Increasing Time Spent at Home, Well and Independent

Project Lead:
Alison Bishop, Urgent & Emergency Care Lead, Hywel Dda University Health Board

Key partners:
Rhian Dawson, Integrated System County Director – Carmarthenshire, Hywel Dda University Health Board & Carmarthenshire County Council
Dr Meinir Jones, Associate Medical Director Transformation & Value Based Health Care, Hywel Dda University Health Board
Martyn Palfreman, Head of Regional Collaboration, West Wales Care Partnership

Hywel Dda University Health Board

A New Approach Improving Whole System Unscheduled Care

Background

You never know when your last 1000 days will start. But when it does start, would you want to spend it stuck in a hospital bed, or spending your valuable time at home with the people you love?

Older people tell us 'what matters' to them is to retain the maximum independence possible and remain at home as long as possible.

As a region we are committed to increasing this time spent at home for our population which is even more pertinent given that in our region we have an aging population that is above the Welsh average for over 65 year olds with a projection that by 2040 a third of our population will be over 65.

Projct Aims

If we are maximising opportunities to keep people at home, how can we understand the ‘ask‘ and demonstrate improvement?

Increasing Time Spent at Home for frail older people is dependent on a complex adaptive system across health and social care working optimally across all system components. We aim to bring simplicity to that complexity by ensuring all organisational directorate, division, service etc focus on one outcome indicator for that population group and that is increasing Time Spent @ Home. Each service should focus on implementing best practice and this is measured. The collective impact of this integrated focus on delivering population outcome will turn the trend on that outcome indicator over time.

- Meaningful measures will enable all partners across the whole system to;
- Establish a baseline measurement.
- Understand activity.
- Improve performance.
- Develop infrastructure and workforce.
- Evaluate initiatives
- Reduced commissioning of ‘formal’ care & support
- It aligns with our heath boards transformation strategy ensuring a visit to hospital is available when individuals need it and with a length of stay as short as appropriate. Achieving this goal will not be possible without seamless working across the system with our partners.

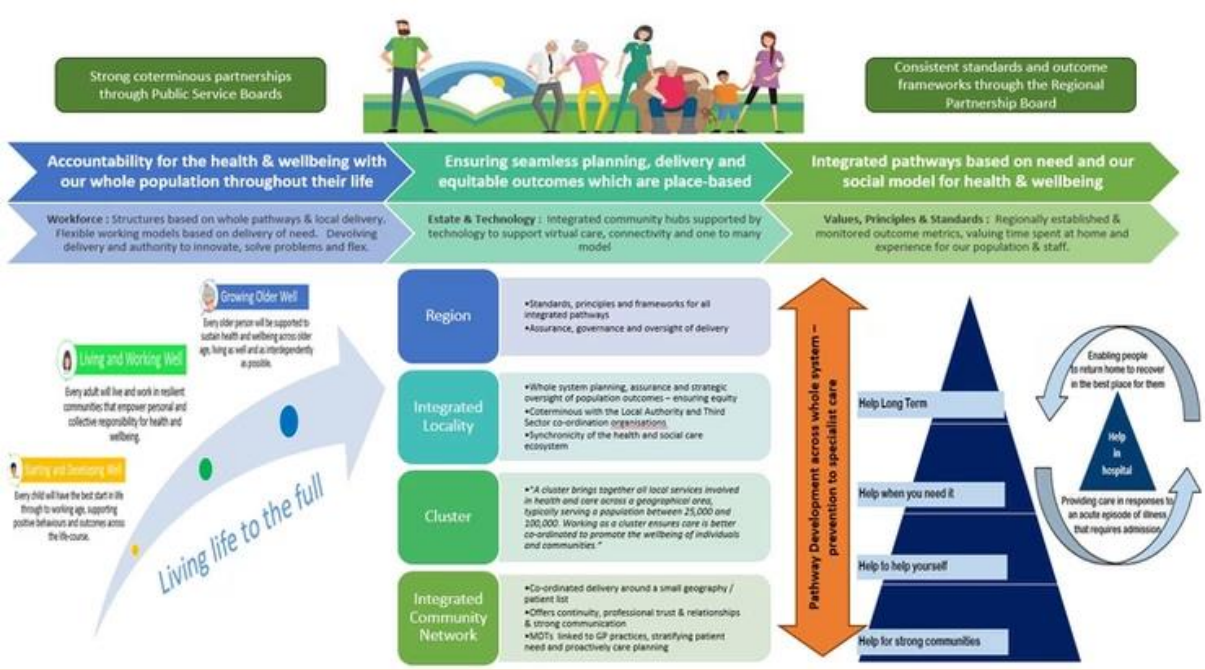

Figure 1

A series of diagrams beneath two pieces of text that read:

- Strong coterminous partnerships through Public Service Boards.
- Consistent standards and outcome frameworks through the Regional Partnerships Board

Diagram one consists of a row of three text boxes, reading:

- Accountability for the health and wellbeing with our whole population throughout their life. Workforce: Structures based on whole pathways and local delivery. Flexible working models based on delivery of need. Devolving delivery and authority to innovate, solve problems and flex.

- Ensuring seamless planning, delivery and equitable outcomes which are place-based. Estate and technology – integrated community hubs supported by technology to support virtual care, connectivity and 'one to many' model.

- Integrated pathways based on need and our social model for health and wellbeing. Value, Principles and Standards:

Regionally established and monitored outcome metrics, valuing time spent at home and experience for our population staff.

Diagram 2 consists of three pieces of text flowing moving across and arrow which says: Living life to the full. The pieces of text across the arrow read:

- Starting and developing well. Every child will have the best start in the life through to working age, supporting positive behaviours and outcomes across the life course.
- Living and Working Well. Every adult will have and work in resilient communities that empower personal and collective responsibility for health and wellbeing.
- Growing old well. Every older person will be supported to sustain health and wellbeing across older age, living as well and independently as possible.

Diagram 3 consists of four headers, each accompanied by a series of bullet points. The first header and series of bullet points reads:

- Region
- Standards, principles, and frameworks for all integrated pathways
- Assurance, governance, and oversight of delivery

The second header and series of bullet points reads:

- Integrated locality
- Whole system planning, assurance, and strategic oversight of population outcomes – ensuring equality
- Coterminous with the Local Authority and third sector coordination processes
- Synchronicity of the health and social care ecosystem

The third header and series of bullet points reads:

- Cluster
- "A cluster brings together all local services involved in health and care across a geographical area, typically

serving a population between 25,000 and 200,000. Working in a cluster ensures care is better co-ordinated to promote the wellbeing of individuals and communities."

The fourth header and series of bullet points reads:

- Co-ordinated delivery around a small geography/patient list
- Offers continuity, professional trust and relationships and strong communication
- MDTs linked to GP Practices, satisfying patient need and proactively care planning

The fourth diagram depicts a pyramid titled "Pathway Development across whole system – prevention specialist care. From top to bottom, text on the pyramid reads:

- Help long term
- Help when you need it
- Help to help yourself
- Help for strong communities

End of description

Challenges & How We Overcame Them

Challenge	Solution
Agreeing clear data definitions, and rationale for choosing that data set	Facilitated integrated workshops to develop and agree data definitions in absence of national data definitions
Ability to "drill down" into data to understand trends	Developing datasets with an external company to be able to drill down and across through data streams
Moving away from "traditional targets" towards more meaningful measures that support decisions	This forms part of the wider system wider discussion and how we can measure population outcomes whilst still delivery locally to meet the needs of our populations
Using multiple systems to extract data, not automated Accepting some measures are "too difficult" at present, but remain desirable for future development	As part of data definitions defined data sources & whether the data is available now, could be available or is aspirational. This allows us to start small and then develop our aspirational data set across systems in the future.
Limited data systems support	Networking with other programs to develop a common dataset which allows economies of scale and pooling of resources
Whole system thinking & cultural change – the 'human factor'	Bringing together whole system champions to work together and create a social movement to develop

Figure 2

A table with two columns; one for challenges and another with corresponding solutions. They read

- Challenge: Agreeing clear data definitions, and rationale for choosing that data.
- Solution: Facilitated integrated workshops to develop and agree data definitions in absence of national data definitions.
- Challenge: Ability to 'drill down' into data to understand trends.
- Solution: Developing datasets with an external company to be able to drill down through data streams.
- Challenge: Moving away from 'traditional targets' towards more meaningful measures that support decisions.
- Solution: This forms part of the wider system wider discussion and how we can measure population outcomes whilst still delivering locally to meet the needs of our populations.
- Challenge: Using multiple systems to extract data, not automated. Accepting some measures are 'too difficult' at present, but remain desirable for future development.
- Solution: As part of data definitions defined data sources and whether the data is available now, could be available or is aspirational. This allows us to start small and then develop our aspirational data set across systems in the future.
- Challenge: Limited data systems support
- Solution: Networking with other programs to develop a common dataset which allows economies of scale and pooling of resources
- Challenge: Whole system thinking and cultural change – the 'human factor'
- Solution: Brining together whole system champions to work together and create a social movement to develop

End of description

Key Outcomes

Increasing 'time spent at home' for our population will;

- Reduce bed days in hospital
- Improve 'front door' performance
- Improve access to emergency services
- Improve referral to treatment times for planned procedures
- Reduce commissioning of care and support
- Reduce delays on discharge
- Maximise availability of finite care resource
- View our Time Spent @ Home Outcome measures:

ADD DOWNLOAD

Feedback

'Working effectively across our agencies to help keep people safely and independently at home for as long as possible is a key priority for partners in West Wales. It's what people want and it is crucial for their wellbeing. The Health Board's health and care strategy, our Healthier West Wales transformation programmes, numerous schemes funded through the Integrated Care Fund and an ongoing focus on improving our Discharge to Recover and Assess pathways will help us achieve this. By accurately tracking progress across the system and being able to understand our performance at any one time will help ensure we learn from what works and what doesn't and focus on the right things. That's why the Increasing Time Spent at Home, Well & Independent project is so crucial and timely in helping us deliver the improvements we all want to see.'

Martyn Palfreman, Head of Regional Collaboration

Next Steps

Bring together programmes of work into a cohesive whole system programme and the relevant governance and management structure to deliver effective transformational change efficiently, effectively and sustainably;

- Transformation Fund
- Integrated Care Fund
- Unscheduled Care Winter Plan
- Urgent Primary Care Pathfinder with Primary Care colleagues
- Same Day Emergency Care Pathfinder
- Contact First Pathfinder with Welsh Ambulance Service Trust
- Physician Triage, Assessment & Streaming with Welsh Ambulance Service Trust Pathfinder
- Frailty / Dementia/ Palliative Care & End of Life Care Plans

Our Exemplar Experience

The support from the specialist advisors taught me to hold my nerve and never be afraid to be passionate about & ambitious to take on the difficult tasks – if it's 'the right thing to do'.

Contact

Alison.bishop2@wales.nhs.uk

@Piebaldbishop