The King's Fund

Co-ordinated care for people with complex chronic conditions

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Developing community resource teams in Pembrokeshire, Wales

Integration of health and social care in progress

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Supported by The Aetna Foundation, a national foundation based in Hartford, Connecticut, that supports projects to promote wellness, health and access to high-quality health care for everyone; and Aetna Inc, one of the nation's leaders in health care, dental, pharmacy, group life, and disability insurance, and employee benefits. The views presented here are those of the author and not necessarily those of The Aetna Foundation, its directors, officers, or staff; or Aetna, its directors, officers, or staff.

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About this research

Age-related chronic and complex medical conditions account for the largest and growing share of health care budgets in all industrialised nations. However, people living with multiple health and social care needs often experience a highly fragmented service leading to sub-optimal care experiences, outcomes and costs. To address this, strategies of care co-ordination have been developed to promote more cost-effective care through integrated services.

For older people in need of both health and social care support, the divisions in the organisation, funding and delivery of care in the United Kingdom (UK) can result in poor user experiences and outcomes. There have been many innovative projects to promote better care co-ordination for older people, but these have often not met their objectives and the failure rate has been high because of poorly designed interventions, difficulties in targeting those most likely to benefit from care co-ordination and the unmet patient needs that improved follow-up can uncover. There is a lack of knowledge about how best to apply care co-ordination tools in practice.

This case study is part of a research project undertaken by The King's Fund and funded by Aetna and the Aetna Foundation in the USA to compare five successful UK-based models of care co-ordination (see Appendix 1 for methods used to collect the study data). The aim of each case study has been to understand the strategies used to deliver care co-ordination effectively; examine barriers and facilitators to successful care co-ordination; isolate key markers for success for the practical application of the tools and techniques of care co-ordination; and to identify lessons in how care co-ordination can best be supported in terms of planning, organisation and leadership.

Further details about this project can be found at: www.kingsfund.org.uk/coordinatedcare

Acknowledgements

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1 Introduction

The health and social care system in Wales

The National Health Service (NHS) is responsible for providing health care to the public in the UK. It is publicly funded, mainly through taxation, and services are provided free of charge to all patients in the UK, excluding certain exceptions permitted by Parliament. Since its establishment in 1948, the overarching principle of the NHS has been to ensure that health care is available to all on the basis of need, not ability to pay.

Responsibility for health care is devolved to the governments of each of the four constituent countries of the UK (England, Scotland, Wales and Northern Ireland). As in the other home countries, integration of health and social care is an important topic in Wales and the Welsh government is actively encouraging co-operation between the sectors (Ham *et al* 2013).

In Wales, community, general hospital and mental health services are provided by statutory NHS organisations. Planning and commissioning of health services is the responsibility of seven health boards, with a national committee answerable to the boards planning and providing highly specialist health care. The seven health boards and the committee were introduced in 2009 after the internal market was abolished for political and economic reasons.

Primary care providers act as the first point of contact for physical and mental health care services. General practitioners (GPs) are local primary care physicians based in GP practices alongside nurses and support staff. They operate as independent businesses paid through a UK-wide contract administered in Wales by the primary care department of the Welsh government. Dentists, opticians and pharmacists also provide primary care services.

General practice accounts for around 90 per cent of all patient contacts in the NHS and the majority of people are registered with a GP practice (The King's Fund 2011). When specialist treatment is needed, patients are referred to hospital or other specialist providers. In this way, general practice acts as the gatekeeper to specialist care. Urgent and emergency care services are available directly through out-of-hours services and hospitals.

The 22 local government authorities in Wales are responsible for the provision of social care. Similar to England, there is a high degree of private sector involvement. Social care is means-tested, ie, people holding assets above a certain threshold are expected to contribute to the cost. This contribution is limited to £50 per week.

Wales faces financial pressures on its health and social care spending, with health care spending for 2014/15 set to be 10 per cent lower than in 2010/11. Social care spending in Wales has fallen by 3.8 per cent between 2009/10 and 2012/13 (Timmins 2013).

2 Community resource teams in Pembrokeshire

Summary

Background

Community resource teams (CRTs) are part of a wider strategic programme to deliver better integrated care to people closer to their homes and communities. The programme is managed by the Hywel Dda Health Board in close co-operation with the three county councils of Pembrokeshire, Carmarthenshire and Ceredigion. The Pembrokeshire model called *Care Closer to Home* comprises four CRTs covering a population of 122,439 across a largely rural setting with low population density. They do not have a specific budget – staff salaries are covered by the respective employers (Pembrokeshire County Council and the Hywel Dda Health Board). The development of the CRTs is supported by additional and recurring funding of £996,000 from a Welsh government fund established to reduce long-term community health care spending.

Aims and objectives

The main goals of the programme are to improve or restore the quality of life and confidence for people with complex health and social care needs, and to reduce avoidable admissions to hospital. The four community-based teams bring together professionals from health, social care and the third sector to provide care for patients at home.

Target population

The CRT services are available to everyone with multiple health and social care needs at risk of hospitalisation (depending on team capacity). The majority of clients are frail older people, typically with dementia and multiple co-morbidities, such as cancer, respiratory illnesses and chronic heart disease (in 2012, the average age of people supported through CRTs was 74). Younger people under the age of 65 tend to have neurological conditions, such as multiple sclerosis (MS), motor neurone disease (MND) or Huntington's disease. Since the inception of CRTs, 1,469 people have had a relationship with the teams, of which 120 patients are currently actively case-managed by the four teams (July 2013).

Approach to care co-ordination

Care co-ordinators act as the main point of contact for patients and work with the team and patients and carers to tailor individual care packages to enable people to stay at home. The four teams consist of social workers, occupational therapists, physiotherapists, district nurses, voluntary sector service brokers and specialist nurses. The two voluntary sector service brokers can arrange for additional services from local charities, such as befriending, dog walking or gardening. The team can also call on the services of dieticians, speech and language therapists, and other health and social care professionals.

One team member acts as team co-ordinator. The teams meet weekly to discuss cases. The CRTs also work with three specialist teams in the acute sector to facilitate early discharge of patients with complex needs and to prevent unnecessary hospital admissions.

Results

Client satisfaction data collected in 2012 from 392 patients demonstrated that 55 per cent of people reported 'improved' or 'restored' confidence following CRT involvement with 38 per cent stating that they felt more independent. Data available for 2012/13 shows a decline in emergency admissions for patients with chronic heart disease (953 to 704). Length of stay for patients with diabetes, chronic obstructive pulmonary disease (COPD) and coronary heart disease (CHD) is also below the mean of 5.5 days for the Hywel Dda Health Board, and emergency admissions for people with CHD dropped from 953 to 704 in the year 2012/13.

Case study

Mrs K's story

Mrs K is 91 and was living alone in her own home. Her grandson asked social services for support as he noticed a change in her behaviour. Social services referred her to the local CRT. Mrs K has advanced dementia with very poor short-term memory. She is doubly incontinent, and inadequately attempts to clean herself. Unsupervised, she gives her food and drink to the dog, resulting in weight loss. Before the involvement of the CRT team, Mrs K had no services in place.

Post-referral, the CRT organised visits from the community psychiatric nurse, a psychogeriatrician, a support worker and a social worker, who subsequently put together a care package that ensures Mrs K is safe at home. This required delicate discussions, as Mrs K becomes very distressed when she hears about long-term care, and due to her advanced dementia she is unable to comprehend why this is needed. Her grandson, who began looking after her after his mother died a few weeks before the referral, moved in and supervises her during the night. The dietician monitors her weight, and carers support and encourage her at meal times. She receives four daily visits from carers at home, and attends a day care centre at a local nursing home once a week. After working with her over the past 12 months, the support worker has her consent to try longer-term interim care to provide respite for her grandson. Voluntary services help with grocery shopping, and a power of attorney document is held by a solicitor.

The care package organised and provided by the CRT supports Mrs K in her own home when the only other alternative would be admission to a nursing home for the elderly and mentally infirm. The current arrangement also reflects the wishes of the family and provides support for the grandson.

Background

Work in progress

The CRTs in Pembrokeshire were purposefully selected for study as an evolving programme of care. By looking at integrated care 'in progress' the case study has highlighted the key challenges and facilitators encountered during the process of integrating health and social care.

Pembrokeshire is a largely rural county in the south-west of Wales. With a population of 122,439 it has one of the lowest population densities in the country. The urban areas in the south of the county have high levels of deprivation. The northern parts are rural and remote. The county has one district general hospital (DGH) with 200 beds. There are two community hospitals with a total of 50 beds in the south of the county.

The Hywel Dda Health Board is one of seven health boards in Wales. It provides health services for three counties in south-west Wales, including Pembrokeshire. The Board works with all three counties to integrate health and social care. In 2009, the Board and Pembrokeshire County Council appointed a joint director of health and social care to lead on the integration of health and social care services in the community (horizontal integration) and between primary and secondary acute services (vertical integration). In Pembrokeshire, the programme has progressed well with the integration of health and social care services, and the introduction of community resource teams (CRTs).

The patient group

Any person over 18 who is vulnerable due to age or a physical and/or sensory disability and suffers from one or more chronic conditions requiring specialist input is eligible to be cared for by CRTs. The majority of patients are over 65. In June 2013, the average age was 74. Older people typically suffer from Parkinson's, dementia or cancer, and are recovering from strokes or falls. Younger people (below the age of 65) tend to have chronic or neurological diseases, such as MND, MS or Huntington's. There are also high prevalence rates of COPD, CHD and diabetes in the local area. In many cases, social circumstances, such as living alone and without immediate family in the area, complicate the situation. Many live in small communities in rural areas with difficult access to formal care.

Terminology

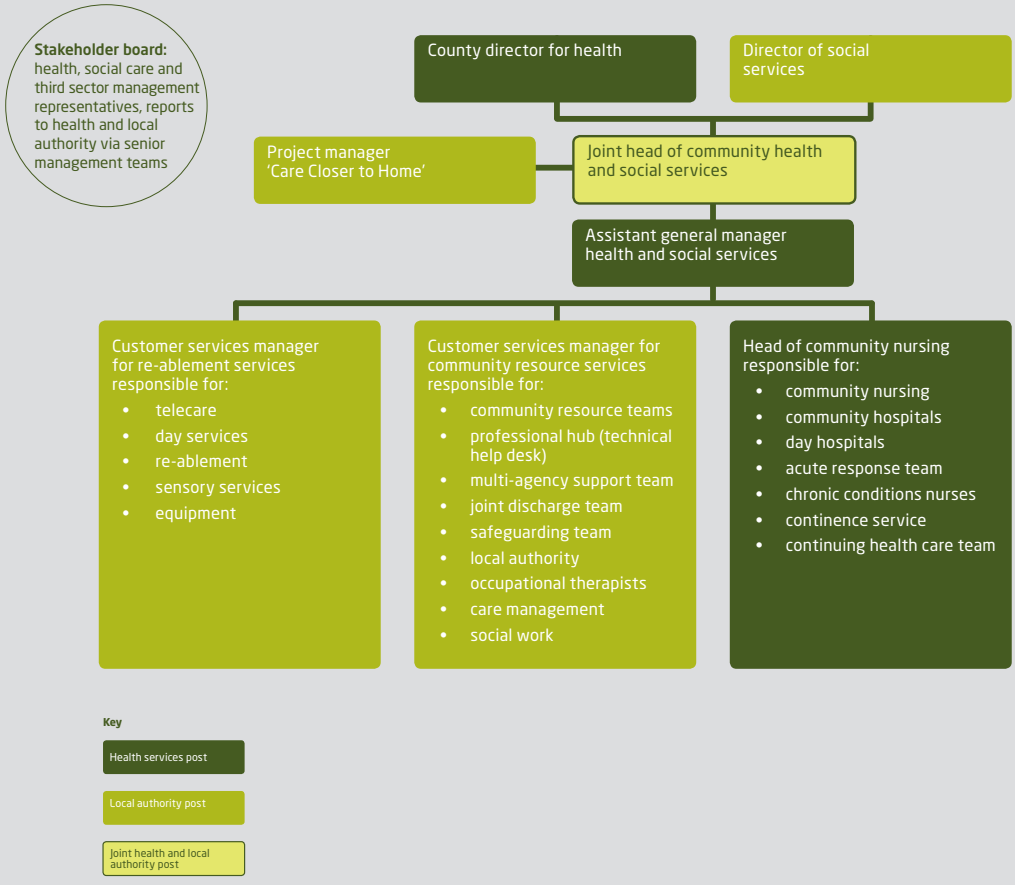
The CRTs use both the terms 'patients' and 'consumers' interchangeably, and both terms are accepted by health and social care providers to describe people with complex needs. For consistency, we use the term patient throughout this report.

Governance structures

Pembrokeshire County Council and the health board have integrated social and health care services operating under a director of health and a director of social services. A joint head of community health and social services holds managerial and organisational accountability for community adult health and social care services supported by the assistant general manager. The project is delivered through an integrated management structure of health and social care teams, co-ordinated by a dedicated project manager.

Service delivery is supported by customer services managers and the head of community nursing. The integrated structure ensures that the teams have a joint vision and managerial framework that enables them to work across organisational boundaries. A project board consisting of health, social care and third sector professionals provides strategic overview and planning advice for the development and organisation of the work streams. Figure 1 gives a simplified overview of management structures as they relate to CRT management.

FIGURE 1: Pembrokeshire management structure



Programme history

In 2007, Pembrokeshire County Council and the then health provider initiated the integration of health and social care services. Formal integration of the management structure took place in 2010.

Planning for CRTs started in 2009. Inspired by the North Devon model of integrated care, a pioneer team was set up in 2010 in the north-east of Pembrokeshire to test and develop the approach. Three further teams were rolled out across the county by April 2011. The teams are still developing, and need improvement in governance and organisational structure. CRTs will include elements of virtual wards by 2014/15, with the introduction of a predictive risk model to improve identification of people in need of care co-ordination and caseload management.

TABLE 1: Timeline of key service developments

2007	Decision by Pembrokeshire County Council and the local health provider to integrate health and social care; planning for integration begins.
2009	Health reform in Wales: creation of Hywel Dda Health Board. Creation of post of joint director for health and social care in Pembrokeshire County Council; establishment of post of project co-ordinator for complex care; planning for CRTs begins.
2010	Formal integration of health and social care in Pembrokeshire: joint management structure and budgets. First CRT established in north-east Pembrokeshire to test the approach.
2011	Roll-out of CRTs across the county. Four teams created by April 2011.
2014/15	Continued evolution of organisational capacity and governance structures; plans to introduce predictive risk model.

Funding

Community resource teams do not have a dedicated budget. Team members are paid by the respective employer – the health board or the local authority. The Welsh government makes some funds available to health boards to reduce the impact of cuts made to continuing health care funding. A recurring investment of £996,000 by the Welsh government enabled the development of CRTs and has increased capacity to support patients.

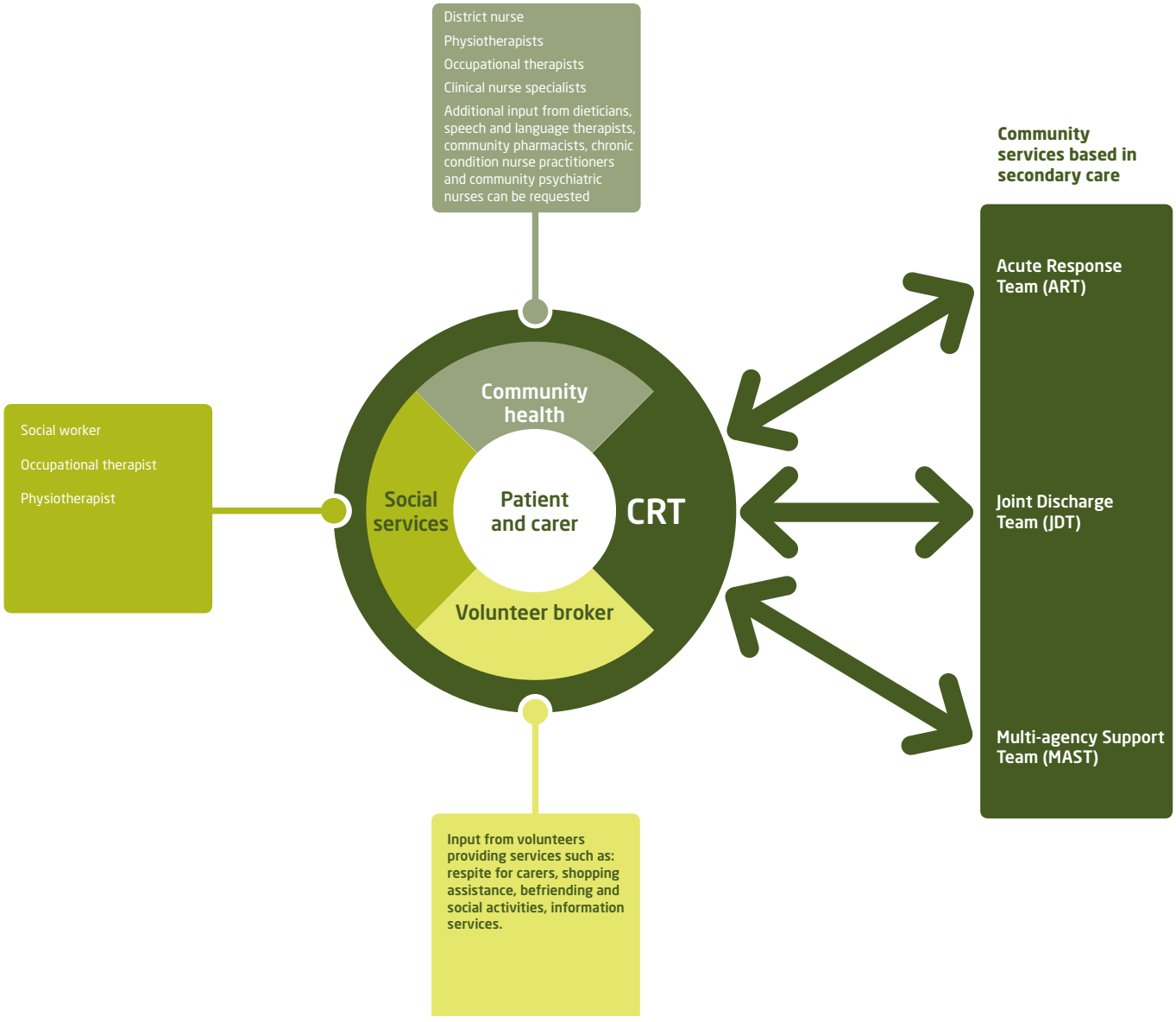
Organisational structure

Four CRTs cover Pembrokeshire, two in the north and two in the south. Each team has slightly different organisational structures and capabilities due to local differences, such as available resources, access to buildings to meet and work in, and geographic circumstances. For example, the majority of team members in the south-west are located in a community hospital. The remainder of the team (district nurses) are based in one GP practice that covers this patch. The proximity of staff to each other helps the exchange of information and the arrangement of informal and formal meetings to discuss patients. In contrast, the south-east team is not housed in one place and the patch has several GP practices, making meeting arrangements more difficult and slowing information exchange (see the section on Functional Integration, p 17, for more detail). All teams meet regularly, but there appears to be variations in attendance, due to workloads and distance. Interviewees thought that the teams where at least some members were located together have progressed further in the development of work processes and team co-ordination. It was not known if organisational and operational differences had an impact on care outcomes for those treated by CRTs.

The teams each consist of community health care, social care and third sector staff. The weekly meetings are typically attended by district nurses, clinical nurse specialists, social workers, physiotherapists and occupational therapists from both health and social care, and volunteer brokers. Specialist staff, such as speech and language therapists, chronic condition nurse practitioners, community pharmacists, dieticians, and community psychiatric nurses attend on an ad hoc basis, depending on availability. Teams discuss patients, which interventions have been implemented by whom, and with what results. The team co-ordinator also checks that all interventions that were agreed for the person have been carried out and, if they have not, asks for reasons and solutions.

CRTs also co-operate with community teams based in secondary care and acute care teams, as described below.

FIGURE 2: Organisational model



Volunteer service

The Hywel Dda Health Board funds two part-time volunteer organisers who each attend two CRT meetings. Their role is to match patients to volunteer services available in the region to help them to stay in their home. They are employed by the Pembrokeshire Association of Voluntary Services, an independent association of voluntary and community associations. There is a broad range of services on offer, from organisations arranging social outings for older people to befrienders and day-sitters who offer respite care. Specialist charities, such as the Alzheimer's Society, provide information and peer support. There are some service-level agreements between the voluntary organisations, local authorities and the Hywel Dda Health Board. A current review of these agreements seeks to secure targeted and appropriate funding levels for the future.

Team members describe the involvement of the voluntary sector as a key feature of the service as it provides the low-level support that is frequently needed to enable people to stay at home. While there is no quantitative evidence of its impact, this perception is in line with other integrated care projects involving the third sector.

Co-operation with the secondary/acute care sector

As part of the Care Closer to Home project, three community teams are based in the emergency department of the district general hospital that serves Pembrokeshire County Council residents. They co-operate with the CRTs to avoid unnecessary emergency admissions and facilitate discharge of patients with complex needs.

The three teams are described below.

- The joint discharge team (JDT) consists of a senior clinical assessor, social welfare assistants, a discharge nurse and a team clerk. The team assesses patients with complex needs for their suitability to be discharged from hospital to their homes. They discuss which services, equipment and level of care need to be in place to ensure the patient's safety. The team informs the relevant CRT by letter of a planned discharge of a patient with complex needs.
- The multi-agency support team (MAST) consists of a district nurse, a social worker, an occupational therapist, a physiotherapist and accident and emergency (A&E) staff. Its role is to prevent unnecessary admissions to hospital. If a patient with non-acute symptoms presents at A&E, they will be assessed by the team. If a patient with complex needs is considered stable enough to return home and if there is sufficient care support in place, the team will send the patient home and inform the relevant CRT team of the A&E visit. If the patient does not have a care package in place, MAST aims to create one within 48 hours and, depending on the complexity of the patient's needs, hands over the case to the CRT or community care team.
- The acute response team (ART) is a team of nurses and health care assistants who provide specialist care for patients in their own home that cannot be provided by the CRT or other community care teams, such as IV antibiotics and blood transfusions. This care prevents admission to hospital or can speed up discharge (if the patient is medically stable)

if a patient has already been admitted. The team operates 24 hours a day, seven days a week. Patients are treated in their homes for up to 10 days. If they have the capacity, the team will also carry out routine care normally provided by district nurses during the day. The ART team will liaise with the CRT to discharge patients with complex needs into their care once the patient has improved. The CRTs will also contact ART if they feel one of their patients could benefit from ART intervention.

The co-operation with the MAST and the ART is working well. Using secure faxes, secure email and telephone calls, the teams exchange information about patients and organise discharge and care. This information exchange does not appear to work as well with the JDT. Interviewees identified communication problems and a lack of understanding of the capacity of CRTs as the main problems. Letters telling the CRT about a planned discharge are often sent out too late. As a result, the CRT may only find out about a patient after the discharge, putting pressure on the team to put together a care package or provide care without the necessary equipment in place. Some interviewees voiced concerns about the increased number of cases they receive from the acute sector teams and the DGH in general:

It's very acute orientated, 'Get these people out', you know, but they're forgetting we haven't got the resources out here. We'd love to do as many complex patients [as acute services send us], I know all district nurses would, but if you haven't got the capacity…

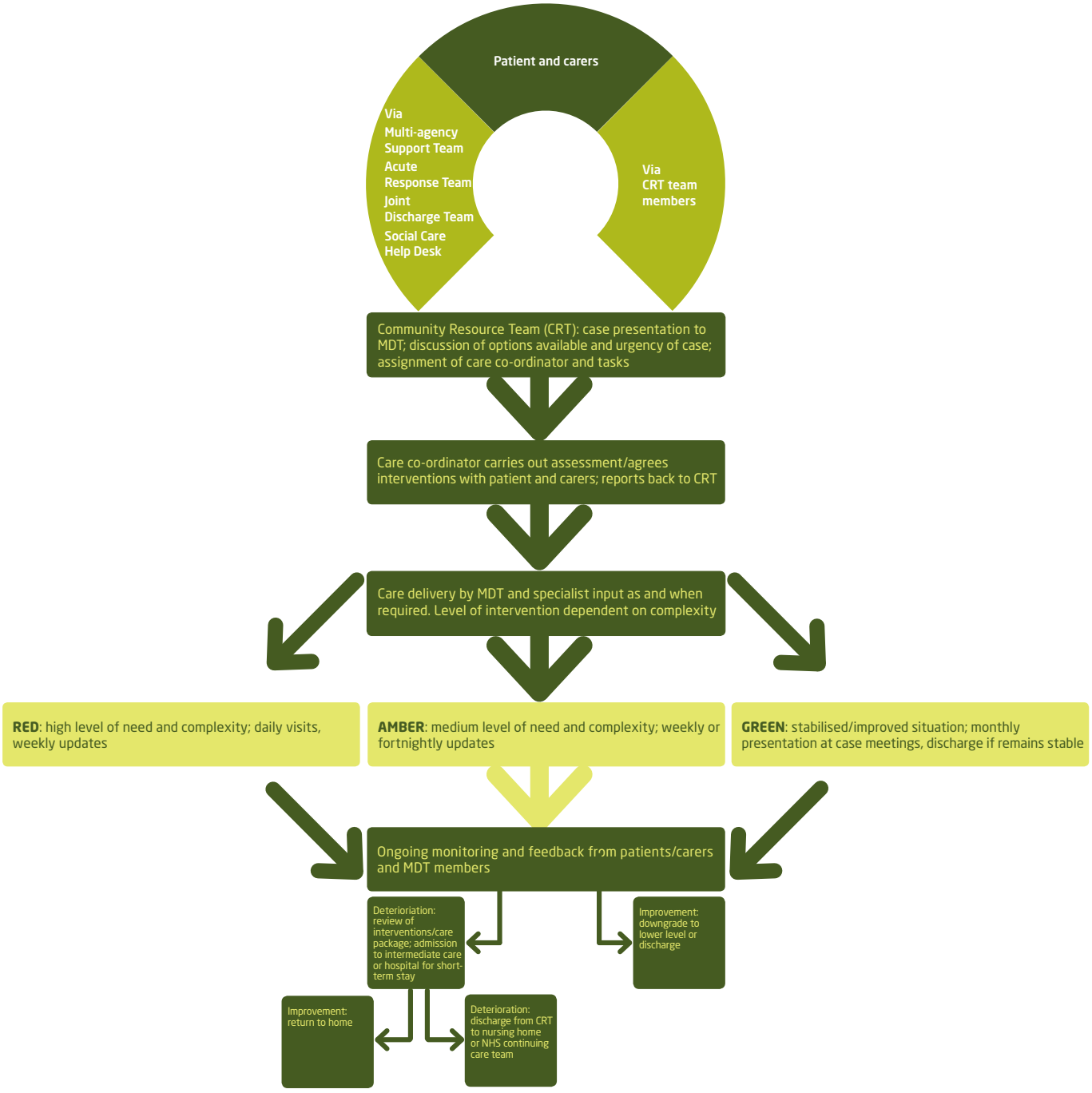
(CRT member)

While the vertical integration and co-operation with the acute sector teams is welcomed, the evidence suggests that there needs to be a better shared understanding of the demand pressures that the sectors are facing to find a sustainable pathway for vertical integration.

3 The process of care co-ordination

The diagram below shows the process of care co-ordination in the four teams.

FIGURE 3: The process of care co-ordination



Referrals

Referrals come from several sources: team members can introduce patients they are already caring for if they think they would benefit from a care co-ordinated approach. GPs also refer patients to the team, as do the hospital-based teams, consultants and specialists.

Referrals come through a contact centre run by the local authority and staffed by social care assistants. The contact centre is advertised in the community as a calling point for people who feel they or their relatives may need help in their everyday lives. People can phone the contact centre directly and social care staff also use it to make referrals. The social care assistants take case histories using a holistic health and wellbeing template that also records economic and living circumstances. Once a referral is accepted, a professional help desk staffed by medical and social care workers assesses cases to determine the level of care needed. If a case requires face-to-face assessment, it is referred to the relevant CRT.

Care planning and co-ordination

CRTs meet weekly to discuss cases. The meetings are chaired by a team co-ordinator who is responsible for disseminating information among team members and exchanging information with GP practices. Team co-ordinators also assign tasks to team members and follow up on implementation and outcomes. The team co-ordinator also has a caseload. Ideally, all CRTs should receive administrative support for meeting organisation and note-taking but only one team does.

Patients referred to the service are assigned to a care co-ordinator based on the initial assessment provided by the referrer, the patient's location, team members' workloads, and whether they are already known to a team member. Assessment of a patient's needs and acceptance as a CRT case is based solely on clinical knowledge and judgement of the health team and the expertise of the social workers.

The care co-ordinator visits the patient at home, tailors an individual care package in co-operation with the patients and their carers, and assigns tasks to CRT members and specialist staff. Care co-ordinators strongly encourage patients and their carers to create an emergency and contingency care plan in case a patient is admitted to hospital or if a carer falls ill. They also offer carers an assessment of carers' needs in line with a Wales-wide policy that seeks to improve carer identification and support.

Patients are given a risk-based code of red, amber or green, resulting in higher or lower frequency of visits and discussion at the team meeting. If a patient remains stable (code green) for several weeks, they are discharged from the service to lower level services. If their health deteriorates, patients can be admitted to short-term intermediate, residential or hospital care until their condition improves. If the deterioration is permanent, the patient may qualify for continuing health care and the CRT's involvement in care provision is reduced or stops. In future, predictive risk modelling will help both the triage process and case identification.

Team members mentioned in interviews that a key problem in producing holistic care packages is the lack of specialist staff, such as chronic conditions nurse practitioners (CCNPs). Currently, CRT cases are additional to staff's

existing workload, causing wide concern among the teams – interviewees stated that attending the meetings and organising the care packages leaves them little time to deliver care, with potentially detrimental outcomes for their patients. Other team members also noted an increase in workloads, but attributed these to an increase in demand on community care in general and to local reforms – for example, recent changes in the assessment process for continuing health care resulting in increased administrative work.

Some team members also mentioned that the process of care co-ordination could be improved through better defined roles. There appears to be uncertainty of the level of authority the team co-ordinator should have, and their level of involvement in the care co-ordination process. One team described their co-ordinator as delegating too little, while another thought that their co-ordinator did not have sufficient authority to lead the team, and therefore team members did not feel responsible for carrying out tasks. This lack of clarity is one area for improvement identified by the project board, and the management team is developing clearer role descriptions and lines of accountability.

GP engagement is also problematic. GPs do not often attend CRT meetings, but refer patients through district nurses based in GP practices. Interviewees reported that the reluctance of GPs to become involved stems from time constraints and a lack of incentives (financial or otherwise) to attend meetings. One GP mentioned that the project was perceived as a top-down initiative that was imposed on them. This could indicate a lack of shared vision and equal buy-in from GPs, although all practices were visited and presented with the project outline during the development of CRTs and invited to feed back and engage. The senior management team continues to seek ways to increase GP awareness and understanding of the programme in order to encourage participation in meetings and in the project as a whole. Quality and productivity indicators introduced to GP practices by the health board in 2013/14 are showing an increased level of involvement of GPs with CRTs.

Clinical governance

GPs retain clinical accountability for their patients, with CRT members delivering care within the remit of their job descriptions. Accountability for care delivery rests with the care co-ordinator for each case.

Continuing health care

Continuing health care is a free service providing NHS-funded care outside the hospital setting for people with a complex medical condition which results in substantial and ongoing care needs. More information is available at: www.nhs.uk/CarersDirect/guide/practicalsupport/Pages/NHSContinuingCare.aspx

Functional integration

Functional integration describes the process of communication between team members. A large proportion of communication takes place face-to-face, over the telephone or via email. Some health staff and some GP practices

have access to the social care system called CareFirst, but they make little use of it because it is slow and cumbersome. Health staff with access to the system commented it was quicker to get relevant information through personal communication. Co-location of the south-west team makes face-to-face communication easier, whereas other teams rely on email and telephone conversations.

> *It was a phone call away to the social worker on the wards to get that information as well, and you had to go through quite a few steps of security to get into the system, so it was all about time I think and what information is at that moment relevant.*
>
> CRT member, not co-located
>
> *Because it takes me 10 minutes to load it up, then my passwords, and then it doesn't work, so it's literally much easier to walk and go talk to someone, and [the social care staff have] always got their computers open and you just say 'Can you just tell me the information about this patient or this client?' and they give it to me.*
>
> CRT member, co-located

Volunteer brokers are not permitted to access most personal information outside the meetings because of governance and data protection issues. They get information about patients through a referral template and attendance at CRT meetings. They use their own system to gather relevant information from people and carers (eg, hobbies and activities, need for respite services) which they feed back to the CRTs.

Team members in all CRTs emphasised that relationships and hence information exchange had improved since the project started. This helps teams overcome the lack of IT integration.

Team culture

Initial reservations about cross-organisational working and silo structures were overcome as teams gained an appreciation of other team members' input and the benefits of care co-ordination for patients. Eighteen months into the project, members of CRTs described working relationships as productive and supportive. For example, the voluntary sector representatives said that in the beginning, they had to be assertive to be accepted and to make other members understand the value of their role and how they could contribute to improve care and reduce workloads. They said that both health and social care staff now understand their input and are actively asking for their advice. Health care staff also mentioned that being part of CRTs helped them create better working relationships with specialist staff, such as chronic condition nurses. The process was aided by a history of informal co-operation between health and social care practitioners.

Some CRT members voiced concerns about relationships with senior management. They perceived their managers to be remote and unaware of the pressures that CRT members experience at the coal face, such as the increased workloads generated through additional referrals from the acute sector teams. This may affect the level of engagement of individual staff members and have a detrimental impact on team culture: senior management said they were aware of these issues. This suggests that the lines of communications between management and practitioners could be improved.

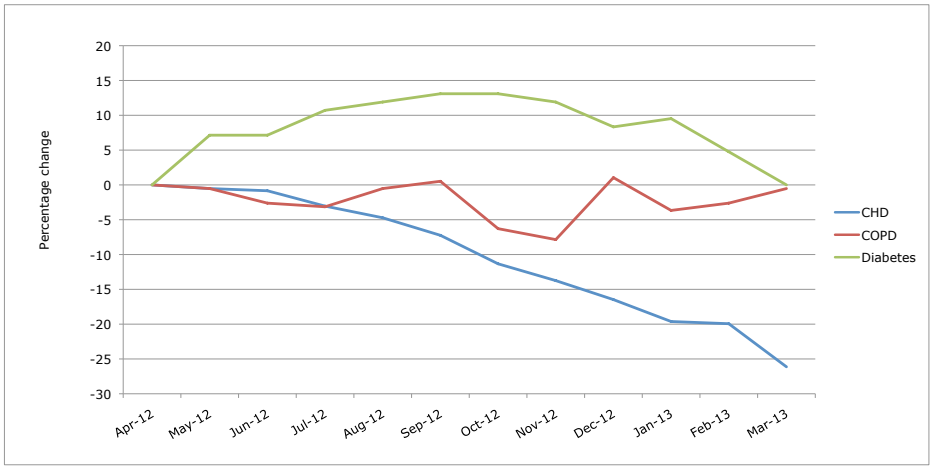
4 Impact

As the integration of health and social care is an overarching project that is still evolving, impact measurements are not yet fully implemented. Based on the results of a multi-agency/multi-professional workshop involving public health professionals, community representatives and local authorities, the project management team has developed a report card to track nine headline indicators, which also represent the key aims of the project:

- reduction in emergency medical admission to hospital for Pembrokeshire residents
- reductions in emergency packages of care
- reduction in emergency admissions via A&E through the intervention of MAST
- reduction in average length of hospital stay
- reduction in admission rates
- percentage of people reporting improvement/restoration in quality of life and level of confidence/independence following involvement of CRTs
- a measure to effectively demonstrate caseload management
- number of people who require a reduced health or social care package after a CRT intervention
- percentage of staff reporting an overall improvement in satisfaction.

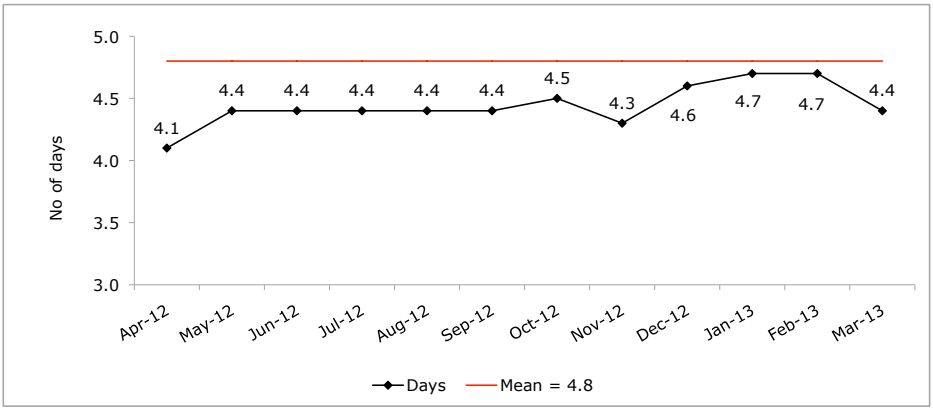
Secondary care sector data currently focuses on three prevalent illnesses: COPD, CHD and diabetes. Data for the period April 2012 to March 2013 shows impact on two indicators in these three focus areas: the district general hospital has seen a drop in admissions for chronic heart disease; admission rates for COPD and diabetes fluctuated, but returned to the base level of April 2012 (see Figure 4). Length of stay for patients with COPD, CHD and diabetes within Pembrokeshire County Council's boundary is below the mean of the whole of the Hywel Dda Health Board (see Figures 5,6,7), with a slight overall decrease in length of stay for COPD and diabetes patients.

FIGURE 4: Admission rates for three main focus areas 2012/13 with April 2012 as baseline



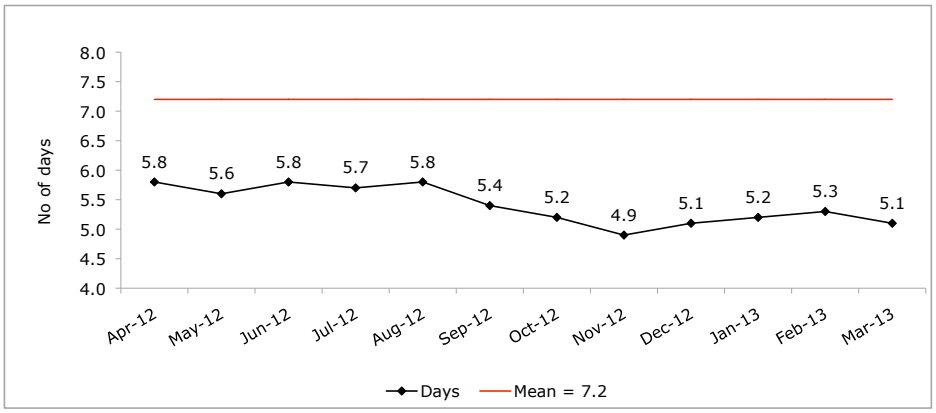
Source: Hywel Dda Health Board (2013a)

FIGURE 5: Average length of stay – chronic heart disease (CHD)



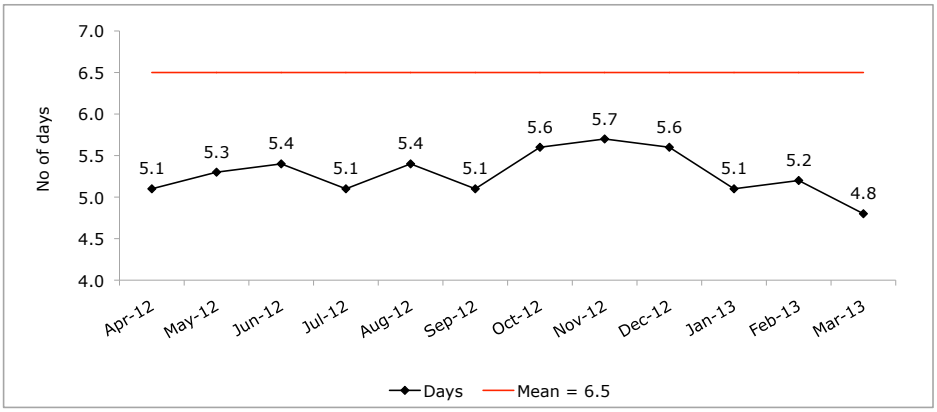
Source: Hywel Dda Health Board (2013a)

FIGURE 6: Average length of stay – chronic obstructive pulmonary disease (COPD)



Source: Hywel Dda Health Board (2013a)

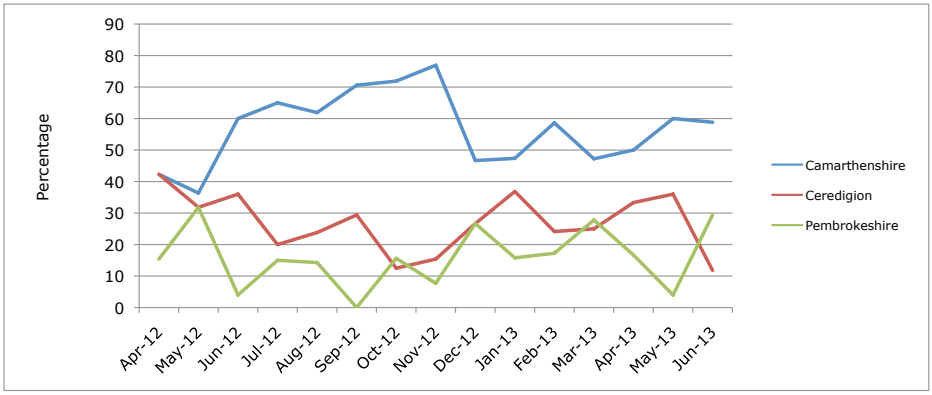
FIGURE 7: Average length of stay – diabetes



Source: Hywel Dda Health Board (2013a)

The county also had the lowest number of delayed transfers of care (discharge from hospital) in the three counties that make up the health board in 2012/13 with the exception of three brief periods (see Figure 8).

FIGURE 8: Delayed transfers of care (hospital discharge) in the Hywel Dda Health Board 2012/13



Source: Hywel Dda Health Board (2013b)

It is, however, difficult to attribute change in data to the work of the CRTs and the teams based in the secondary sector, and the trends need to be established over time. Delays in discharge can be very dependent on case mix and severity of illness, and without further analysis the significance of these low percentages is limited. However, the trends in this data are encouraging.

An outcome directly attributable to the CRTs is the drop in waiting times for assessment from up to three weeks to a maximum of four days (Hywel Dda Health Board and Pembrokeshire County Council 2012). Another key performance indicator for the CRTs is the uptake of emergency and contingency plans by individuals and their carers. These plans detail emergency contacts and alternative accommodation for people should their main carer be taken ill. In July 2013, 100 per cent of patients in CRTs had such a plan in place.

Senior management acknowledges that data collection needs to be further improved as performance management systems are not well developed. This is a priority for 2013/14.

Personal and carer experiences

Preliminary results from patient feedback on CRT involvement shows that 55 per cent of 392 respondents reported an increase in, or restoration of, confidence following CRT involvement, and 38 per cent agree that they are more independent.

Case study

Mrs A's story

Mrs A, aged 91, was referred to the community resource team by her family because she was experiencing difficulties living at home on her own. Mrs A was not previously known to social services.

It became clear that Mrs A had lost all confidence in her ability to manage at home and was spending 24 hours a day in bed. Mrs A said she was in chronic pain although medical investigations were inconclusive as to why. Mrs A's family were very concerned and were asking Mrs A to give up her home and enter long-term residential care. Mrs A was asking for admission to hospital to be looked after there.

The CRT responded to the referral within 24 hours and discussed potential options with Mrs A as part of the assessment process. Mrs A acknowledged that she was very low in confidence about her ability to manage and felt that things had got on top of her. A decision was made to access short-term residential care in a local authority home to try and help Mrs A regain her abilities and confidence using trained rehabilitation carers.

Within four weeks at the home Mrs A returned to a physical and mental level where she felt able to return home with some home care support. The home care support was designed to work with Mrs A to regain her independence.

After six weeks' of re-ablement in her home, Mrs A returned to a level of function that she had not been at for many years, and was completely independent. She no longer needed the support services and continues to live independently in her own home. Mrs A and her family have been very complimentary about the way that services responded to Mrs A's needs thereby preventing admission to hospital and long-term care.

Case study

Mr and Mrs H's story

Mr and Mrs H are both 90 years old and live in their own home. They have been receiving some home care services for some years. Mr H has dementia, is visually impaired and also has some continence issues. Mrs H has Ménière's disease leading to frequent falls and has had transient ischaemic attacks. Mrs H also has incontinence problems and is hearing impaired.

Before CRT involvement, the couple had 16 A&E admissions between them caused by their complex health needs. After referral to the CRT, the team reassessed their individual care needs and with the involvement of the community psychiatric nurse (CPN) gained a clear mental health perspective. In liaison with a psychiatric consultant the CPN reviewed their medication and prescribed appropriate treatment to help with the couple's confusion and erratic sleep patterns. The district nurse, the occupational therapist and physiotherapist also helped with incontinence care and medication, mobility and falls. Through these interventions and the care co-ordination, the CRT was able to introduce a care package that enabled the couple to remain in their home and considerably reduced their attendance at A&E.

After further deterioration of the couple's physical and mental health, the CRT discussed care options with them and they jointly agreed that long-term residential care was the best option. While the CRT could not care for the couple until the end of their lives, their input enabled them to remain in their home with a good quality of life as long as possible, only entering residential care when their safety and care needs could no longer be guaranteed.

5 Challenges and facilitators

Systematic challenges

The geography of Pembrokeshire presents challenges for staff capacity and employment. Its low population density and rural nature lead to time-consuming journeys for staff, reducing their capacity for face-to-face contacts and interventions. These characteristics also reduce the amount of informal care and support available from family and neighbours and mean those in need of support are often not identified.

While overall staff retention is good, the area's remoteness means that recruitment can be difficult. This has resulted in delays recruiting directors in both services after retirement left the positions vacant. This affected the pace of integration. A new director of adult social services in the local authority and a new county director of health are now in place and the senior management team hopes that this will create stability and speed up implementation.

Funding pressures faced by both health and social care across Wales also reduces management's ability to react to increased workloads resulting from the shift of care from the secondary to the community sector.

The roll-out of the predictive risk model (PRISM) that would assist in the case-finding for virtual ward patients to the CRTs on an all-Wales basis has been stalled as there were questions around its suitability. The results of a pilot of an alternative tool within GP practices in Hywel Dda are pending, so it is not yet known which model will be used.

Organisational challenges

As the CRTs are still evolving, this study uncovered many challenges relating to the development of management and governance structures. For example, we saw variations in the CRTs' operational structures and capabilities with some teams appearing to have established better working practices than others, facilitated by co-location and administrative support. Practitioners on the ground and management attributed some of these variations to a lack of clarity of roles within teams, for example, the exact accountability and responsibility of the team co-ordinators. In some cases, this contributed to delays in the implementation of care plans. The senior management team plans to improve the existing governance and accountability policies.

Some interviewees mentioned that their CRT work had added a burden to their existing workloads. For example, the lack of time to attend additional meetings or carry out organisational and caring duties led some staff to feel that care for some patients might deteriorate. While this is closely related to the funding pressures described above, management is seeking to address this by improving functional integration and case identification through the rolling out of the predictive risk model.

Silo thinking persists between community and secondary care staff: CRTs mentioned a lack of understanding in the secondary sector of the time it takes to put a care package in place and discharge a patient safely. As a result, CRTs sometimes have to care for people at home before a care plan and equipment needed are in place. Interviewees also said that, unlike a hospital, their capacity did not have clear boundaries. Morally as well as professionally, they

often felt unable to turn someone away, increasing working hours to meet their needs:

> *There's no slack in the system, no. No, in fact people just work that bit harder and a bit longer… to get the work done.*
>
> (Manager)

While GP engagement is improving, it is a slow process requiring great effort from the project team. Staff on all levels are aware that this will take time. One manager thought that the introduction of the predictive risk modelling tool would facilitate this, as it would help to define the role of CRTs and the involvement of GPs in relation to clinical accountability and patient identification. New quality and productivity indicators that incentivise GP practices to actively find cases in their patient lists will also help the process.

Facilitators

The development of CRTs is helped by a supportive policy environment, both nationally and at a county level. Management interviewees clearly identified the early integration of health, social and third sector representatives in the project management board as a key facilitator. The vision developed at board level meant that managers could engage and direct staff towards joint ways of working. Managers also mentioned a non-hierarchical working culture across management levels both in the local authority and the health board as a facilitator for integrated working.

The culture of integrated working that has evolved over the past years has also been facilitated by a history of co-operation between social and health care in both formal and informal ways. Interviewees who have worked in the area for a long time described CRTs as returning to working practices that were in place until the early 1980s, when social and health care staff were co-located and jointly funded. Despite a formal separation between the two sectors, personal relationships and informal co-operation remained, supported by a largely stable practitioner workforce. Silos that still exist between social and health care staff relate mostly to budgeting, accountability and language use; while health care speaks of patients, social care uses customer or client. These silos are slowly broken down as staff start to use terms interchangeably, and gain trust and confidence to allow others access to funds and equipment.

Lastly, the improved care co-ordination for patients resulting from the collaborative approach ensures continued buy-in from staff. Despite the current increase in workload and difficulties in co-operation with the secondary sector, practitioners were unanimous in their support of CRTs as they saw overall benefit for the patients. The reduction in assessments using a single care co-ordinator, the involvement of the voluntary sector, and the fact that people can remain at home, outweighed the concerns voiced by some frontline staff of a reduction in quality of care. Satisfaction studies are still being prepared, but interviewees reported largely positive feedback.

6 Key lessons

The Care Closer to Home project and the CRTs are still developing, and observing them for this study presented a unique opportunity to draw out some key lessons from the organisational formation and the processes used. The overarching lesson is that system integration takes time and that developments can neither be imposed nor rushed. Other case studies examined in this project (eg, the Midhurst Macmillan Community Specialist Palliative Care Service (Thiel *et al* 2013)) took six to seven years on average before their programmes began to report positive impacts. The lessons from Pembrokeshire suggest that a 'maturity model' to integrated care exists, a finding suggested by other studies of integrated care in the UK (eg, Rand Europe and Ernst and Young 2012).

Voluntary sector involvement

The involvement of the voluntary sector organisers in the CRTs enables the teams to include services in the care package that contribute greatly to patient care. Experience shows that it may take some time for their input to be appreciated, but if they were involved at the inception of the team this process could be shortened.

Patient targeting and risk stratification

The increase in workload and the capacity issues mentioned by staff highlight the importance of developing clear patient targeting strategies early. Introducing a risk stratification model helps to triage cases and can also help to focus on the most urgent. The development of CRTs is hampered by the delay in the roll-out of a risk stratification model, especially as interviewees thought improved patient identification would help with GP engagement. The project board is looking to find alternatives such as the aforementioned quality indicators for GP practices.

Co-operation with the acute sector

Operating as part of the wider Care Closer to Home project, the CRTs' co-operation with acute-based teams to prevent unnecessary admissions and to facilitate discharge has helped patients to remain at home. However, remarks by interviewees highlight the importance of creating a joint vision and a better understanding of the requirements and pressures the CRTs face – and vice versa. Currently, the lack of clear communication channels, especially between the CRTs and the JDT, are putting unnecessary stress on the CRTs.

Continuous learning and development

While not discussed in detail in this report, management strategies include a continuous reflection on the experience of staff and patients, and evaluation of organisational procedures to improve the programme. Senior management are aware that they and the CRTs are on a steep learning curve, which appears to be communicated well to the team members. This facilitates a culture of learning and improvement, and gives staff confidence to speak openly about problems with managers.

Importance of appreciation of team members' roles and contributions

A key point to emerge was the importance of understanding and appreciating the roles of others and their potential for improving care co-ordination. Such relationships require time to develop: interviewees indicated that after 18 months of working in CRTs, much progress had been made, but that it still had some way to go.

Performance measurement in step with organisational development

While key performance indicators should be agreed early and data collection systems developed for performance measurement, it is equally important to ensure that the teams are in a position to deliver on these measures before their performance is judged. In Pembrokeshire, CRTs are given key performance indicators (KPIs) that reflect their organisational status and their capacity to gather data. For example, a current KPI is the creation of contingency plans for families and carers, on which the CRTs are delivering. More sophisticated KPIs will be introduced over time, such as the ones used in the report card, but only when the capability exists to collect data which is currently not routinely gathered.

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Appendix 1 Methodology

The research team used a mixed-methods approach which involved:

- 18 semi-structured qualitative interviews with CRT staff, GPs, acute sector staff, and senior managers from the Hywel Dda Health Board and Pembrokeshire County Council
- observational analysis of a weekly multidisciplinary team meeting, and a delayed transfer of care meeting
- content analysis of key documents and impact data provided by the Hywel Dda Health Board and Pembrokeshire County Council.