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Planned Care Innovation Programme

BORTH INTEGRATED HEALTH AND CARE COMMUNITY SERVICES

Dr Sue Fish – GP Partner Borth Surgery – Project Lead

Claire Bryant – Advanced Nurse Practitioner and Clinical Care Co-Ordinator

Jacqui Jones Browne – Practice and Project Manager

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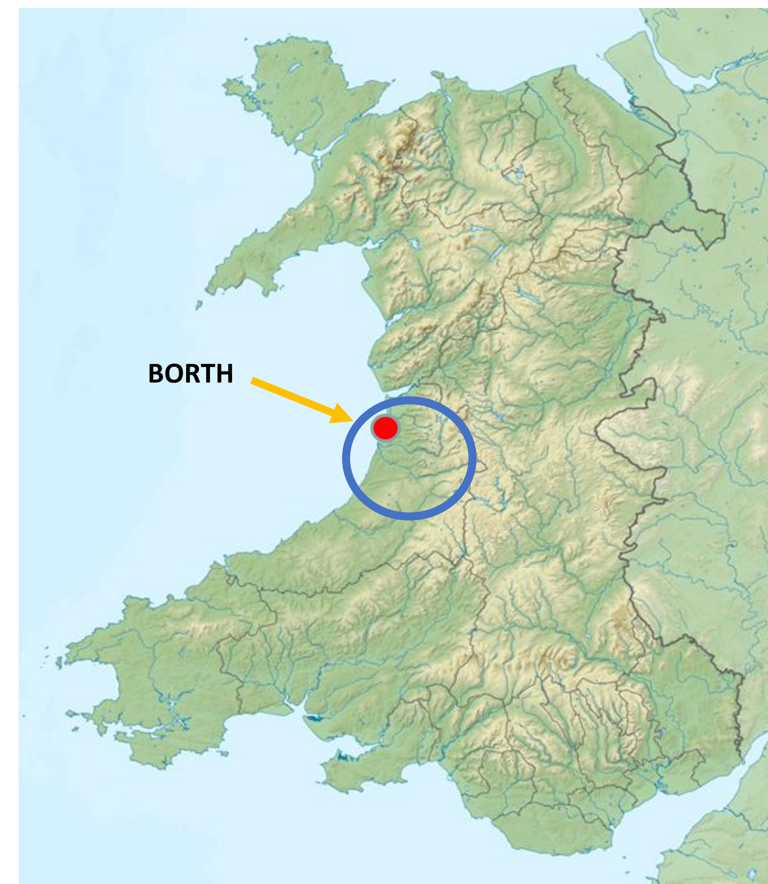
Project Background

- Borth and surrounding population
- Number of multi-disciplinary teams (MDTs) working in silos
- General Practice was not integrated within the MDTs
- Bureaucratic referral processes
- Very little patient centred integrated working
- All parts of the system post pandemic under extreme pressure



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Borth Integrated Health and Care Community Services Project

- Bevan Commission Planned Care Innovation Programme.
- In order to improve the delivery of planned care stakeholder organisations needed to increase their capacity.
- Whole system transformation was required in the delivery of health and care community services through Patient Centred Multi-agency Team Working.
- Increased use of Third Sector Services required

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Project Approach

- Clinical Care Co-Ordinator – Band 8A Advanced Nurse Practitioner employed in General Practice
- Established weekly one hour long multi-agency team (MAT) meetings
- Any member of the MAT could discuss any patient registered with Borth Surgery under their care

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Members of the MAT meeting

- Clinical Care Co-Ordinator (Chair)
- Administrator (Minute Taker)
- GP
- Borth Practice Nurse
- Community Pharmacist
- District Nursing Team
- Community Therapy Representation
- Community Dietician
- Older Person's Mental Health Team
- Bronglais Hospital Frailty Team
- Bronglais Hospital Flow Team
- Palliative Care Team
- Social Worker/Assistant
- Reablement
- Red Cross
- Community Connector/Carers Service
- Bronglais Hospital Frailty Team
- Bronglais Hospital Flow Team
- Borth Community Hub

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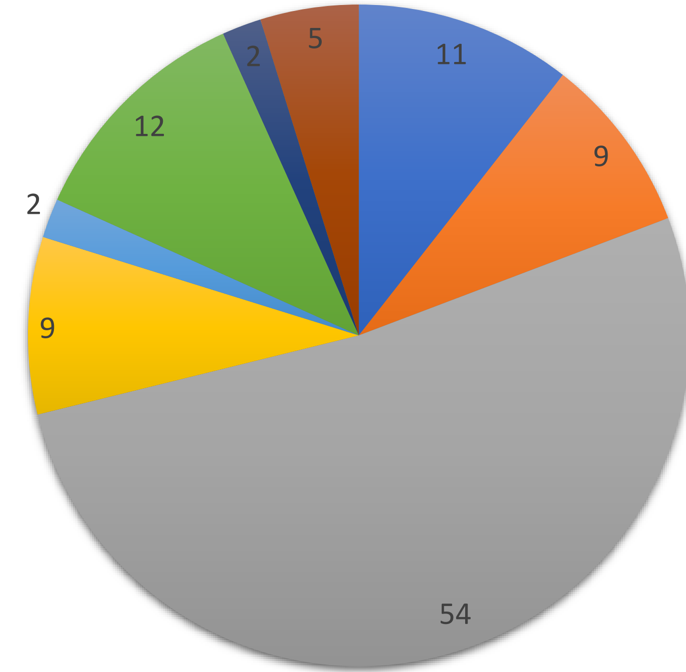
Number of Patients Discussed and Referral Source

- **Total Number of Patients** **104**
  - Patients not in hospital 50
    - Primary Care 9
    - Hospital out-patient referrals 5
    - Palliative Care 12
    - Referrals to Porth Gofal 9
    - Frail elderly in person 11
    - Mental Health 2
    - Cartref Tregerddan 6
  - Patients admitted to hospital 54



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Feedback from people attending MAT meetings in person:

I found attending the MAT a very positive experience

People listened to what was important to me

It is very reassuring to know that there are so many people and services available to me that I did not know about before the meeting

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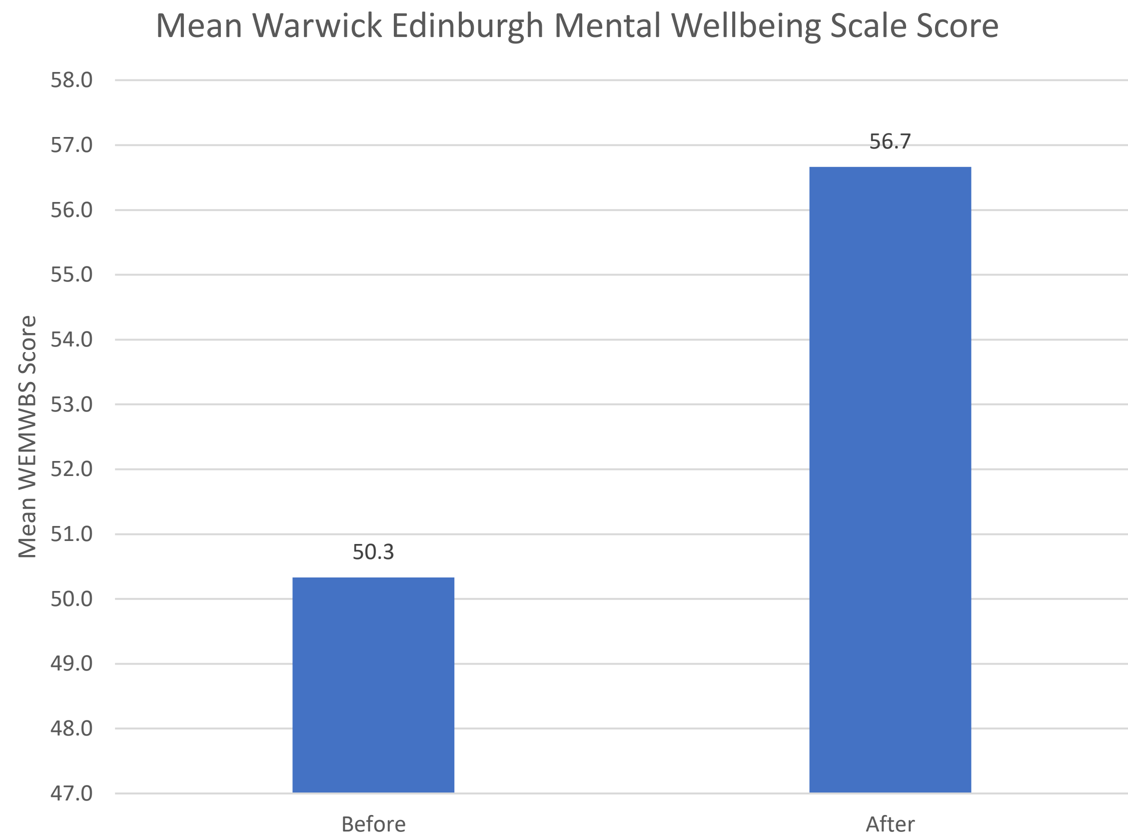
In Person Mental Wellbeing Scores



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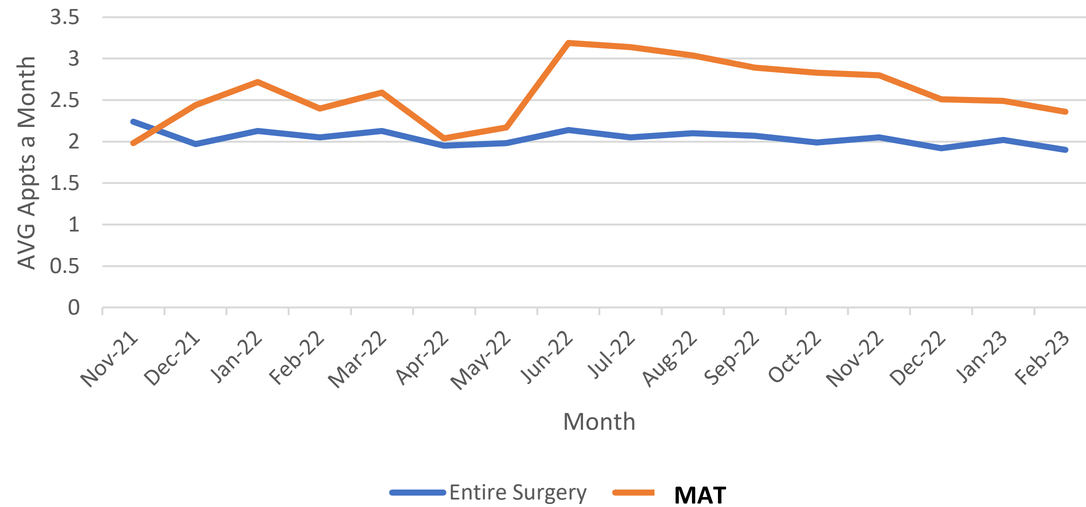
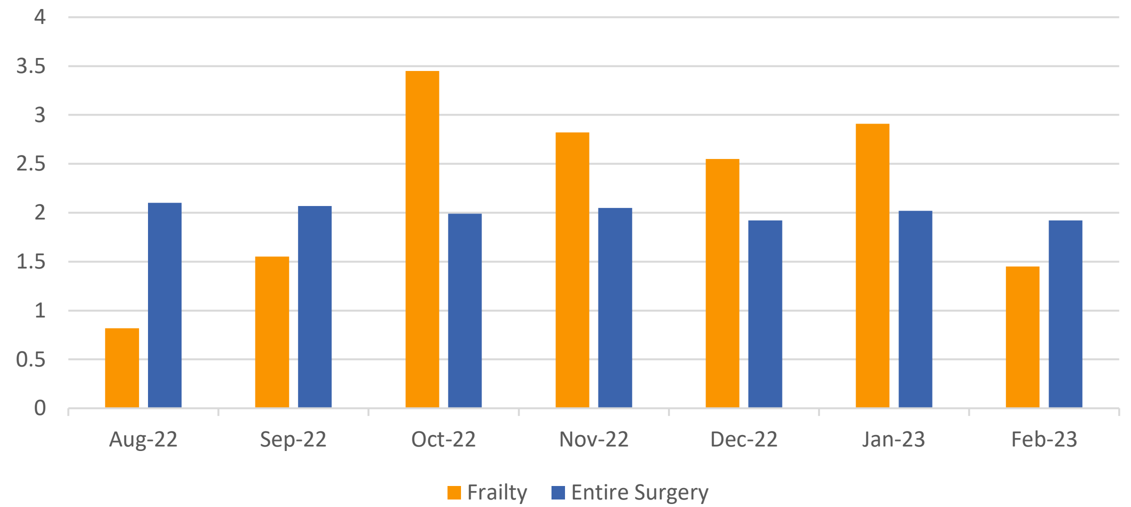
Effect on GP Appointments– Frailty





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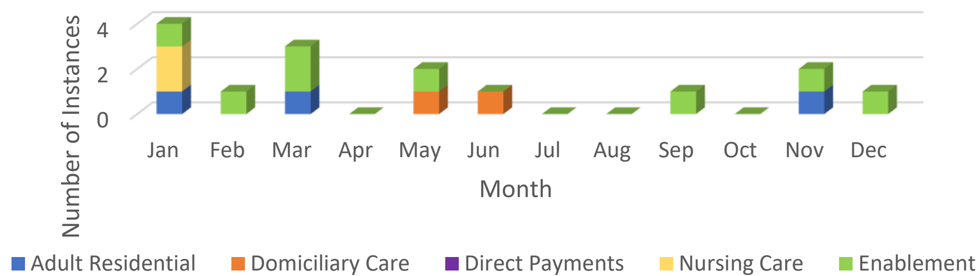
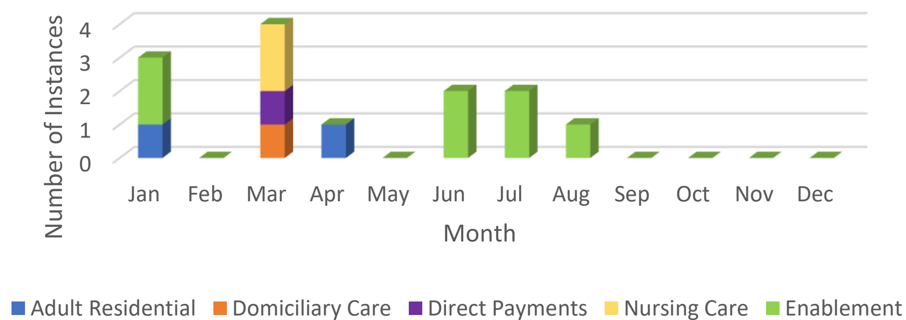
Number of Social Service Instances per Month 2021



Number of Social Service Instances per Month 2022

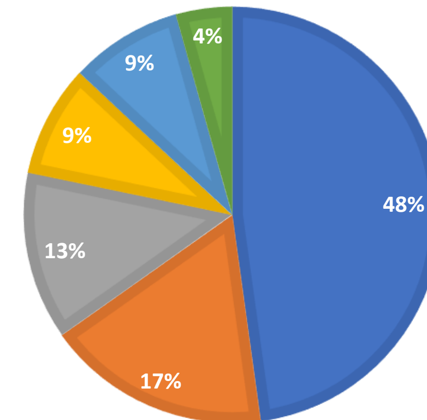


The Carers and Community Support Team

16 referrals – 15% of patients discussed at MAT

REASON FOR SUPPORT

Social isolation
Carer support
Mental health
Domestic help
Finance and education
Transport



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Number of Patients Referred to 3rd Sector

	Number Referred	Percentage of Patients Discussed	Number of Patients still engaged
Borth Community Hub	16	15%	12

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MAT Member Feedback

reduced-duplication advantageous
time-consuming interesting familiarity system
proactive enjoyed-attending referrals-system communicationions
brilliant
service collaborative clinical essential independent
ensures addressing holistic highlight reviewing in-person
managed relevant clarity
identify local-services new patients-needs
more-confident liaise
different-sectors knowledge referrals services participants
effectively
gained
background-detail detailed available access value improved-care
no-negatives
attending learning great health strong impacting duplication
strict-structure information efficient build
signpost MAT actions
on-task third-sector-services additional learn
proactive-not-reactive represent
successful-project community processes
effective express families issue excellent networking
beneficial approach
patients integrated
support
better
matters awareness involved
clearer
ensure communication
occupational-therapy relationships management positive
successful invaluable feedback attend

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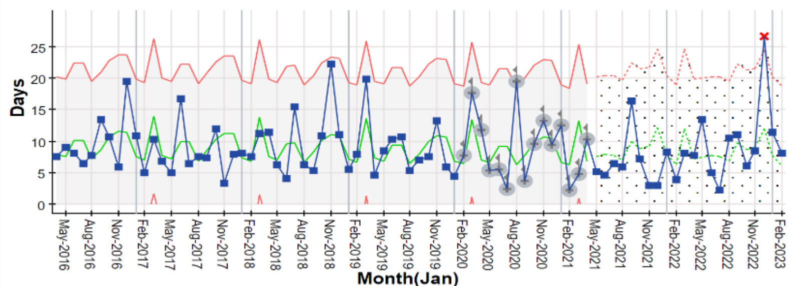
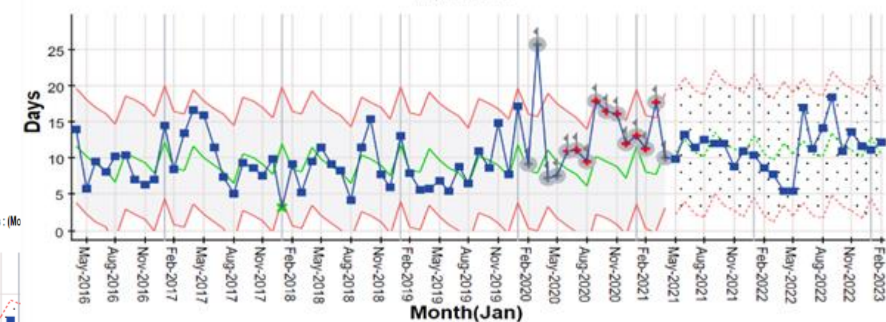
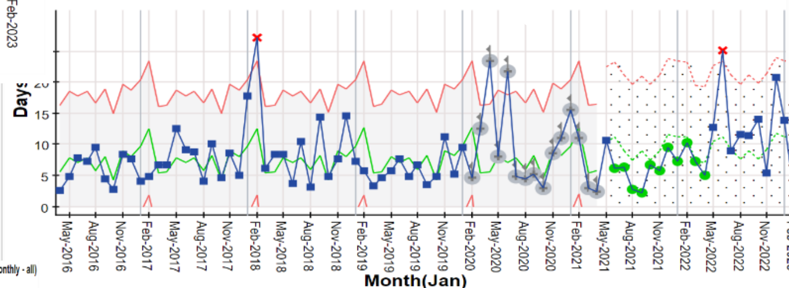
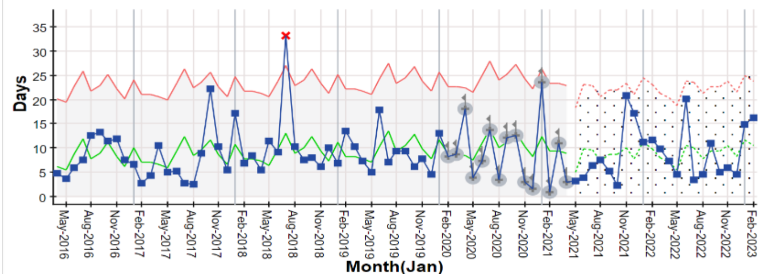
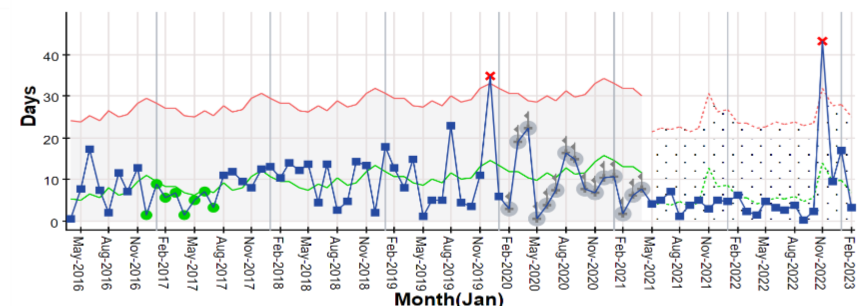
Length of Stay











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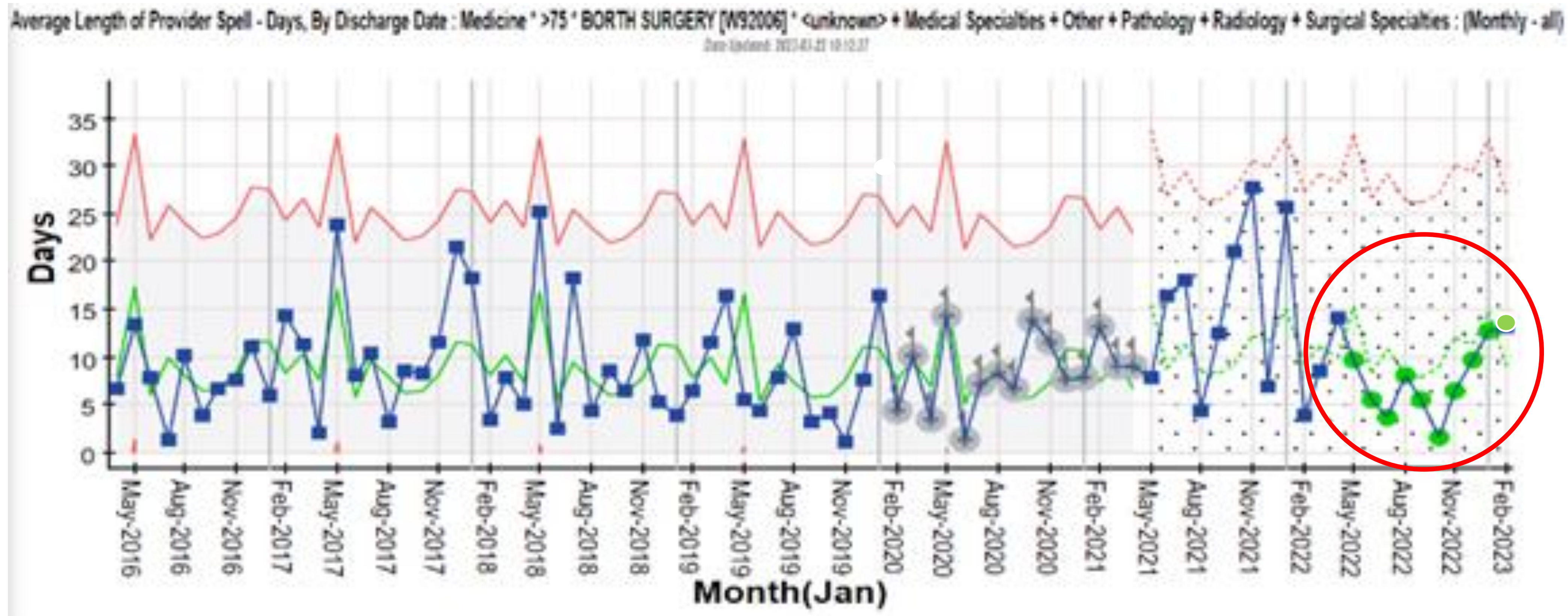
Effect on Length of Stay Borth Surgery



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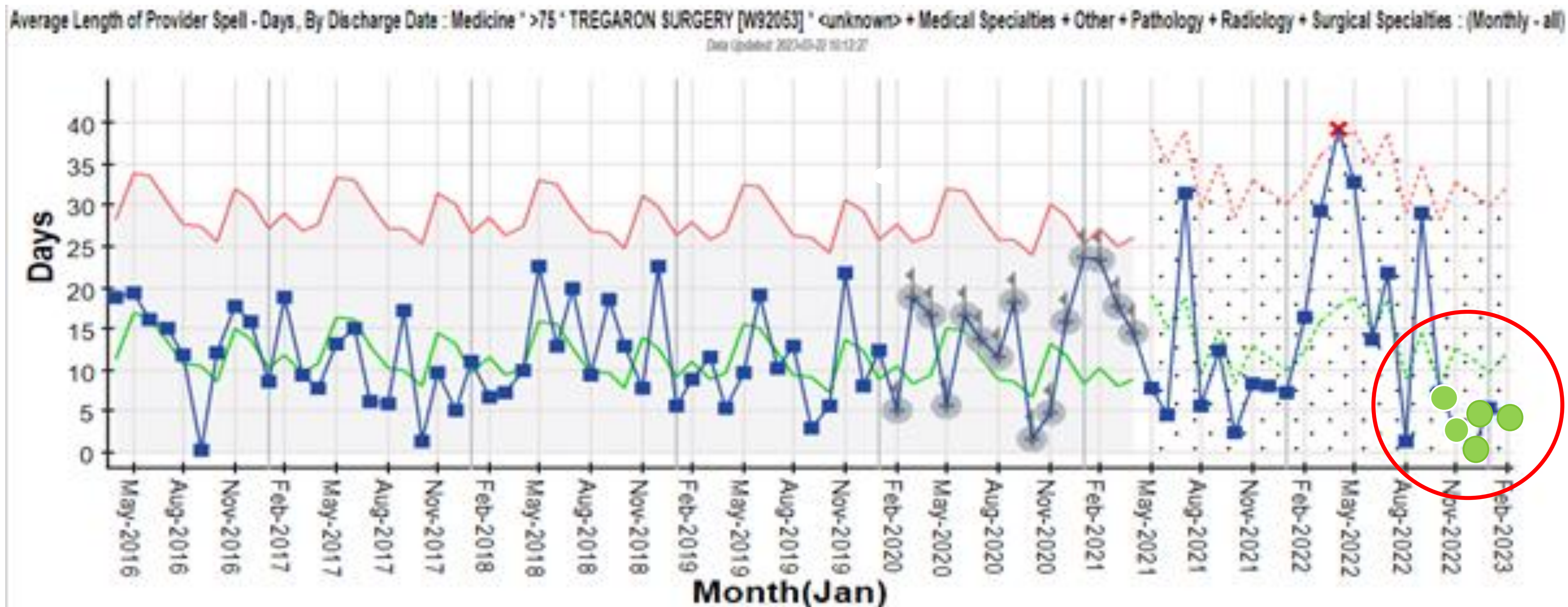
Effect on Length of Stay Tregaron Surgery



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Borth Surgery - Bed Days Saved

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

Total number of bed days saved due to reduction in length of stay – 553

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Further Evaluation

- Planned admissions increased but the average LOS reduced by 37% - saving around 160 bed days
- ED attendances appear to increase significantly but the conversion rate increases
- Of those people who died after contact with MAT – 38% died in hospital

Resources

Area	Cost per day / attendance
Fully absorbed cost – BGH general medical bed	£1,094
"Releasable" resource cost – BGH gen medical bed	£640
BGH ED attendance average cost	£314

Likely reduction in resource usage for IP spells is around £579k (fully absorbed) / £340k (releasable)

Likely increase in ED attendance resource cost is £38k

Project cost £60k

Net overall effect is therefore resource releasing – approx. £250k net benefit

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Reflections

Enablers

- Clinical Care Coordinator in Primary care
- Relationships, trust, ‘can do’ attitude
- Focus on person-centred care
- Building on and establishing new networks

Barriers

- Culture
- Bureaucratic referral process
- Silo working across organisations
- Resource deficits/service gaps
- IT systems
- Funding silos

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Mrs B

Borth MAT

A Healthier Ceredigion

Person-centred

Staying well at home

Community based approach

1 Health and Social care working together 'Joined up working' 'A Single System' Starting locally

2 Services out of hospital and into the communities Resources into communities

3 Measuring what really matters to people

Using technology to support staying in own home

SUPPORTING CARERS AND VOLUNTEERS

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Conclusions

- 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.
- 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 deliver more planned patient care.
- There has not been an increase in demand for social services care packages and there may have been a reduction.

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Contact Details

Email :	Dr Sue Fish	sue.fish@wales.nhs.uk
	Claire Bryant	Claire.M.Bryant@wales.nhs.uk
	Jacqui Jones Browne	Jacqui.JonesBrowne@wales.nhs.uk

Twitter: @DrSueFish