Addysg a Gwella Iechyd Cymru (AaGIC)
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Y Weithrediaeth Executive

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Trusted Assessor

Case Studies

Contents

Case Study 1

Home First Team: West Glamorgan Partnership Integrated Health and Social Care

Background

Within the WG regional partnership, Swansea City Council Local Authority, Neath Port Talbot Local Authority and Swansea Bay University Health Board have well established Integrated Health and Social care teams and workforce arrangements across the region aligned to community services.

These roles have developed through work streams with immediate care initiatives, regional integrated funding, CRT's, Hospital to Home and now Home First.

Integral to the service is an element of trusted assessment within the Home First Team namely to support transfers in our reablement residential beds, domiciliary care and a proportion of our care home beds in the region within the D2RA and step-up step-down pathways.

Pathway 1: Support at Home

Integrated reablement at home services supported by Local Authority domiciliary internal care providers and integrated CRTs for up to 6 weeks.

What is established

- Community In-reach Discharge Liaison Nurses (DLN) and Therapists identify patients on the ward and carry out a proportionate assessment on behalf of the domiciliary and integrated community services, facilitating the discharge home. There is an electronic referral form and a work document which is uploaded to the Community systems
- Assessment is proportionate and only discharge dependant equipment is issued via the assessors
- A digital referral platform for all hospital staff to support referrals managed by a community integrated hub/multi-disciplinary team (MDT) and triaged for the relevant services
- Daily MDT allows hospital teams to seek support of community services and present individual cases if discharge destination not clear
- Collaboration with partners in the third sector to reduce number of care calls and offer wider wellbeing and social prescribing solutions

- In-reach team attend board rounds, clinically optimised flow meetings and visit wards to identify potential patients creating a ‘pull’ out to services
- Referrals can be completed via the ward teams are not totally dependent on the in-reach service
- Nurses undertake basic competencies in providing equipment and small aids to patients for a timely discharge
- PROMS and PREMS are developed in this pathway

Pathway 2: Residential Short Term Reablement Facility: Bonymaen House

Bonymaen House (BYM) is a 24 bedded step-down and step-up residential facility in integrated services supported by an in-reach MDT and the wider integrated community services. The facility provides reablement for up to 6 weeks from hospital when home first is not an option due to overnight support or concerns between calls. The service provision is reablement focused for older adults delivering a care and support plan that is goal focused and therapy-led, reducing dependency on long term care by working in collaboration with the patient. All hospital transfers are supported via the trusted assessment from the Home First DLNs who identify and proportionately assess patients in the hospital either in a ward or in Emergency Dept and arrange the transfer on behalf of the team at BYM. This role has been established since 2017 and was agreed by Heads of Services from both the Health Board and Local Authority.

What is established:

- Home First DLN have responsibility for hospital assessments and transfers following a referral from the acute ward or identification themselves of a patient by attending board rounds and visiting wards
- Home First DLNs will decide if appropriate or not for transfer and signpost if an alternative pathway is more suitable with a home first ethos
- The DLN will discuss with the patient what matters to them and what they want to achieve at BYM then carry out a short proportionate assessment (agreed local documentation) and liaise with BYM manager to support the transfer across
- Home First DLNS have a daily handover from the BYM team to manage bedded capacity, acuity and troubleshoot any issues with referrals and admissions transferred across from the acute sites including reporting of any discharge issues via the right process
- The DLN lead attend a weekly board round with the BYM team to monitor progress and support outcomes which then support education on what works well with the patient cohort they refer as a team

Pathway 3 – Complex Cases: Care home assessment and transfers

Initially, a jointly commissioned 2-week pilot led by the hospital-based Home First community DLN and social work practitioners was implemented to undertake a trusted assessor role and support patients on the wards into a residential or nursing placement within D2RA principles. Patients would have a proportionate assessment (jointly agreed assessment document) including a best interest for next steps, until a full assessment had been undertaken, usually within 2 weeks of discharge within the care home. This period was commissioned from WG for the pilot period which operated between November 2021-April 2022.

Funding ended following the pilot period, however due to the partnership success it evolved to a full implementation as business as usual supported by the wider Home First Social Work Teams and Community DLNs. It would include patients returning to an existing care home or to a new care home placement with an assessment period of up to 2 weeks following discharge from hospital into a care home continuing to deliver within D2RA principles.

The pathway aimed to promote patient outcomes by reduced duplication, the number of professionals involved in assessments process and to reduce the time lags with transfer of care. This included releasing care homes assessment capacity as the clinical lead from the home would usually come onto the ward to assess before accepting and admission.

A follow up joint assessment by the Home First SW and DLN ensures the person needs are met and that the care home and their staff are provided sufficient support to meet the person outcomes. The funding for long term care eligibility is also finalised at this point and home first will also be considered if patients are optimised.

A communication and engagement plan was implemented to raise care home owner's awareness and understanding of the pilot; the trusted assessor role, and arrangements for reviewing its effectiveness in terms outcomes for the person, workforce and providers. The DLN over time are gaining wider providers trust and confidence in their role as Trusted Assessor which has led to quicker discharges and reduced the number of homes who undertake their own assessment while the patient is in hospital.

By having knowledge of the environmental set up within each care home across the region aids to advise patients and families due to the intelligence of what works well with certain cohorts of patients and working with the provider to offer solutions.

What is established:

- Time and capacity to develop trusting long term relationships including opportunities to understand what matters to various stakeholders including patients and their families, the workforce and service providers
- A daily MDT for the community and hospital referrals where both Health and Social Care leads meet to discuss the referrals and identify the right people to be prioritised early and assessed for the right service at the right time
- Enhanced partnership working with Local Authorities and Health Board colleagues in this process
- Trust and long-established local relationships, intelligence and knowledge of both people, workforce and services strengths and capacity resulting better informed proportionate assessment; improved the patient flow and workforce capacity
- Informal training and buddying opportunities that focuses on developing professionals' awareness of one another's strengths, skills roles and responsibilities which promotes stronger and trusting

working relationships, e.g., all assessors have undertaken additional training in deprivation of liberty, end of life care and advanced care planning

- A culture that promotes informed and shared risk taking, learning and continuous improvement by promoting open, honest, reflective conversations and coproduction of shared solutions
- Feedback sessions with the providers have been facilitated
- Reporting support for discharge issues
- Aligned Social Worker (SW) to Home first services co-located at various bases
- Project Band 4 support workforce to support pathway

Case Study 2:

Stay Well @home Service (SW@H)

Partnership arrangement between Cwm Taff Morgannwg University Health Board, Rhondda Cynon Taff County Borough Council and Merthyr Tydfil.

Background

The SW@H Service is a partnership 7-day service provision between Rhondda Cynon Taf County Borough Council (RCTCBC), Merthyr Tydfil County Borough Council (MTCBC), Cwm Taf Morgannwg University Health Board (CTMUHB), providing multi-agency support to people across the RCTCBC and MTCBC footprint. The service is for individuals who attend the Emergency Department or have been admitted to hospital and require community health and/or social care support on discharge home.

The service aims to avoid hospital admissions and shorten the lengths of stays for those individuals who no longer need to remain in an acute hospital environment but require a community health / social care service at home.

The primary entry point to the service is via the hospital-based SW@H teams, based in either one of the acute hospital sites of Royal Glamorgan and Prince Charles.

The ways in which professionals access the SW@H team to assess individuals for support at home are:

- upon presentation at Emegency Department and following an initial medical assessment
- following a short stay on AMU/CDU for treatment/further medical assessment
- an integrated proportionate assessment from a hospital ward

Where the person is clinically optimised and requiring health/social care support at home, a contact is made to the SW@H team located at the hospital.

SW@H staff will then complete a proportionate assessment to determine if the patient is suitable to access the service and if so, what service would be most suitable.

This could include:

- Information and signposting to community services

- Direct access to domiciliary/reablement support, either RCTCBC's Support @Home Service or MTCBC's Initial Response Service. Homecare support at home such as support with personal care e.g., getting dressed/undressed. If required, individuals can access support from intermediate care and reablement services that provide short term rehabilitation
- Access/installation of aids and adaptations (via Care and Repair) at home
- Direct access to CTMUHB @home nursing service to provide community nursing care at home
- Direct access to a dedicated Your Medicines @home service to advise and support medication provision and administration

Any individuals who receive a service via SW@H will be subject to a review of their needs, which will be carried out within 2-weeks of service commencement in the community.

Case Study 3:

Vale of Glamorgan Community Resource Service

The Vale Community Resource Service (VCRS) is a 7-day integrated Health, Social Care and Third Sector service based at Barry Hospital, working in collaboration with other services across Cardiff and the Vale of Glamorgan.

The service works with people in their own home to maximise functional independence in activities of daily living through the provision of therapy and reablement home care support, thus reducing the need for longer term Social Services care services. The service aims to support hospital discharges, reduce delayed transfers of care and, also prevent unnecessary and premature admissions to hospitals and care homes.

The team includes Occupational Therapists, Social Workers, Physiotherapists, Speech and Language Therapists, Dieticians, Nurses, Pharmacy Technician, Care Co-ordinating staff and Reablement Support Workers (Home Carers).

The reablement service is delivered 7 days a week with access to Occupational Therapy and Physiotherapy over these 7 days to respond to urgent requests of admission avoidance and to support timely hospital discharges.

There is a single point of access to the service via e-referrals and can be accessed by any professional across health, social care and the third sector.

What is established

- A Trusted Assessor training programme (delivered by VCRS staff) for in-patient staff across Cardiff and the Vale UHB. Training programme focuses on these key areas- strength based assessments, risk enablement, person centred care planning and prudent healthcare principles
- In-patient Trusted Assessors complete proportionate assessments on behalf of VCRS and identify the essential care and therapy needs for a safe discharge
- Once proportionate assessment is completed, the request is sent to VCRS via e-referral and is passed directly to the Care Co-ordinators for care scheduling

- Reduced duplication of assessments between hospital and community services- thus streamlining discharge planning and improving trust and communication
- Timely ‘what matters to me’ conversations in the hospital and improved patient experience through more co-productive care planning
- To date there are 24 Trusted Assessors (Occupational Therapists and Physiotherapists) across all clinical sites within Cardiff and Vale UHB- including A+E.
- Training programme to continue to be rolled out, to also include specialist nurses e.g. frailty nurses, clinical specialists
- Improved knowledge and understanding of VCRS with overall improvements in quality of referrals through Trusted Assessors cascading principles of the training to colleagues and junior staff.