support. Build into Phase 2 model where required.
There may be a registration or legal challenge to the Health Board providing this type of care	2	4	8	Seek legal advice on delivery model and any potential partnership agreement / pooled fund
This may generate an additional cost across the system as will be addressing a historic shortfall in provided care	4	4	16	Develop a financial framework to support delivery, carefully modelling the costs and benefits
The benefit may not be felt across the system if the empty beds created are filled by patients we may currently be discharging	3	4	12	Develop a benefit realisation plan with acute colleagues.
Potential VAT obligation where the supply of staff is VATable.	2	3	6	Consider carefully the funding model and where and recharges may lay Consider pooled budget / partnership agreement approach.