Neath Port Talbot Social Care Health and Wellbeing Scrutiny Meeting with Swansea Bay University Health Board

10 June 2019

Overview

- Key Health Board developments
- Recap and update on our quality improvement and service transformation work
- Health Services in Valley Communities
- Joint working priorities
- Q&A

Bridgend Boundary Change

The population of Swansea Bay University Health Board

POPULATION OF THE HEALTH BOARD

386,000
APROX. POPULATION

Projected increase in population including +9% in Swansea (the third largest increase in Wales). The Welsh population structure is projected to change, with substantial rise in the older population and a projected fall in working-age adults.

LATER YEARS

45% In 2020, across the Health Board, just under half of the number of people aged 65+ will be living alone.

33% 1 in 3 will suffer a fall each year. Only 1 in 3 will return to former levels of independence and 1 in 3 will end up moving into long term care.

Yet many falls are preventable.

DEPRIVATION

>25%

The Health Board has more deprived communities than average for Wales, with over a quarter of our communities falling into the most deprived categories. Urban parts of Swansea, NPT and upper valley communities are particularly deprived.

CANCER

40%

4 in 10 cancers are preventable

BURDEN OF DISEASE

* 1 in 4 people will have a Mental Health problem at some time in their lives

The greatest causes of disease burden in Wales, as measured by the Disability Adjusted Life Year (DALY), are:

*** 20%** The Health Board has a high rate of suicide, particularly in Neath Port Talbot

MSK Musculoskeletal Disorders

19% Cancer

SUBSTANCE MISUSE is a particular issue in the Neath Port Talbot area

18% Cardiovascular Disease

11% By 2030, 11% of people in the Health Board will have a Diabetes diagnosis

CHILDREN AND YOUNG PEOPLE

>20%

More than 1 in 5 children and young people aged under 20, live in poverty in Wales. Swansea West is one of the top 25 electorial wards with highest levels of child poverty in the UK.

life expectancy continues to rise

82.3 YEARS | **78.5 YEARS**

...but the difference in life expectancy between the least and most deprived and most deprived areas is 9.7 years. Also, there is a >20 year (M) and 18 year (F) gap in *healthy life* expectancy.

BEHAVIOURS AFFECTING HEALTH (all wales)

19% 1 in 5 currently smoke (7% use e-cigarettes)

18% 1 in 5 currently drink over weekly guidelines

53% 1 in 2 active for 150 mins or more a week

23% 1 in 4 eat five or more portions of fruit or veg

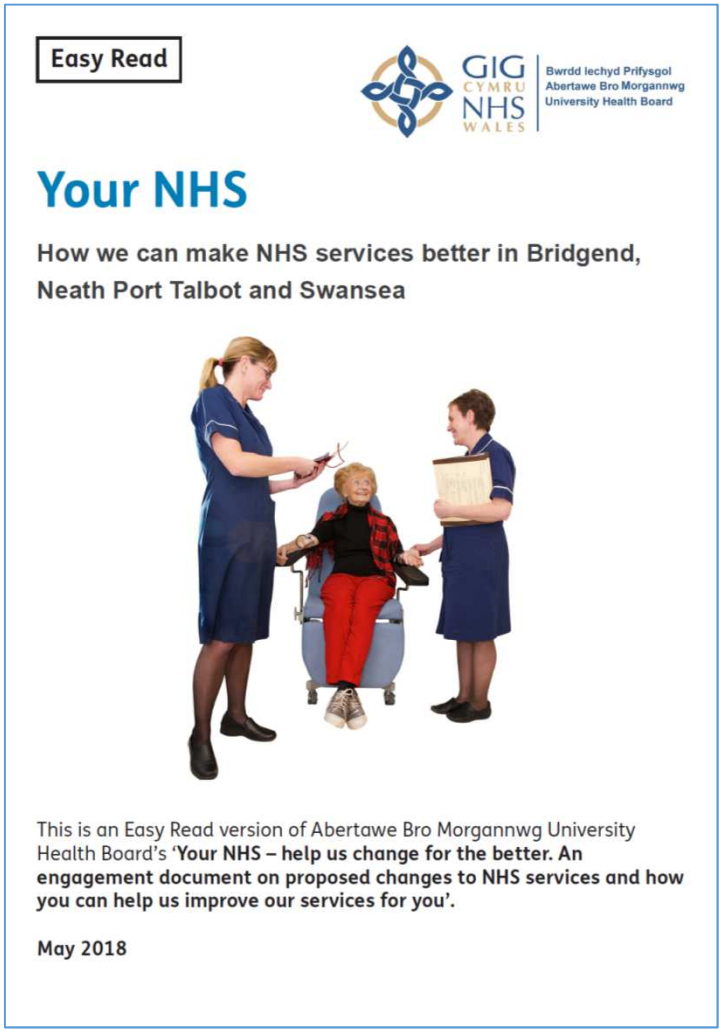
60% 3 in 5 are overweight or obese

10% Followed 0 or 1 healthy behaviours

Our vision for Swansea Bay University Health Board

Better Health, Better Care, Better Lives

Recap - quality improvements and service transformation



Easy Read

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Abertawe Bro Morgannwg University Health Board

Your NHS

How we can make NHS services better in Bridgend, Neath Port Talbot and Swansea

This is an Easy Read version of Abertawe Bro Morgannwg University Health Board's '**Your NHS – help us change for the better. An engagement document on proposed changes to NHS services and how you can help us improve our services for you'.**

May 2018

National Drivers

- Expectations of 'Wellbeing of Future Generations Act', and 'Social Services and Wellbeing Act'
- Parliamentary Review and 'A Healthier Wales'

Local Drivers

- What patients tells us
- Local Welsh Audit Office Discharge Report 2015
- Workforce challenges
- Challenges to patient flow across the system
- The need for working together to transform and find sustainable solutions

Recap - why did we embark on this work?

This is about securing the best outcomes for people within the resources (people and money) we have available to us

We know ……

- Demographic projections
  - Ageing population
  - Increased prevalence of long term chronic conditions and frailty
  - Complex health needs
- 65% admissions attributed to frailty (RCP, 2012)
- Older persons with frailty - prone to the longest lengths of stay
- Highest re-presentations at A&E

Efficient discharge for the frail older person:-

- Improves health outcomes
- Supports effective patient flow
- Maximises use of acute hospital beds
- Reduces risks associated with long hospital stays
  - Functional deconditioning/loss of independence
  - Associated risks; falls, pressure ulcers, infection, delirium
  - The need for prolonged rehabilitation/ long term care

Recap - what services have changed?

- There are two main areas we are continuing to change:
  - Reducing the numbers of people needing to be admitted to hospital and if admitted, spending less time there - so allowing us to reduce inpatient capacity
  - Developing more community based services to support older people with mental health problems, again allowing us to reduce our inpatient capacity
- We undertook a public engagement process on these changes in 2016.

Service Improvements – Neath Port Talbot

Phase 1
June 2017

- **Transfer of Care Advice and Liaison Service (TOCALS) introduced based at Morriston Hospital**
- Increased direct discharges across all acute sites
- Cumulative bed days saved

Phase 2
July 2017

- **Remodelled 32 beds (Ward E) to a 28 bed focussed reablement ward**
- Redesigned workforce and new Rehab Assistant Role
- Reducing length of stay
- Right sizing of packages of care
- Medicines optimisation

Phase 3
ctober 2018

- **Tested Early Supported Discharge Model**
- Therapy led – providing rehab at home
- Clinical Pharmacist will outreach to community

More recent developments – Neath Port Talbot

- Early Supported Discharge Model is now supporting on average 25 NPT catchment patients per day that would have previously been inpatients across SBUHB
- Following changes in earlier 3 phases ward recruitment continues to be a restrictive factor and in addition there has been an increase in the number of patients with complex needs. Therefore proposing to consolidate the existing 104 medical beds that are spread across 4 wards onto 3 wards.
- As part of the change process there is a significant investment in staffing a multi professional team to provide a different model of care for patients with complex needs
- From 1st April, as part of increasing the profile at NPTH, some additional planned surgical activity has already commenced at the Hospital

Service improvements – Mental Health and Learning Disabilities

We have:

- Invested £1.5m in enhanced older people's community mental services including investment in evidence-based services such as physiotherapy, occupational therapy, nursing and psychology
- Developed a team to support people in care homes in each Local Authority area
- This has allowed more patients with challenging behaviour and other difficulties to be cared for in the community
- This has reduced our bed occupancy and supported a reduction in our inpatient capacity

As a result we have we have reduced the beds available in each LA area, as outlined below:

Locality	Original No of Beds	Total	Revised No of Beds	Total
NPT	54 Tonna 20 NPTH	74	34 Tonna 20 NPTH	54
Swansea	18 Tonna 60 CCH	78	60 CCH	60
TOTAL		152		114

Health Services in the Valleys

Multi-agency three- year **cluster plans** with a focus on developing local services to improve health and wellbeing

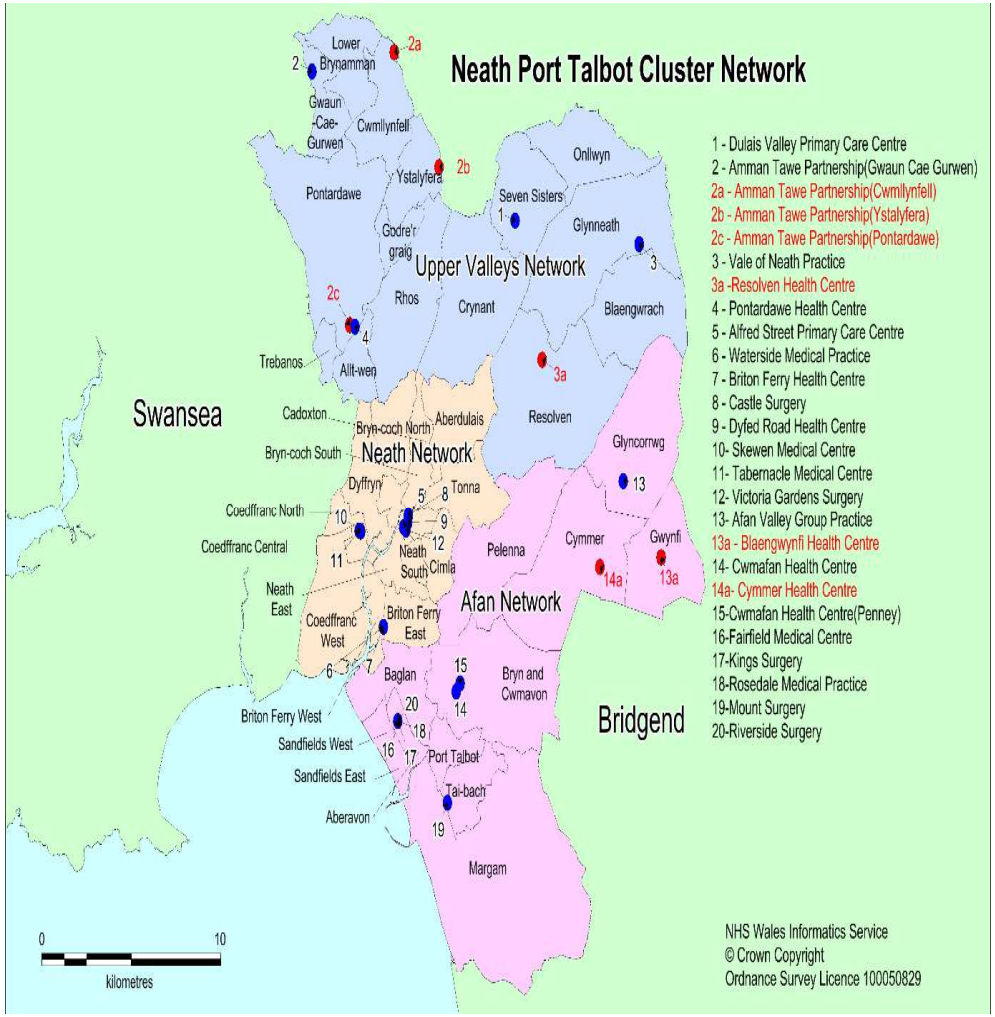
Patient focus and involvement sessions; improving access, premises

Cluster Whole System Transformation

- Better at measuring what really matters to people
- Cluster led decisions with patients
- Greater emphasis on wellbeing
- Health and social care working together

Building Safe Resilient Communities

- Asset based decision; shifting the focus to “what’s right with us”.
- Building effective partnerships; Community and process development; Plan and Implement Activities



Cluster Transformation

reased **partnership working with the third sector**

evelopment of a P**atient**
ticipation Group (Upper
n Valley)
tial stages of developing
uster **patient**
agement group (Upper
eys)

PATIENT PARTICIPATION GROUP

- ✓ Joint work to consider options for redeveloping Croeserw Enterprise Centre

THE PRIMARY CARE HUB

- ✓ Working collaboratively with GPs to help patients get **faster and more direct access to treatment.**

- ✓ **Patient specific events**; dying matters week, Flu.

✓**Helping the population mana**
their own health and long term
illnesses through pre-diabetic p
initiative to increase flu vaccinati
signposting to services that supp
patient self-care and independer

FIRST

✓Better management of demand through prudent healthcare with implementation of a **telephone first/triage access model** to direct patients to the most appropriate health care professional.

Delivering through partnership – priority areas

Delivering new models of care – including transformation fund proposals

Delivering integrated, person-centred care

tive participation in the Public Service oard and Regional Partnership Board

Partnership ambitions:

- To be recognised as a good partner
- To deliver against our promises
- Shared objectives
- Open, trusting relationships

In the interests of our population

Managing winter pressures – better together

Working with NPT on supporting rapid access domiciliary services

Implementing Area Plans and wellbeing plans

Thanks & Questions