CAPITA

Western Bay Community Services Demand & Capacity

August 2017

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1. Introduction

Following our work to develop a 5 Year Demand & Capacity Model for ABMU, we were asked to develop a demand and capacity model to support planning for **out of hospital services** across health and social care in the Western Bay area.

Core to the vision within both ABMU and the wider Western Bay sits a desire to treat people in the most locally-appropriate care setting. In summary, moving away from bed-based care in either the acute setting or residential care being the default.

To deliver this commission, we again deployed Horizon, our innovative health economy planning model, to create and analyse a baseline and model future change scenarios. Alongside the data analysis and modelling we undertook desktop research and engaged with stakeholders to better understand the services within the local context and the major challenges faced.

This report will cover:

- The modelling methodology and process
- Stakeholder engagement
- Current and projected demand
- Baseline – current community services configuration
- Scenario modelling – out of hospital services
- Recommendations arising from the modeling outputs
- Our observations and further recommendations

This first-stage review is an attempt to begin to gather data and evidence to demonstrate the case for change for delivering services differently out of the acute hospital environment. This report, and its' recommendations, aims to support Western Bay to further develop options to develop and deliver new models of care that will not only relieve pressures on the acute sector but, as importantly, enable patients to be cared for, where appropriate, in their local community avoiding the need for admission into the acute sector.

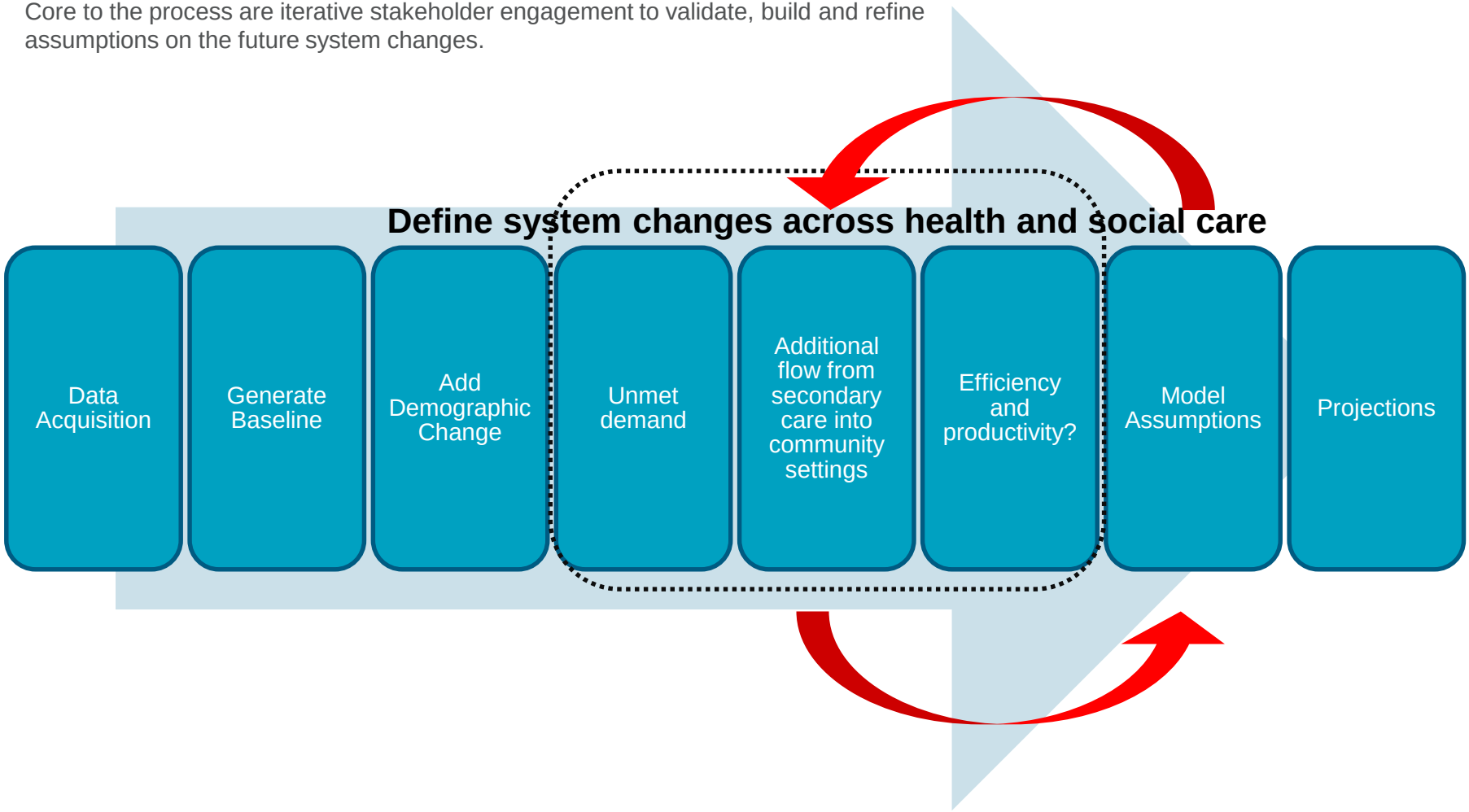
Our scope was only to consider opportunities for delivering current community services differently but, from our other work, we are aware that opportunities also exist, through different ways of working, for an alternative model of care for some acute activity out of the acute hospital environment.

Please note that due to the level of consistency, completeness and granularity of service data, we were not able to establish specific capacity requirement conclusions. In lieu of this, we have, however, provided an indication of where the likely impacts of demographic change and further shifts to community settings will be manifested.

Western Bay out of hospital modelling process

An overview of the modelling approach is below.

Core to the process are iterative stakeholder engagement to validate, build and refine assumptions on the future system changes.



Western Bay out of hospital stakeholder engagement

To inform, clarify and validate our interpretation of data and information we conducted interviews, workshops and validation sessions with key stakeholders from ABMU and the three Local Authorities. Details of those who took part are included at Appendix A.

Interviews

Whilst waiting for our initial data request to be fulfilled we undertook a series of one to one interviews with key senior staff members. The purpose of these interviews was to gain an understanding of the configuration of services, the key challenges , successes and future aspirations. Everyone we spoke to during the course of these interviews was helpful, open and candid and all demonstrated a desire to improve services for patients and service users.

In addition to these individual interviews we also met with the three District Nursing Leads as a group.

Workshops

We held two workshops to support our work. Workshop 1 was used to validate service maps for the three areas and playback our initial data analysis around future demand projections and what secondary care data analysis might tell us about community services. Workshop 2 was used to further refine the service maps and used patient scenarios to draw out core pathways. We had intended that we would also use this session to validate service level data and analysis but were unable to do so as we were still awaiting some key data and information. It was agreed at this workshop to hold a data validation session with each of the three areas.

Data Validation Sessions

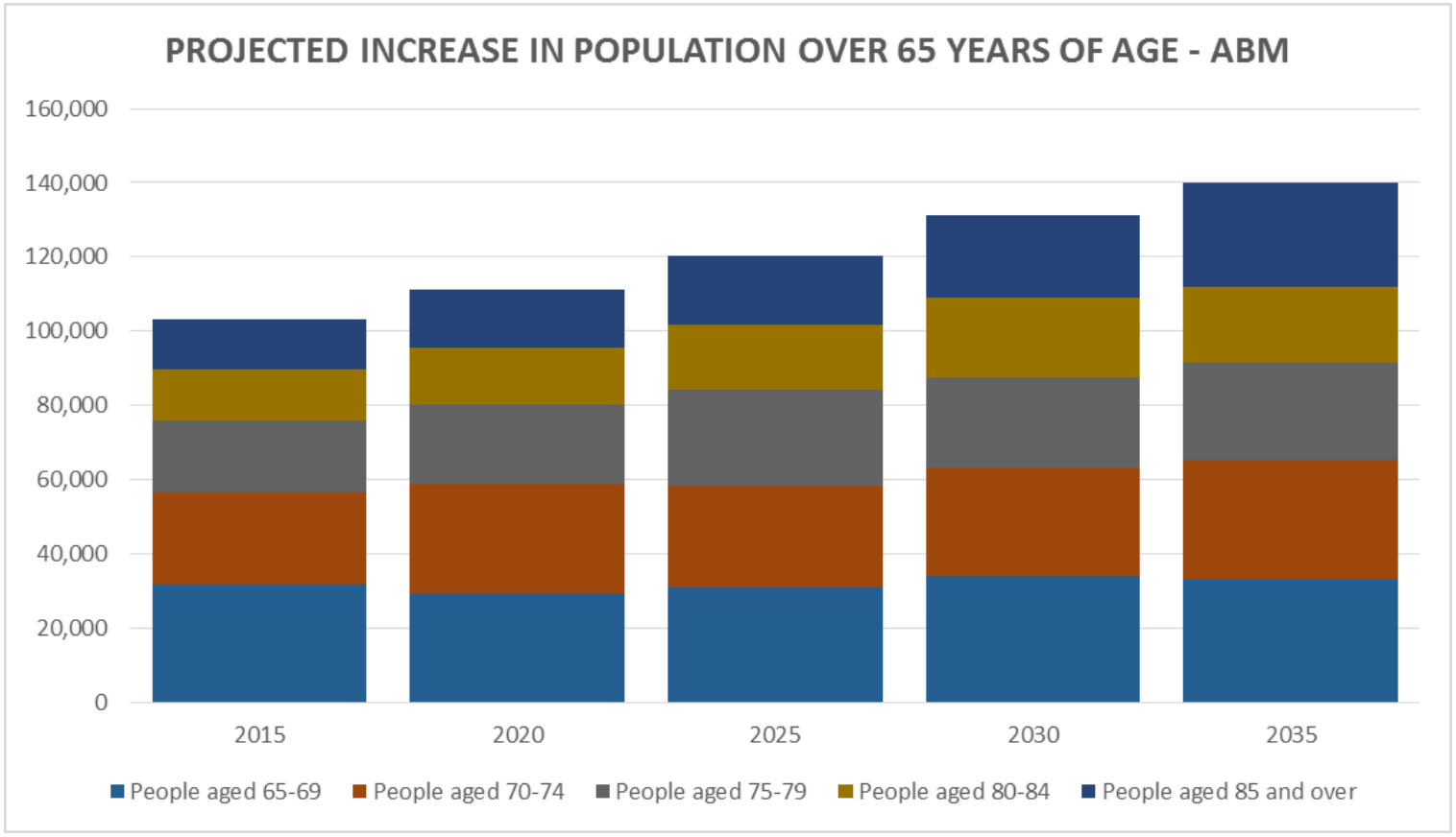
A lack of complete and consistent activity and performance monitoring information for services across the three local authority areas made analysis and in particular comparative analysis very challenging. These sessions, which were additional to our original proposal, were used to playback and validate comparative service level activity and staffing data and analysis. We also tested and validated assumptions to underpin modelling future activity and capacity requirements. We held a validation session with each of the three areas.

2. Current and future community demand

Patterns in demographics and external pressures

Projected demand increases on community services

Our main focus for this work is the over 65 age group, in which there are 104,000 people across Western Bay with a 35% increase projected by 2035. Of this, increases are expected particularly in the older age bands - the 85 and over age group is projected to more than double in this period, with over 5% growth every year – this will clearly have a significant impact on care requirements as this population age group is where the majority of older peoples community and social care services is most in demand..

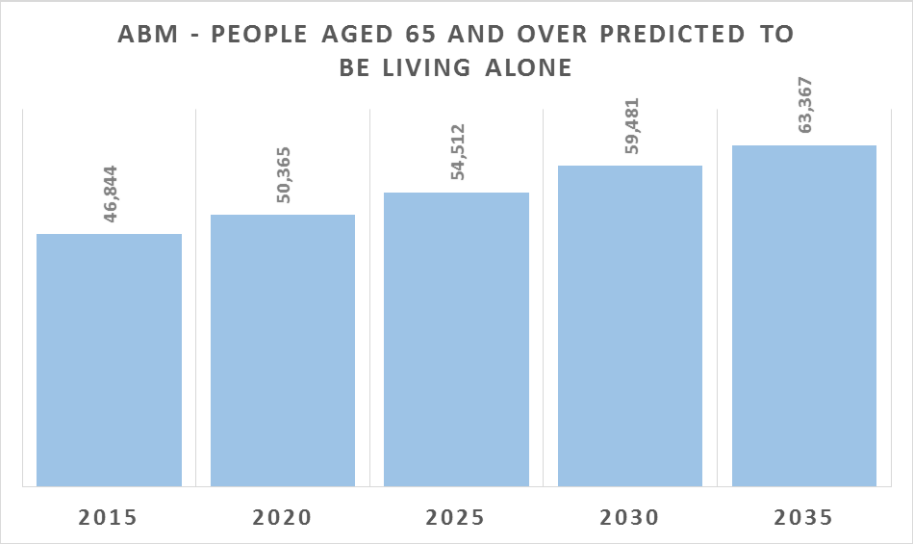


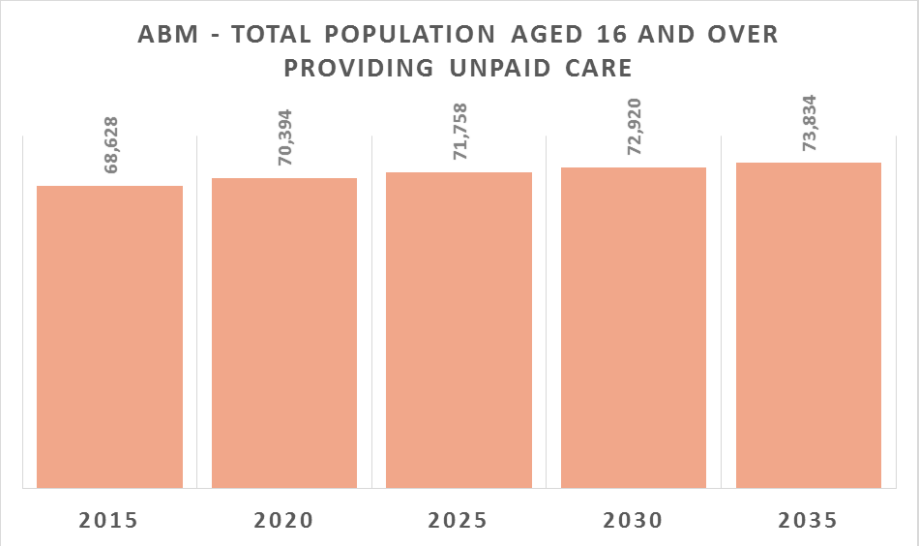
*Source: 2011-based subnational population projections for Wales

Projected demand increases on community services

In addition to an increase in the older population, there is also a related increase in the number of people predicted to be living alone, with an additional 16,000 individuals (35%) expected by 2035.

In contrast to this, due to changing demographics, there is only a very small increase in the population able to provide unpaid care, meaning potentially that there are proportionally less people receiving help or support from family members, friends, neighbours or others because of long-term physical or mental ill health or disability, or problems related to old age. All of which will continue to increase pressure on a range of services.





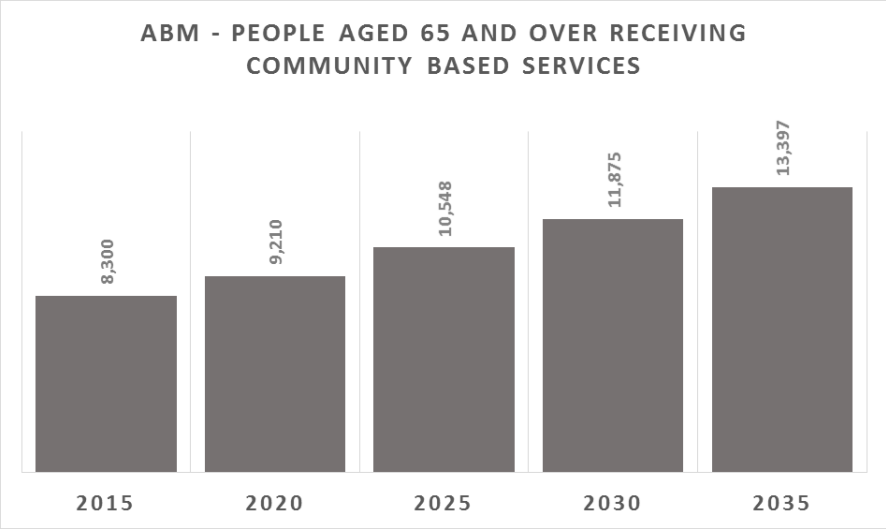
*Source: Daffodil – Adults and older people projections, based on 2011 Census

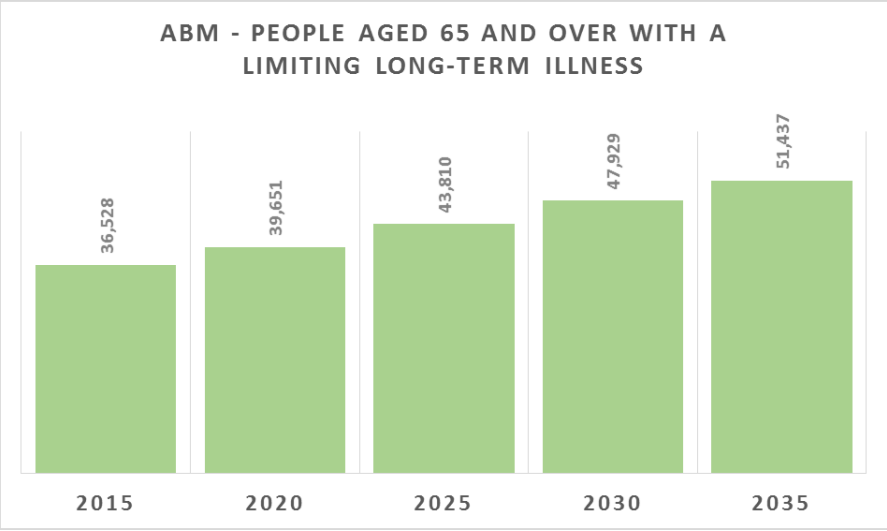
Projected demand increases on local authority community based services

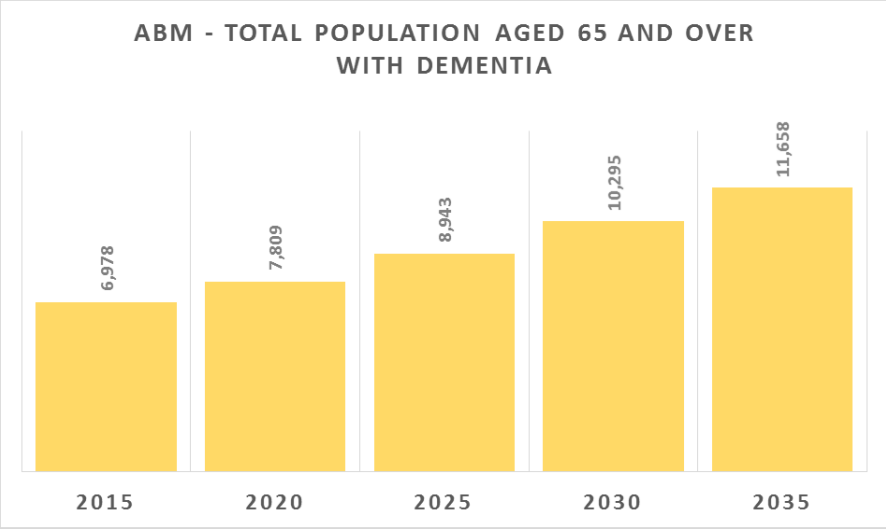
Based on Daffodil* projections, 8,300 people were receiving local authority community based services in 2015, and a 60% increase is expected by 2035.

There are also significant increases in those in the population predicted to have a limiting long-term illness, with approximately 10% increase every 5 years. Of particular significance to service planning is the predicted increase in the number of people in the population with dementia, with a 67% increase in the population aged 65 and over with dementia projected to 2035. This has also been noted as an important area for Western Bay, with feedback suggesting a number of services treating a significant proportion of service users who have a cognitive impairment.

These projections are solely reflective of demographic change rather than model of care changes.



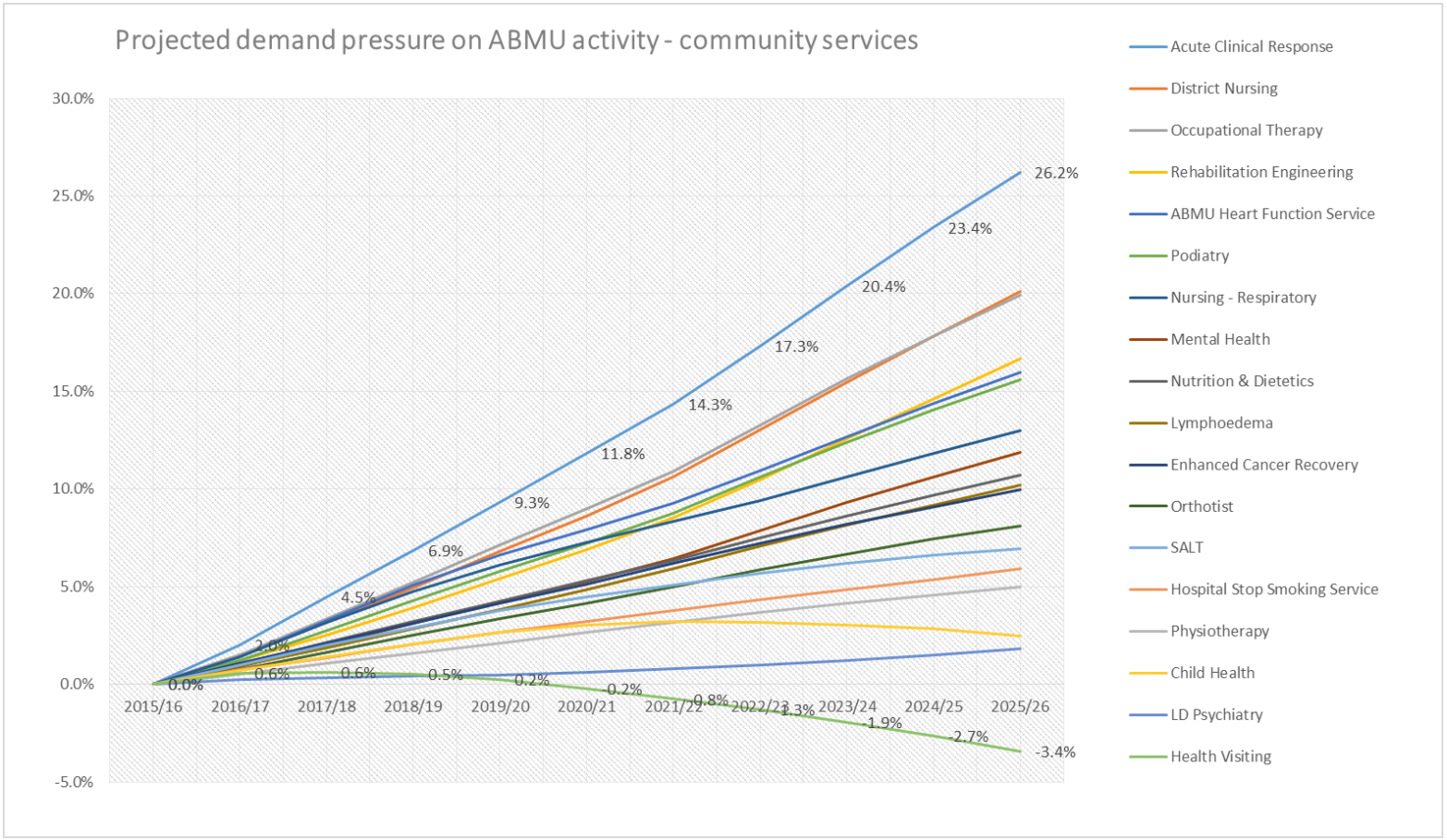




*Source: Daffodil – Adults and older people projections, taking into account the Welsh Health Survey 2012

Projected impact of demographic change in individual Community Services

There is more variance seen when viewing projected demand growth on community services at a service level, based on the current model of care and demographic characteristics of community health services, the biggest demand pressures will be felt in the Acute Clinical Team (26% increase between 2015/16 and 2025/26), followed by District Nursing and Occupational Therapy (20% demand increase). All other community services show a projected demand pressure of between 5% and 10% for the same time period. Some services for younger age groups (e.g. health visiting) are projected to see a slight reduction in demand in to the future.

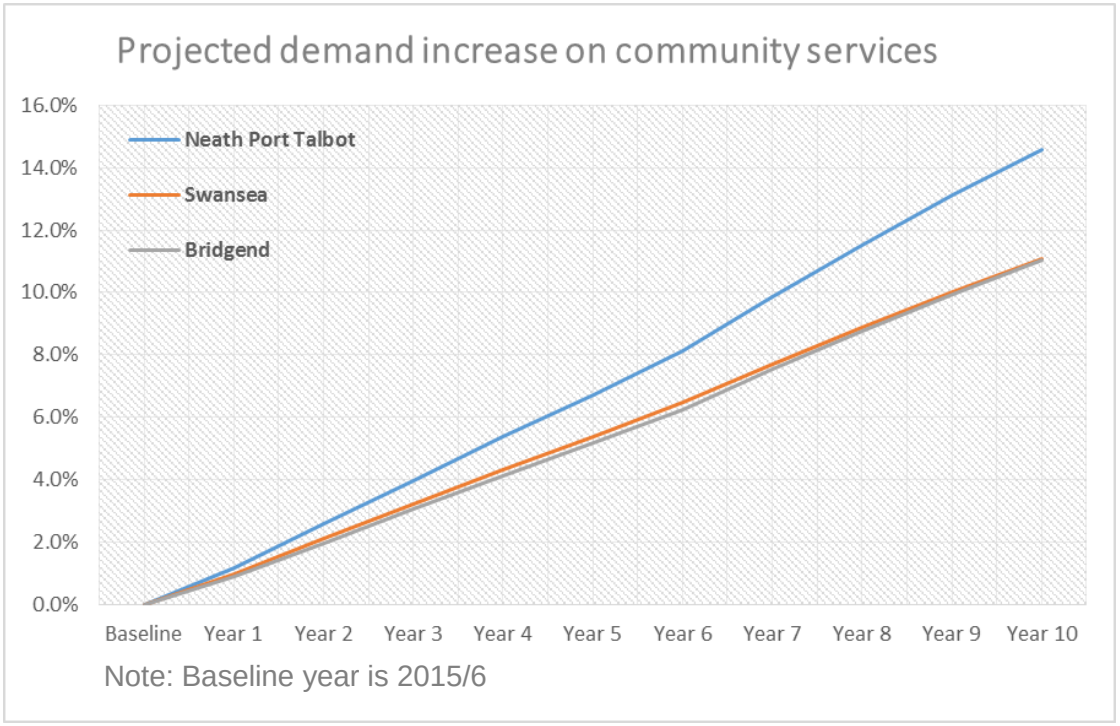


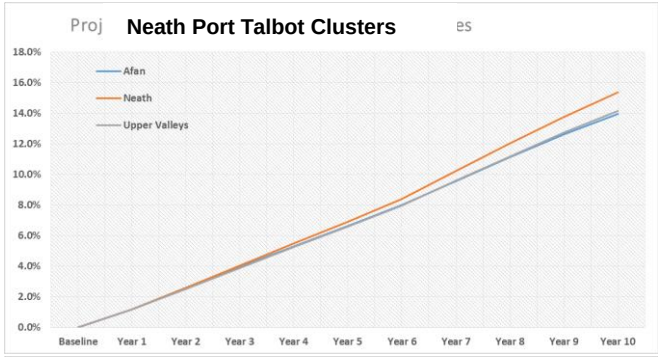
*It should be noted that service names are based on those for which detailed record level data is currently recorded, some of which are based on small samples.

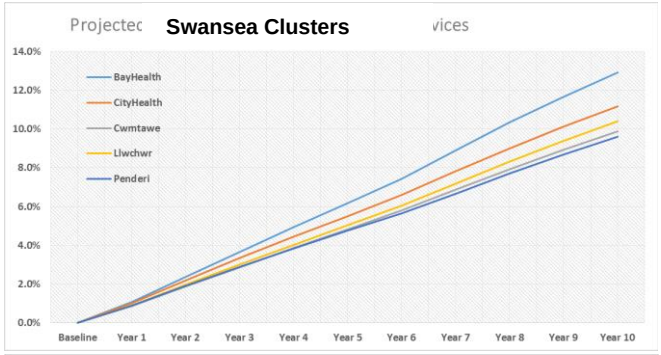
Projected demand increases on community services in different localities

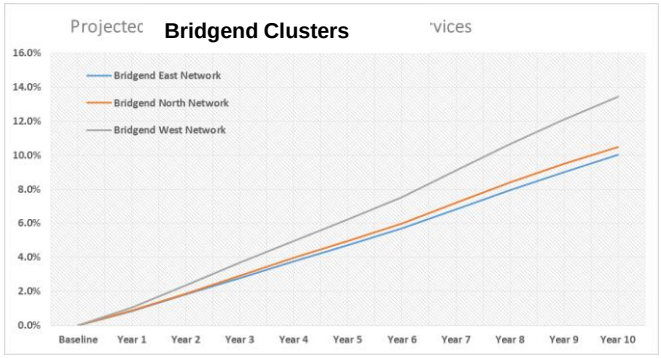
The overall projected growth for community services for each locality and cluster, based on demographic growth alone, is shown in the charts. There are small differences between areas, with a higher growth rate projected for Neath Port Talbot, and also differences at a cluster level – though the overall trend is similar for all areas.

The projected five year demand growth is +5.2% in Bridgend, +5.4% in Swansea, and +6.7% in Neath Port Talbot.









3. Acute Demand - ABMU Hospital Sites

Reducing admissions and delayed transfers of care from the acute setting

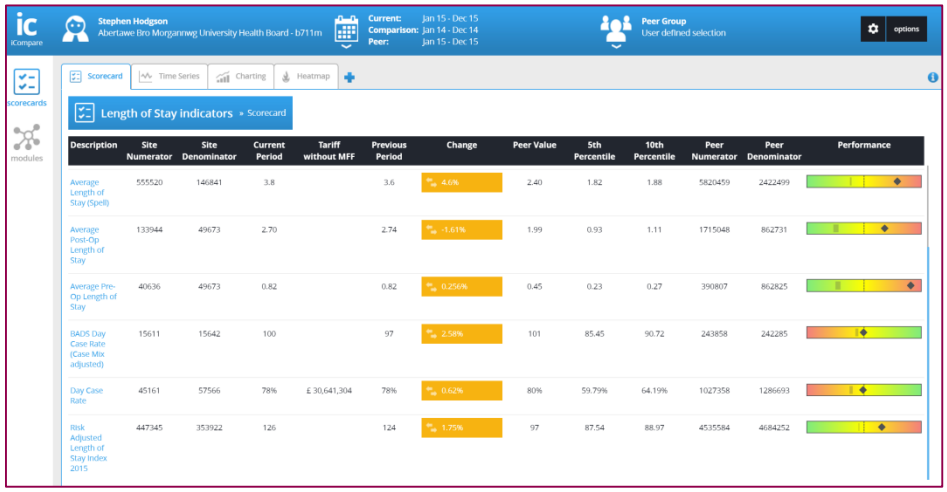
Length of Stay

Our previous work with ABMU has focussed on acute hospital demand and activity, where it was noted that the length of stay across ABMU is high compared to peer group; this has been recognised by ABMU as an issue for some time. Some of this will be due to hospital practices such as discharge planning and inconsistent processes, and some will be related to whole system working such as availability of community placements and packages of care.

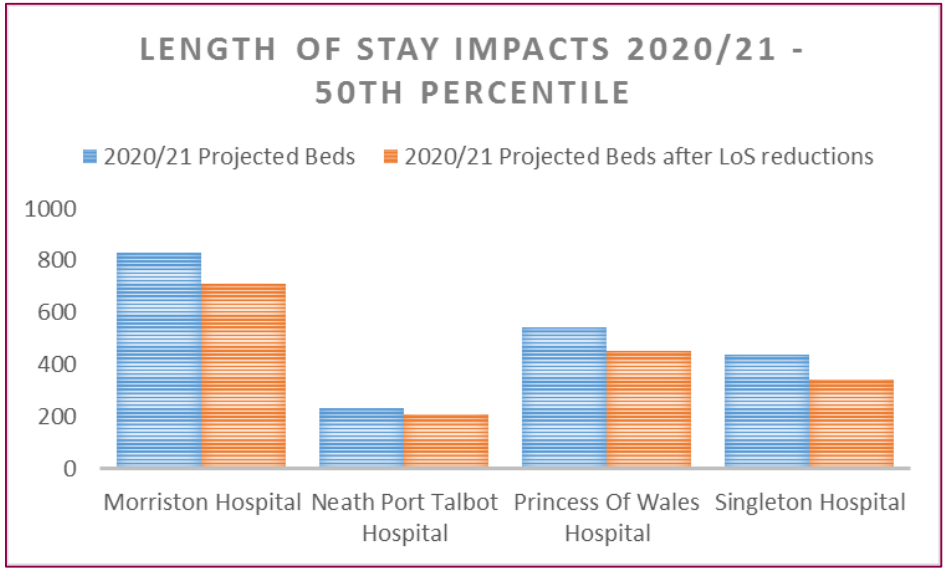
To estimate the potential to reduce demand for beds, lengths of stay for high-volume conditions and procedures were compared against performance at peer providers (case mix and volume adjusted).

The ABMU measure includes acute bed days in main sites and have been modelled at a site specific level. The model allows a number of different scenarios of length of stay including benchmarks versus peer, trim points, delayed discharges and specific pathway length of stay changes.

We based our main scenario on achievement of the 50th percentile level across all sites, and the significant opportunity to reduce length of stay across the organisation suggested that issues are system wide - achieving the benchmark targets will require a number of operational factors being implemented or changed both within the acute sites and the wider system.



Description	Site Numerator	Site Denominator	Current Period	Tariff without MFF	Previous Period	Change	Peer Value	5th Percentile	10th Percentile	Peer Numerator	Peer Denominator	Performance
Average Length of Stay (Spell)	555520	146841	3.8		3.6	4.6%	2.40	1.82	1.88	5820459	2422499	
Average Post-Op Length of Stay	133944	49673	2.70		2.74	-1.61%	1.99	0.93	1.11	1715048	862731	
Average Pre-Op Length of Stay	40636	49673	0.82		0.82	0.256%	0.45	0.23	0.27	390807	862825	
BADS Day Case Rate (Case Mix adjusted)	15611	15642	100		97	2.58%	101	85.45	90.72	243858	242285	
Day Case Rate	45161	57566	78%	£ 30,641,304	78%	0.62%	80%	59.79%	64.19%	1027358	1286693	
Risk Adjusted Length of Stay Index 2015	447345	353922	126		124	1.75%	97	87.54	88.97	4535584	4684252	

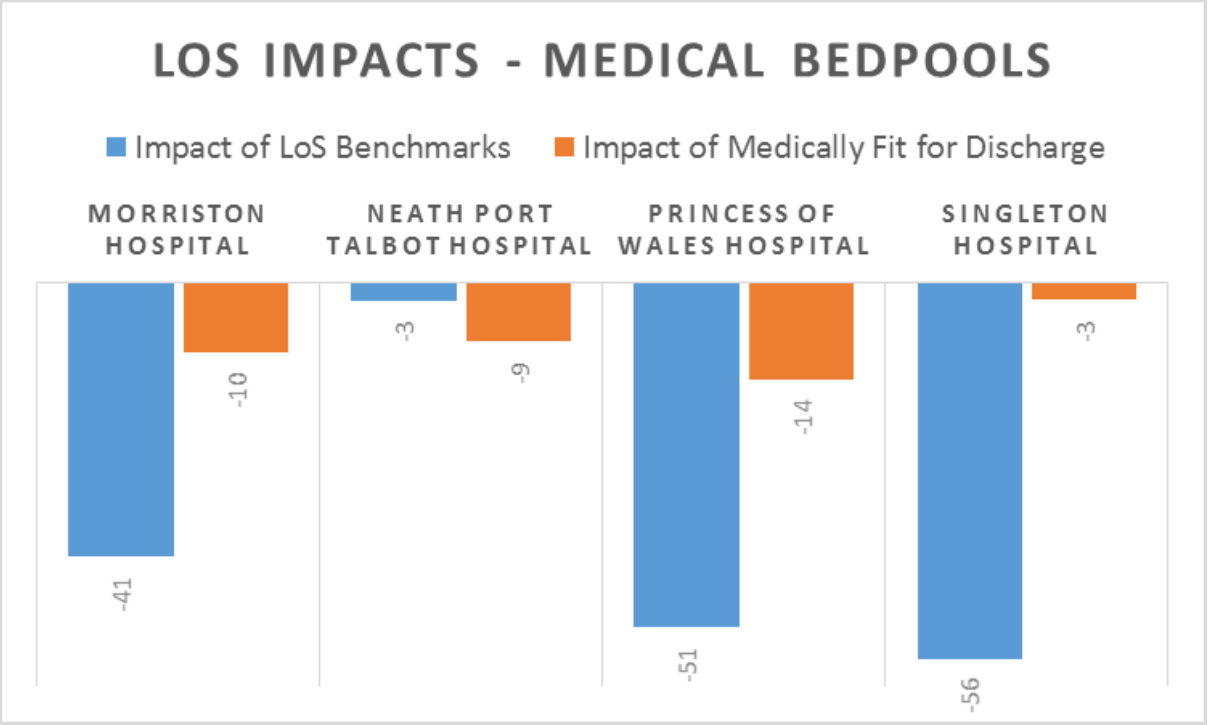


Medically fit for discharge

Alongside length of stay benchmarking assumptions we have analysed and modelled the volume of days lost, as recorded by ABMU, where the patient is medically fit for discharge but the discharge has been delayed for non-medical reasons.

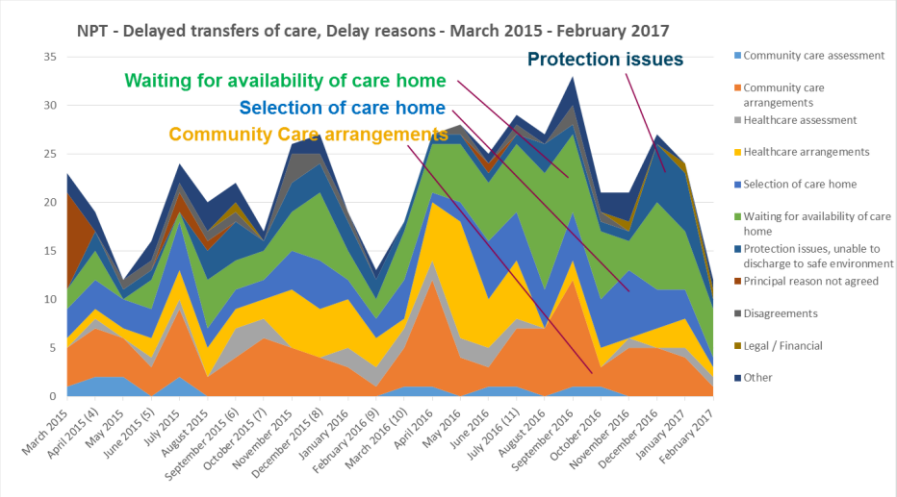
The volume of bed days consumed in this category as modelled equates to approximately 50 beds across all bedpools, approximately 36 of these are in the core medical bedpools of acute sites.

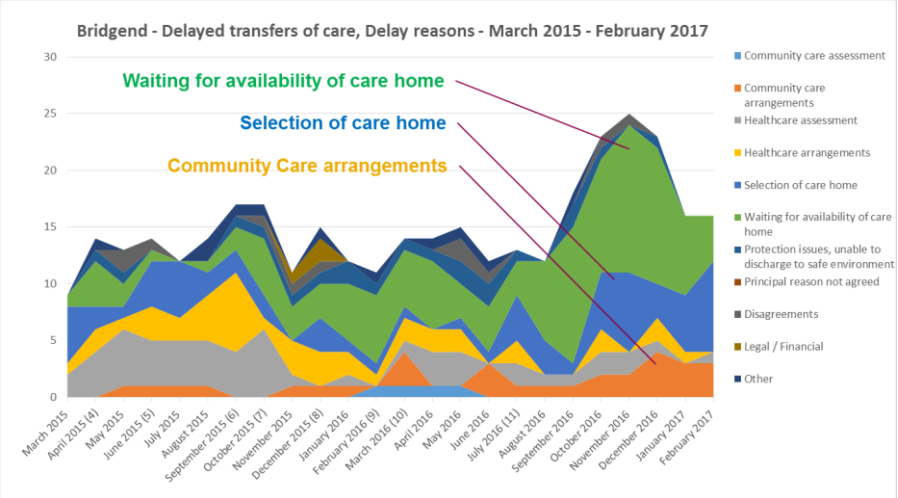
The chart shows how this compares against benchmarked reductions at the 50th percentile in core medical bedpools across main ABMU sites. There are some differences between sites but overall approximately 25% of the full length of stay reduction to 50th percentile standard in core medical beds could be explained by delays where the patient is medically fit for discharge. We know from ABMU delayed discharge audits that some of these delays are attributable to internal processes in the acute hospitals and some are related to issues around access to community services.

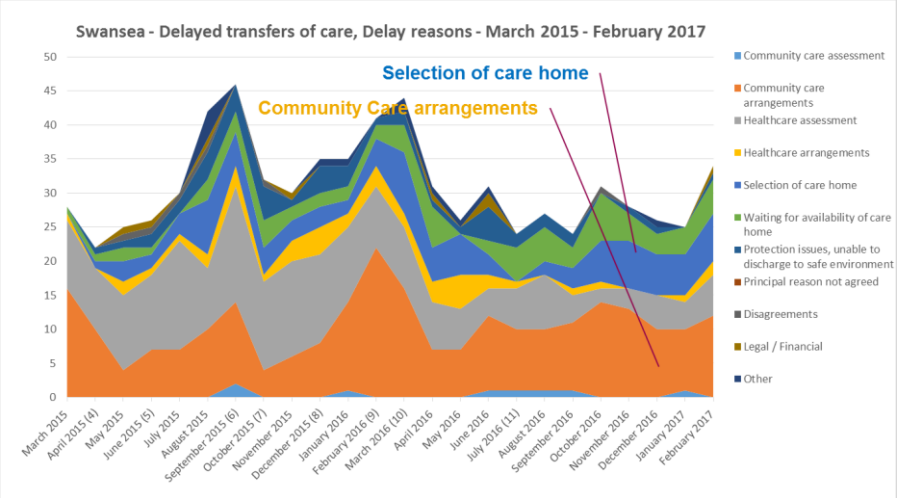


Delayed Transfers of Care

For Swansea, Bridgend and Neath Port Talbot the top three reasons for delayed transfers of care from secondary care (March 2016 to Feb 2017) were waiting for care home place, selection of care home and community care arrangements. This suggests that there may be an under provision of care home places.







Ambulatory Care Sensitive (ACS) Conditions

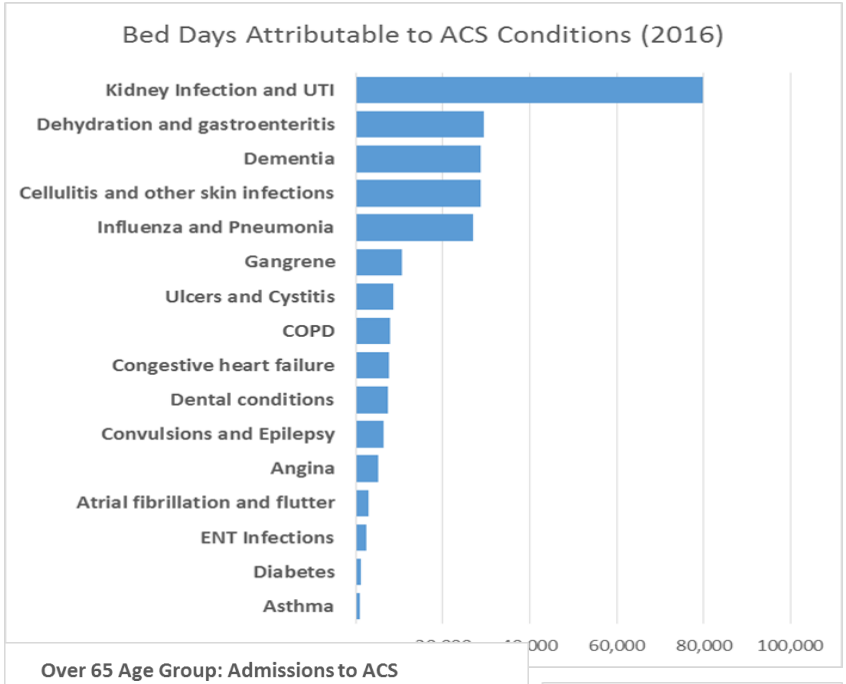
We have analysed emergency admissions for acute conditions that should not usually require hospital admission. These ACS conditions are conditions where effective community care and case management can help prevent the need for hospital admission. There are 19 ACSCs identified across the following categories:

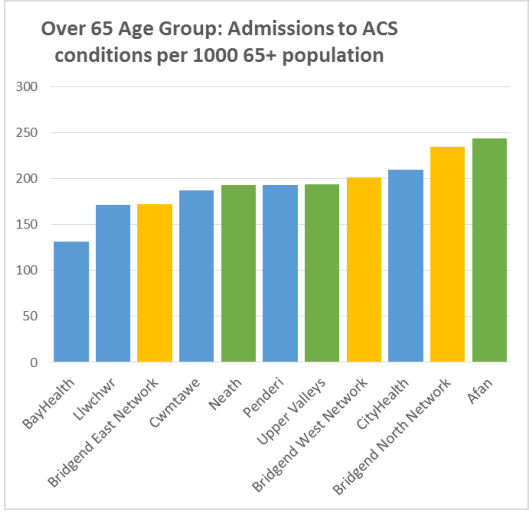
- Vaccine preventable
- Chronic
- Acute

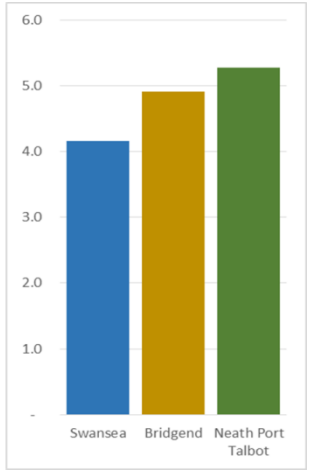
Where an individual has been admitted for an acute ACS condition, it may indicate that they have deteriorated more than should have been allowed by the adequate provision of healthcare in primary care or as a hospital outpatient.

Where an individual has been admitted for a chronic ACS condition, it is an indicator of how successfully long term conditions like asthma, diabetes, epilepsy and dementia are being managed in the community setting.

Approximately 40% of all adult non-elective bed days across ABMU sites can be attributed to one of these conditions, though there are variances in the rate between different localities, suggesting that there is more scope in some areas for improvement in admission avoidance and supporting people with long term conditions more effectively in the community.







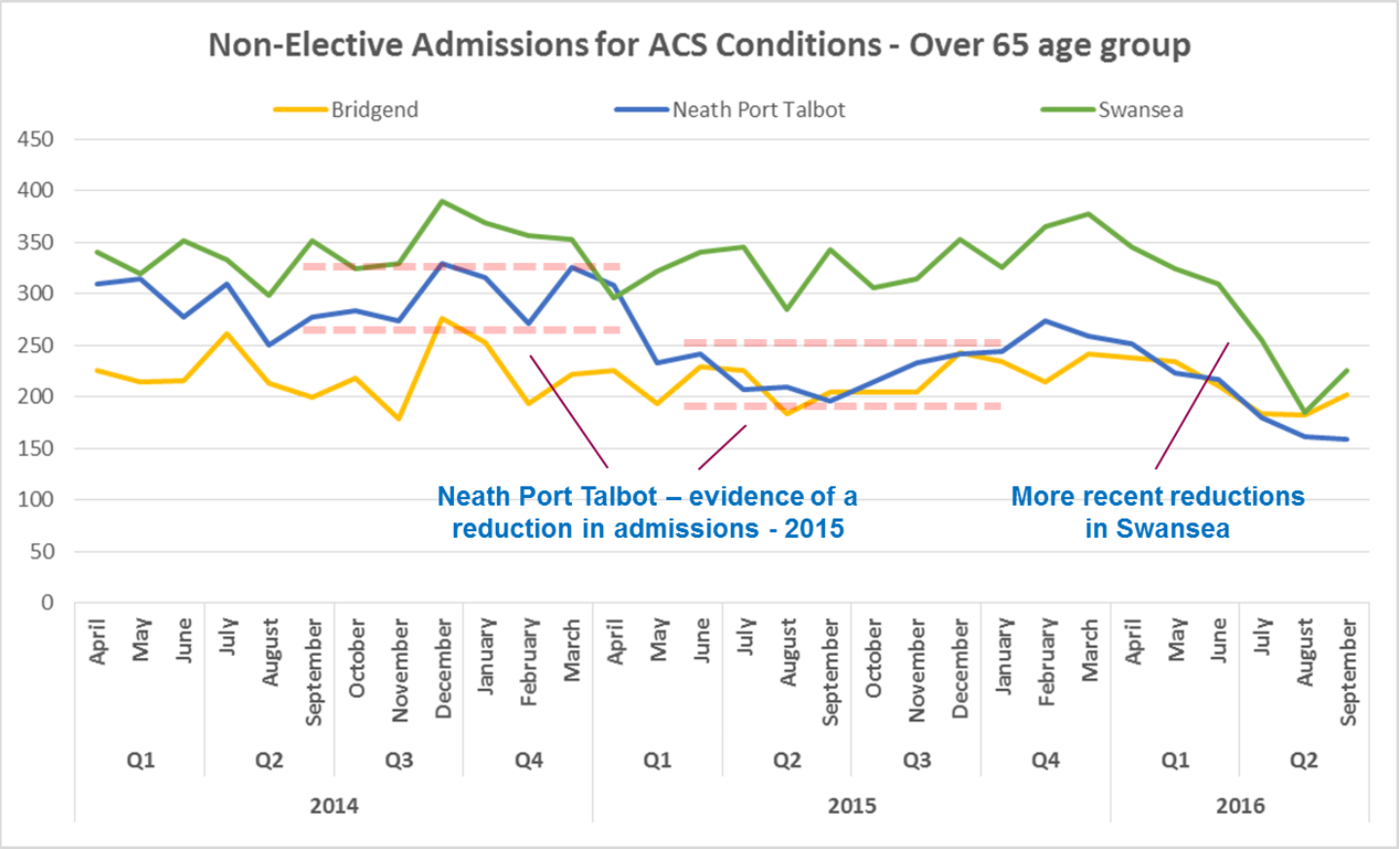
Ambulatory Care Sensitive Conditions – trend in the over 65 age group

There does appear to be recent reductions in non-elective admissions for ACSs in the over 65 age group, particularly in NPT and more recently in Swansea, which may indicate the positive impact of intermediate care services, in particular the Acute Clinical Teams, as they become more established.

Importantly, emergency admissions for these conditions have not increased in this period, where the 'do nothing' scenario suggests a clear upward pressure, which indicates a utilisation of alternatives to emergency admission. This means that the reductions seen in NPT and Swansea are significant and the fact that even in Bridgend where the ACT is not so advanced, there has not been an increase, demonstrates that alternatives to admission are being utilised for this cohort of patients.

The reduction in unscheduled admissions for ACS conditions seen in NPT in Q1 of 2015 and in Swansea beginning at the end of Q4 2015 does correlate with the ACTs becoming established in these areas.

It will be informative to continue to monitor this activity and in particular to see if a similar reduction is seen in Bridgend in around six months time when their ACT will have moved to a seven day service.



4. Baseline - Community Service Configuration

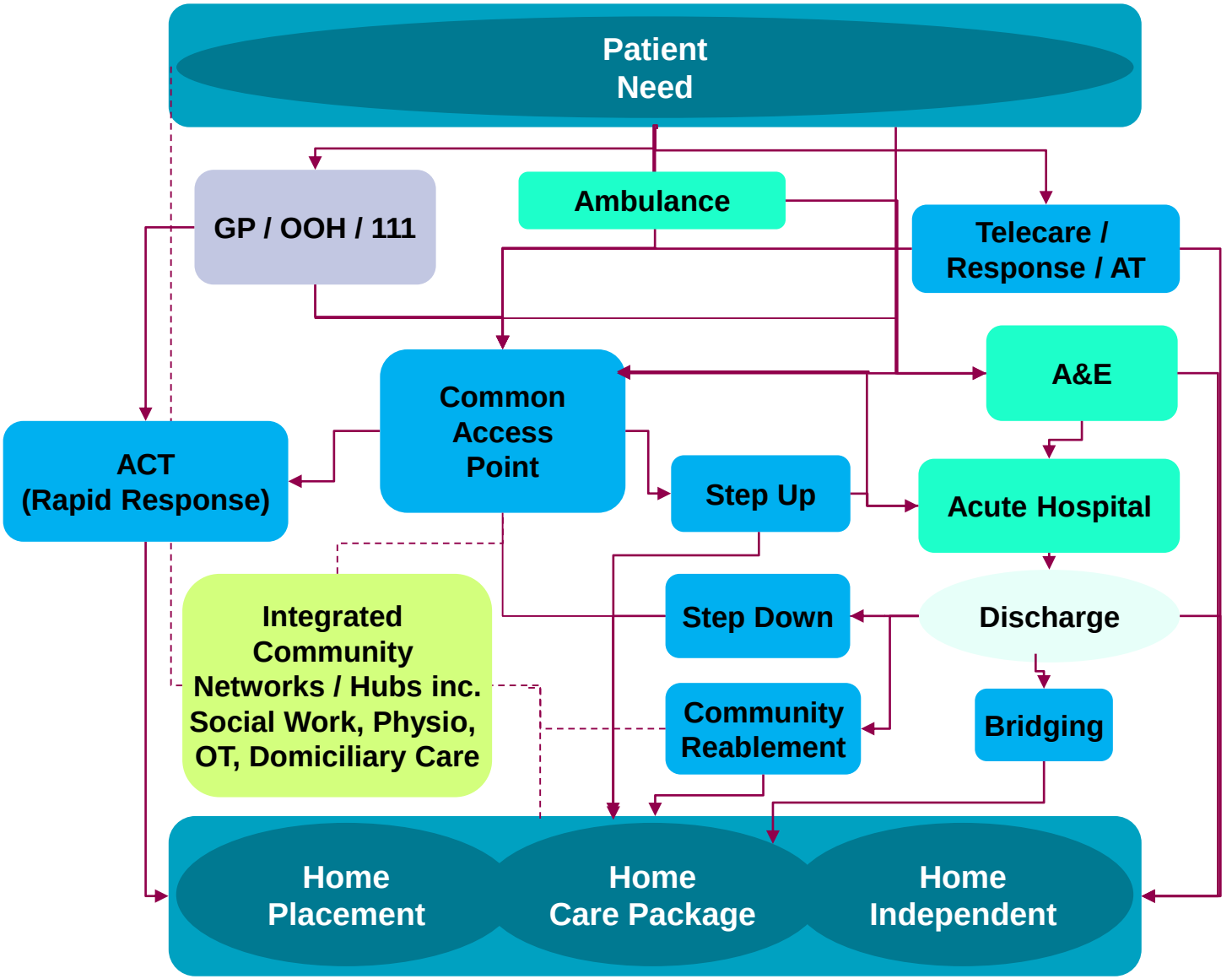
Current Community Services and Interdependencies

Model schematic

As we gathered information around the configuration of services and became aware of the common services but also the differences we developed this schematic representation to illustrate the major flows.

Note that we have not attempted to name every individual service here.

Building on from this we mapped Bridgend, NPT and Swansea services onto similar diagrams. These are shown in Appendix B



Common Access Point

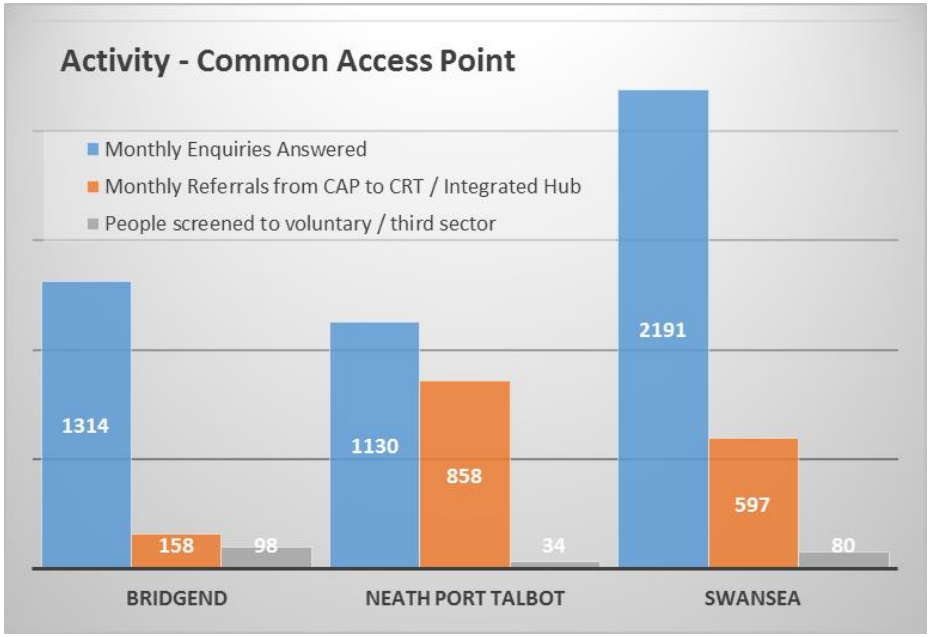
Each of the three areas of the Western Bay region has a common access point multi-disciplinary service which provides triage and directs callers to the most appropriate service or further information based on their individual needs.

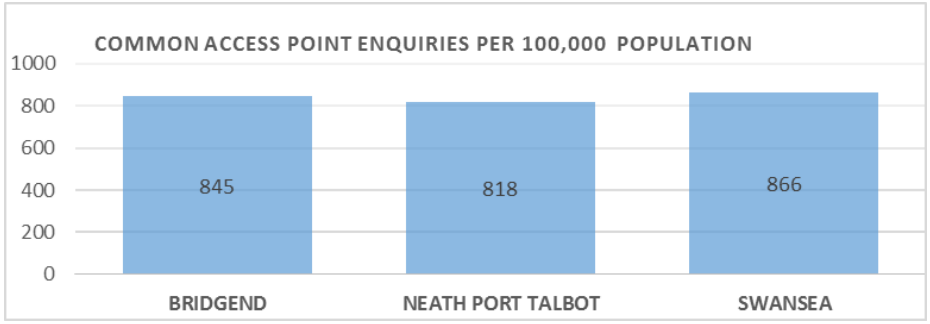
The number of enquiries dealt with by the common access points across all three areas is quite consistent, with a total between 818 to 866 per 100,000 population.

Recent figures from Swansea (based on January 2017), where abandoned calls are recorded, shows approximately 30% of calls into the CAP were abandoned, this was much higher than June 2016 where only 6% of calls were abandoned – feedback suggests that this is in part due to a reduction in staff (a reduction in 5 WTE in the CAP) having a direct impact on calls answered. There was only a small difference in outbound calls in the same period, indicating a possible change in triaging practices. We do not have abandoned call data for NPT and Bridgend.

Bridgend has the highest number and proportion of calls diverted directly to the voluntary and third sector. There is a query over the way this data is captured in NPT so their number may actually be higher than shown in the chart. Anecdotally we have heard that there is scope to further develop links to voluntary and third sector services. The majority of these referrals related to isolation or loneliness.

A proportion of calls are resolved within the common access point, for example signposted out to other service. In Swansea, this amounted to an additional 123 calls in January 2017. We were informed in a data validation session that Bridgend has a number of referrals to CRT through other routes, so the referrals via the common access point look lower than other areas.





Acute Clinical Team (ACT)

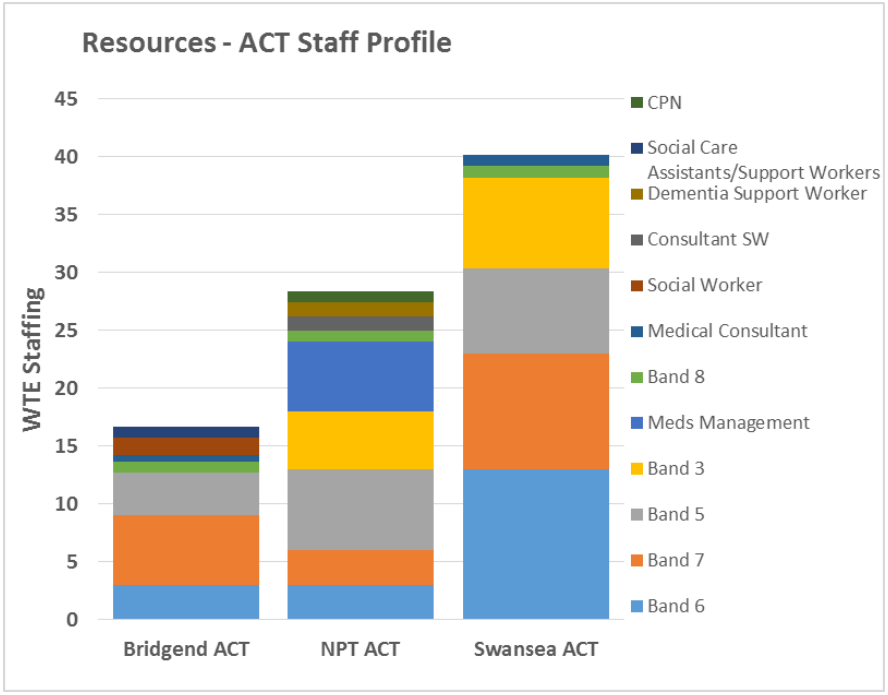
The acute clinical team (ACT) offers a multidisciplinary service, providing rapid assessment and clinical intervention for patients in the community setting, including residential and nursing home clients.

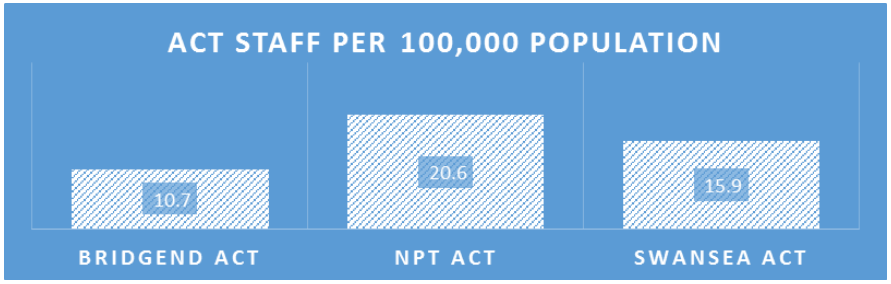
It is of note that there are a number of differences between the ACT services in Bridgend, NPT and Swansea, which leads to inequity of ACT services across Western Bay. For example, NPT currently operate a 7 day service (8.30am to 10pm, with referrals only taken up to 5pm at week-ends), Swansea operates a 7 day service (8am to 10pm) but only accepting referrals Monday to Friday, and Bridgend currently a 5 day (9am to 5pm) service. These factors will inevitably impact on the type and volume of patients that the service can accept.

Overall approximately 10% of referrals to the ACTs are from secondary care, with resultant earlier discharge, compared with 90% from the community – many of which relate to an avoided admission.

It was noted by stakeholders that due to a lack of staffing contingency there are issues in the service when there is staff sickness absence or vacancies. This has a direct impact on the service's ability to accept new patients. These patients will be dealt with in other settings rather than held on a wait list for ACT, so it is difficult to quantify this unmet demand. It was noted that particularly in NPT there was a considerable level of monthly variation in new starters to the service. This may be in part caused by the lack of service resilience.

*It should be noted that the NPT staffing figures include Dementia management / meds management, which is not included in other areas.





Acute Clinical Team (ACT)

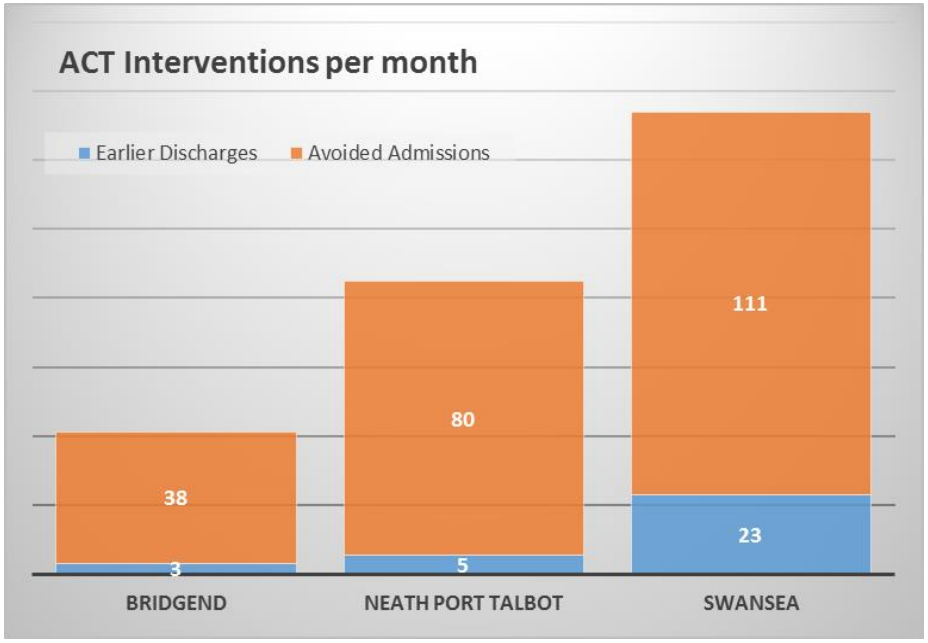
The differences in hours of operation detailed in the previous page leads to inevitable variance in the numbers and types of intervention that can be carried out. For example maintaining IV antibiotics over a weekend period is not possible in Bridgend's 5-day service.

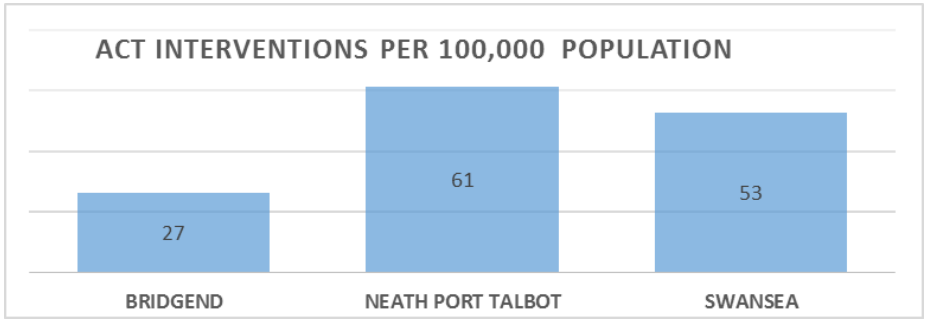
This is most evident in the volume of activity for the Bridgend ACT, which in proportion to the population is approximately 50% of that seen in NPT. Bridgend ACT stakeholders were of the view that the ACT could match the levels of activity seen in NPT if it were able to expand and move to 7 day working.

We would have expected to see more of a difference in activity levels for Swansea and NPT in view of Swansea not taking new referrals at week-ends. This may indicate that there is scope to increase activity in NPT. If Swansea moves to a full 7 day service we would expect to see interventions per 100,000 population match or exceed the current NPT number.

We were also surprised at the low level of earlier discharges supported by the NPT ACT, considering a 7 day service is in operation. This is perhaps due to inconsistency in identifying and recording earlier discharges rather than a true reflection of the service provided. This should be investigated.

The variance in ACT staff WTE per 100,000 population shown on the previous page will also be a factor in the number of interventions undertaken i.e. may not simply be in line with servicing additional hours. As plans to standardise operating hours to a seven day model are implemented it will be easier to compare like with like and draw conclusions as to efficacy and optimal staffing profile.



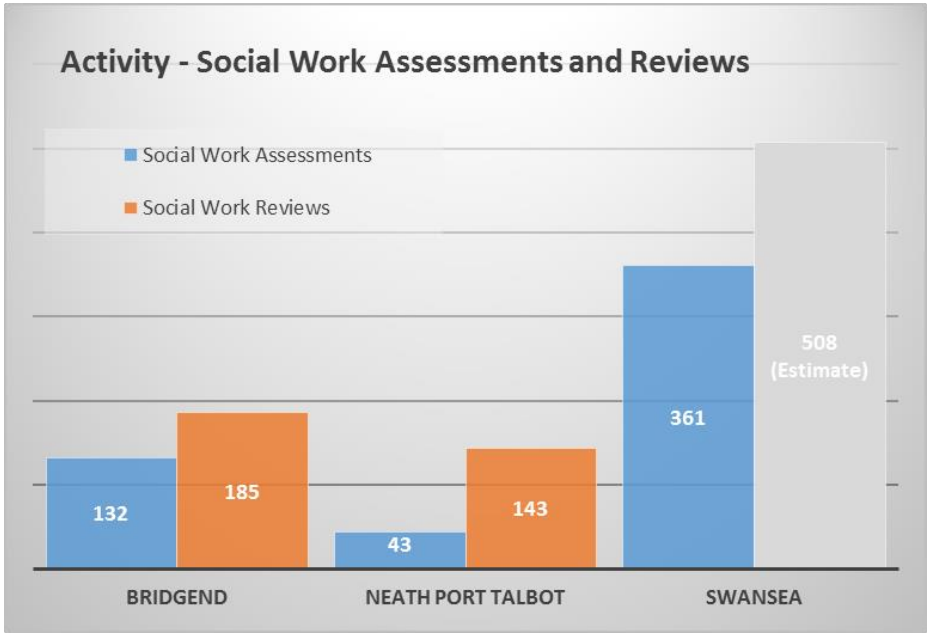


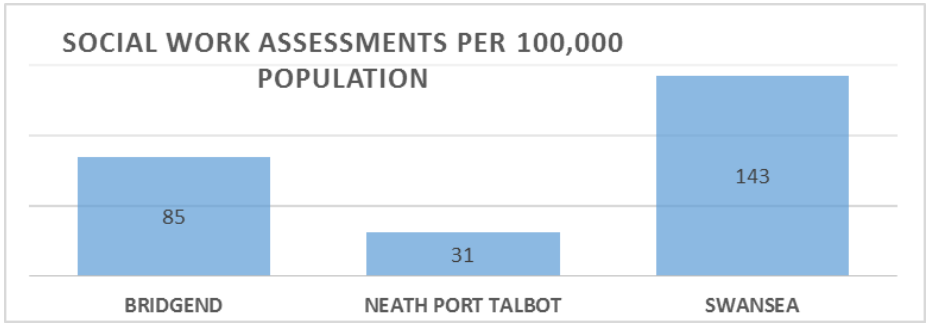
Social Work Teams

Due to the variance across Western Bay, it is not possible to undertake a meaningful comparison solely based on Hospital Social Work Teams. For example NPT does not have a Hospital Social Work team, rather this function is performed by staff within the Community Resource Team (a social worker and support worker providing coordination rather than assessment). The validation sessions suggested that it would be more useful to make a comparison of total SW staff and activity and this is shown in the charts.

The wide variance between the number of assessments per 100,000 population in the three areas suggests that there are differences in the way assessments and reviews are defined and recorded rather than a true difference in activity, however this would benefit from further investigation.

We did note from information recorded from Swansea that there was an average of 19 days for hospital social work teams to Complete Assessments (comparative data for NPT and Bridgend was not available). We would need further data to be able to verify this but this would appear to indicate a contributing factor to delayed transfers of care.





Community Reablement

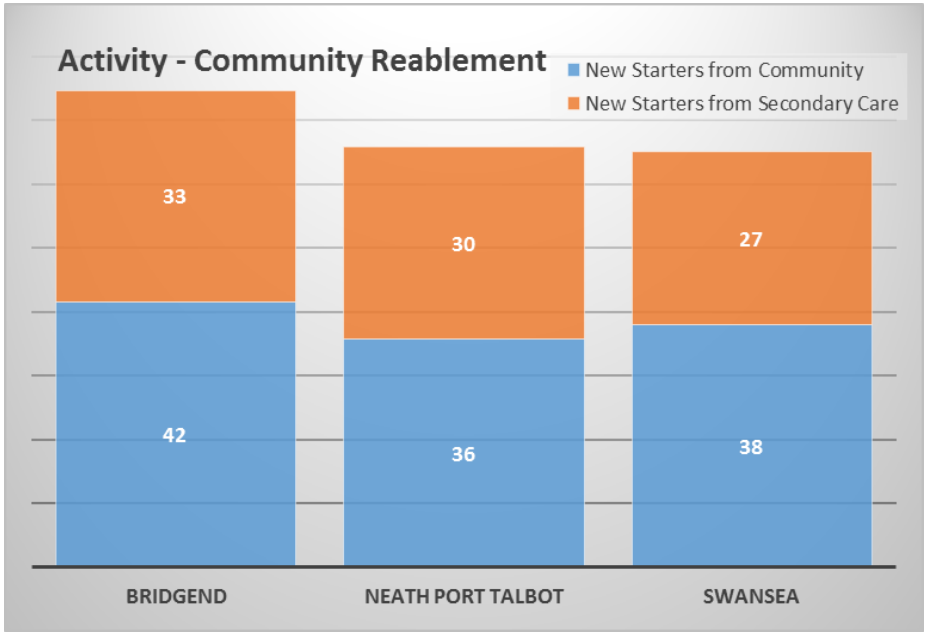
The community reablement teams provide a time limited package of support for up to 6 weeks with the aim of maximising independence and reducing the need for long term packages of care or admission in to a care home.

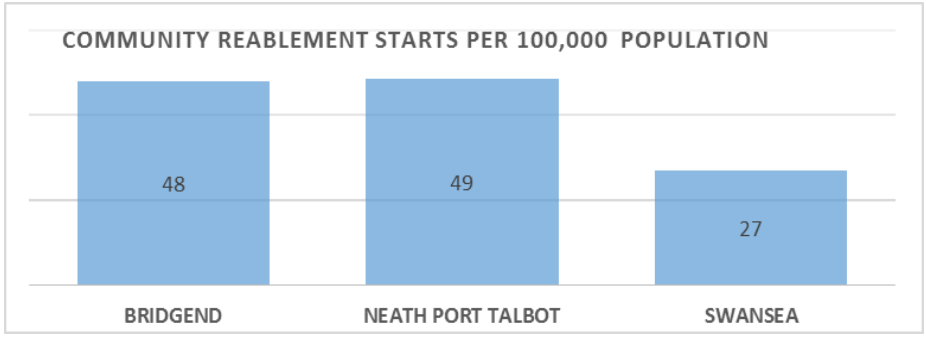
We have noted some variance across the 3 areas, largely due to different service models. For example, Swansea operate a selective model whilst Bridgend and NPT follow the intake (discharge to assess) model. It is not surprising therefore that Swansea have a far lower number of reablement starts per month.

Beyond this there are also differences in length of time in the service, although overall length of time in service across Western Bay would indicate issues in discharge from the service. The average time in service is 36 days in NPT, 41 days in Bridgend and 57 days in Swansea. These averages do not however provide the full picture as, although the average at NPT and Bridgend is within the 6 week target, each area have patients staying in the service considerably longer than this. The following page provides more detail on time in the reablement service.

In addition, Swansea don't have a separate bridging service, which will lead to higher likelihood of a delay within the reablement service itself, which is the likely cause of a comparatively longer time in the service. True reablement length of stay for NPT and Bridgend would include time in the bridging services.

Each month the impact of the reablement services across Western Bay has a total reduction, measured from admission to leaving the service, of 834 hours in domiciliary care packages.





Community Reablement – further detail on Bridgend provision

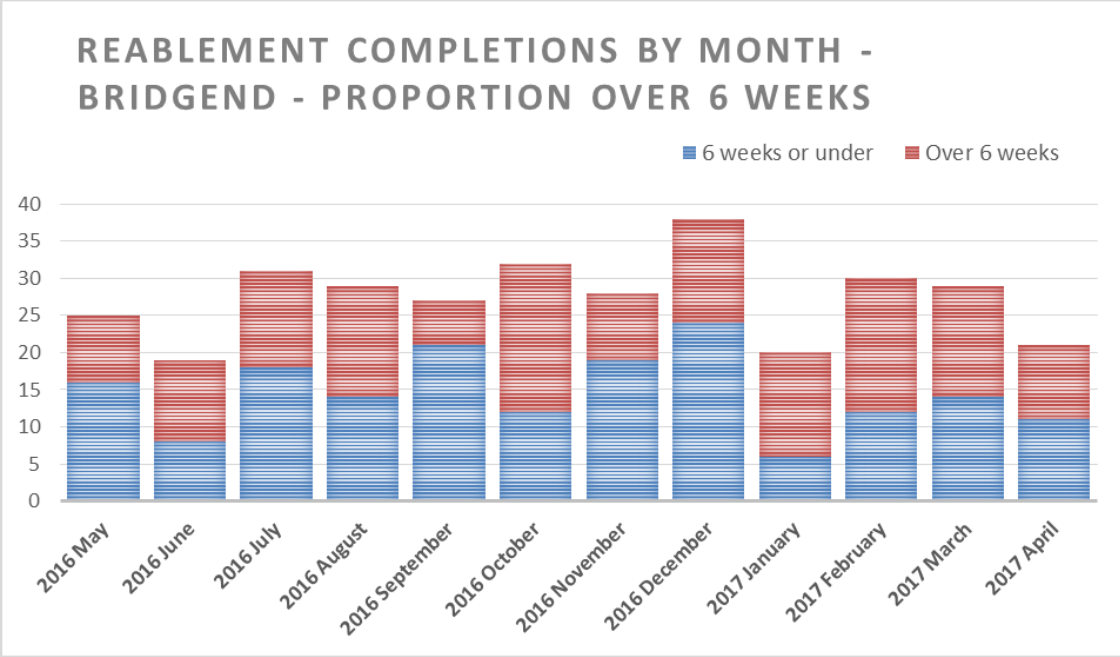
We have obtained further more detailed information for the activity of the reablement service in the Bridgend area.

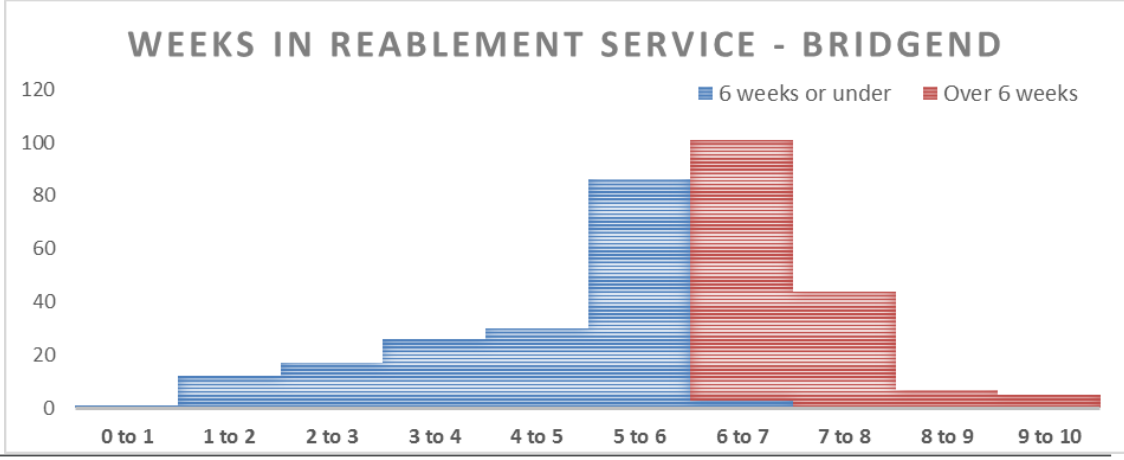
As a time limited 6 week service, anything over 6 weeks in the service is an indicator of delayed discharge and difficulty to transfer from the service. The graphs illustrate the month-by-month proportion of patients staying in the Bridgend service over 6 weeks and the distribution of these patients. Approximately 45% of patients have a LoS within the service over 6 weeks; the equivalent to approximately 350 hours per month. Given the average LoS of the service this is likely to be representative of other areas.

NPT also track the number of patients waiting to transfer to alternative services – which is an average of 30 patients at any time.

Based on feedback historically the main cause of the delay is awaiting for domiciliary care packages. That said, there are also instances when additional time is provided to focus on a particular functional need to negate the requirement for an ongoing care package e.g. independent showering.

There is also evidence of a delay in accessing the service, for example NPT report on average 47 people awaiting reablement in the community.





Assistive Technology

Assistive Technology (AT) covers a range of community equipment designed to help maintain people safely in their own home.

More people across the Western Bay are being supported to live independently with the support of technology but there is inconsistency around the types of technology provided and the way the AT services are operated.

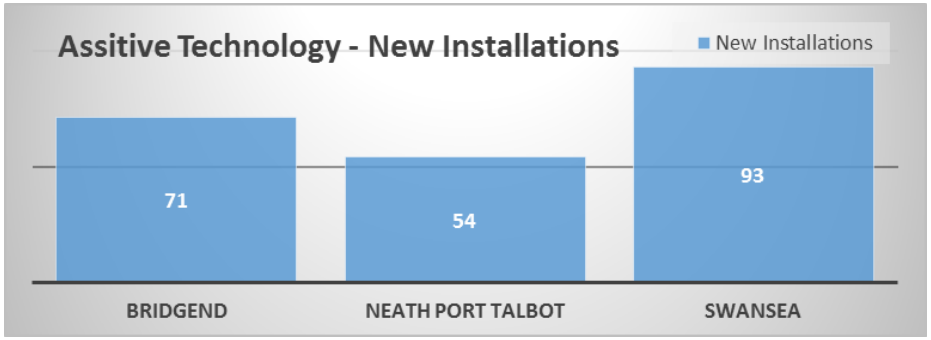
- NPT have Lifelink, Lifelink plus, Lifelink Extra
- Swansea have Telecare, Lifeline, and 'Just Checking'
- Bridgend also have mobile response, including telecare alerts for falls, tracking an average of 70 ambulance calls per month. Also have Just Checking

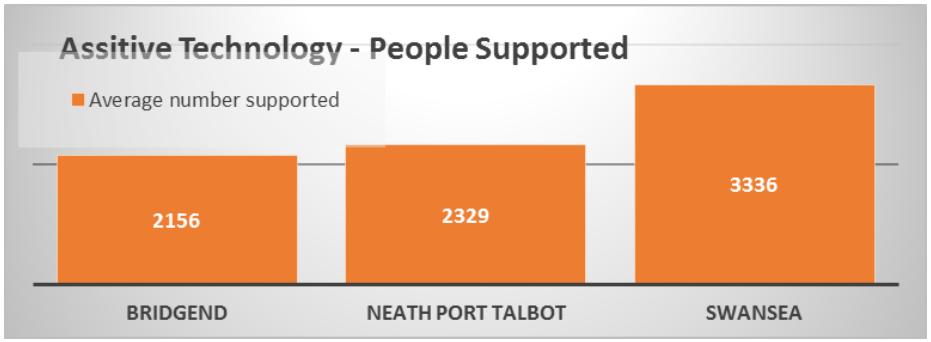
Whilst we do see some variance in the numbers of people supported with AT per head of population it is not possible to draw any real conclusions as the comparisons are not like with like. For example Just Checking is a motion sensor system which is primarily used to aid assessment to ensure appropriate deployment of domiciliary care, rather than an means of actively supporting a patient.

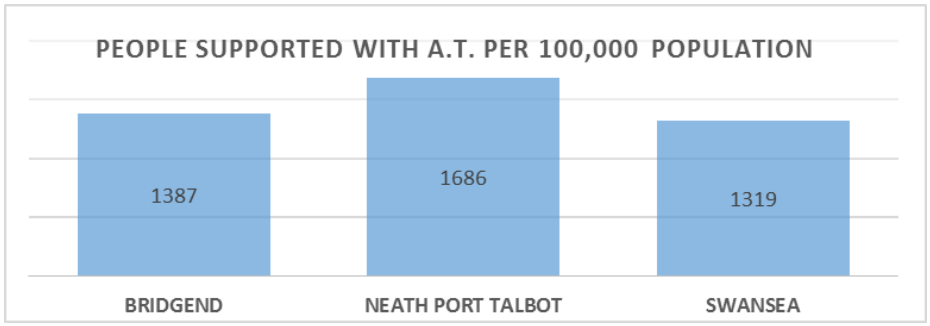
Stakeholder feed-back suggests that although Bridgend have a lower number of patients supported with AT, the services they offer are more effective.

An example is the Bridgelink Telecare Mobile Response team who respond to a variety of situations in a person's home via calls raised to the community alarm monitoring center. They provide prompt, short term, flexible personal care within the Acute Clinical team providing information, reassurance and support to individuals and families, to enable them to remain in, or return to, their own homes, avoiding unnecessary admissions to hospital and assisting safe discharges.

This service is not replicated in Swansea and NPT.







Residential Reablement – Step Up/Down Intermediate Care Beds

Residential reablement beds across the Western Bay cover both step-up and step down intermediate care, providing a package of planned health and social care support for up to 6 weeks following either a crisis event in the community (to avoid admission), or admission to hospital (to facilitate earlier discharge), in order to maximise recovery and reablement.

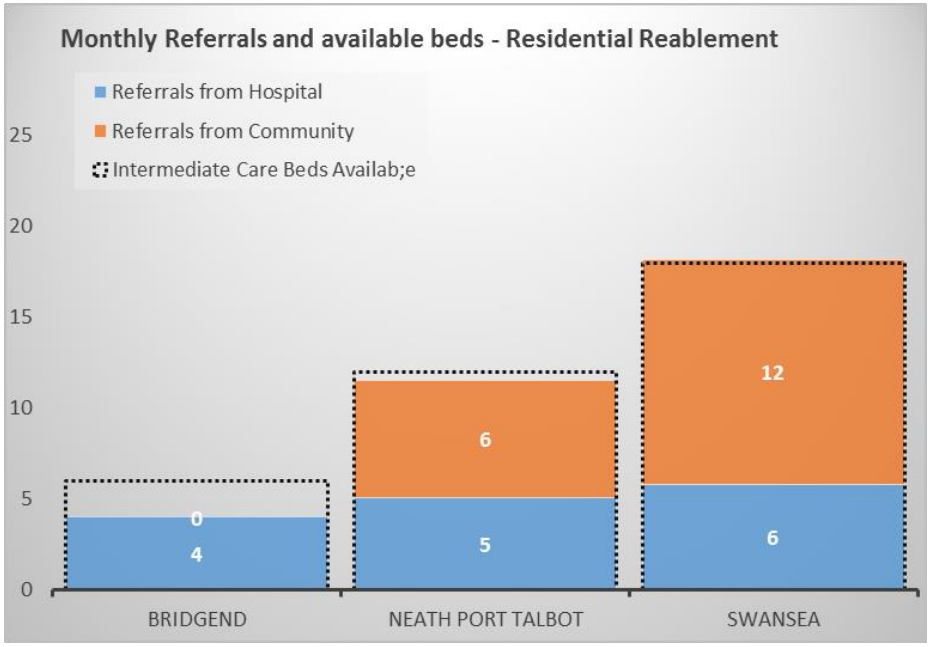
The chart illustrates the average monthly referrals to residential reablement beds from both hospital and the community, as compared to the total number of beds available.

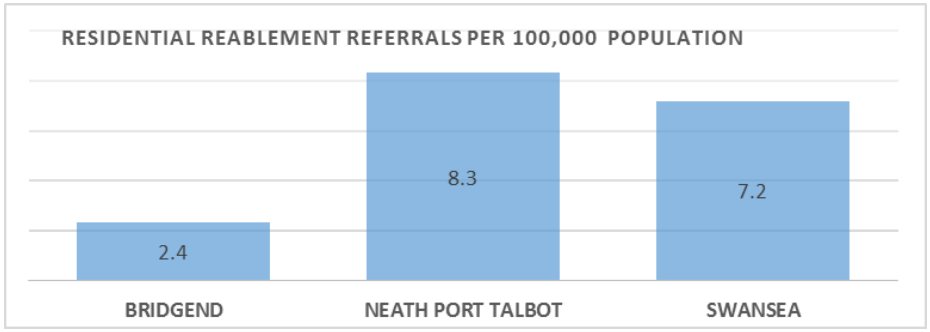
A key difference between services is the lack of step up beds in Bridgend, with provision for 6 beds to deal with patients discharged from acute hospital. There was a view from stakeholders in Bridgend that if step up beds were available then it might be possible to help people to stay at home longer.

The average length of stay in these facilities is as follows:

- Bridgend: 40 day LoS in Reablement Bed
- NPT: 39 day LoS in Reablement Bed
- Swansea: 29 day LoS in Reablement Bed

From the information we received from the services there seems to be a very broad access criteria for residential reablement e.g. “Adults who reside in Bridgend County Borough, with no acute cardiac/ physical illness requiring hospital intervention”.





District Nursing

District Nursing (DN) services across Western Bay aim to provide a holistic assessment, planning and evaluation of care from engagement in discharge planning to proactive health surveillance and promotion for patients with long term conditions. District nurses support the management and treatment of many conditions such as diabetes, continence issues, immunisation and wound care. District Nurses also support medicines management and have a key role in End of Life Care and post bereavement support.

During our stakeholder interviews, DN services were frequently highlighted as being under pressure and requiring investment. There was a feeling that as integrated intermediate care services were developed the knock on effect was an increase in activity (volume and acuity) in DN services. We were unable to validate this assumption as the services were unable to provide any supportive data within the required timeframe.

Data

We examined the available data from DN services in Swansea, NPT and Bridgend. Patient registers and activity data for all three are currently inputted and collated by hand into excel spreadsheets. There has been question marks raised over the accuracy of some of the data, in particular an anomaly in referral data. That said, we have been able to make some comparisons between the three services and also with UK benchmarks.

Service configuration

There is variance in the way ABMU DN services are currently operating. In both Swansea and Bridgend the DNs are part of the integrated hubs, but in NPT the DN service is not integrated, although some staff are co-located.

Referrals

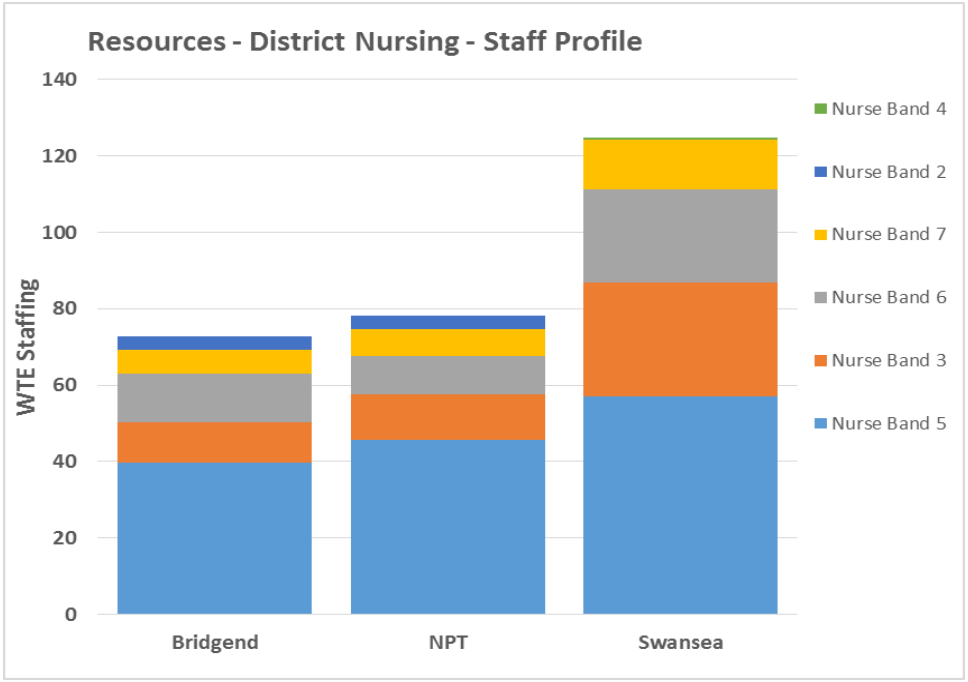
Referrals to the services are also managed differently, with none being managed via the Common Access Points at present.. Swansea referrals are received via the three hubs but the Central hub also picks up referrals from GP surgeries. In Bridgend all referrals are picked up from GP surgeries, they are looking into moving to electronic referrals but there is resistance from GPs. NPT receive electronic referrals direct to the DN service and also collect from GP surgeries.

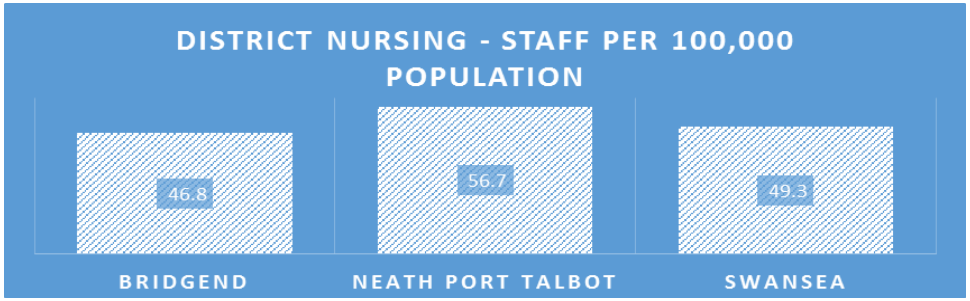
District Nursing : staffing

We have noted some variance in staffing between Bridgend, NPT and Swansea. At a high level, DN staff (qualified nurses and HCSW) per 100,000 population in NPT is higher than other areas with 56.7 WTE staff per 100,000. This compares with 46.8 WTE in Bridgend and 49.3 WTE in Swansea, though broadly speaking skill mix and staffing numbers are comparable.

The 2016 NHS Benchmarking Network Community service Report shows the England average for DN WTE staff per 100,000 population is 42, considerably lower than ABMU. The range however was from 8 to 92. This is likely reflective of the variance in services provided and activities included within core DN services. The report shows the All Wales average as 38; again, considerably lower than ABMU. This suggests that either demand (volume and/or acuity) are higher in ABMU and so require more staff to service the activity, or that the ABMU services are providing inputs that the benchmark services do not. We have not found any evidence of either scenario, so suggest that this is looked at in further detail.

Current skill mix in the ABMU DN services (Qualified Nurse:HCSW) is around 80:20. This is higher than we would expect to see, with a typical service operating at around 65:35. The DN Lead Nurses don't feel that the ratio needs to change but may be as a resultant of the view that the high volume of phlebotomy undertaken has deskilled the HCSW.

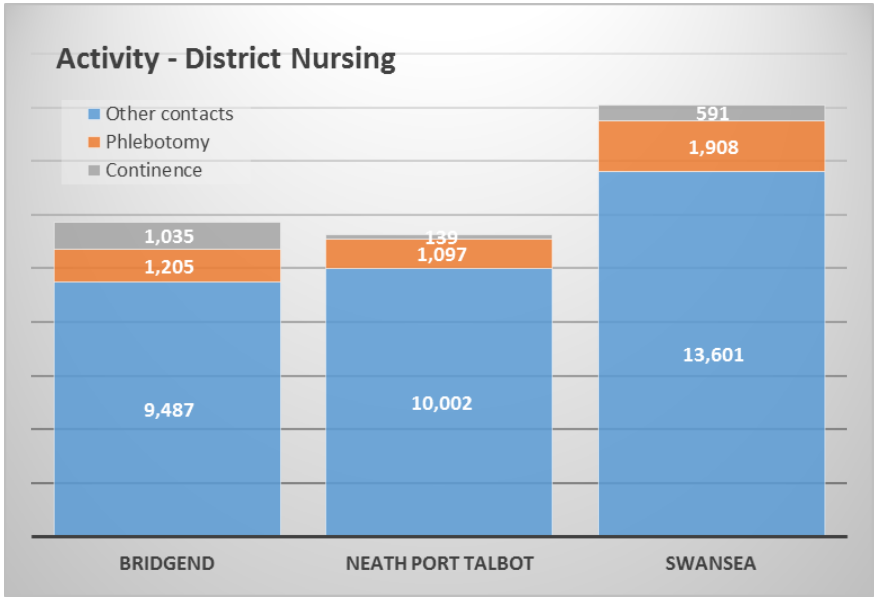


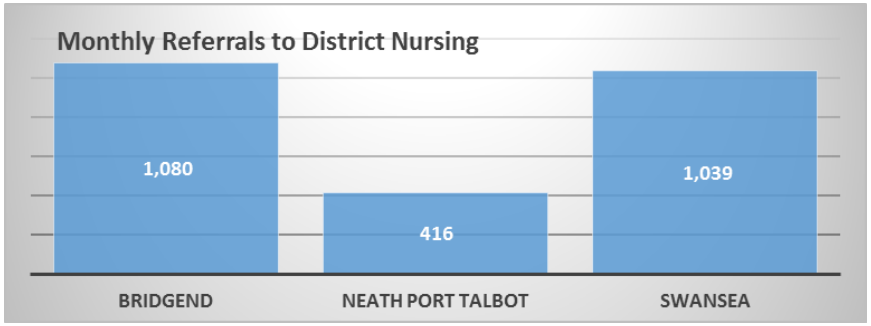


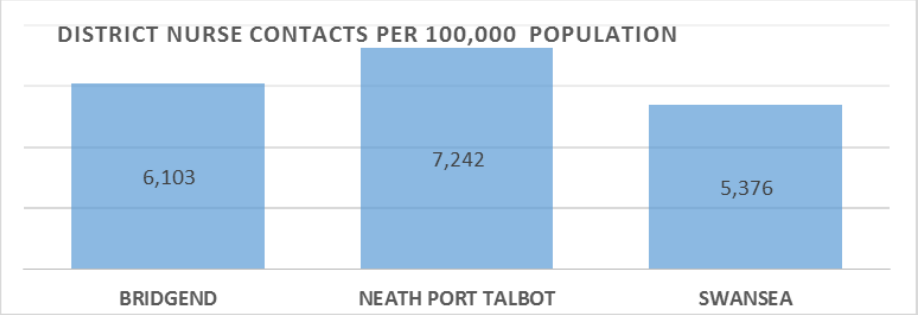
District Nursing : activity

Monthly DN contacts per 100,000 population varies from 5,376 (Swansea), to 6,103 (Bridgend) and 7,242 (NPT). This would suggest that the NPT DN service may be servicing higher demand, but this is not borne out in the referral data (NB referral data is currently being checked due to an anomaly in Bridgend data). Alternatively it may indicate that NPT are providing more visits per patient and/or keeping patients on the caseload for longer.

The 2016 NHS Benchmarking Network Community Services Report indicates that the UK average for monthly DN contacts per 100,000 population is 4,750. Considerably lower than reported activity across ABMU, even when phlebotomy and continence are excluded from the ABMU figures. The benchmarking figure is an average taken from 84 DN services. It is likely that a number of different service models are included in the 84 services as there is a considerable range shown in the report. That said, it would be worth investigating further as high contact numbers may be an indicator of pressurised staff becoming task oriented and not taking time to assess and evaluate. This could lead to unnecessary visits and be demotivating for staff who may not feel that their skills and knowledge are being best utilised.







District Nursing : activity

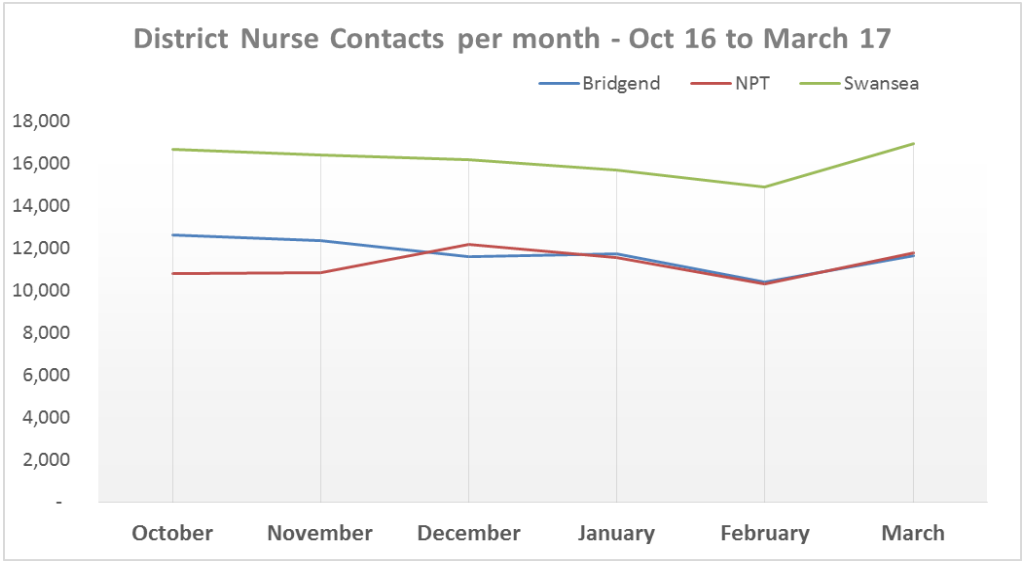
Looking more closely at the district nursing figures reveals some further insight. We have analysed data for each locality against UK benchmarks in the NHS Benchmarking Network Community Services Report (December 2016) in order to provide a comparative view.

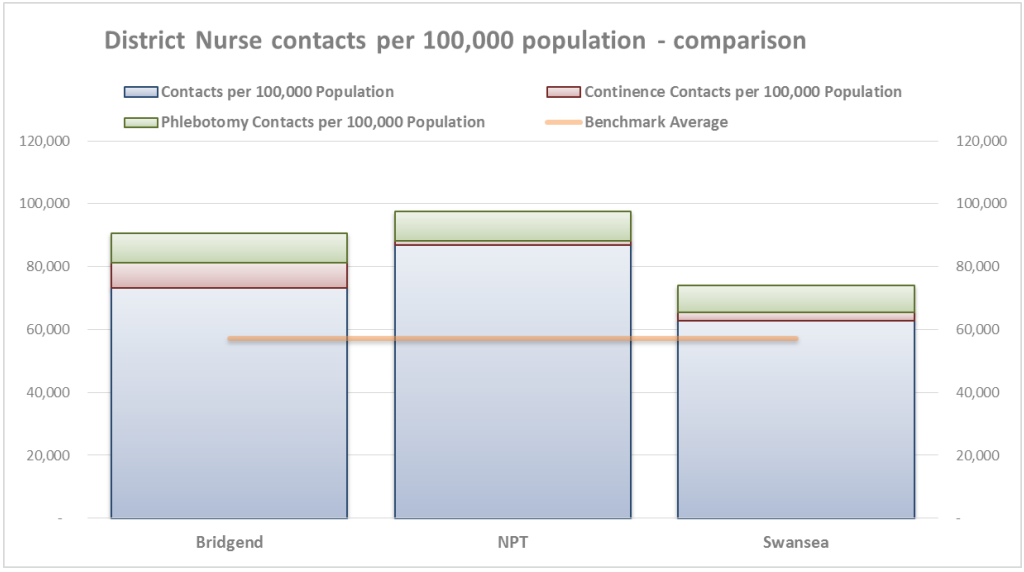
District Nurse activity (contact) levels have remained broadly consistent over the last 6 months. The number of face to face contacts per 100,000 population gives an indication of the coverage of the service.

The mean average number of contacts across Bridgend, NPT and Swansea is higher than the benchmark group average (57,193), particularly in NPT – even when accounting for high volume activities such as phlebotomy and continence. This gives an indication that the intensity of input received by each person is higher than in other areas.

The DN lead nurses acknowledged that they do not currently use Expected Discharge Date (EDD). This is likely to contribute to longer stays within the service. There is also not a consistent policy on “not at home” visits, which may lead to unnecessary visits.

To triangulate further with this, the next page considers levels of resourcing and caseloads.

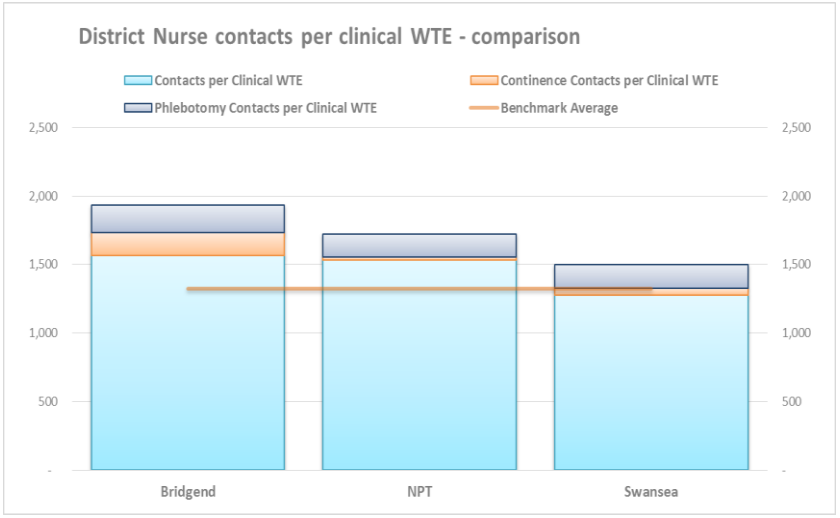


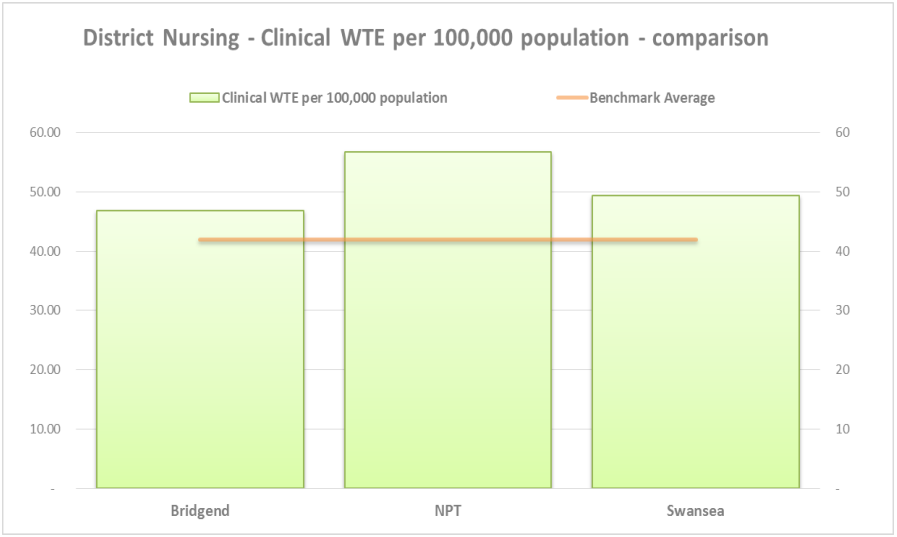


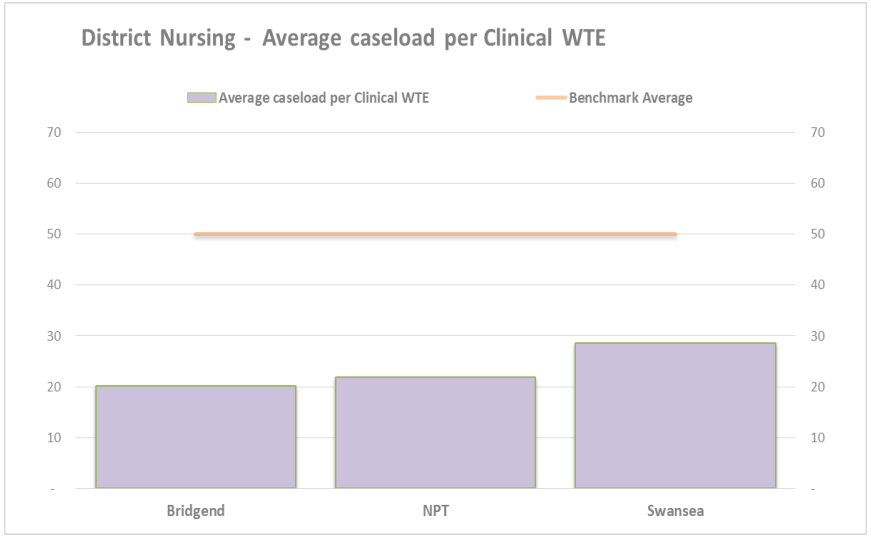
District Nursing : activity

The average number of face to face contacts per clinical WTE across ABMU is higher in then the benchmark average (1,326), and the number of clinical WTEs per 100,000 higher than benchmark, indicating that levels of resource are generally higher than other areas, but the contact level is also considerably higher.

The average caseload per WTE, however, is lower, indicating a lower number of individuals supported by each staff member - this figure has wide variation in the benchmark, reflecting differing service models, but combined with other measures this does indicate potentially longer length of stay on the caseload, and/or a higher intensity of contacts per individual. LoS in service is not currently available for ABMU. The average time spent on caseload in the benchmark group is approximately 4.5 months, and has been decreasing nationally highlighting a faster turnaround of service users. It would be informative to compare this with ABMU service model.







Domiciliary / Home Care

Over 2 million hours of homecare are provided for the Western Bay population each year to support people with household tasks, personal care or other activity that allows them to maintain their independence. Approximately 70% of this is provided by the independent sector under contract.

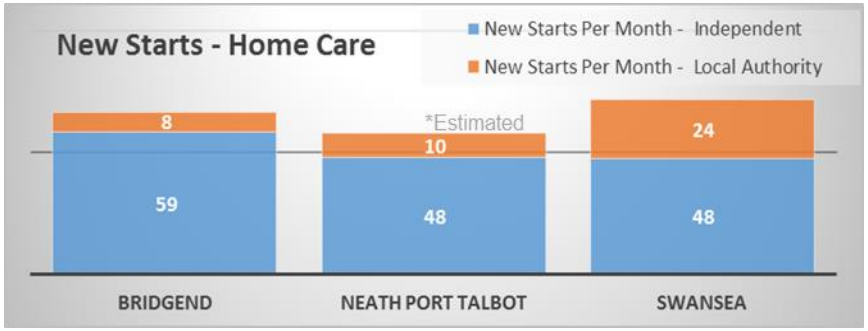
Throughout stakeholder interviews and at staff workshops availability of home care was consistently cited as a block to patient flow (either up or down).

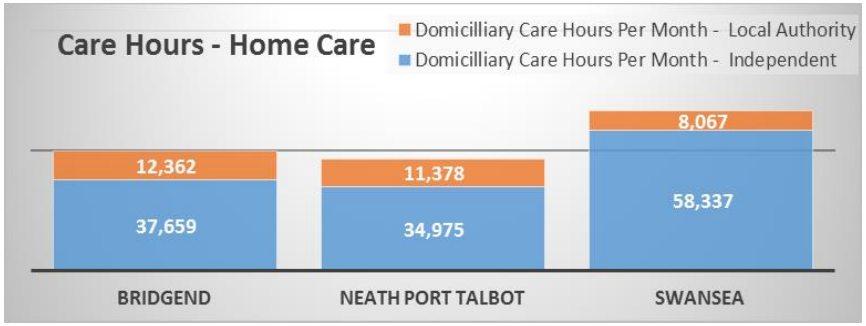
This was particularly noted in Swansea, where at any point there may be 110-150 people across community and hospital awaiting care. This was also noted in Bridgend (circa 20 patients), and NPT - though based on feedback there may be recent improvements here due to new staff in post and a new provider being established in the area.

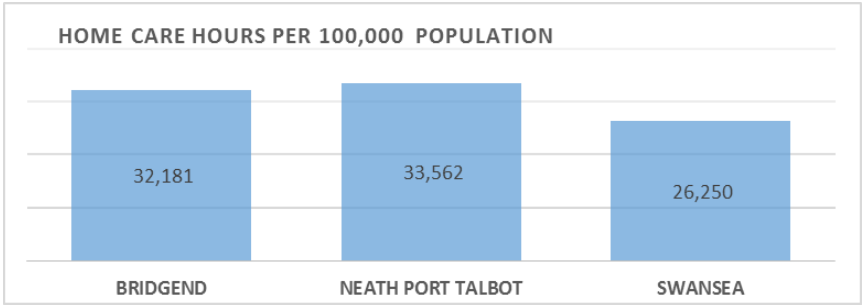
We are also aware of anecdotal evidence of over-prescribing of social care packages, particularly from secondary care. There are also a number of Long Term packages that require review – there may be capacity to be found here, see next page.

In order to enable a shift to more community-based services and care in homely settings, the availability and development of community-based staff (including home care staff) with the right skills is crucial. We are aware that there are significant difficulties in recruiting and retaining care home and homecare staff and from our understanding, the balance of community-based staff has not increased significantly in recent years.

The external home care market is extremely fragile and local geography makes some areas very difficult to service. The issue is one of supply rather than funding. We understand that work is ongoing to stimulate and support the market but it is likely that alternatives to create community resilience will also need to be explored and developed.







Source: New Start Figures are based on actual start dates, Local Authority and Independent Domiciliary Care Services 01/04/2016-31/03/2017

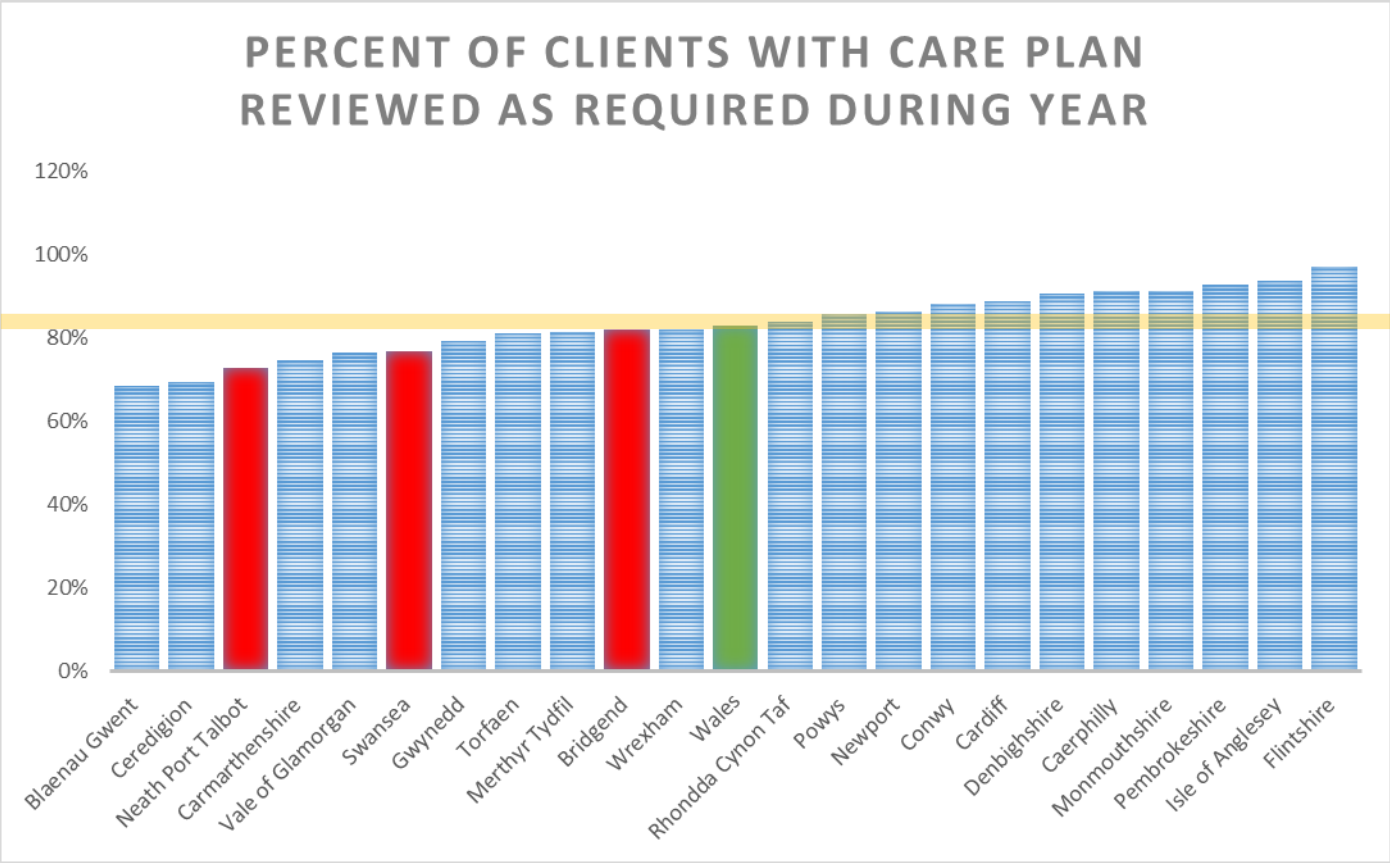
Domiciliary Care - Reviews

The requirement for care plans is that an initial review of care plans should take place within three months of services first being provided, with subsequent reviews then required annually.

NPT, Swansea, and Bridgend are all below the Wales average in the % of clients having a review when required.

27% of individuals in Neath Port Talbot who should have been reviewed were not, and across the Western Bay there were approximately 2000 clients who did not have their care plan reviewed within a year.

Regular reviews may help to free up capacity where care needs have changed. Approximately 80% of the reviews will relate to adults receiving community-based services, which is particularly important for domiciliary care, where supply is limited.



Source: Stats Wales, Adults assessed and care plans reviewed by local authority as at 31st March 2016

Figures relate to adults receiving both community-based services and in care homes.

Care Homes – Residential and Nursing Care

There are approximately 1750 older individuals supported in a care home and placed by Bridgend, Neath Port Talbot and Swansea.

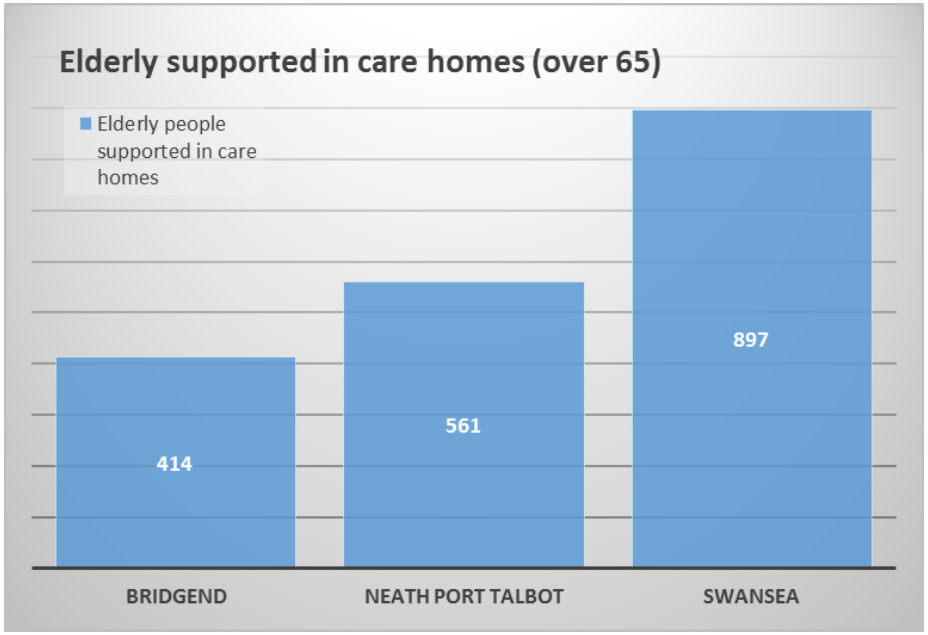
Bridgend has the lowest number of over 65s supported in a care home for its population size. Bridgend also has the highest domiciliary care hours for its population size, which may mean that more people are supported at home rather than in a placement. However, this correlation does not hold across all three areas.

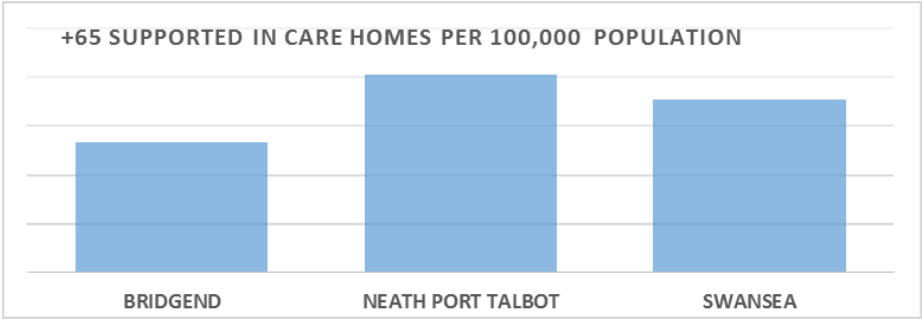
Further, a large proportion of the delayed transfers of care for Bridgend patients cite waiting for availability of care home as the key factor in delay, which would suggest issues with care home availability.

Whether or not the current provision of residential and nursing care home beds is sufficient now and into the future is dependent on the desired model of care.

One area that may represent true under provision is EMI nursing home beds and the need for these facilities will likely increase in coming years.

We recommend that the planned trajectory for numbers of residential and nursing care home beds and the impact of any reductions on other services is modelled as part of the planning process.





Note: Figures based on January 2017

Other services

Medicines Management

We were not able to quantify and compare medicines management activity or impact as very little data on these services was provided to us. We know that 600 people in Swansea supported by Medicines Management staff. On the face of it this does not seem to be very many considering there are 8.4 WTE staff in post. Whether or not this constitutes value will depend on the level of service provided and the impact their interventions may have on patients.

Older peoples Mental Health (OPMH)

Detailed data on these services was not provided to us. Clearly this is area of growing demand and we know that a range of initiatives are in development. For example a Rapid Response service for dementia.

The OPMH teams are accessed via Mental Health liaison worker in the CAP and they provide support in the domiciliary setting to maintain people at home and prevent admissions.

Physiotherapy

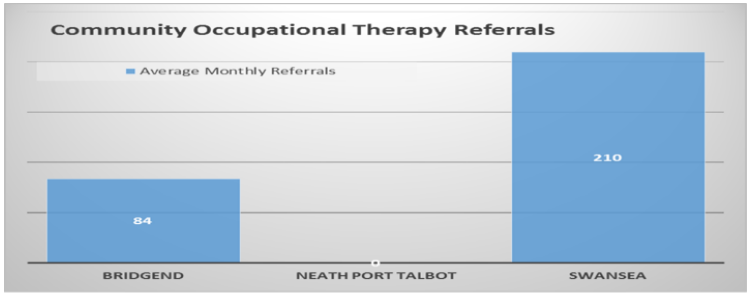
Physio services are integrated within the network hubs and clusters and so not examined separately.

Community Occupational Therapy

Community Occupational Therapy was highlighted in by stakeholders as a service under increasing pressure, with possible knock on impacts to other areas. Community OT is a gateway service, providing the assessment required prior to accessing some other services.

Community OT is integrated within the community hubs in Swansea, and part of the network clusters in Bridgend, rather than a separate team. Thus, staffing and activity is rather hidden within networks/hubs data and so we are unable to make any meaningful comparisons.

Community OT is typically a service where there is opportunity to work more closely with the DN service and provide a more joined up service. Any skills review in DN should also take account of community OT.



Community Sites - Maesteg and Gorseinon

With clear and active management, these community hospital facilities are vital for the provision of step up /step down care. The Maesteg and Gorseinon facilities also have a key role in acute admission avoidance with GP access to diagnostics and Consultant led hot clinics. There may be opportunities around expanding referral rights to include Nurse Practitioners and Advanced Therapy roles.

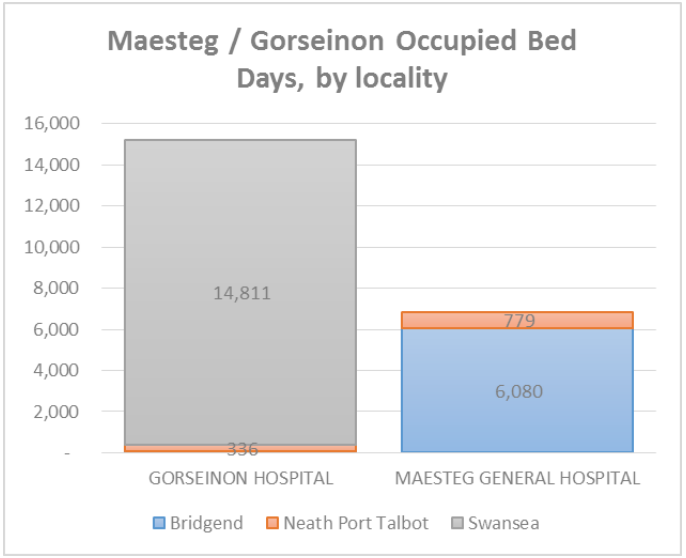
There are approximately 650 admissions to Maesteg and Gorseinon per year, with an average length of stay of 38 days. 95% of patients within these sites are over the age of 65 and 85% over the age of 75. 13.3% are discharged to a nursing or residential home after their stay.

The majority of patients admitted to Gorseinon are from the Swansea area, with a small number from NPT and Bridgend, and the majority of patients admitted to Maesteg are from Bridgend, with a small number from the Afan network of NPT.

The highest demand pressure for beds (in percentage terms) is also seen in these community sites. Maesteg and Gorseinon show a considerable increased projection due to growth in the older population – up to 30% over a 10 year forecast.

Bed days for patients within each cluster

Locality / Cluster	GORSEINON HOSPITAL	MAESTEG GENERAL HOSPITAL
Bridgend	**53**	**6,080**
Bridgend East Network		1,201
Bridgend North Network	53	2,954
Bridgend West Network		1,925
Neath Port Talbot	**336**	**779**
Afan	38	779
Neath	131	
Upper Valleys	167	
Swansea	**14,811**	
BayHealth	4,042	
CityHealth	2,796	
Cwmtawe	2,522	
Llwchwr	3,724	
Penderi	1,727	
Grand Total	**15,200**	**6,859**



Community Sites - Maesteg and Gorseinon continued

Modelling the impact of demographic change shows that the highest demand pressure for beds (in % terms) is seen in the community hospital sites, Maesteg and Gorseinon.

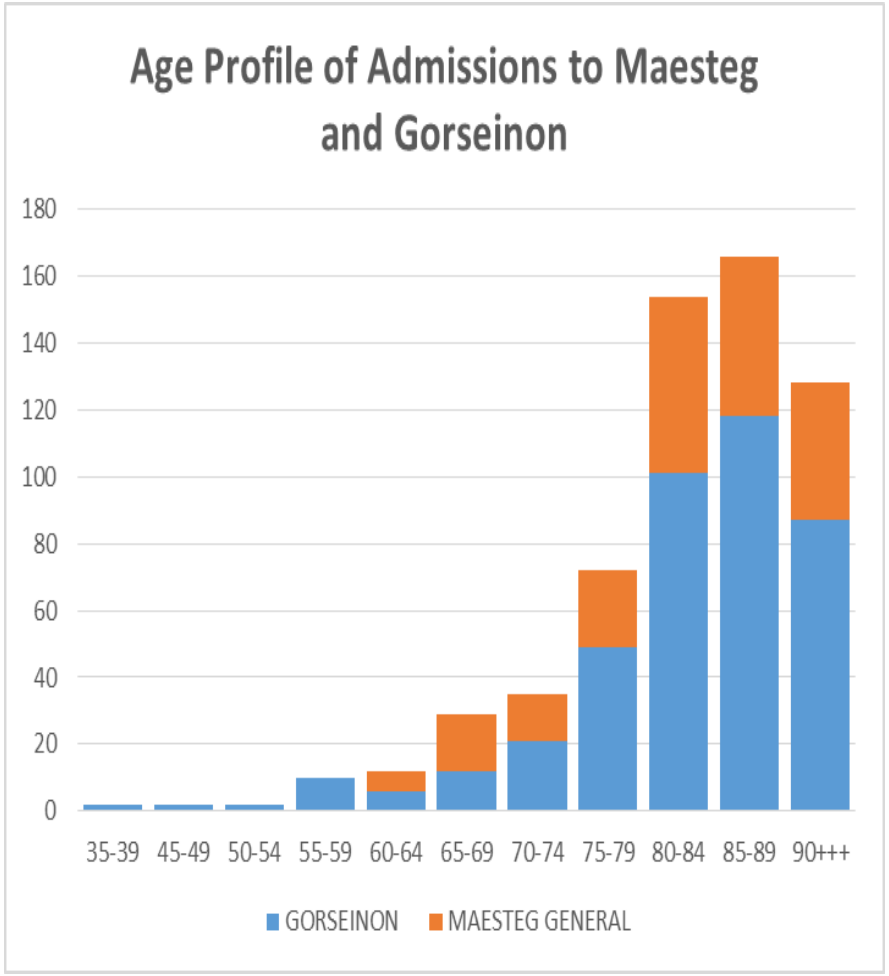
There is a considerable increased projection due to growth in the older population – up to 30% over a 10 year forecast. This projection is based on using the beds as they are now i.e. no change in the model of care.

We understand that both sites are currently reviewing their operating model and will be looking to put in place access criteria and more robust management of length of stay. This should be done as part of a review of the overall model of care to identify options to enable more optimal ways of working and utilising resources.

We understand that the two wards at Gorseinon are cramped and there is a plan to take out 6 beds to improve the patient environment.. Future target length of stay will be two weeks which is considerably less than at present.

In order to achieve this goal there will need to be:

- application of access criteria to ensure appropriate patients are admitted
- robust processes to manage the patient journey and patient expectations e.g. setting “expected date of discharge”, and commencing discharge planning on admission
- close working with community and social care services with in-reach and active “pull” to ensure appropriate length of stay.



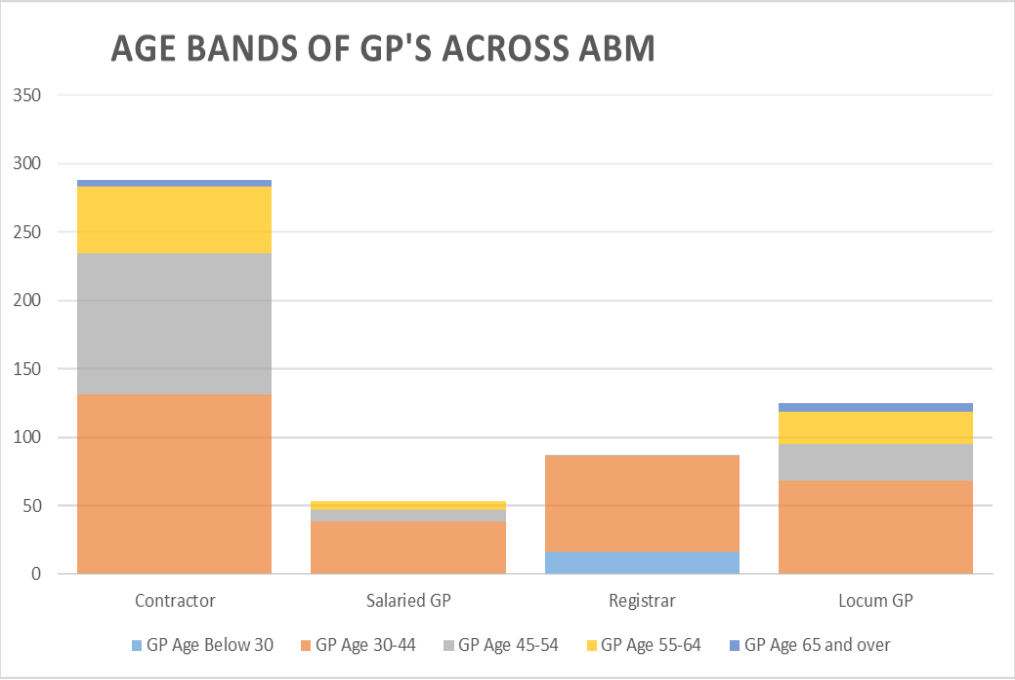
Primary and Out of hours Services

With a total registered population of 547,000 (2015), there are 73 practices within 11 Cluster Networks. Further, there are circa 350 GPs across ABMU, as well as approximately 200 registrar and locum GPs. From this, there are an estimated 3.3 million consultations per year across ABMU with an estimated 700,000 of these related to practice nurse activity. Across the UK over 90% of all contacts with the NHS occur in general practice. Each month there will be an estimated 126,000 consultations in Swansea, 78,000 consultations in Bridgend, and 70,000 consultations in Neath Port Talbot.

A significant proportion of contractor GPs (19%) are in the 55-64 age bracket, including 5% over 60. Whilst ABMU anticipate that the supply of GPs will result in being able to recruit to a number of these posts, a change in retirement profile (for example more GPs choosing to retire before they reach 60 – which is a real risk with pension/tax changes) could have a significant and de-stabilising impact in a number of areas.

Recruitment is an issue as it is very difficult to compete with the lucrative locum market. There are a large number of GPs on part time contracts and fewer than ever are interested in being a Partner. A number of practices are at risk of becoming unsustainable. We understand that ABMU is developing Practice Support Teams to provide Practice diagnostic, clinical support for up to six months and a managed locum service.

The challenge of recruitment is not new (although it does seem to be increasing) and is not specific to ABMU, with the same pressure felt in other Health Boards. This highlights that alternative care models should be explored as there is unlikely to be a quick or easy solution to GP recruitment. These might include the use of Advanced Nurse Practitioners, Paramedics, Pharmacists etc. to support the Practice.



Estimates based on 'General Practice In The UK', July 2014
Assumes 6 consultations per patient each year, 62% by GP, 34% by nurses, 4% other clinicians

Out of Hours

A new 111 urgent care service was introduced in the ABMU area on 4 October 2016, with the service now live across Swansea, Neath Port Talbot and Bridgend. This service operates a call centre and telephone triage.

Telephone or face to face consultations are carried out via a home visit or from one of three centres in Morriston, Neath Port Talbot, and Princess of Wales. Treatment prescription pick up arrangements are also in place.

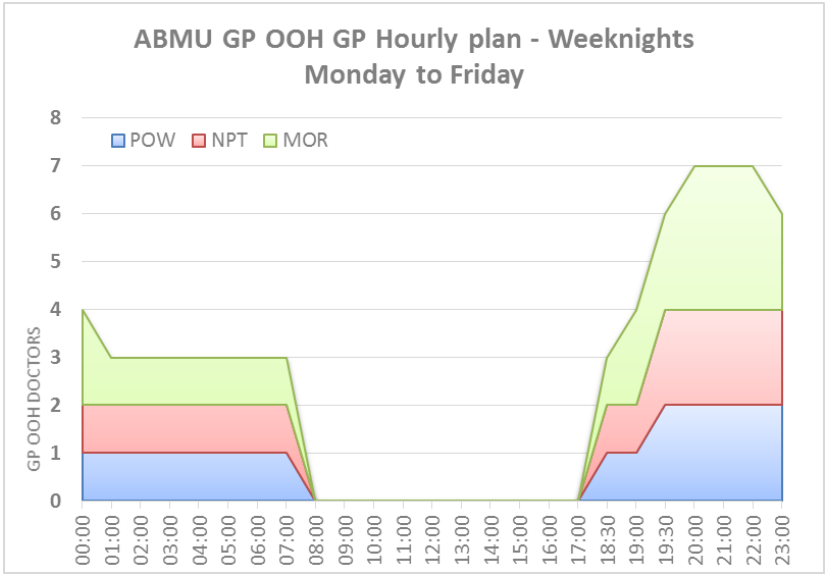
The treatment centres have 28 receptionists / drivers (12.8 WTE) and 3 supervisors (2 WTE). Management of the service is via 4 staff in the GP out of hours team, who are in the office on a 9-5 basis. 50 GPs are employed on a sessional basis with an average shift fill rate of 98%.

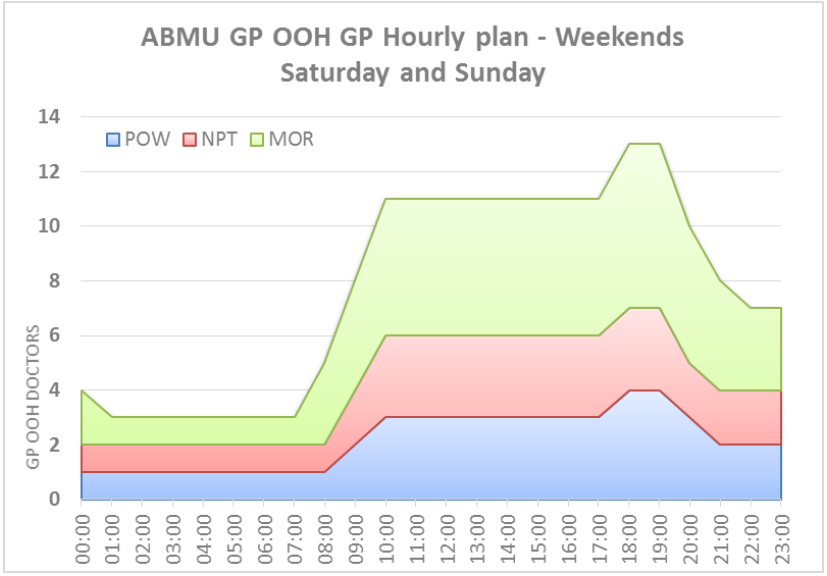
The NPT centre is the most difficult to staff, particularly since NPT Hospital lost the medical take.

The service is provided from 6pm to 8am Monday to Thursday; then through Friday night, all day Saturday, Sunday and Bank Holidays into the following weekday morning at 8am.

The call centre functions are delivered by a WAST-hosted 111 service, and includes Health Board employed clinical hub staff.

We heard from several sources that dental calls are significant in number and alternative ways of managing these should be sought. For example, other areas have established a separate Out of Hours Dental Service, staffed by dental nurses.

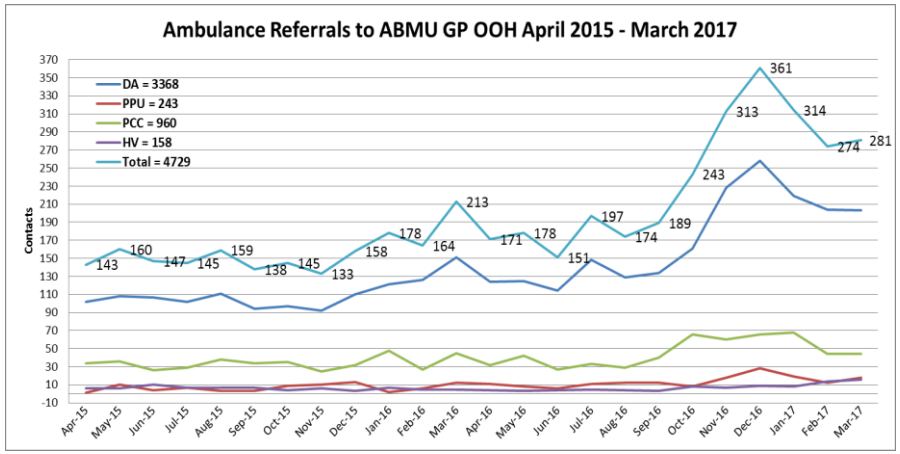


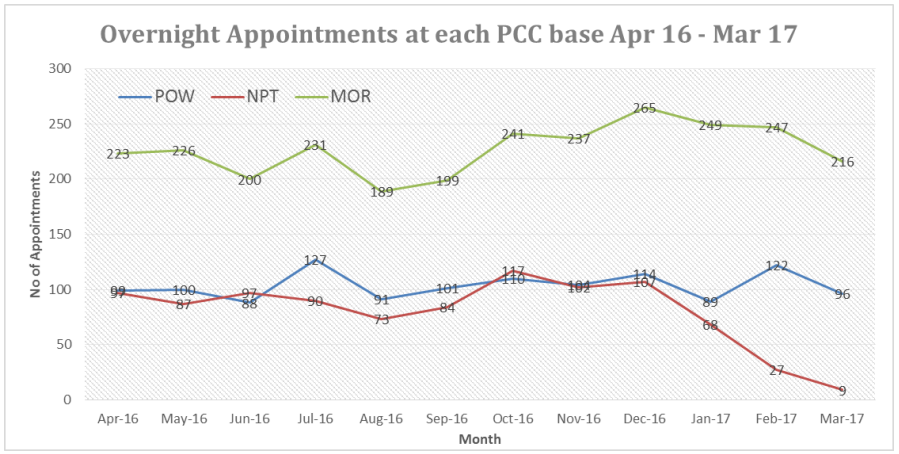


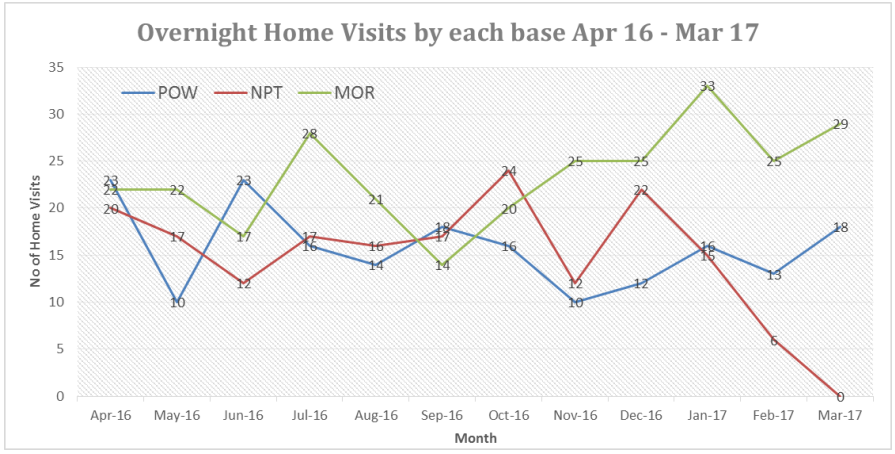
Out of Hours

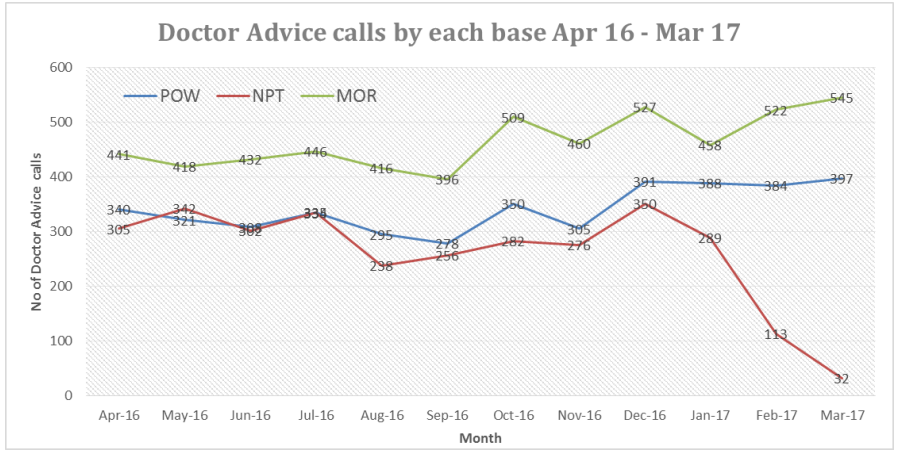
The diagrams below illustrate the overnight (12midnight to 8:00am) activity.

The increase in ABMU GP OOH monthly contacts towards the end of 2016 is reflective of the increase in ambulance referrals and nursing / residential home referrals, which may have contributed to a reduction in the number of conveyances to hospital and also 999 calls from care homes. Neath Port Talbot Hospital is utilised less than the other sites; We understand that the service as it is in the process of being remodeled to better cope with demand, reduce risks associated with (former) lack of supervision out of hours, and to deliver within the a reduced cost envelope.



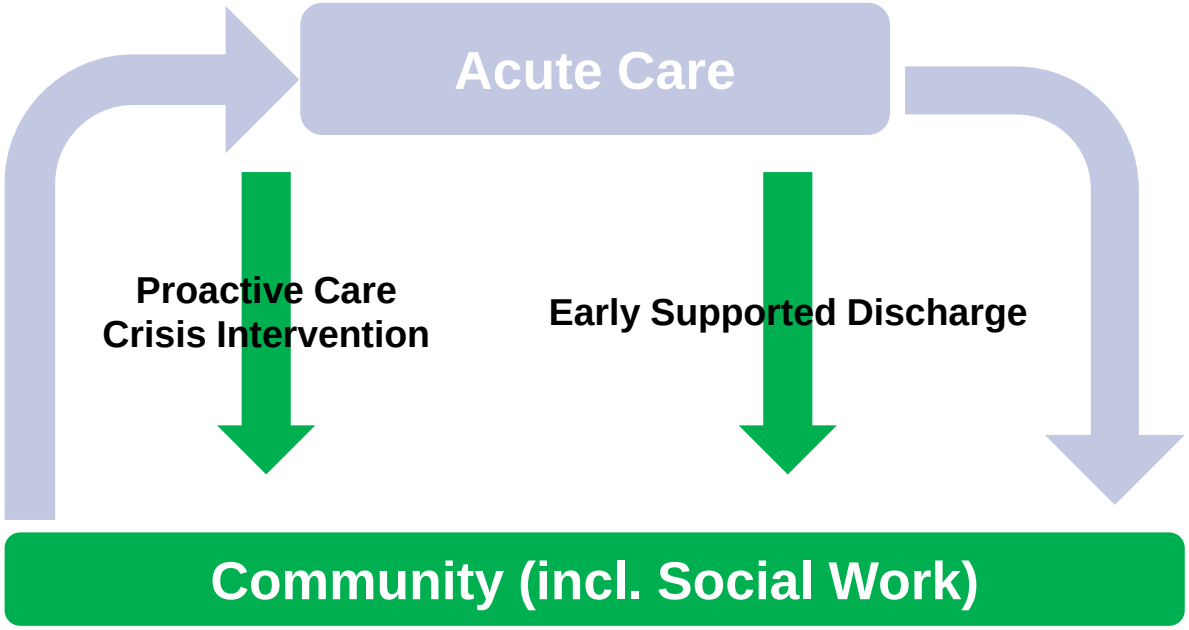






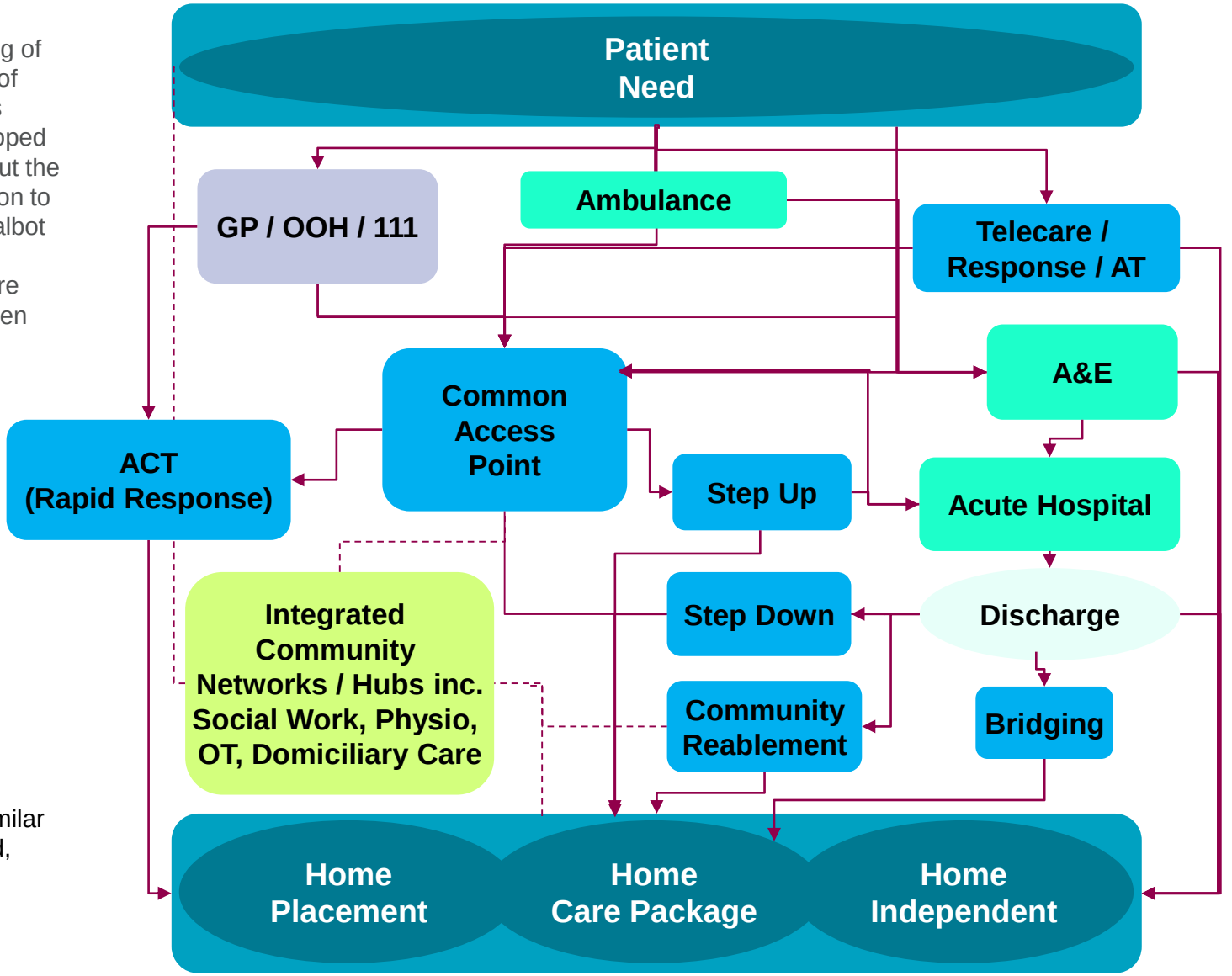
5. Out of Hospital Scenarios

Modelling Future Demand and Capacity Scenarios



Scenario Modelling – Model overview

To aid our understanding of the configuration of out of hospital services across Western Bay, we developed this schematic to map out the key patient flows common to Bridgend, Neath Port Talbot and Swansea, while recognising that there are some differences between areas.

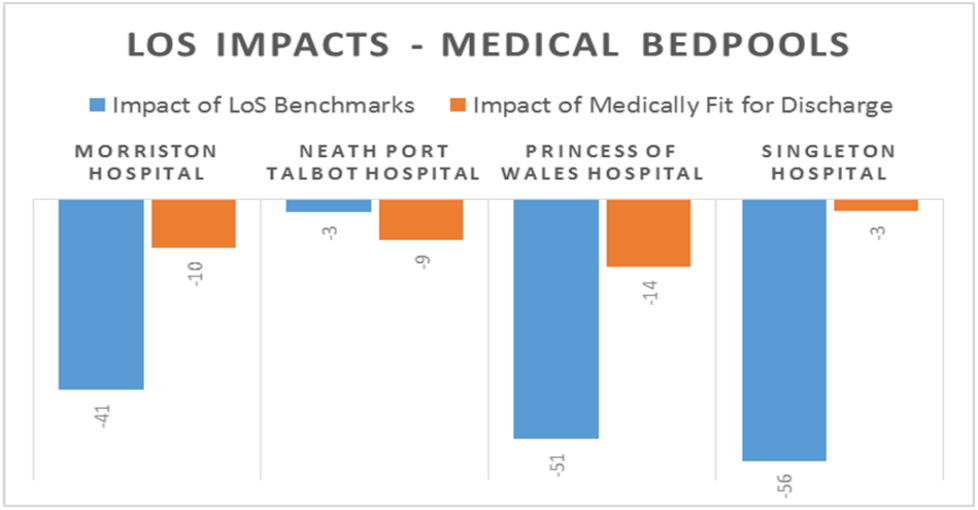


Appendix B provides similar schematics for Bridgend, NPT and Swansea.

Assumptions for admission avoidance/ delayed discharge

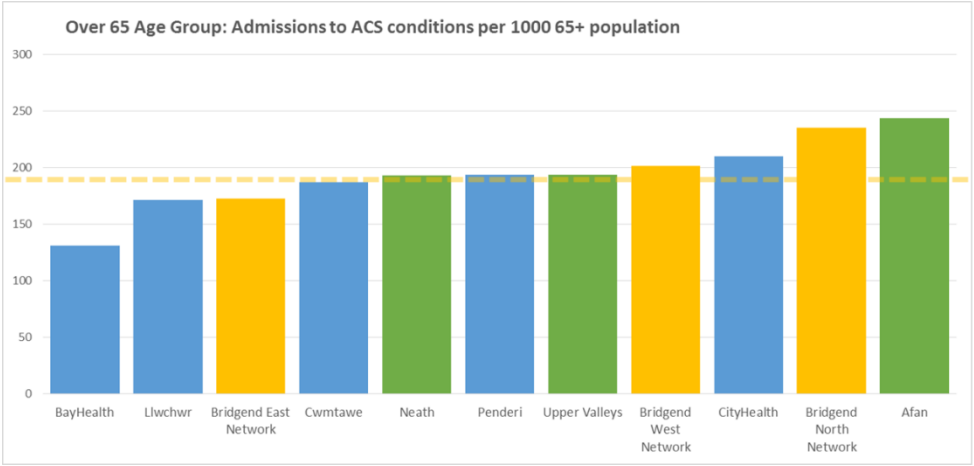
Delayed Discharge

Previous modelling has focussed on avoiding acute bed days based on length of stay comparisons and benchmarking, informed by analysis of delayed transfer of care information and medically fit for discharge days. There was an assumption of 25% of the core medical bed day reductions to the 50th percentile require additional support in the community, which is comparable to the volume of days recorded as medically fit for discharge. To estimate the indicative impact on all community services, we have extended this 25% across length of stay improvements in all bedpools (i.e. including surgery) making the assumption that 25% of reductions in Length of stay require additional support in the community. This equates to 25,000 bed days (equivalent of approximately 75 beds) in need of support in alternative settings.



Admission Avoidance

In order to understand impact of further admission avoidance, we analysed the variation in the rate of admission for ACS conditions between locality networks, and measured the impact of reducing variation to the median. The impact is a reduction of approximately 15,000 bed days (equivalent of approximately 45 beds). The level of impact would depend on the level of ambition but this is intended to show an indicative impact.

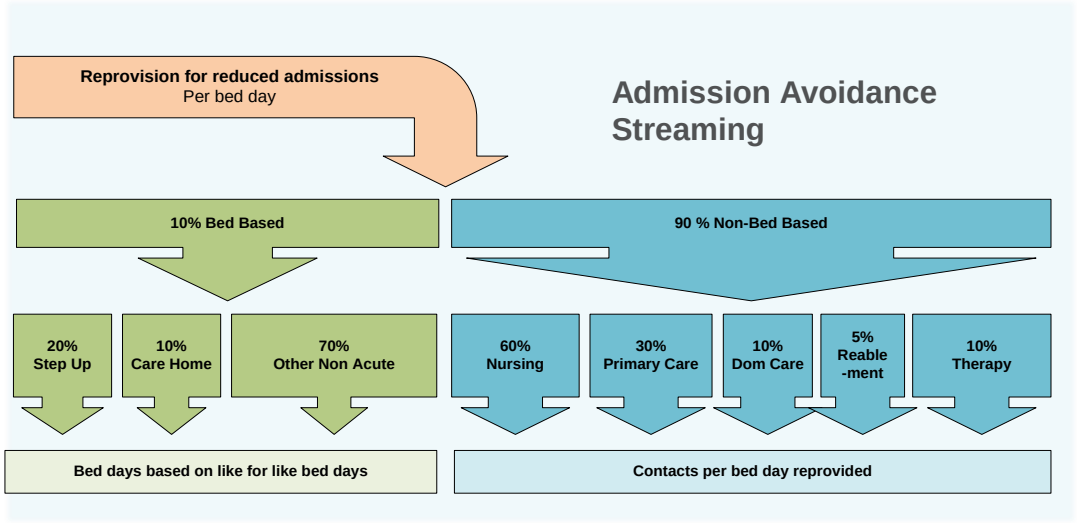


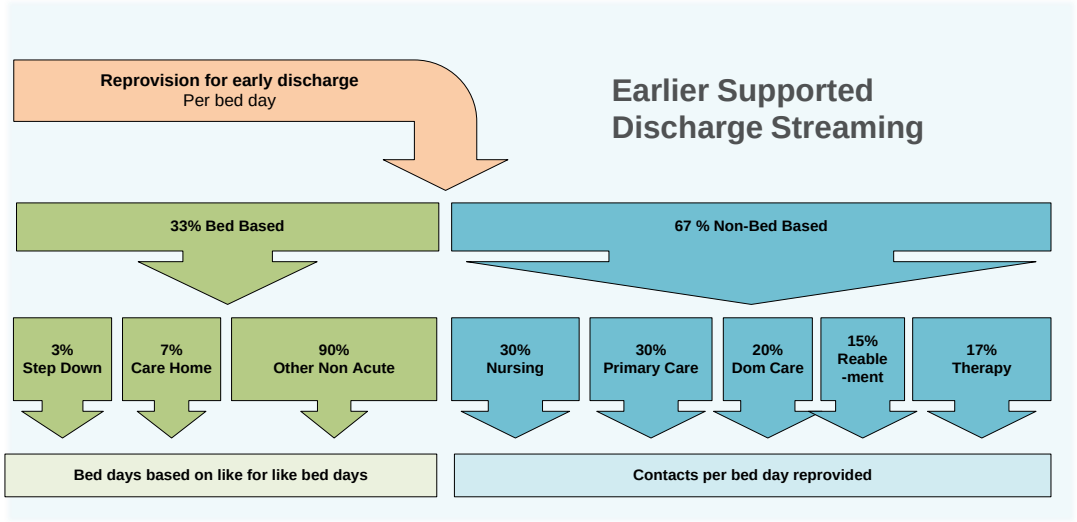
Modelled Changes – Additional admission avoidance and early supported discharge

In previous work with ABMU, we built up assumptions on re-provision in alternative settings. These were based on streaming applied to each acute bed day avoided to give a blend of service re-provision, and percentages relating to care locations based on point prevalence studies, with the figures relating to number of contacts based on assumptions on the levels of re-provision for each acute bed day moved to alternative settings.

The streaming assumptions have been applied to each bed day associated with an early discharge / avoided admission to give an indicative view of the areas and scale of likely impact.

The streaming assumptions used for the modelling have been adjusted from our base model in light of current flows across Western Bay and feed-back from stakeholders in the validation sessions.





Modelled changes - Impact of unmet need

Modelled changes

There are a number of specific areas and factors where we can estimate and quantify the impact of a change. For some of these areas this has been estimated via the impact on capacity assuming current models of care continue to apply, though in some of these (e.g. domiciliary care) there may be additional mitigating factors.

Key changes are summarised below:

- **Expansion of the Bridgend ACT to include 7 day working**
  - Based on activity levels in other areas this would mean approximately double the activity being able to flow through this service, with associated reductions in hospital admission and on other services.
- **Expansion of the Swansea ACT to become a full 7 day service i.e. new referrals taken at week-ends**
  - Based on activity levels in Neath Port Talbot where a full service exists, this may mean an additional 15% of activity. However this would need to be further validated using more granular information to understand current and future phasing of activity across the week and differences to NPT. It may be possible to further increase activity, with associated reductions in other serves.
- **Domiciliary Care – reduction in the backlog**
  - Based on numbers waiting to transfer into the service, this may require a 5% increase in Bridgend, 6% increase in NPT and 8% increase in Swansea. This could be mitigated by more prompt reviews, and increased use of reablement. It should be noted that there are factors beyond pure capacity (including geography/specialism) that impact on availability.
- **Reablement – Reduction in extended stays in service**
  - It is unclear how much of the extended length of stay in reablement and delay in starting is due to downstream impacts in domiciliary care, but there is approximately 11% of additional capacity that could be found within the community reablement service based on a limit of 6 weeks in the service before discharge. Prompt discharge from the service would also help to mitigate the delays in accessing the reablement service, and as a further knock on impact, additional patients flowing through reablement may help to further reduce domiciliary care requirements.

Modelled Changes – Impact of additional shifts from Acute Care

Impact of shifting additional activity to the community (Earlier Supported Discharge and Admission Avoidance)

The modelled impact of earlier supported discharge and admission avoidance across community services is seen across a number of areas. The impact on core services is expected to be felt particularly in nursing – with a possible 4% increase in demand for district nurses for the scale of shift we have modelled. Some of this additional required nurse input may be absorbed within intermediate care, CRT and integrated network/hub teams. This is particularly true in the case of admission avoidance where intermediate care rapid response services (primarily ACT) would likely form the majority of the increase in patient contact – this may also include possible increased use of telecare. The impact on core teams including district nursing, where it may be difficult to absorb any additional pressure without making changes to the service model, is still likely to be significant. That said, the DN services when compared against benchmarks do look to have scope to create capacity within the current staffing complement by adopting new ways of working.

There is also expected to be an increased requirement for therapy services, with an increase of 2% estimated for additional shifts required.

Additional demand for care homes and additional home care as a proportion of current provision is likely to be lower, with modelled increases of 1% or less in these areas, which may in themselves be mitigated by increases in intermediate care activity and improvements in assessment, preventing over-prescribing of care packages and reviews to reduce long term support where it is no longer required.

Intermediate care will continue to play an important role in managing demand for hospital beds, and community reablement services would be expected to see an increase in demand of 6%. There would also possibly be an increase in demand for further bed based services, including step down intermediate care beds (estimate of 5% additional demand). Admission avoidance modelling also shows a significant increase in requirements for step-up beds, with a 4% increase in this area - this is particularly important where facilities are not available in all areas.

A summary of all these impacts is shown on the next page.

All the above would depend on the level of ambition (in both secondary care and community services), cohorts of patients being addressed, and the desired model of care. The modelled streaming is primarily based on core service areas, and the intermediate and integrated care teams would help in mitigating additional pressure on core services and facilitating appropriate patient flow.

Summary – all impacts

The table below summarises the indicative modelled impacts on services of demographic change over 5 years, the potential impact of a shift in care from the acute setting, and the impact of specific changes including a move to a full 7 day service in all localities, and the impact of current mismatches between demand and capacity where it has been possible to quantity this.

It should be noted that these impacts are primarily based on current service models, and the actual impact on services will very much depend on service models adopted in the future – and should be seen as an indication of where the pressure of additional demand may be felt. In some cases this additional pressure may be mitigated, for example in domiciliary care through more timely review, or reablement by reducing extended stays in the service – both of which are closely interrelated – increased throughput in reablement may further mitigate demand pressure in domiciliary care.

Service impact will also depend considerably on the role of intermediate care plays alongside core services, for example a move to a full 7 day service for ACT across all localities may help mitigate increased demand pressure on the district nursing services.

Area	Population increase – 5 years	Specific Modelled Changes	Impact of shifts from acute care	Total 5 year change
ACT	↗ 12%	↗ 100% (Bridgend) ➡ 0% (NPT) ↗ 15% (Swansea) Impact of ACT full service	Further increases depending on service model	↗ 112% (Bridgend) ↗ 12% (NPT) ↗ 27% (Swansea)
Step up	↗ 12%		↗ 4%	↗ 16%
Step down	↗ 12%		↗ 5%	↗ 17%
Reablement	↗ 11%	↘ -11% Reductions of extended stays in service	↗ 6%	↗ 6%
District Nursing	↗ 9%		↗ 4%	↗ 13%
Domiciliary Care	↗ 11%	↗ 5% (Bridgend) ↗ 6% (NPT) ↗ 8% (Swansea) Based on current 'Unmet demand'	➡ 1%	↗ 16% (Bridgend) ↗ 17% (NPT) ↗ 19% (Swansea)
OT	↗ 9%		↗ 2%	↗ 11%
Care Homes	↗ 11%		➡ 1%	↗ 12%

6. Conclusions and recommendations

Western Bay Out of Hospital Demand and Capacity

Summary conclusions and recommendations

This section of the report summarises our key findings and observations and makes some recommendations which we hope the Western Bay Partnership will find helpful.

Our approach

In order to make an assessment of demand and capacity for out of hospital services across Western Bay we looked at current and projected community demand and the impact of further shift from secondary to community care settings.

We examined available data for each of the community services and where possible made comparisons across the three areas or with national benchmarks. This data analysis in conjunction with qualitative data gained through interviews and workshops helped to form a picture of how the services are configured and operate.

From this baseline we modelled some assumptions around the future requirements in community services.

Current and future community demand

Demand for community services is expected to increase significantly over the next 5-10 years, particularly due to an ageing population. The number of people over the age of 85 in Western Bay is projected to more than double over the next 20 years – and linked to this more people living with long term conditions such as dementia, more people living alone and proportionally smaller population providing unpaid care for their family, friends, or neighbours. There are some small differences between localities and clusters across Western Bay, but these all share a similar upward trend in demand. The largest increases in demand are expected in services such as district nursing and occupational therapy (20% increase over 10 years), as well as the client groups currently served by Acute Clinical Teams.

This first-stage review is an attempt to begin to gather data and evidence to demonstrate the case for change. This would then naturally lead to the development of a range of ideas of how to innovate and rejuvenate the community hospital healthcare provision and its role in the system of care, and considered the logistical options for delivering this in the future.

Overarching Out of (Acute) Hospital Services

Although this commission has not extended to a review of related strategies for community based care across the Western Bay population, we are aware that evidence on the ground demonstrates a variance in practice.

We understand that the ARCH Programme is beginning to develop a vision across Western Bay, with the intention of bringing together a combination of local GPs and other clinicians to determine options for models of care. With this first baselining exercise beginning to develop the need for change, we would recommend there would be value in bringing local GPs, clinicians, social care staff, alongside other key stakeholders to discuss options for different models of care in the future. Models that will enable the population to be looked after in their local environment.

Our work also excluded data from the housing sector. We are aware that other options, i.e. enhancing housing provision to enable people to stay in their homes longer. This will also have a positive impact on reducing pressure on the acute provision.

Our scope was only to consider opportunities for delivering current community services differently but, from our other work, we are aware that opportunities also exist, through different ways of working, for an alternative model of care for some acute activity out of the acute hospital environment.

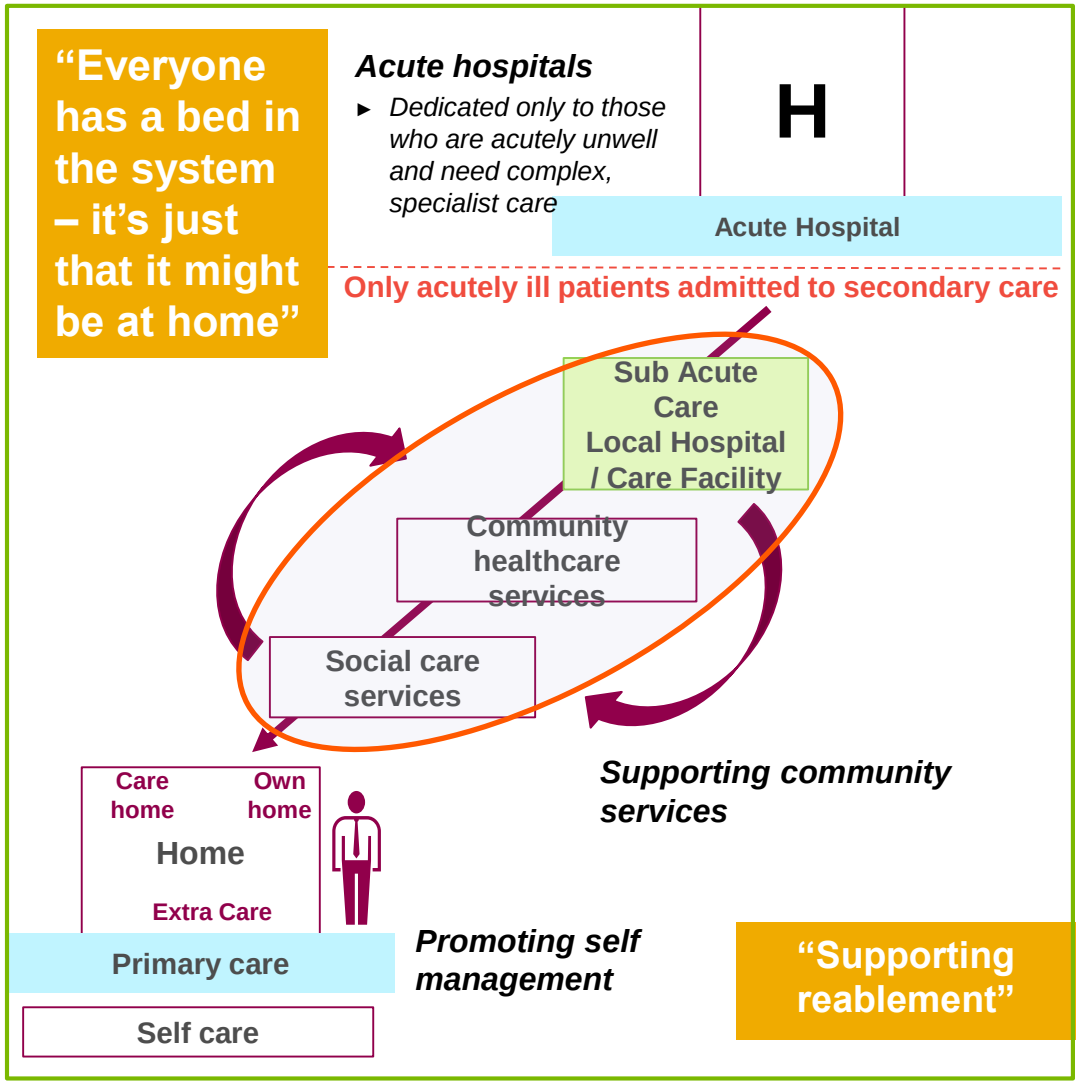
Model of care across the Western Bay health and care system

To achieve a sustainable model of integrated care we believe that a whole system approach is required. Currently the various services are accessed and used differently by patients, clinicians and the wider group of stakeholders.

Our previous work for ABMU identified that there were considerable opportunities to reduce length of stay in the acute hospitals (to bring them closer in line with a peer group average). A whole system approach will enable a genuine move towards shifting the balance of care (and potentially resource).

This approach requires acute service redesign to be integrated with changes to primary, community and social care. It also needs to be supported by mainstreaming different models of delivery, such as digital and mobile health, to drive channel shift and reduce the pressure on both unscheduled and scheduled care services.

By examining interdependencies and blocks to patient flow across the whole system we can begin to understand where capacity and resources are not correctly aligned to the desired patient pathway and model of care.



Conclusions and recommendations

Observation 1 Acute demand: shifting the balance of care

A whole system approach is required to achieve a sustainable model of integrated care, and enable a genuine move towards shifting the balance of care.

In 2016 we undertook a piece of work for ABMU entitled “Whole system demand and capacity modelling - 5 Year planning 2016-21”. In this work we identified opportunities in acute services, which would require integrated change across primary, community and social care. Part of this opportunity relates to the current high length of stay across ABMU sites, some of which relates to whole system working to allow earlier discharge. Part of the opportunity also relates to admissions into hospital which are potentially avoidable with more proactive and preventative management in the community. We have modelled reductions in both of these areas in order to estimate impacts in the community setting and potential requirements to support service changes.

Observation 2 Out of hospital scenarios / Modelled changes and impacts

Our previous modelling has focussed on reductions in acute bed days based on length of stay comparisons and benchmarking, informed by analysis of delayed transfers of care information and medically fit for discharge days.

In order to understand the impact of earlier supported discharge, we have modelled the impact of community services supporting 25% of the reduction in length of stay to the 50th percentile.

In order to understand the impact of further admission avoidance, we have modelled the impact of reducing variation across ABMU in emergency admissions for specific ACS conditions. We have based assumptions of the streaming of care from acute to community services on both quantitative and qualitative information, based first on point prevalence studies undertaken in a number of different areas, then informed by baseline activity levels seen across the Western Bay, and also through stakeholder feedback on expected service impact.

We also based specific scenarios on feedback and evidence of unmet demand or current capacity issues in the system, including expansion of ACT teams across all areas, and backlogs seen in reablement and domiciliary care services.

Projected population change over the next 5 years will add pressure across all community services, with projected increases in demand of between 9% and 12%. The predicted impact of a shift in the balance of care is indicative as in reality this would depend on a number of factors including the level of ambition, specific cohorts of patients, and the desired model of care – though projections suggest increased pressures particularly in district nursing (4%), community reablement services (6%) and intermediate care beds (5-6%).

Analysis does indicate opportunities to mitigate additional pressures through new ways of working. For example based on comparisons of activity levels in the district nursing services, and based on extended length of stay in the reablement service. Intermediate and integrated care teams may help in mitigating additional pressure on core services and facilitating appropriate patient flow.

Conclusions and recommendations

Observation 3 Future model of care for out of hospital services

As is often the case, community services across Western Bay have to some degree been developed reactively rather than in line with a well defined overarching vision for the model of care. As people age they are more likely to have multiple conditions and become frail. Frailty is a decreased ability to withstand illness or stress without loss of function. For frail people, a minor injury or illness can result in a significant loss of function. Common conditions, such as dementia, also contribute to frailty. Not all older people need support from health and care services, but for those that do, it is important that these services are well coordinated. They should focus on preventing ill health and where possible reduce the need for hospital based care.

Older people make more use of hospital services than the rest of the population, particularly unplanned care such as A&E services and emergency admission to hospital. Older patients are more likely to remain in hospital for longer. The majority of people who are nursed at home, and get help with daily living activities such as washing, dressing and eating, are aged 75 or older.

There is currently a variety of care models being developed across Western Bay, including community preventative approaches, better access to primary care and routine hospital treatments, enhanced community care models, developing intermediate care models and other initiatives designed to reduce delayed discharges.

Recommendation R1

Although not recommending that a universal approach is appropriate, a more strategic approach to development of future care models is recommended We recommend that work is undertaken to define the desired future model of care for out of hospital services. We suggest that a standard set of core services is agreed for each area and then agree what is required/appropriate for each area beyond that based on population need. A set of core principles should be developed and any future developments must be aligned to these. These measures will help develop a coherent model of care.

It may also be worthwhile to consider learning from NHS England's Evaluation of New Vanguard Models. Capita have been involved in the Evaluation of New Models and so happy to share learning from these, as appropriate.

Recommendation R2

Changing models of care also have implications for the structure and skills of the health and care workforce across Western Bay and so a regionally coordinated approach is needed to help resolve current and future workforce issues. The approach should assess longer-term changes to skills, job roles and responsibilities within the sector as well as aligning predictions of demand and supply with recruitment and training plans. This is necessary to help ensure the integrated health and care workforce adapts to changes in the population's needs and how services are delivered in the future.

Conclusions and recommendations

Service delivery variance

Observation 4 Service delivery variance : summary observations

During the course of this work we have found that, although there is some commonality, there is also considerable variance in services offered in Bridgend, NPT and Swansea. For example, Intake versus Selective models of reablement. We used available data to estimate the percentage of older people using a range of care services in each area across Western Bay.

It is not possible to tell if a person is using more than one kind of service as NHS and social care data is not linked in most areas. This makes it difficult to conclude much about whether resource is being spent on the right services from this information due to the way it is recorded. Variance in the way in which activity and performance data is recorded and collated makes meaningful comparison between services very difficult. It is recognised however that there may be very good reason for this variation. For example, differences in people's health needs might lead different areas across Western Bay to provide a different mix of services. For example, more hospital care may be needed for older people in areas with higher levels of ill health.

Recommendation R3

Before any future service developments are approved, they should be evaluated in terms of whether or not they will improve consistency of service across Western Bay. We also recommend that where there are similar services across the three areas e.g. Acute Clinical Teams, that the service specifications are reviewed with the aim of agreeing a standard service model across the three. Also, where there are similar services, the names of those services should be standardised to make the system easier to navigate for professionals and patients and carers.

Recommendation R4

We recommend that a minimum data set is agreed and implemented for all services and where there is currently manual recoding of activity e.g. District Nursing, that this is moved to an electronic system as a matter of urgency.

Recommendation R5

We recommend that measures of avoided admission and expedited discharge (saved bed days) are developed and implemented across Western Bay, with regular peer review to ensure consistency. This approach is vital to providing evidence as to where and which services are having most impact and thus informing future planning.

Recommendation R6

We also recommend a standardised approach (with agreed dashboard of measures) to the provision of management information across Bridgend, NPT and Swansea. As part of this, there should be a review of the factors that may contribute to local differences when planning and managing services. The development of more consistent information on how much Western Bay partners spend on different types of care for older people and the impact that services are having on older people will help indicate how services are shifting from institutional to community care.

Conclusions and recommendations

Observation 5 **Service delivery variance : Common Access Points (CAP)**

There are inconsistencies in the way in which these services record activity, e.g. NPT and Bridgend don't record abandoned calls. This is an important measure of efficiency and unmet demand and should be captured consistently. There are also differences in the make up of the MDT within the CAPs.

Recommendation R7

We recommend an objective review of outcomes/efficacy with a view to standardising Common Access Points to align with the optimal staffing profile. Anecdotally we understand that there is scope to increase referrals to the third sector and as current data capture is acknowledged to be inaccurate we recommend that this is investigated.

We also recommend a standardisation of the naming of theses services across Western Bay.

Observation 6 **Service delivery variance : Acute Clinical Teams (ACT)**

There is variance in the way these teams operate and particularly in their hours of operations. We understand the ABMU has plans in place to expand the hours of service in Bridgend.

Recommendation R8

We recommend that hours of operation are standardised with a move to full 7 day services for Bridgend and NPT. This will enable a more consistent service to be offered and going forward we recommend that a common approach to recording activity and quantifying impact is adopted.

Observation 7 **Service delivery variance: Residential Reablement**

From the information made available to us, the current access criteria for residential reablement is very broad. This may mean that this resource is not being provided to those patients most likely to benefit. It also makes any comparison difficult, in relation to the understanding the impact that this model is having on shifting the balance of care away from the acute service.

Recommendation R9

We recommend that the access criteria for residential reablement services is reviewed. In practice there may well be more specific criteria applied but as this is not evidenced in the information provided it would be worth checking and this would also an opportunity to check there is consistency of approach and equity of service across Western Bay.

Recommendation R10

All of the above service delivery variations recommendations would be aided by shared or at least more joined up IT systems. We echo the recommendation, made by Cordis Bright in their "Evaluation of the intermediate care service transformation programme: summative report 2017", for a move towards a shared performance management system across Western Bay to enable consistent, reliable, accurate and timely reporting.

Conclusions and recommendations

Observation 8 District Nursing

The District Nursing (DN) services have a pivotal role in supporting patients in their home environment and were repeatedly highlighted by stakeholders as an area under pressure. The DN services contribute to admission avoidance and also support earlier discharge.

The general perception is that there has been a significant increase in demand for DN services since the intermediate tier services have been established. We accept the logic of this but have not been able to quantify the increase in activity volume as data provided did not cover the timeframe that would be required in order to demonstrate this. We were also unable to confirm an increase in patient acuity as the DN services do not currently use/record any acuity measure.

The availability of comparable data across the three areas (albeit there are some inconsistencies due to manual data collection and collation) alongside UK and Wales benchmarks has allowed us to make an assessment of current productivity. We have also been able to gain an understanding of how the services operate through interviews and workshop sessions. We have found considerable variance in the way the services operate:

- **Integration**: Swansea and Bridgend are part of integrated hubs but NPT are not integrated
- **Referrals**: all have an element of collecting referrals from GP surgeries, none yet receive referrals via Common Access Point. Bridgend use paper referrals, Swansea via hubs and NPT electronic.
- **Not at Home**: inconsistent policy for managing not at home calls

We do understand that the three DN Lead Nurses are working to develop a common annual plan.

Recommendation R11

We recommend that the DN Annual Plan includes:

- *Review of required skill mix; currently at 80:20 which is much higher than we would expect. There is a need to consider the needs of the population and the skill set of the available workforce.*
- *DN activity recording and data collection is moved to an electronic system as a matter of urgency.*
- *Expedited roll out of iPads to DNs*
- *Move to electronic systems to include allocation of patients and scheduling – is there an opportunity to look at the system being rolled out in Domiciliary Care?*
- *Implement a simple measure of complexity/acuity (no need to wait for the all Wales work to conclude, a number of measures are used elsewhere and could be adopted)*
- *Robust implementation of Expected discharge date (EDD) which is not currently in place*

Conclusions and recommendations

Observation 9 District Nursing (continued)

We compared the ABMU services against available benchmarks.

- **Staffing**: DN staff per 100,000 population varies from 46.8 (Bridgend) to 56.7 (NPT). All are higher than the Wales average of 38
- **Contacts**: 2016 UK average contacts per 100,000 population is 4,750. All three ABMU services are considerably higher (5,376 Swansea, 6,103 Bridgend and 7,242 NPT).
- **Caseload**: All three ABMU services have average caseloads that are considerably lower than the UK benchmark

The staffing, contacts and caseload comparisons with benchmarks suggest that ABMU DNs have smaller caseloads than their peers but they have more contacts per patient. ABMU do not currently measure the length of time patients stay in the service but it would be informative to be able to compare this with the benchmark average of 4.5 months. We acknowledge that there may be variance in the way DN services run and that this may mean benchmarks are not comparing like with like, although the All Wales comparators are likely to be similar. That said, the variance between the three ABMU services warrants further investigation in the first instance.

We know that, typically, when services come under pressure staff become more task oriented. Anecdotally we hear that this is indeed the case in ABMU. This probably means that staff are not taking time to assess and review patient progress and this may well lead to unnecessary visits. This is an unnecessary drain on resources and unsatisfactory for staff who are not using their skills and knowledge to fully benefit their patients.

Acknowledging the potential inaccuracies in data we hesitate to make a hard and fast recommendation on resourcing; rather we believe a full review of the DN services is required, with a view to bringing the services in line with best practice. We note that the Wales Audit Office: Review of District Nursing Services 2015 report makes a number of recommendations and many of these have yet to be fully implemented. This suggests that further support is required to enable the DN services to make the necessary changes.

Recommendation R12

We recommend that support is provided to the DN services to enable:

- *a review of their current service model and practices*
- *development and implementation of a common annual plan*
- *Implementation of Wales Audit Office: Review of District Nursing Services 2015 recommendations*

Conclusions and recommendations

Observation 10 **Impact of new intermediate care services on existing services**

During interviews and workshops we repeatedly heard that the introduction of the intermediate tier services has had the knock on effect of increasing activity (volume and acuity) for the core services such as District Nursing. Although this would be an expected consequence of the new service (with changes in care pathways inevitably leading to more patients with higher acuity needs being managed in these core services), we have been unable to quantify the impact from the data made available to us. It appears that new services have been introduced without the required review – or reconfiguration - of existing core services.

In addition, there is also inconsistency in the way the impact of Intermediate Tier services on the wider health and social care economy is measured and interpreted e.g. does every referral taken by ACT equate to an avoided admission? Although this is unlikely to be the case, this is often how it is interpreted and reported in some areas.

Recommendation R13

We recommend that for any proposed future service changes or developments an assessment is made of the impact across the whole pathway, with any required reconfiguration of existing services identified. The assessment should include a review of the future integrated workforce planning across the health and social care pathway to support intermediate care services.

Observation 11 **Care Homes : Residential and Nursing Care**

Whether or not the current provision of residential and nursing care home beds is sufficient now and into the future is dependent on the desired overall model of care. Discussions with stakeholders suggest that there is a desire to move from a position of defaulting to residential care to considering alternatives.

Currently Bridgend looks to have under provision, with availability of care home places cited as a major contributor to delayed transfers of care. However, Bridgend also has a larger proportion of domiciliary care hours per head of population, so it may be the case that the lack of care home places is driving a change to the care model and more people are being supported in their homes as an alternative. One area that may represent true under provision is EMI nursing home beds and the need for these facilities will likely increase in coming years.

Recommendation R14

We recommend that the planned trajectory for numbers of residential and nursing care home beds and the impact of any reductions on other services is modelled as part of the planning process.

Conclusions and recommendations

Observation 12 **Domiciliary / Home Care**

In order to enable a shift to more community-based services and care in homely settings, the availability and development of community-based staff (including home care staff) with the right skills is crucial. We are aware that there are significant difficulties in recruiting and retaining care home and homecare staff and from our understanding, the balance of community-based staff has not increased significantly in recent years.

The external market capacity (which accounts for approximately 70% of home care hours) is extremely fragile alongside the challenging nature of the Western Bay geography with some rural areas being particularly difficult to service. In addition to the increase in demand for domiciliary care from demographic changes, it would be expected that the strategic intention to move to look after people in their local care setting, there would be a related increase in demand for home care services. In parallel, there would be an associated reduction in length of stay in acute care settings.

Regular reviews on long term care packages alongside closer working with acute hospitals may help to ensure a more effective use of home care. Individuals and their carers are in an equal relationship with staff and have choices and expectations of the care and support they require. Staff need to be equipped to support people within this dynamic.

Recommendation R15

As highlighted in an earlier recommendation and, recognising the specific challenges of the home care market and geography we recommend that Western Bay explore alternative models to support and develop community and personal resilience. In parallel, staff (acute and community) should be supported and trained to have different discussions with people to enable them to move from a culture of dependency to empowerment.

Recommendation R16

Our work also highlighted that, as with most of the health and care system across Wales, there is a lack of information on the need and demand for care at home. As well as the need to consider a more integrated future model of care (see Recommendation A), we would also recommend that the Western Bay partnership reviews all available data to consider out of hospital (and in particular, home care) services are effectively focusing on the people who need them most, or if these suggest some people are not getting access to shorter, less intensive support to help support them at home. From experience, the current data on homecare also excludes people who use direct payments to buy homecare.

Conclusions and recommendations

Observation 13 **Community Occupational Therapy (OT)**

We were unable to draw meaningful conclusions from the data for OT due to the configuration of services i.e. OT activity being included within the integrated hubs. Stakeholder feedback highlighted that OTs are typically supporting people with more complex needs with many requiring double handling and equipment. A pilot (Enabling Ethos) in NPT has shown that extra OT, Physio and HCSW input on the ward has reduced length of stay.

Recommendation R17

The evaluation of the pilot scheme should be reviewed to understand the potential opportunity in reshaping the OT, Physio and HCSW roles would result in reduced length of stay within the acute facilities.

Observation 14 **Social Work**

The differences in the way the Social Work services across Western Bay operate and record information makes it impossible to identify variance or draw any specific conclusions around efficiency and productivity.

Recommendation R18

We recommend that a common activity data set is agreed and implemented across the SW teams, in particular a common approach to how assessments are recorded will aid any future analysis.

Observation 15 **Integrating Older People's Mental Health (MH) Services**

Due to existing initiatives to reduce bed based mental health services and reconfigure MH community teams our work excluded further review of this area. During our interviews, however, stakeholder did highlight the discrete way in which Older Peoples Mental Health Service and Older People's Community Services operated. With the projected growth in people living with dementia, integrating services would provide an overall, coordinated service more able to support people with dementia in their own homes.

Recommendation R19

If work is not already underway in this area, we recommend that consideration is given to integrating Older Peoples Mental Health Services within the integrated community services, with a view to providing more flexibility and resilience.

Conclusions and recommendations

Observation 16 Integration

Although our remit was not to evaluate the levels of integration across health and social care services, as we have engaged with stakeholder, we have made some hopefully help observations.

The Social Services and Wellbeing (Wales) Act provides the legislative framework for a new, integrated model of social care based on core principles of wellbeing and prevention and, further, looks to the regional partnership boards (in this case, Western Bay) to (i) undertake Population Assessments; (ii) promote the creation of pooled funds and (iii) prioritise the integration of services in key areas.

Firstly, there is still variance in the degree to which services are integrated across Western Bay. Stakeholders universally agreed that co-location of services was positive and facilitated closer working and mutual trust and understanding. There was less agreement as to the potential added benefits of full integration, with some feeling that the effort of achieving this was not worth the reward. We saw little evidence of cross-skilling of the workforce to create greater flexibility and reduce duplication. This may be because the integration journey is still in progress.

We understand that there are currently a number of mechanisms in place to integrate resources but these are not widely used and tend to focus on specific services or initiatives. There are tools that can facilitate the transfer of resources across a local system and Western Bay could apply learning from other countries. For example, Canterbury, New Zealand, shifted the balance of care through strong leadership, a clear vision, and a collaborative and whole-system approach. An important factor was its focus on 'one system, one budget'. It prioritised spending on those in greater need to reduce relying on residential care and to keep people in their own homes for longer. This had the effect of reducing demand and costs for hospital and other institutional care, and allowed for more investment in the community

Recommendation R20

The Western Bay Partnership has the opportunity to facilitate the acceleration of a more integrated approach to health and care. This could include focusing funding on community-based models and workforce planning to support new models. This review, supplemented by other similar reports, will aid Western Bay in gaining a better understanding of the needs of their local populations. This should be supplemented by a more comprehensive evaluation of new models of care.

We also recommend that cross-skilling of the integrated workforce is looked at in the near future to really drive further benefits from integration. For example developing "trusted assessor" role across disciplines will reduce duplication of effort and improve services to patients.

Conclusions and recommendations

Observation 17 Data Quality

As part of this process we have collated available data and information on the activity, resources and performance of a range of community services across Bridgend, Neath Port Talbot, and Swansea. We have analysed data for each of the services to give a picture of current activity and a comparison across the three areas, where possible.

Acquisition of this data has been particularly challenging due to a number of factors:

- The range of systems used – difficulties are created due to different services operating different IT systems
- Manual processes for data collation - including manual recording of service user data in Excel
- Lack of standardisation in both collection and recording across the three areas.
- Lack of standard processes for sharing management information outside of individual services.

Manual data collection in some services, in particular, leads to queries over accuracy and makes evidence-led modelling and decision making more difficult, and we would recommend improvements are made in the standard reporting of information in order to support complete and timely data that can be used to monitor and manage services. This includes routine reporting of data for all services and areas, and also more effective and consistent the recording of measures such as referrals, caseload and contacts.

This is has been recognised as an issue and there have been developments to improve community information flows across Western Bay, including:

- Improvements in intermediate care services to demonstrate effectiveness and help to develop the programme, but this is still not consistent and is incomplete in a number of areas.
- Information dashboards are being developed, which bring together and use available data from a number of sources, as these are extended and evolve they should drive better data quality and help feed back to focus areas of inconsistency for improvement in collection of management information in a clear and consistent way.
- Introduction of the Welsh Community Care Information System (WCCIS) across the whole area should help health and social care professionals work together, and should help to overcome some of the obstacles of using different IT systems by storing information on a range of activities. Further advances in technology such as electronic call monitoring will improve information both operationally and strategically.

Recommendation R21

An interim solution is required ahead of the implementation of CCIS to enable services to gather meaningful, consistent data underpinned by a common language and interpretation e.g. what is a referral ?, what is a contact? This is vital to enable services to evidence the good work they are doing and provide a robust platform from which to plan for the future.

Appendices

Appendix A

Stakeholder engagement

Individual interviews were held with the following.

Adrian Bradshaw Community Services Manager NPT
Alex Williams Head of Adult Services Swansea
Alison Ransome District Nursing Swansea
Amanda Aldridge Community Resource Manager Swansea
Andrew Jarret Head of Adult Services NPT
Andy Griffiths CRT manager NPT
Carmel Donovan Community Services Manager Bridgend
Dermat Nolan, Mental Health Services, Bridgend
Helen St John Community Services Manager Swansea
Jackie Davies Head of Adult Services Bridgend
Karen Gronert Head of Nursing and Community Services
Liz Collier District Nursing Bridgend
Malcolm Jones, Mental Health Services, Swansea
Michelle King CRT manager Bridgend
Paula Heycock District Nursing NPT
Robert Goodwin, Mental Health Services, NPT
Sara Forster Head of Occupational Therapy
Sharon Miller Head of Primary Care
Tanya Spriggs Head of Nursing and Community Services
Zoe Wallace Head of Primary Care

Workshops attendance

Name	Designation	Organisation
Adrian Bradshaw	Principal Officer – Community Networks	NPT CBC
Amanda Aldridge	Community Resources Manager	City & County of Swansea
Amanda George	Social Worker	City & County of Swansea
Amanda Thomas	CRT Development Manager	Bridgend CBC
Andy Griffiths	Integrated Community Services Manager	NPT CBC
Carmel Donovan	Integrated Community Services Manager	Bridgend CBC
Caroline Roberts	STAR Team Leader	Bridgend CBC/ABMU HB
Celia Ware	Integrated Network Manager, North	Bridgend CBC
Craig Barker	Performance Manager	ABMU HB
Elizabeth Collier	Integrated Community Network Manager	ABMU HB
Fay Bowen	Team manager for Older People Mental Health	Bridgend CBC
Francesca Grice	Intermediate Care Services Officer	City & County of Swansea
Hazel Dance	Community Services Gateway Manager	NPT CBC
Helen StJohn	Integrated Community Services Manager	City & County of Swansea/ABMU HB
Hilary Dover	Service Director, Primary and Community Delivery Unit	ABMU HB
Janet Morgan	Support at Home Organiser	Bridgend CBC/ABMU HB
Jeanette Oakley	Clinical Lead Nurse for District Nursing in the West Network, Bridgend	ABMU HB
Jess Fitzpatrick	Project Coordinator, Community Services	Western Bay
Karen Gronert	Head of Nursing	ABMU HB

continued over

Workshops attendance (cont).

Name	Designation	Organisation
Lucy Friday	Transformation Manager	City & County of Swansea
Mandy Archibald	Occupational Therapist Team Leader	City & County of Swansea
Melanie Collins		ABMU HB
Michelle King	Integrated Community Services Manager	Bridgend CBC
Paul Newman	Team Leader	City & County of Swansea
Patricia Hughes		ABMU HB/Swansea
Pete Hopgood	Finance	ABMU HB
Sarah Waite	CRT Support Manager	ABMU HB
Sian Walker	Community Network Manager	NPT CBC
Siobhan Mathias	Community Network Manager	NPT CBC
Susan Wilson		ABMU HB
Tanya Spriggs	Head of Nursing, Bridgend and NPT	ABMU HB
Tania Turner	Senior Practitioner	Bridgend CBC
Teresa Barker	Senior Practitioner	City & County of Swansea
Thomas Barton	Lead Advanced Nurse Practitioner	ABMU HB
Vicky Warner	Unit Nurse Director, Primary and Community	ABMU HB
Zoe Wallace	Head of Primary Care and Planning, Bridgend and NPT	ABMU HB

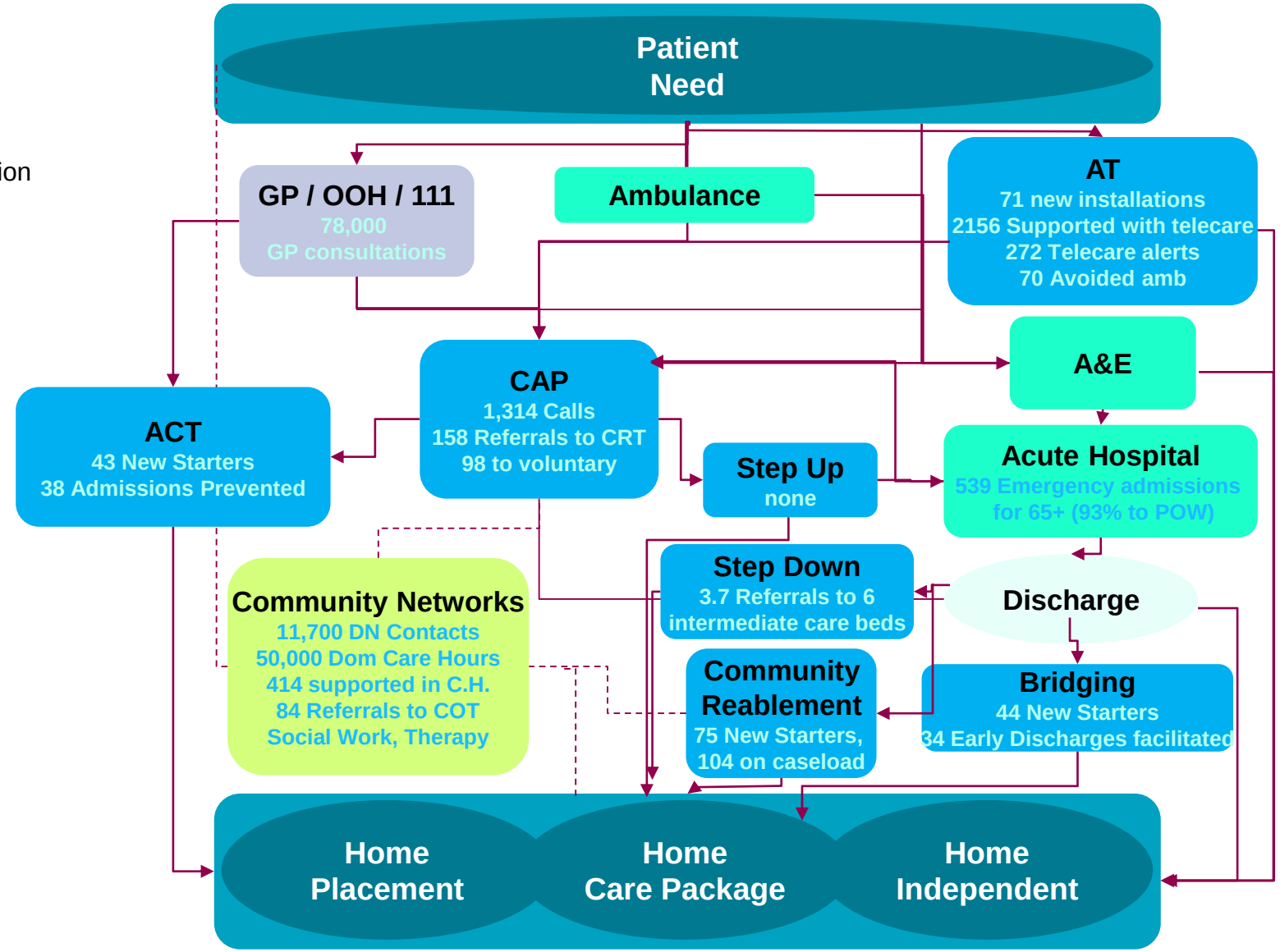
A number of additional staff attended the three validation sessions

Appendix B

Service configuration schematics

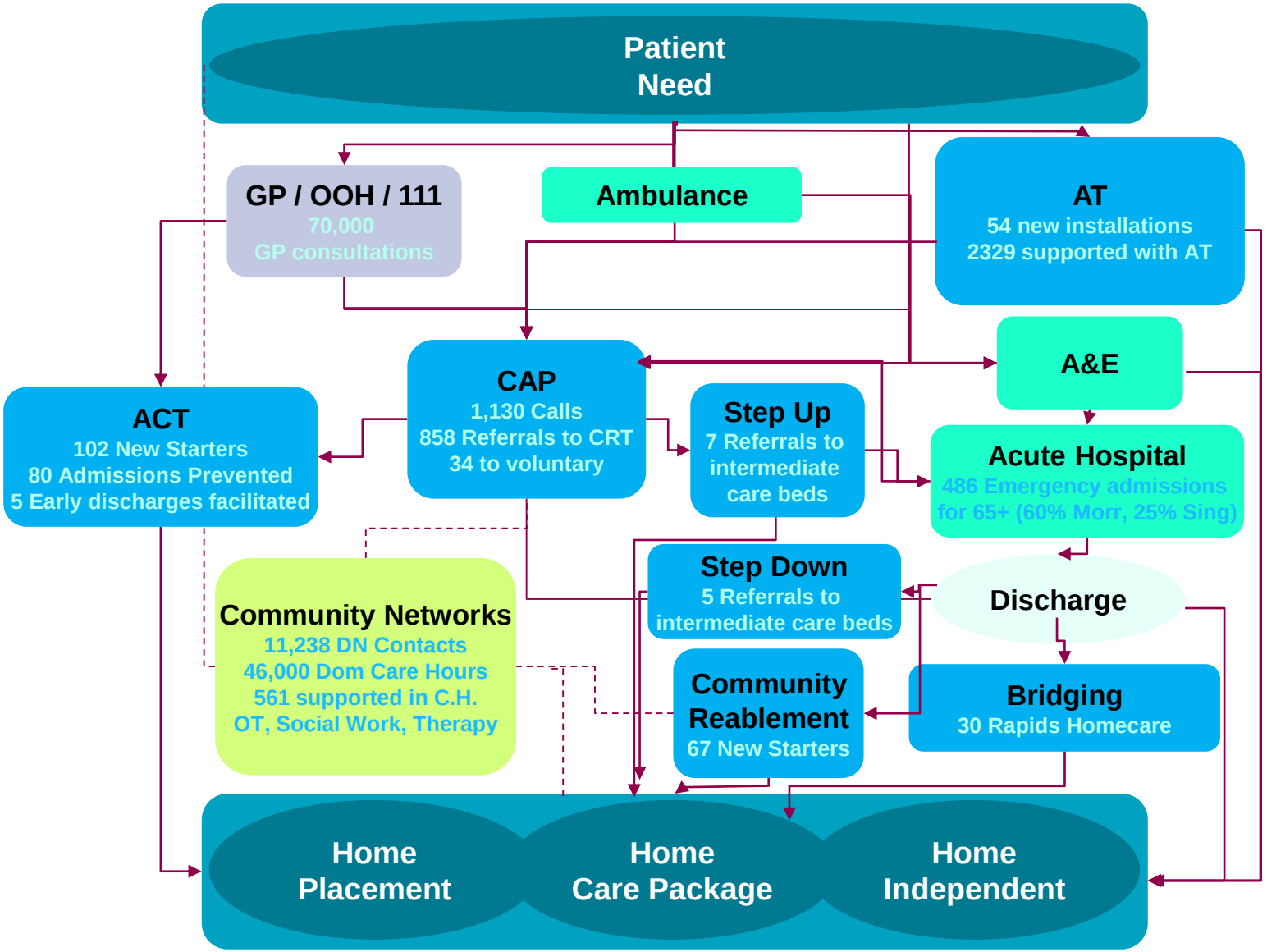
Summary of services – Bridgend

Average **monthly** activity figures are shown on the schematic for the **Bridgend** population and services.



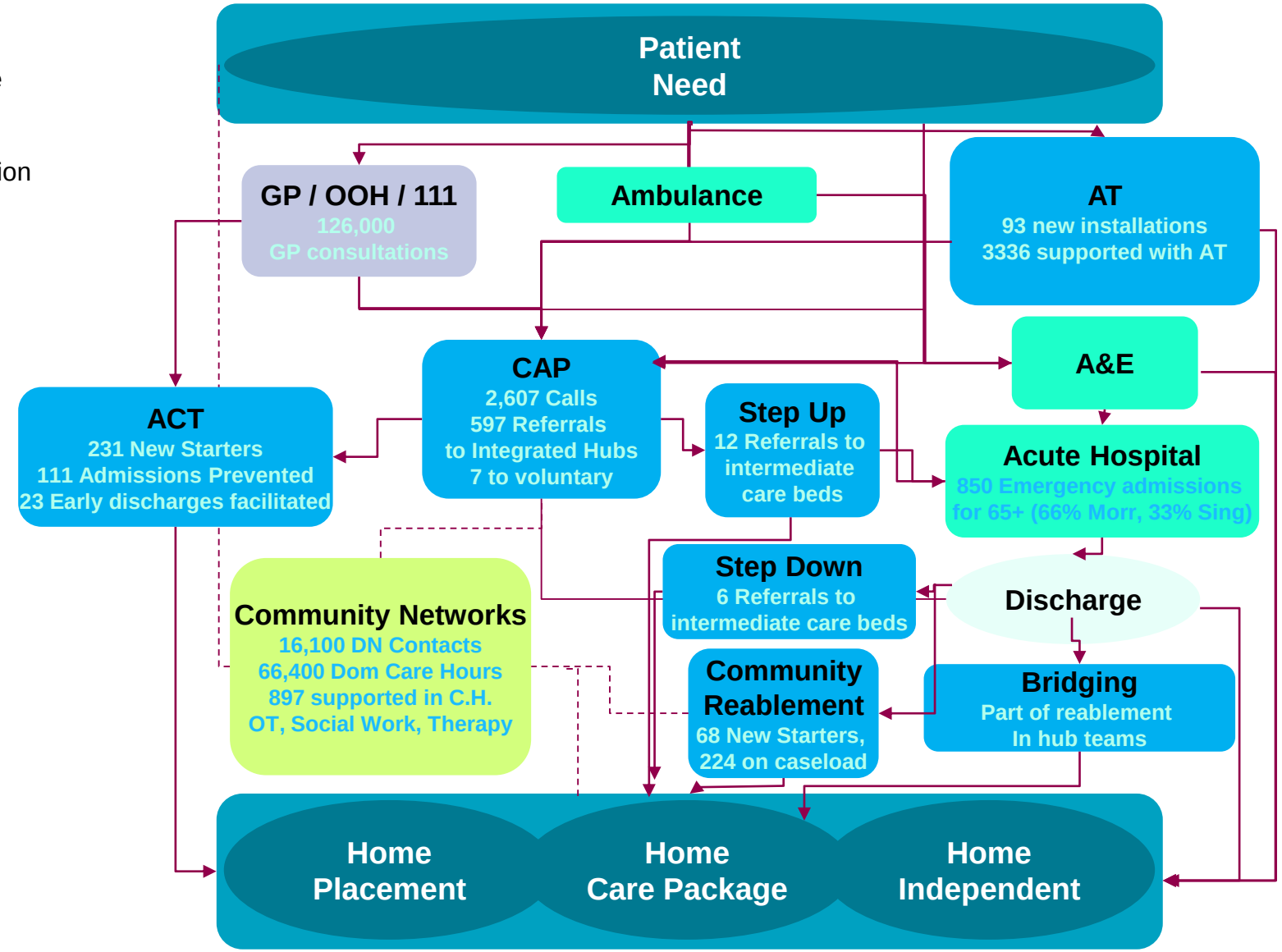
Summary of services – Neath Port Talbot

Average **monthly** activity figures are shown on the schematic for the **Neath Port Talbot** population and services.



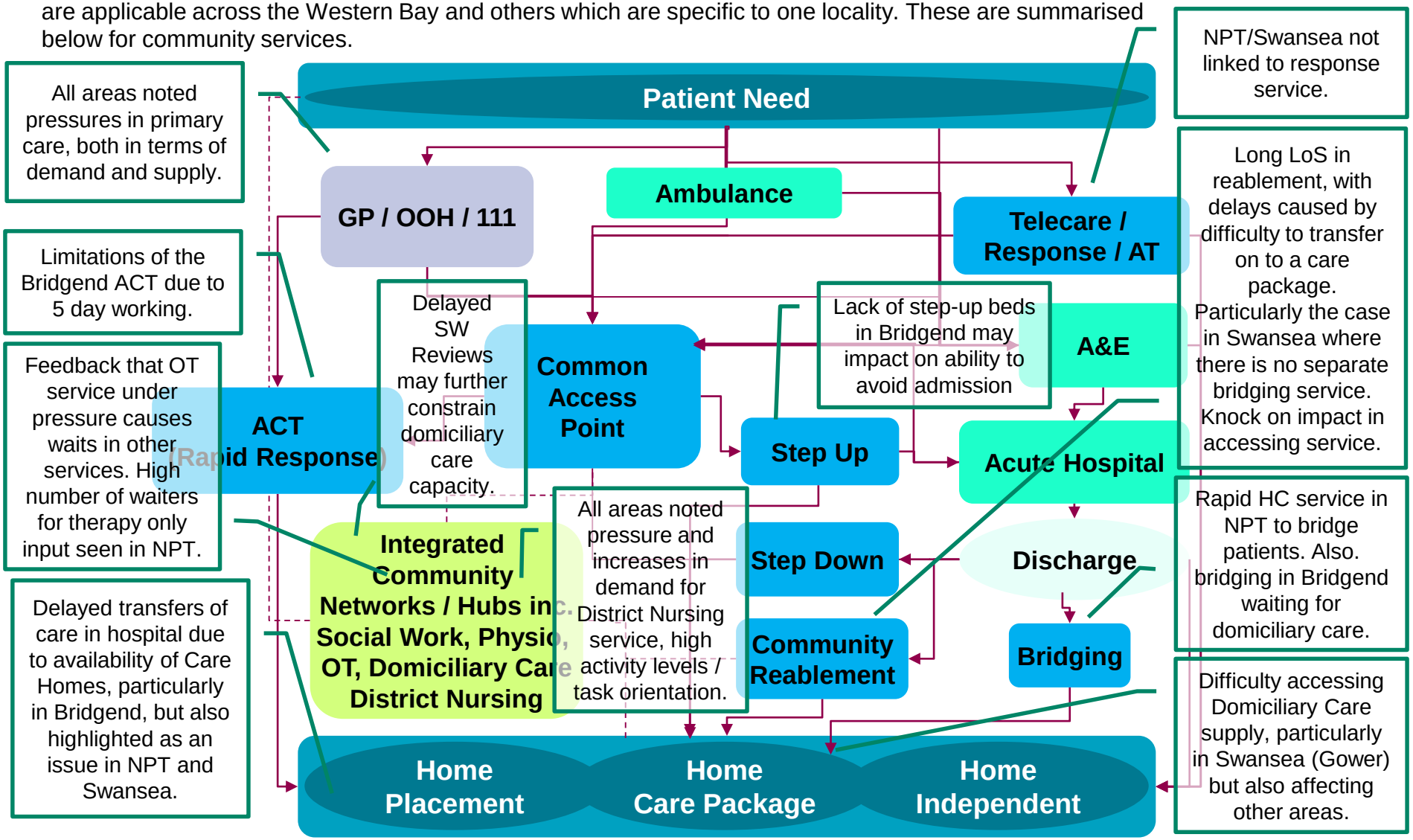
Summary of services – Swansea

Average **monthly** activity figures are shown on the schematic for the **Swansea** population and services.



Scenario Modelling – Accounting for unmet demand and current capacity issues

We have heard different issues raised in relation to community service capacity in each area, some of which are applicable across the Western Bay and others which are specific to one locality. These are summarised below for community services.



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