Borth Integrated Health and Care Community Services
Borth Multi-Agency Team (MAT) Project

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Background

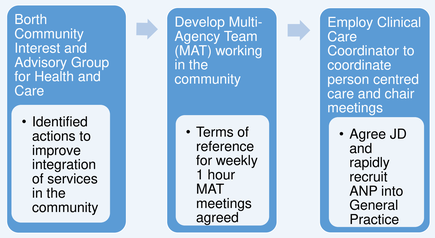
Borth is a village and seaside resort in Ceredigion, Mid Wales, 11km north of Aberystwyth on the Ceredigion Coast Path. The community has a high elderly, as well as rural farming population, who often engage late in statutory health can social care services. The community is well served with a GP surgery, community pharmacies, health and social care teams and third sector organisations. Borth GP surgery provides primary health care services to the local population and visitors to the area, with approximately 2700 people registered with the surgery.

Although there are several community multi-disciplinary teams (MDTs) in North Ceredigion, they are facilitated by different organisations working in silos, involving very little integration with primary care. Access to these teams requires completion of bureaucratic referral processes and results in very little person-centred integrated working.
This has been exacerbated by the pandemic, resulting in all parts of the systems being put under extreme pressure. In April 2021, the Borth Community Interest and Advisory Group for Health and Care was launched. Subsequently the Borth Multi-Agency Team (MAT) project was established to transform the way general practice, community health services, secondary care, local authority services and third sector work together to provide integrated person-centred care in the community. Through enabling the local community (including statutory partners in health and care) to deliver effectively, the resilience, health and wellbeing will be improved for all residents, visitors and their families in the locality.

Aims and Objectives

- ❖ Review community needs assessments and locality data and information to assess the strengths and needs across the locality.
- ❖ To improve the health and wellbeing of the community by providing anticipatory care to the population.
- ❖ To recruit into and embed the role of Clinical Care Co-Ordinator (CCC) into general practice to work with multi-agency teams and facilitate MAT working.
- ❖ To establish an effective referral process including self-referral for patients to third sector health and wellbeing organisations reducing duplication.
- ❖ To establish an MAT including general practice, health board, local authority and third sector services to regularly review patients with increasing health and care needs and to facilitate discharge from hospital.
- ❖ To provide a MAT review of all patients who are referred to Bronglais General Hospital and Social Care.
- ❖ To increase the use of technology in supporting people in their own home.

Process



To enable this a successful bid proposal to the Bevan Commission (2022) Planned Care Innovation programme provided funding, mentorship, and support enabling the appointment of a part time Clinical Care Co-Ordinator Advanced Nurse Practitioner employed in General Practice.

Any MAT member could bring any person registered at the surgery for discussion at the weekly MAT meetings.

During the project the MAT meetings focused on specific groups of people:

- New hospital admissions/recent discharges
- Primary care team identified people who may benefit from MAT support
- Hospital outpatient referrals
- Palliative care
- New community referrals into social care (Porth Gofal)
- Frail elderly in-person
- Mental Health
- Cartref Tregerddan – step-up/down/across beds in local residential home.

Outcomes

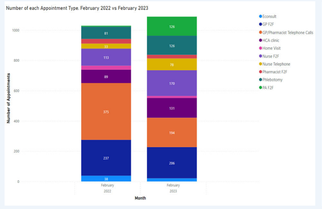
A review of Ceredigion Assessment for Local Wellbeing 2022 (3) for the surgery catchment population showed that people are living longer with increasing frailty levels in rural communities, often in single person households. This supports the need for multi-agency coordinated care in the community to reduce deterioration in health and the impact on health and care services.

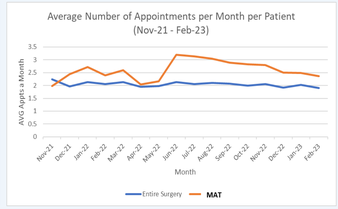
Population Characteristics:

	Borth & Bont-goch	Ceredigion	Wales
Mid-year population 2012	7,582	75,932	3,049,971
Mid-year population 2020	7,466	72,895	3,169,586
Males	3,632	36,262	1,563,524
Females	3,834	36,633	1,606,062
Aged 0-15	1,232	10,774	562,730
Aged 16-64	4,345	43,453	1,938,266
Aged 65+	1,889	18,668	668,590
Speak Welsh	3,773	47.3%	19%
No Skills in Welsh	2,792	42.4%	73.3%

Source: Census 2011

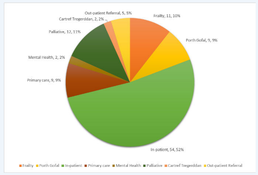
Demand on general practice was increasing following the pandemic, with a move away from remote consultations to more face-to-face.
The community patients who were discussed at MAT meeting had a higher number of GP appointments per month on average compared to the rest of the practice population

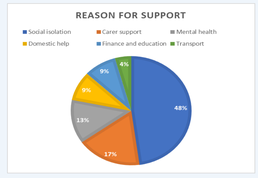




Rate of hospital admissions for over 75 year olds at Borth surgery continued at same rate.

The total number of patients discussed, the source of the referral, reason for support and the proportion of the total for each patient group is shown in the pie charts below:





16 referrals were made to the Ceredigion Council Carers and Community Support Team, this was 15% of the total number of patients discussed.

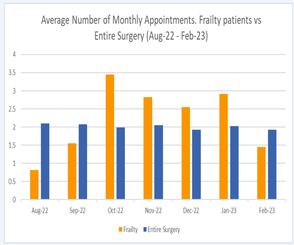
15% of the patients discussed also attended the third sector activities at the Borth Community Hub.

The feedback from the MAT members was extremely positive with a focus on patient-centred wholistic health care and collaborative working as demonstrated in the word cloud below:

Impact

Primary care

The patients that were identified to attend the MAT in person attended in November and December 2022. One of the methods used to identify these patients was their higher than average use of GP time and appointments. Following their attendance at the MAT and the input of both third sector, local authority and other community health care professionals the number of GP appointments fell to below average thus freeing up appointments and increasing GP capacity.

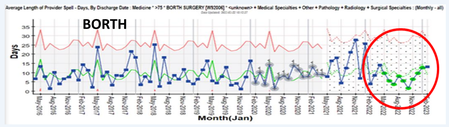


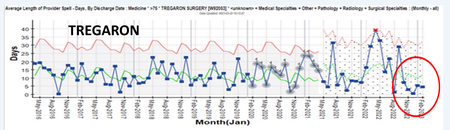
As a result of regular discussions about the hospital in-patients and palliative care patients at the MAT their needs in the community could be anticipated in a timely manner. This meant the correct care could be put in place early, maintaining them in the community and avoiding crisis and GP time in resolving any unmet health and care issues.

Secondary care

Secondary care data demonstrates a statistically significant reduction in length of stay for Borth Surgery patients over 75 years old from June 2022 until February 2023 for the duration of the MAT. The data for Tregaron Surgery for the same time period shows that there was no statistically significant reduction in length of stay from June – December 2022 when they were not part of the MAT however the length of stay reduced when the surgery joined the MAT in January 2023.
Between June 2022 and February 2022 the total number of bed days occupied compared to the same period the previous year, is reduced by 553 days despite the number of patients admitted increasing by 40.

	Total Number of Bed Days	Total number of Patients
June 21 – Feb 22	1881	133
June 22 – Feb 23	1328	173





Cost Savings

Number of bed days saved due to reduction in length of stay – 553
Cost of hospital bed/day - £882
Cost of bed days saved – 553 x £882 = £487,747
Cost of Band 8a nurse 0.6WTE/9 months = £36,572
Cost of Band 2 administrator 1 session a week/9 months - £1,442.70
Total Costs saved over 9 months - £449.732.30

Local Authority

Due to small numbers and availability of information collected, analysis of the social services data is limited. However there has not been an increase the number of new care packages put in place by social services since the start of the MAT and may have been a reduction.

Enablers

- Recruitment of Clinical Care Co-Ordinator (CCC) with dedicated time to facilitate MAT
- CCC role in Primary Care means no referral or assessments needed to access MAT
- Developing relationships, trust and a 'can do' attitude with the focus being person-centred care
- Leadership, experience, local knowledge and already established networks of GP lead and CCC

Barriers

- Cultural working practice, organisations with duplicative and bureaucratic referral process, silo working across organisations and a reluctance to change
- Resource and service deficits and gaps
- IT system and organisational firewalls create barriers to integrated working
- Funding silos often either Health or Care reducing opportunities to pool funding for person-centred benefits.

Conclusions

- ➢ Having a dedicated Clinical Care Coordinator based in general practice has been one of the essential ingredients for project success.
- ➢ Positive engagement of multi-agency team members and improved communication between agencies and seen a reduction in duplication and improved wholistic person-centred care for patients.
- ➢ A number of barriers have been highlighted, in particular Information technology barriers between organisations, cultural behaviours within secondary care in relation to discharge processes, bureaucratic systems and silo processes across organisations.
- ➢ Through multi-agency team working facilitated by a clinical care co-ordinator based in general practice savings can be generated in cost and capacity in secondary care. This increase in capacity will enable more planned care services to be delivered.
- ➢ The benefits from the MAT model appear to be due to improved communication and reduced duplication between agencies because no other investment has been needed.
- ➢ Through increased referral to third sector services there is increased capacity generated in general practice to enable the primary care team to concentrate on patients with more complex care and delivered more planned patient care.
- ➢ There appears to be a reduction in demand for social services care with resulting cost savings however further analysis is required to evidence the true impact.
- ➢ If the project was rolled out more widely then the impact on primary care capacity, length of stay in secondary care, reduction in social care packages, quality of patient care and staff job satisfaction would be significant.
- ➢ The cost savings generated due to the reduction in length of stay could be reinvested to provide additional health and care and third sector community services thereby reducing the systems reliance on hospital beds.

References
Bevan Commission (2022). Planned Care Innovation programme. Retrieved from:
https://www.bevancommission.org/programmes/planned-care