NEATH PORT TALBOT COUNTY BOROUGH COUNCIL

SOCIAL CARE, HEALTH & HOUSING CABINET BOARD

18 FEBRUARY 2016

REPORT OF DIRECTOR OF SOCIAL SERVICES, HEALTH & HOUSING – N. JARMAN

Matter for Information

Wards Affected: ALL

UPDATE ON THE DEVLIVERY OF THE INTEGRATED COMMUNITY RESOURCE TEAM IN NEATH PORT TALBOT TO ME' SERVICE MODEL AND AGREEMENT BETWEEN NEATH PORT TALBOT COUNTY BOROUGH COUNCIL AND ABERTAWE BRO MORGANNWG HEALTH BOARD IN ACCORDANCE WITH SECTION 33 NATIONAL HEALTH SERVICE (WALES) ACT 2006

PURPOSE

1.1. The purpose of this report is to update Members on the progress in delivering the Integrated Community Resource Team (CRT) model following approval of the formal Section 33 (National Health Service (Wales) Act 2006) agreement between Neath Port Talbot County Borough Council (NPTCBC) and Abertawe Bro Morgannwg University Health Board (ABMU) in October 2015.

BACKGROUND

2.1. In September 2013 the Western Bay Health and Social Care Programme set out a joint commitment to work together to integrate and improve the planning and delivery of community services for older people, *Delivering Improved Community Services.* The commitment was a whole systems approach to addressing the challenges of the issues presented by an ageing population. It stated clearly the first phase of integration would focus on intermediate care services which in turn would act as a catalyst for change across the rest of the system. A detailed business case, *'Delivering Improved Community Services* –

Business Case for Intermediate Tier Services' was developed. This was approved by the Social Services Health and Housing Cabinet Board in May 2014.

2.2. The crux of the *Delivering Improved Community Services* and the subsequent business case was; to achieve sustainable health and social services for frail or older people, we need to provide better assessment, care and support at lower cost; something that is impossible were we to be tied to traditional, silo-type forms of both health and social care delivery.

2.3. As a consequence of the business case, investment was made in an optimal intermediate care service model. The optimal model comprised 3 elements:

- Common Access Point - an integrated common access point that consists of a multi-disciplinary team who are able to effectively triage callers and direct them to the most appropriate outcome: urgent clinical response, reablement, long term community network service, specialist mental health service or a third sector or community solution (e.g. housing)
- Rapid Response - The rapid response service provide a rapid clinical response (doctor, nurse and/or therapist) for people who require immediate assessment, diagnosis and sometimes treatment who would otherwise be admitted to hospital. Clinical response is within 4 hours of referral.
- Reablement – therapy led reablement helps people to retain or regain skills that they may have lost, due to hospital admission or illness, with the objective of minimising the need for ongoing domiciliary care and support.

2.4. In October 2015, Council approved a formal pooled fund arrangement for the delivery of the Intermediate Care Services between NPT CBC and ABMU HB in accordance with Section 33 of the National Health Service (Wales) Act 2006. In doing so Council required regular updates on the financial position and performance of the service.

2.5. This paper presents the most recent jointly approved financial report (Appendix 1) and the most recent performance management report (Appendix 2).

2.6. In summary – the financial forecast is that the service will complete the financial year in a balanced position. In terms of performance management and outcomes for citizens of NPT CBC, we have seen improvements in all key areas that the Intermediate Care Business case sought to deliver, specifically we have seen a reduction in the number of people entering residential care homes, a reduction in the number of new people requiring domiciliary packages of care and the Unscheduled Care admission rates to hospital for people aged over 65 and over 75 have reduced as has the unplanned readmission rate at 28 days. These represent a positive picture for the population of NPT.

APPENDICES

3.1. Appendix One – Finance Report
Appendix Two – Performance Report

LIST OF BACKGROUND PAPERS

4.1. None

OFFICER CONTACT

5.1. Andrew Griffiths, Integrated Community Services Manager – Community Resource Team
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Appendix 1

POOLED FUND MANAGER

FINANCE REPORT

January 2016

Introduction

The Intermediate care Section 33 has a budget of £4.9m, of which AMBU contribute £2.3m and NPT CBC £2.6m

S33 Budget Monitoring to January 2016

Combined Performance

	Budget to date £'000	Actual to date £'000	Variance to Date £'000	Variance at Year End £'000
NPT CBC	2,194	2,097	-97	-137
ABMU	1,934	1,929	-5	131
Total	4,128	4,026	-102	-6

As at the end of month 10 the s33 budget is showing a combined underspend of £92k. The main reason is an underspend on the aids and equipment budget, it is expected that the budget will be spent by the end of the financial year.

Based on current information the combined service is projected to underspend by £6k.

Neath Port Talbot CBC

	Budget to date £'000	Actual to date £'000	Variance to Date £'000	Variance at Year End £'000
Employees	1,904	1,765	-139	-151
Premises	42	90	48	40
Transport	133	99	-34	-19
Supplies & Services	241	143	-98	-7

Income	-126	0	126	0
Total	**2,194**	**2,097**	**-97**	**-137**

Notes:

- Transport costs are a month in arrears
- Supplies & services – equipment expected to be on budget by the end of the year

ABMU

	Budget to date £'000	Actual to date £'000	Variance to Date £'000	Variance at Year End £'000
Pay	1,663	1,771	108	131
Non-pay	271	158	-113	0
Total	**1,934**	**1,929**	**-5**	**131**

The main pressure areas are expenditure on agency staff covering vacancies and increasing travel costs. The positions above include the relevant adjustment for any agreed cross charging between funding areas as part of the integrated management across Organisations.

Appendix Two

Performance Report – 26th January 2016

Community Resource Team– *Neath Port Talbot Local Authority and AMBU HB*

Intermediate Care Business Case:

The Intermediate Tier Business Case was developed in conjunction with Whole System Partnership (WSP), in order to achieve sustainable health and social care services for frail or older people. Following approval of the business case in April/ May 2014, considerable work has been undertaken to develop an effective intermediate tier of service, in order to provide a boundary between wellbeing and the need for managed care, with the potential to enable more people to maintain their independence. The following table outlines Neath Port Talbots progression towards the optimal model of intermediate services including the baseline status.

Key feature of optimal model	Baseline status 2013	Current status 2016
Multi-disciplinary triage in common access point	Y	Y
Mental Health provision within common access point	N	D
Third Sector Brokerage in common access point	N	Y
Therapy led reablement service	Y	Y
Intake & review reablement	N	Y
Therapy led residential reablement	N	Y
Support & stay for people with dementia	N	Y
Step up / down intermediate care (residential or community)	N	Y
Key: *Y(yes) N(no) D (in development)*		

Programme Outcomes:

- More frail and older people are supported to remain independent and keep well, as well as to have improved quality of life
- More frail and older people to become cared for at home rather than in institutional care, i.e. in hospitals / care homes.
- More older people are supported to live independently with the support of technology
- There is a financial saving to the health and social care system as a whole, through a reduction in expected usage of hospital and care home beds.

Performance Measure: Hospital Admissions

Total Number of Emergency Unscheduled Hospital Admissions (>65) within Neath Port Talbot for Quarters 1 to 3 between 2013 and 2015

Year	Quarter 1 (April—June)	Quarter 2 (July—Sept)	Quarter 3 (Oct—Dec)	Quarter 4 (Jan—Mar)	Total
2013	971	967	978	884	**3800**
2014	974	939	1,006	942	**3861**
2015	879	792	925	-	**2596**

Emergency Unscheduled Hospital Admissions (>65) made by NPT Resident Patients

Emergency Unscheduled Hospital Admissions (>75) made by NPT Resident Patients

Performance Measure: Hospital Admissions continued...

28 Day Unplanned Readmission Rates for (>65) for Quarters 1 to 3 Between 2013 and 2015

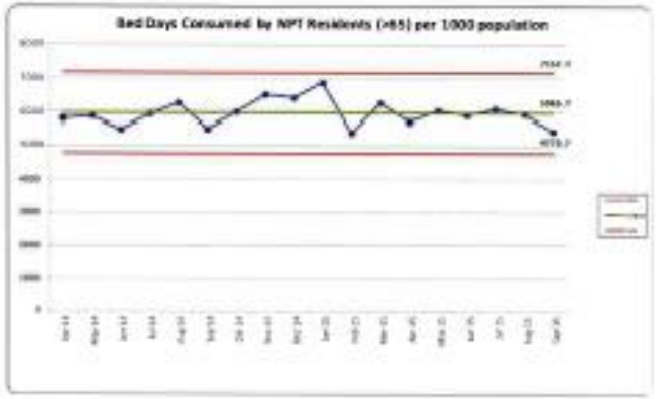
Year	Quarter 1 (Apr—Jun)	Quarter 2 (Jul—Sept)	Quarter 3 (Oct—Dec)	Quarter 4 (Jan—Mar)
2013	14.9%	14.7%	14.3%	14.2%
2014	14.1%	14.8%	13.6%	12.6%
2015	13.1%	13.3%	12.5%	-

Bed Days Consumed by NPT Residents (>65) for Quarters 1 to 3 Between 2013 and 2015

Year	Quarter 1 (Apr—Jun)	Quarter 2 (Jul—Sept)	Quarter 3 (Oct—Dec)	Quarter 4 (Jan—Mar)
2013	15,645	16,517	17,503	17,237
2014	17,047	17,442	18,696	18,403
2015	17,541	17,019	18,111	-

Hospital Admission Rates (>65) per 1000 population NPT Locality

Bed Days Consumed by NPT Residents (>65) between April 2014—December 2015



Performance Measure: Care Home Admissions

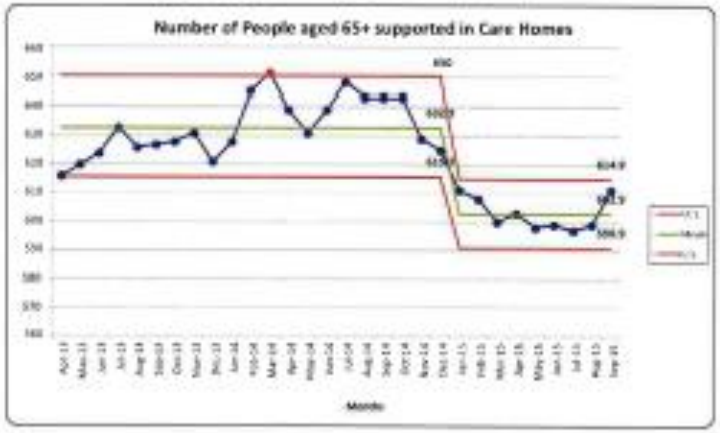
Number of People Supported in Care Homes aged 65>
For Quarters 1 to3 between 2013 and 2015

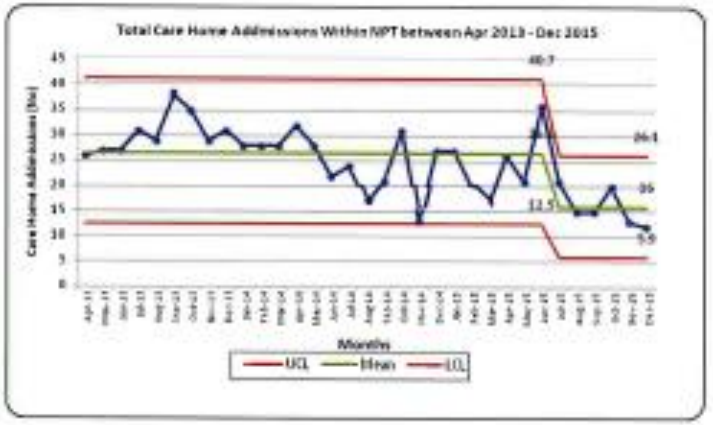
Year	Quarter 1 (Apr– Jun)	Quarter 2 (Jul—Sept)	Quarter 3 (Oct—Dec)	Quarter 4 (Jan—Mar)
2013	682	733	718	-
2014	740	747	711	-
2015	666	641	659	-

Total Number of Care Home Admissions within Neath Port Talbot
For Quarters 1 to3 between 2013 and 2015

Year	Quarter 1 (Apr– Jun)	Quarter 2 (Jul—Sept)	Quarter 3 (Oct—Dec)	Quarter 4 (Jan—Mar)	Total
2013	80	98	95	108	**381**
2014	82	62	71	125	**340**
2015	83	51	45 (51)*	-	**179**

* Nov 2015 saw the closure of 2 home; residents re-located to new homes were recorded as a new care home admission, skewing the data for quarter 3. The red figure takes into consideration this variance.

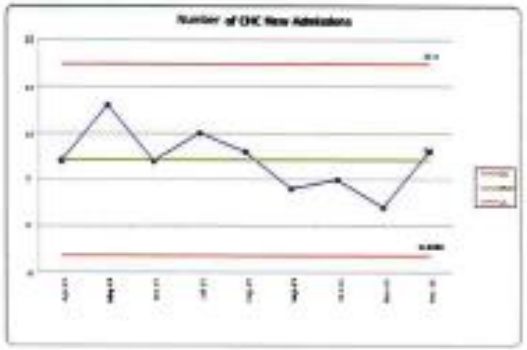




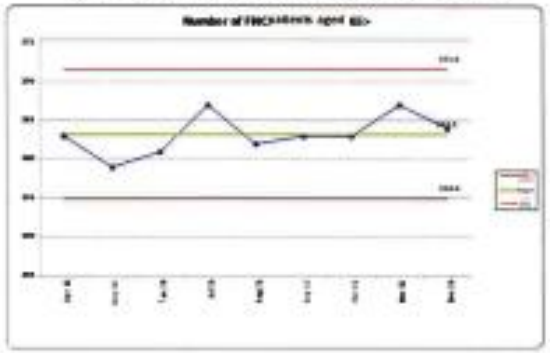
Performance Measure: Care Home Admissions continued...

Total Number of New FNC Admissions between April and December 2015

Total Number of New CHC Admissions between April and December 2015



Total Number of FNC Patients Aged 65 years + being supported within Neath Port Talbot between April and December 2015



Total Number of CHC Patients being supported in Nursing Homes within Neath Port Talbot between April and December 2015

Performance Measure: Domiciliary Care Starts

**Total Number of Domiciliary Care Starts within Neath Port Talbot ,
For Quarters 1 to3 between 2013 and 2015**

Year	Quarter 1 (Apr –Jun)	Quarter 2 (July—Sept)	Quarter 3 (Oct - Dec)	Quarter 4 (Jan — Mar)	Total
2013	103	103	122	108	**436**
2014	106	100	87	125	**418**
2015	84	100	69	-	**253**

**Average External Home Care Hours per Client
between April 2013—December 2015**

**Total External Home Care Hours per Client
between April 2013—December 2015**

Between October 2015 and December 2015 the Community Resource Team contributed to the to the Programme Outcomes in the following way:

Rapid response Acute Clinical Team:

- Worked with **316** individuals
- Facilitated **13** early discharges from hospital
- Avoided **219** admissions enabling individuals to remain in their own homes instead of being admitted to hospital
- Avoided approximately **2190** hospital bed days which would have cost in the region of **£240,900** (based on a daily bed rate of £110).

Intermediate Beds

- Worked with **24** new individuals
  - **15 – Reablement unit**
  - **9 – Step Up Step Down unit**
- **71%** (n-10) of people discharged from the intermediate beds (n=14) returned home therefore preventing a long term Care Home admission.
- Avoided an average cost of **£3460** per week (based on average weekly costs of £346)

Intake Reablement

- Worked with **104** new individuals
- Average length of time supported by reablement is **20 days**
- Facilitated **80** early discharges from hospital
- Avoided approximately **240** Hospital bed days.
- Avoided **822.9** Domiciliary Care Hours at a cost of **£11,405.39**

Gateway

- Received **2167** calls
- MDT Responded to and closed **515** calls
- **174** calls were referred directly to the third sector

Quarterly Breakdown of CRT Performance

CRT SERVICES	Quarter 1			Quarter 2			Quarter 3		
	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15
Gateway									
Total Number of referrals	1080	1171	1295	1149	885	774	850	736	623
Total Number of Referrals sent to the Gateway team	232	410	308	263	199	231	215	161	139
Total Number of Referrals to Voluntary Sector	41	34	58	73	56	69	77	60	37
Acute Clinical Team									
Average Monthly Caseload	35	25	35	25	23	24	31	26	26
Total No. New Starters	100	101	131	99	92	103	114	106	96
Total No. from Community (Prevent Admissions)	104	79	106	81	75	87	88	79	52
Reablement									
Average Monthly Caseload Reablement	98	105	111	122	112	101	75	83	102
Total No. New Starters	47	37	56	69	43	48	38	26	40
Total No. Discharges	58	43	48	57	69	53	55	56	53
Total No. Number from Hospital (Earlier Discharge)	18	11	19	32	22	11	19	30	31
Total. No Reduction in hours from admission to leaving service	178.3	250.05	263.3	211.45	201.45	307.15	438.4	138.5	246
Total Cost avoidance	£2,471.24	£3,465.69	£3,649.34	£2,930.47	£2,792.10	£4,257.10	£6,076.22	£1,919.61	£3,409.56
Residential reablement									
Average Monthly Bed Occupancy	7	7	8	7	7	8	7	8	8
Total No. New Admissions to RR	5	2	8	6	6	4	5	4	6
Total No. of Admissions to RR from Hospital (subset of total new admissions)	5	1	7	6	6	3	4	4	4
Total No. Discharges	2	7	0	7	3	3	5	4	4
Total No. Discharged to own home	2	5	0	6	1	3	3	4	2
Total No. Discharge to long term placement	0	1	0	0	2	0	0	0	0
Step Up Step Down (SUSD)									
Average Monthly Bed Occupancy									9
Total No. New Admissions to SUSD									9
Number of admission to SUSD from Hospital									
Number of admissions to SUSD from Community									
Total No. Discharges									
Total No. Discharged to own home									1
Total No. Discharged to long term placement									

Story Behind the Data:

- **Whilst there was an in quarter rise in the number of people being admitted to hospital in an emergency, our admission rates still remain within normal control limits.**
- **Readmission rates to unscheduled care remain low.**
- **New admissions to care homes has continued to decline**
- **The number of people being supported within a care home has reduced, along with the number of overall care home admissions, as more people are supported to live independently within their own homes for longer.**
- **The number of new domiciliary care starts is reducing year on year,**
- **As of Dec 2015, the total number of Home Care Hours and average hours per client now includes the provision of internal domiciliary care hours. This accounts for the sharp increase in the total number of home care hours being reported. However, despite this increase, the average number of hours per client has reduced.**
- **More older people being effectively discharged from hospital**
- **CHC and FNC rate remains within variance but is on a downward curve.**
- **Anticipatory Care Planning has been rolled out across 7 GP surgeries within the Afan Network.**
- **Developed joint recording system for patients in hospital awaiting CRT (creation of the single version of the truth)**

Proposed Actions to facilitate progress:

- Step up step down available from December 2015.
- Development of CRT Sitrep to be clear about capacity and demand within the community to allow for a whole system view.
- Further refinement of Hospital/CRT list of people waiting in hospital for CRT that are discharge fit.
- Increase and improve the number of individuals taking up Direct Payments, either as the sole providers of services or as part of a mixed package of care.
- Co-location of DN/SW and CPNs across the community networks
- Planned roll out of Anticipatory Care across the Neath and Upper Valleys Networks
- Review and right sizing of existing double handed cases
- Pilot CRT respite service, to support patients with more complex needs that cannot be met in a residential setting, by providing 24 hour nursing supervision, supported by professionals from CRT. It is anticipated that this provision will have a positive impact on the demand for hospital beds by preventing unnecessary hospital admissions.