CABINET BOARD

14th MAY 2014

SOCIAL SERVICES, HEALTH & HOUSING

REPORT OF THE HEAD OF COMMUNITY CARE AND HOUSING SERVICES – C. MARCHANT

INDEX OF REPORT ITEM

PART 1 – Doc. Code: CAB-140514-REP-SS-CM

1. **Western Bay Community Services Business Case**

1. **Purpose of Report**

The purpose of this paper is to present the work undertaken by the Western Bay Health and Social Care Partnership to develop sustainable services for people experiencing frailty and dementia. It seeks approval of a business case to deliver an optimal service model, at scale, for intermediate tier services. This represents a significant next step in the integration of health and social care services in Neath Port Talbot.

The paper seeks agreement to undertake further work to develop the integrated financial model and governance arrangements in line with the business case. Approval in principle is sought to establish a pooled fund for intermediate tier services in accordance with Section 33 of the National Health Service (Wales) Act 2006 by 2015/16 financial year.

The paper also seeks endorsement of the proposals submitted to Welsh Government Intermediate Care Fund to deliver investment in intermediate tier services across the Western Bay footprint in 2014/15 in accordance with the business case. (**Both attached as Annex A**). The challenges presented by a one year fund are highlighted as is the requirement for all organisations to make available bridging finance and the need for reinvestment of cash releasing savings, until the full benefits of investment in intermediate tier are realised.

A comprehensive recruitment programme is underway to appoint the workforce required to deliver the intermediate tier services and Boards/ Cabinets are asked to consider recruiting on a permanent basis. This is necessary to deliver sustainably the transformation of services required to address the demographic challenges described in this paper.

2. **The Intermediate Tier of Services**

To date intermediate care services have developed in an opportunistic and sometimes disjointed manner across Western Bay. Good practice and positive outcomes for individuals are in evidence, but there is a lack of consistency within, and between, different Local Authority areas. A consistent model for an integrated intermediate tier of services will

provide a number of functions, focussed on time limited support to people that helps them to recover their independence either at a point of crisis or after an incident that may have led to a hospital admission. Services in the intermediate tier are targeted at the key areas of impact illustrated in Figure 1, i.e.

1. Rapid response at times of crisis.
2. Providing a few weeks of reablement to maximise independence before a care package is agreed or increased.
3. Ensuring that after a hospital admission people have the best chance possible of returning home.

Figure 1 Key areas of impact through intermediate care

These services make a real and positive impact on the lives of individual citizens. In the words of one such person receiving this type of joined up care elsewhere…….

> *"I have had various assessments from social care giving me a range of support to help me continue caring. I have been ill myself recently due to being tired and exhausted, and received short term help, which was provided promptly giving me support and peace of mind.* ***I know that without me caring for them, both my mother and brother would almost certainly be in full time residential care. However with the support I have received, we as a family are able to stay together at home."***

The range of functions covered by the intermediate tier are also illustrated in Figure 2.

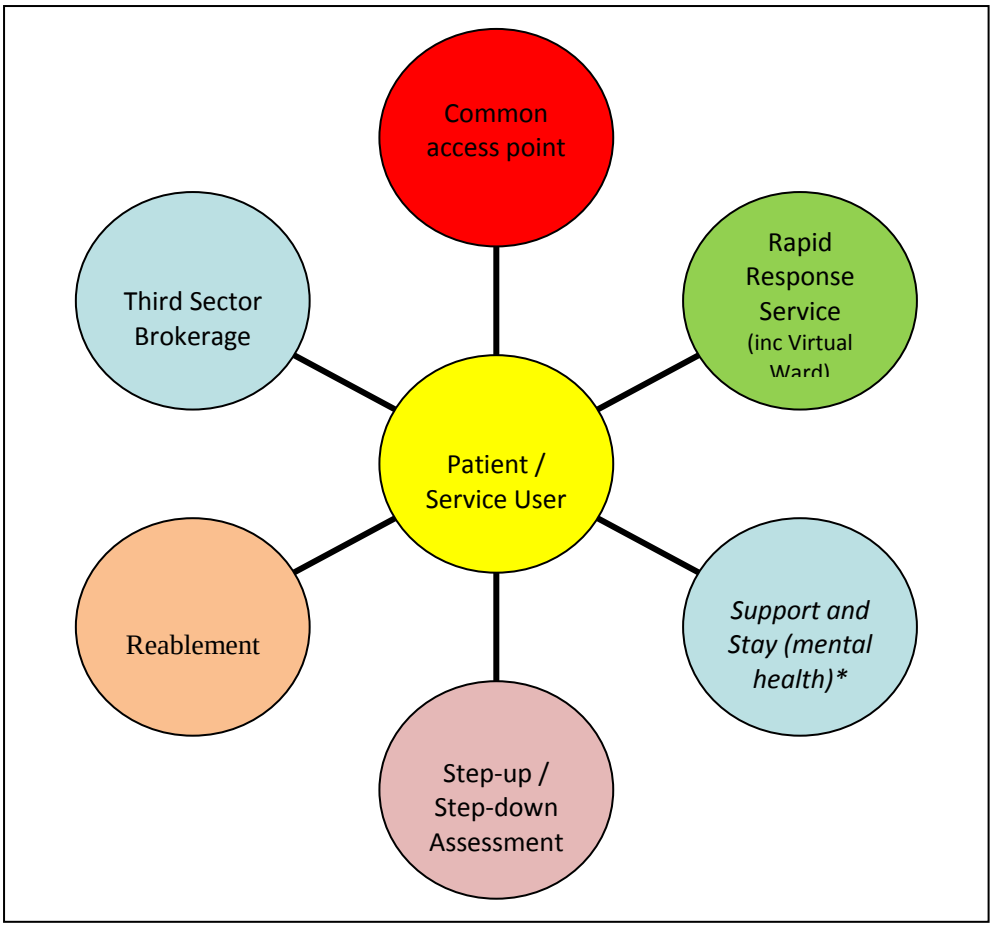

Figure 2 Functions undertaken by the Intermediate Tier

[*Support and Stay provides a dedicated service for older people with mental health needs and is being pursued in the context of the local dementia service development process.]

In undertaking these functions services therefore aim to:

- Support people to remain independent and keep well;
- Ensure that more people are cared for at home, with shorter stays in hospital if they are unwell;
- Change typical pathways away from institutional care to community care;
- Ensure that less people are asked to consider long term residential or nursing home care, particularly in a crisis;
- Provide more people with the support of technology and associated services;
- Join up services around the needs of the individual with less duplication and hand-offs between health and social care agencies;

- Provide more treatment at home, as an alternative to hospital admission;
- Ensure that services are available on a 7 day basis;
- Encourage earlier diagnosis of dementia and quicker access to specialist support for those who need it.

Together, this service model will help us to achieve significant improvements for people with frailty and dementia, including:

- The person, their choice and preferences will be at the centre of every intervention, where appropriate.
- More people will remain independent, confident and safe in their own homes for longer.
- Appropriate assessment and intervention will be carried out in a person's home, and there will be a realignment of capacity to enable this to happen.
- A suite of support care services will be available so that less people are asked to consider long term residential or nursing home care, particularly in a crisis.

4. Context

- 3.1 The journey so far

In March 2013 the Western Bay Programme Board stated that in order for there to be greater integration between the Health Board's strategic change programmes, Changing for the Better (C4B), and the Western Bay priorities then partner agencies should work together on key projects. As a result, the Community Services Project was established with a particular focus on older people and dementia. Whilst combining this work meant that duplication was avoided and the sharing of resources achieved, the work carried out by C4B to test ideas on community services with the general public could be used to inform the project going forward and provided a rich foundation for this work.

In July 2013, the Community Services Project, through working with the Whole Systems Partnership, added to that foundation of public opinion by producing a case for change. This document presented both the demographic issues facing the Western Bay area and the potential financial challenges if we do nothing. This is described in outline in the sections below.

As a result of the case for change, ABMU Health Board and the Local Authorities developed a strategic way forward '*Delivering Improved Community Services'*. This document set out a joint commitment from each of the organisations to plan and deliver better community services for citizens and presented an ambitious transformation programme over the next three to five years, with a particular focus on:

- The wellbeing of older people and keeping them healthy in their own communities so they enjoy happy and independent lives;
- Strengthening community teams, making sure people default to the community for assessment and care rather than hospitals and institutional care;
- Making community services sustainable, ensuring community teams are the best they can be through better technology and better financial and workforce planning models.

The document was founded on the information gathered from the general public through the C4B engagement exercise but also from wider discussions with the third sector and primary care colleagues. The ambition is to deliver a vision for the future of a truly integrated health and social care system; one which is designed to meet the needs of citizens and achieves the highest standards of care.

Whilst *Delivering Improved Community Services* set the foundation for improving community services as a whole, it did clearly state that in order to begin the process it was important to start with the intermediate tier. The reason for this is that this tier of service is where community teams need to work together the most and where the best care depends on integrated delivery by health, social care, housing and third sector providers. The Community Services Project has therefore focused the initial element of their work on developing a business case for the Intermediate Tier.

3.2 The current position

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 tied to traditional, silo-type forms of both health and social care delivery. The tendency toward individual agencies cost-shunting in an uncoordinated system that lacks

significant integration is also highly undesirable as we know that this only leads to poorer outcomes for older people.

Cost pressures due to demographic change are, however, considerable, and they impact across social care and health services. The Western Bay and Changing for the Better Programmes have therefore undertaken joint work to understand the current capacity of services compared to future need for people who are frail or elderly. This has helped it to determine how, in the context of demographic pressures, the goal of a sustainable health and social care system can be built.

Developing an effective intermediate tier of services is central to this wider transformation programme. They provide the critical boundary between wellbeing and the need for managed care, with the potential to enable more people to maintain their independence. A partnership between health, social care, housing and the third sector is therefore essential in meeting current and future needs.

In recognition of this critical strategic goal, the Welsh Government announced the creation of the Intermediate Care Fund (ICF) in December 2013, consisting of £35m revenue and £15M capital funding for 2014/15. Partners submitted a successful proposal to the ICF in line with the proposed business case. As the Fund has only been identified for 2014/15 only, this will help to address the investment required in year 1, but will require partners to agree an approach in respect of year 2 onwards.

4. ‘Statement of Intent’ for integration

To deliver the vision for fully integrated health and social care services for older people with complex needs, a Statement of Intent for Integration has also been developed. The Western Bay and Neath Port Talbot Statement of Intent are appended for approval. The paper confirms the intention of the 3 Local Authorities to integrate their social care services for older people with complex needs with ABMU on a locality / Local Authority footprint, working to the following model:

- “Delivering transformation through integration of health, social care and mental health services for a common access point, intermediate tier and on-going community support using local pooled budget arrangement for transformation funding and on-going business.”

- 5. The Business Case for the Intermediate Tier
- 5.1 The case for change

The demographic challenge across Western Bay is shown in Table 1.

	Total >65s		Est. of frail population		People with dementia	
	2018	Change	2018	Change	2018	Change
Bridgend	29,980	+15.8%	3,001	+16.2%	2,074	+18.2%
NPT	31,214	+13.7%	3,198	+12.7%	2,239	+13.6%
Swansea	49,396	+11.5%	5,226	+11.5%	3,696	+13.0%

Table 1 The increase in population and type of need from a baseline of 2012

The cost of 'doing nothing' is shown in Table 2. The approximate share of these cost pressures by 2016/17 would be £1.5M for ABMU and £2.8M shared across the three Local Authorities (£0.8M for Bridgend, £0.8M for NPT and £1.2M for Swansea). If all of these cost pressures fell on one or other of the partner agencies it would be equivalent to either failing to support 450 vulnerable who need social care or opening another 100 hospital beds to cope with increasing demand – both of which are clearly undesirable.

	2014/15	2015/16	2016/17
Bridgend	£409k	£865k	£1,344k
NPT	£455k	£833k	£1,185k
Swansea	£582k	£1,178k	£1,787k
TOTAL	£1,446k	£2,876k	£4,316k

Table 2 The cost of doing nothing – recurrent additional spend on services for frail older people across health and social care compared to 2013/14 baseline (£'000's)

5.2 Engagement and underpinning analysis

The Business Case for investment in the Intermediate Tier of services, agreed by the Western Bay Programme Board in January 2014, has been the product of considerable local engagement between health and social care partners. Regular briefings and opportunities for 3rd Sector involvement have also been provided. Detailed analysis of current activity for frail older people, and those with dementia, has also been undertaken on a locality basis, again on a joint basis between health and social care.

We have therefore identified the baseline levels of activity within intermediate care services, which has then enabled us to gauge the gap between this and an optimised service. This optimised level of service has been informed by good practice elsewhere, as well as being 'sense checked' against local aspirations for the development of these services. By modelling this increased capacity, and the impact it will have, we have also identified the financial framework for the three year Business Case, which will enable each organisation to transition to a more sustainable system and provides people with greater opportunities to remain independent.

5.3 Building the financial case

The baseline spend on Intermediate Care Services across Western Bay, and in each Local Authority area, is shown in Table 3, with the equivalent wte staff numbers given in Table 4. Also shown in Table 4 is an initial estimate for the increase in staff necessary to deliver the transformation envisaged in the business case. This has been identified through a process of pathway modelling to achieve ambitious, but achievable changes in how and where people are supported by intermediate care services.

	Social care spend £000 pa	**Health spend £000 pa**	**Total spend £000 pa**
	Social care spend £000 pa	Health spend £000 pa	Total spend £000 pa
Bridgend %	£704k 48%	£751k 52%	£1,455k
NPT %	£972k 52%	£882k 48%	£1,854k
Swansea %	£2,702k 55%	£2,228k 45%	£4,930k
W Bay	£4,378k	£3,861k	£8,239k

Table 3 Spend on intermediate care in 2012/13

	Existing staff	Additional staff
Bridgend	39.8wte	36.2wte
NPT	65.1wte	39.6wte
Swansea	147.1wte	65.5wte

Table 4 Baseline and new staff in Intermediate Care services

The additional staff includes Nurses, Social Workers, Care Staff, Occupational Therapists, Physiotherapists, Speech and Language Therapists, Dieticians and Pharmacists. They will provide additional and new services in the key functions of intermediate care. Because of the significant increase in staff opportunities for integration, shared support, efficiencies of scale and joint training and development will be possible making this not only an effective part of the local system of care but also one that we expect to be an increasingly rewarding environment for staff.

5.4 The journey to sustainability

2014/15 will be a transitional year during which time the Welsh Government Intermediate Care Fund will play a crucial part. During this first year of transformation there will also be an emphasis on the monitoring and evaluation of service change. Governance arrangements for gathering, reporting and validating financial impact are being designed in such a way as to include all staff in the services in this important exercise.

Conditional on the effectiveness and progress made in implementation, and evidencing of its impact, further investment to meet the full year financial effect of an non recurring investment in 2014/15 will need to be made. It is expected that the Programme will become self sufficient after a period of 3 years whereby the financial benefits outweigh any growth in underlying demand. The degree of 'bridging finance' required in all areas in 2015/16, and Swansea and Bridgend for 2016/17, will depend on the speed with which benefits can be realised. The business case indicates a significant bridging requirement of £4.151m in 2015/16, £0.821m in 2016/17 and a break-even position across Western Bay in 2017/18 although an indicative £0.463 m of bridging finance will still be required in Bridgend. This is based on conservative assumptions as to

how quickly services can be remodelled to release cash into sustainable intermediate tier of service in light of the demographic pressures.

	Bridgend	Neath Port Talbot	Swansea	Western Bay
2015/16 indicative bridging finance	£1,162k	£1,338k	£1,625k	£4,151
2016/17 indicative bridging finance	£558k	-£33k	£229k	£821k
2017/18 indicative bridging finance	£463k	In surplus	In surplus	£463k

Table 5 – Indicative Bridging Finance Requirements

The requirement for bridging monies is currently assumed to fall roughly equally between health and social care in 2015/16 based on a 50/50 split.

	Bridgend CBC	Neath Port Talbot CBC	C&C of Swansea	ABMU
2015/16 indicative bridging finance	£581k	£669k	£812k	£2,075k
2016/17 indicative bridging finance	£279k	- £16k	£114k	£410k
2017/18 indicative bridging finance	£231k	In surplus	In surplus	£231k

Table 6 – indicative Bridging Finance requirements by organisation

The requirement for bridging finance is as a consequence of the need to recruit the workforce required to deliver the intermediate tier of service on a permanent basis in order to both attract the right calibre of candidate to the posts and to ensure sustainability of the services being delivered. It is important to note that the business case will require all organisations to commit to reinvesting benefits realised through reductions in post acute length of stay and fewer care home and long term domiciliary placements into a pooled fund to enable the recurring investment costs to be met and to deliver the full impact of the business case. This is currently subject to further modelling and will need to be considered by each organisation in light of their existing forward financial/ medium term plans. The impact on respective organisations based on the modelling underpinning the business case is identified in table 7.

Cash releasing savings	**Bridgend** **£'000**	**Neath Port Talbot** **£'000**	**Swansea** **£'000**	**Total Western Bay** **£'000**
14/15				
Local Authority (Bridgend CBC / NPT Council / C&C of Swansea)	£140k	£251k	£248k	£639k
ABMUHB	£342k	£508k	£569k	£1,419k
Total	£482k	£759k	£817k	£2,058k
15/16				
Local Authority (Bridgend CBC / NPT Council / C&C of Swansea)	£373k	£608k	£704k	£1,685k
ABMUHB	£313k	£755k	£847k	£1,915k
Total	£686k	£1,363k	£1,551k	£3,600k

Cash releasing savings	Bridgend £'000	Neath Port Talbot £'000	Swansea £'000	Total Western Bay £'000
16/17				
Local Authority (Bridgend CBC / NPT Council / C&C of Swansea)	£247k	£565k	£448k	£1,260k
ABMUHB	-£152k	£243k	£429k	£520k
Total	£96k	£808k	£877k	£1,780k

Table 7 – Cash releasing savings 20014/15 – 2016/17 by organisation

6. **Equality Impact Assessment**

Each of the statutory Western Bay partners has undertaken an individual equality impact assessment of the implications of the business case and intermediate care fund proposals. Board/Cabinet members are asked to have due regard to the equalities impact assessment in considering the recommendations of this report.

7. **Recommendations**

Cabinet/ ABMU Board are asked to:

1) Approve the business case for the intermediate tier of services, in so-doing:

    a. Note the demographic challenge facing the Western Bay area and the service and financial risks associated with a 'do nothing' option

    b. Endorse the submission made to the Welsh Government Intermediate Care Fund for 2014 in line with a 5 year programme of transformational change

    c. Note the challenge presented by the bridging requirements in 2015/16 and 2016/17 and that further work is required to detail the benefits realisation framework and risk sharing arrangements required

    d. Agree the requirement to re-invest the cash releasing savings achieved from remodelling services into intermediate tier pooled funds to achieve the sustainability of the intermediate tier of service

2) Approve the recruitment on a permanent basis of the workforce necessary to deliver the intermediate tier services on a sustainable basis.

3) Approve in principle the establishment of an arrangement to pool resources with partners in the Western Bay Programme, subject to

formal agreement in accordance with Section 33 of the National Health Service (Wales) Act 2006 by April 2015.

4) Approve the Western Bay and Neath Port Talbot 'Statement of Intent on Integration'.

8. **Reasons for Proposed Decision**

To establish sustainable integrated services for people with frailty and dementia which deliver better outcomes for individuals and are cost effective for public sector partners.

9. **List of Background Papers**

None

10. **Wards Affected**

All

11. **Officer Contact**

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COMPLIANCE STATEMENT

WESTERN BAY COMMUNITY SERVICES BUSINESS CASE

(a) Implementation of Decisions

The decisions are proposed for implementation after the three day call-in period.

(b) Sustainability Appraisal

Community Plan Impacts

Economic Prosperity	-	no impact
Education & Lifelong Learning	-	no impact
Better Health & Well Being	-	positive
Environment & Transport	-	no impact
Crime & Disorder	-	no impact

Other Impacts

Welsh Language	-	no impact
Sustainable Development	-	no impact
Equalities	-	no impact
Social Inclusion	-	positive

(c) Consultation

There is no requirement for formal/external consultation on this matter.

Annex A

INTERMEDIATE CARE FUND 2014-15

APPLICATION

Before completing this form please read the Intermediate Care Fund Guidance, available at:

http://wales.gov.uk/topics/health/publications/socialcare/guidance1/?lang=en

It is strongly recommended that you discuss your proposal with Welsh Government officials before applying for funding.

Any enquiries relating to, and submissions of, applications should be sent to: **IntermediateCareFund@wales.gsi.gov.uk**

Alternatively, any enquires arising regarding applications is available on **02920 82 5860**

The deadline for applications to be submitted is **Midday 7 March 2014**.

All applications will be acknowledged via e-mail within 1 week of receipt.

PART 1 PROPOSAL DETAILS

A: Outline

Proposal Title	Delivering improved community services
Lead Local Authority	Neath Port Talbot CBC
Senior Responsible Officer	*Name* Stephen Phillips *Address* *Telephone* *Email*
Other organisations/partners involved in delivery	ABMU Health Board City & County of Swansea Bridgend CBC
Estimated total cost of proposal	ICF Revenue £5,263k
	ICF Capital £2,526k

Estimated Start and Finish date of proposal
The proposals in this application represent the first phase of a strategic transformation programme for community services. This comprehensive programme is supported by a 3 year business case to deliver the transformational change envisaged.

B: Description and Fit against Criteria

Note: Please be as concise as possible, ***within a maximum of 150 words for each section below****. The table in the guidance sets out the eligibility criteria against which proposals will be considered.*

NOTE WHERE YOUR PROPOSAL CONTAINS SEVERAL SCHEMES PLEASE USE THE SUMMARY TABLE ATTACHED AT ANNEX 1.

BRIEF OVERVIEW / SUMMARY OF PROPOSAL: (*summarising aims, objectives and milestones)*
The Western Bay proposal represents the first year of funding to support a 3 year Business Case for the Intermediate Tier. The primary objectives for this proposal are: 1. To strengthen the 'demand management' function undertaken by common access points into the intermediate tier of services. 2. To support 3rd sector involvement in brokerage and short term support as an integral part of the intermediate tier. 3. To optimise services, and provide the necessary housing adaptations, equipment and support, in order to provide genuine alternatives to a hospital or long term care admission. 4. To provide the context, physical estate and care pathways for integrated services between health and social care and, where appropriate, with mental health services. 5. To act as a catalyst for the transformation of services for frail older people and achieve, over time, a shift in how and where this care is delivered.

STRATEGIC ALIGNMENT: Briefly outline how this programme of work will align with Welsh Governments strategic aims for Social Services
This bid will: 1. Improve care coordination across statutory and 3rd sector organisations through its emphasis on the key functions that need to be delivered by an intermediate tier of services and by carrying through the local ambition for integration described in the output from a multi-agency workshop held in September 2013. 2. Promote and maximise independent living opportunities by providing additional capacity (including adaptations and equipment) at times of crisis, where, and to the extent to which, this has been identified by analysing existing activity and impact for intermediate care services. 3. Support recovery and recuperation through the development of additional capacity in 'step-down' services where this has been assessed as currently not meeting the optimal level of demand.

INTEGRATION: How will the programme of work demonstrate better integration across delivery partners within the region?

Your proposals should clearly demonstrate the role and contribution of all relevant partners within the region

The Business Case on which the bid is based has been the product of extensive local engagement over the last year which has resulted in a clear and consistent service model for the intermediate tier, the analysis of current costs and activity and the development of what we believe to be an optimised set of services undertaking key functions within an intermediate tier of services. The engagement process has been undertaken in the context of the Western Bay Programme Board and its Community Services Project Team, both of which have inclusive membership and extensive means of providing ongoing engagement.

The programme of work reflected in this bid therefore combines:

- The 3rd sector, in its contribution to the brokerage function within the initial common access point and any subsequent short term periods of support;
- Housing, in the provision of adaptations and equipment in a timely way where this supports any of the key stages within an intermediate care episode;
- Social care, by integrating the demand management function within a common access point, the provision of reablement support, and the impact on the commissioning for ongoing support;
- Health care, both acute and community, as key reablement, rehabilitation or recuperation services are provided in an integrated way alongside other agencies.

TRANSFORMATIONAL MODELS OF CARE: How will new service models be mainstreamed into future delivery models?

The proposals should demonstrate a recognisable shift in the way services are delivered or in the ways the collaborating organisations operate. They must create a long-term impact and achieve sustainable integrated services.

The establishment of an integrated approach to the intermediate tier will act as a catalyst for further integration across community services. The key transformational elements of the bid are:

1. The emphasis on bringing together an effective demand management function that will direct people to appropriate services or interventions according to need.
2. The new ways of working that will be required ‘at scale’ in a community setting, though still for discrete episodes of care aimed at improving independent.
3. The development of a new culture and set of behaviours that assume the potential for reablement and rehabilitation which will be carried forward into future years and will therefore sustain the transformation programme.

NEW/ ADDITIONAL SERVICES: How will you demonstrate this programme of work is in addition to existing provision?
The Fund must be used to support new/additional provision of services and ways of working. Proposals must clearly demonstrate how they will be delivered and measured. The specific proposals contained within this bid have all been developed as part of the 3-year Business Plan (which has been provided a supplementary information). Each service development has been the output of work to baseline existing capacity and then to estimate, using local intelligence and comparative benchmarks, the scope for optimisation. This additional investment has then been translated into workforce wte of an appropriate mix to ensure that on implementation additional capacity, throughput and impact will also be delivered. The fund will also support new ways of working, as well as additional capacity. This will focus on new opportunities for integration in each of the key components of the local model for the intermediate tier, including: • Closer working between statutory and 3rd sector organisations in the common access points where diversion from hospital or reablement services are offered; • Closer working with housing as 'step-down' care and support is supplemented with additional resources for home adaptations and equipment; • Closer working with mental health services as a mental health link worker takes up their role in the common access point; • Closer working between health and social care in each part of the system as it is scaled up and allows for economies of scale, joint management and training opportunities.

C: Delivery of Benefits:

The Fund can be used to build on existing good practice and to increase the scale of provision of integrated services across Wales. It can also be used as pump-prime funding to assist transformation and change and to test out new models of delivery.

The next three boxes indicate the key objectives of the Fund. For these, and the additional evidence box, please set out, **within a maximum of 150 words for each section,** the benefits your proposal will deliver, how this will be done and when they will be realised.

IMPROVING PREVENTATIVE CARE AND AVOIDING UNNECESSARY HOSPITAL ADMISSION AND DELAYED DISCHARGE OF OLDER PEOPLE, PARTICULARLY THE FRAIL ELDERLY:
Please detail your plans to address this through improved care co-ordination between social services, health, housing, third and independent sector. The Common Access Point proposals in the bid build on existing common points of access but refocus these to provide the key intermediate tier function of demand management and rapid response. The strengthening of the brokerage role using third sector involvement also ensures integration with this sector. The business case sets out how it will seek to optimise the impact of these services across Western Bay such that: • The rapid response service will save an additional 29 hospital admissions per week. • The intake reablement function will address the needs of an additional 16 people a week.

PROMOTE AND MAXIMISE INDEPENDENT LIVING OPPORTUNITIES:
Your proposals may include ensuring increased provision of timely home adaptations in response to referrals from health and care services. A significant proportion of the people identified in the box above will also expect to benefit from the provision of timely home adaptations. Capital sums have been included to provide for specialist equipment as well as 'lower level' care and repair support to ensure people's homes remain safe as people's need increase. The 'Trusted Assessor' scheme including the fitting of equipment to avoid falls will also support this key objective. Development of the intermediate tier will speed up response times for those who need support, with packages of care implemented in a timely manner leading to better outcomes. The 'right sizing' of care packages from the outset will lead to better outcomes and improved independence.

SUPPORT RECOVERY AND RECUPERATION BY INCREASING THE PROVISION OF REABLEMENT SERVICES:

Your proposals must demonstrate the provision of those services at home or through the provision of step-down/convalescence beds in the community setting):

The focus on planned reablement and intermediate care as a step-down from hospital features as a key function within the business case. As a result of this investment:

- By the end of 2014/15 750 more people across Western Bay will have had step-down rehabilitation and reablement at home or in a 'step-down' bed rather than in an acute hospital.

This will be secured primarily through enhanced home based intermediate care services with some residential beds.

EVIDENCE OF YOUR PROPOSAL DELIVERING BENEFITS

This may include reference research, pilot study work etc.

Please refer to the full business case in support of this set of proposals and appendices on evidence from elsewhere.

In particular evidence emerging from areas who have pioneered the development of intermediate tier services have been reviewed, including Torbay, Pembrokeshire and North East Lincolnshire. This has enabled a picture of an optimised intermediate tier to be developed for the intermediate tier functions included in the 3 year business case. An optimised system is described as one that will deliver the following:

- Single Point of Access: increase percentage of new contacts relating to community health and social care directed through the single point of access.
- Rapid Response: 15% of baseline unscheduled admissions for >65 year olds are diverted to Rapid Response.
- Intake: 100% of all potential new homecare clients receive intake intermediate care.
- Review: 100% of homecare clients for whom a potential significant change is identified receive review intermediate care.
- Step down care: 100% of post-acute care that is suitable for domiciliary intermediate care is delivered at home rather than in a hospital bed.
- Step up care: Step up care provision is expanded proportional to future change in the frail older population.
- Residential intermediate care: provision of intermediate care in residential beds continues to be provided at the current rate in each locality with full utilisation of planned developments.

D: Delivery Arrangements

i) Governance Arrangements

What is the governance framework for delivering this proposal? How will all partners be involved in oversight and delivery?
Proposals should set out how delivery will be managed within a rigorous and transparent governance framework, with clear leadership accountabilities, milestones and progress measures. (Max 250 wds) Governance arrangements for the implementation of the Intermediate Tier transformation programme will be firmly embedded within the existing Western Bay Programme Board, and in particular in its Community Services Programme Board. The proposed arrangements include: • Strengthening community teams to ensure delivery as well as to be a key part of the monitoring and learning process as implementation proceeds; • Establishing dedicated programme management and support capacity; • Developing a strong internal monitoring and validation process for impact and identifying cash-releasing savings for reinvestment, mirrored by an externally commissioned piece of evaluation work. This will be supported by formal monitoring and governance arrangements that will consist of: • Local weekly reporting of key activity & impact by practitioners gathered by team managers in 'real time'; • Monthly reports to the Community Services Programme Board prepared by locality managers, supported by the central Intermediate Care Programme Office. These will be linked to budget reporting and will include an alignment with budgets and the planned investment profile; • Quarterly reporting to the Western Bay Programme Board with external validation and comment, prepared by the Intermediate Care Programme Office. The process will ensure the involvement of all staff in understanding and evaluating the impact of the new services to ensure early feedback of lessons learnt and any adjustments necessary in the implementation process.

List the key milestones i.e. the main things that will be done to deliver the programme of work. *Note payments will be made against evidence of delivery against these milestones. Without detailed milestones we will be unable to schedule payments.*	
Key Milestone	**Indicative delivery date**
Governance arrangements in place HR recruitment team operational Performance Framework in place and operational Appointment of early posts (tranche 1) Evaluation commissioned Third sector contracts in place	End June 14

Appointment of tranche 2 posts (the majority) Common Access Point (Swansea) taking all health and social care enquiries Rapid Response & enhanced reablement in place (Bridgend) Rapid Response & planned health response in place (Swansea) Rapid Response in place NPT Operational hubs in place (Bridgend)	End Sept 14
Remainder of posts recruited (tranche 3) Enhanced reablement function in place (NPT) Operational hubs in place (NPT & Swansea)	End Dec 14
Section 33 arrangements developed for pooled fund for implementation 1/4/15	End March 15

Please state any key risks identified and mitigation measures proposed

Risk	**Mitigating Action**
A full risk assessment and management plan forms part of the Intermediate Tier Business Case and will be part of the ongoing project delivery approach. Key identified risks are:	
Recruitment and training of the appropriate skilled workforce	Recruitment team / programme established. Previous experience in recruiting to step changes will be drawn on and discussions entered into with local education provider to secure fast track training or development of cohorts of staff to fill key roles.
Confidence in the enhanced intermediate care services is lacking within the consultant and primary care workforce	Involvement of key clinicians in the development of the service model and aligning the intermediate care developments with proposed developments in medical staffing
Ability to release cashable savings to support recurrent funding requirements	Finance and operational managers have been fully engaged in development of the proposals and will be involved in the implementation process retaining a focus on the need to release savings.
The impact on on-going primary and community services is no properly understood and addressed	Alignment of project teams across community services with a remit to continue the development of on-going services in the community in such a way as to dovetail with the intermediate care implementation.

Please confirm that you have the following (If not yet in place please indicate when you expect them to be in hand):	
Proposal management arrangements in place	Yes
Evaluation Framework developed	In development – specification currently being designed in collaboration with Swansea University
Necessary Impact Assessments carried out	Impact of proposals assessed re activity / finance Impact assessments to be completed by end June

ii) Monitoring and Evaluation

(Please include in your answer, key performance indicators (KPI's) and whether a measurement baseline has been established.

Briefly outline your plans for how you will monitor the progress and evaluate the achievements of the programme
A full evaluation of the Intermediate Tier developments to be implemented in Western Bay is to be commissioned from an academic institute. Discussions are currently taking place with Swansea University regarding the design of a specification. £100k has been allocated for the evaluation. Internal formal monitoring of progress will consist of: • Local weekly reporting of key activity & impact by practitioners gathered by team managers in 'real time'; • Qualitative reporting via case studies, service user satisfaction surveys and service user stories linked to the I ROC & Hope framework. These will focus on the concept of highlighting 'social return on investment'. • Monthly reports to the Community Services Programme Board prepared by locality managers, supported by the central Intermediate Care Programme Office. These will be linked to budget reporting and will include an alignment with budgets and the planned investment profile; • Quarterly reporting to the Western Bay Programme Board with external validation and comment, prepared by the Intermediate Care Programme Office. The process will ensure the involvement of all staff in understanding and evaluating the impact of the new services to ensure early feedback of lessons learnt and any adjustments necessary in the implementation process. This strategic programme will deliver transformational change over a three year period with benefits developing over the three years and fully realised by the end of 2016/17. The identified position for key indicators at this point is detailed below:

Description of indicator	Baseline (13/14)	Expected future state (March 2017)	Frequency of data collection
Home Care starts	1,578	1484	Monthly
Care home admissions	1,107	943	Monthly
>65 unscheduled admissions to hospital	14,505	14163	Monthly
Post acute episodes in hospital	1,344	944	Monthly
Rapid response clients	1,653	5124	Monthly
Intake of review reablement clients	2,682	3954	Monthly
Domiciliary or bed based intermediate care	4,533	5823	Monthly

What arrangements are you proposing to capture and cascade the lessons from this programme?

Implementation of the Intermediate Tier Business Case constitutes a major programme of transformational change. The process identified to monitor and evaluate both implementation and impact has the full involvement of staff at its core. This will ensure capture and early feedback of lessons learnt and any adjustments necessary in the implementation programme.

Through the governance arrangements there will be regular reporting to the Community Services Programme Board that will include both progress on implementation, impact and lessons learnt. These will be fed back to services and teams (both within the intermediate tier and more broadly) through both on going mechanisms and specific learning and development events. Detailed plans for this will be developed as part of the implementation programme.

Regular multi agency learning events are already held as part of the Western Bay Changing for the Better Programme and these will provide a forum for the cascading of information on the changes and the lessons learnt from the Intermediate Tier proposals.

E: Funding Details

The £50 million Fund (£35 million revenue, £15 million in capital) is available for the 2014-15 financial year only and cannot be extended after the 1st of April 2015

Please provide details of funding required:					
A brief explanation of activity should be provided as appropriate. Please provide in the table below an overview of revenue and/or capital costs for your proposal.					
Revenue Funding	Q1	Q2	Q3	Q4	Total
Bridgend	£115k	£345k	£405k	£405k	£1,271k
Neath Port Talbot	£121k	£440k	£510k	£541k	£1,612k
Swansea	£45k	£360k	£880k	£1,095k	£2,380k
Capital Funding	Q1	Q2	Q3	Q4	Total
Bridgend	£390k	£101k	£72k	£72k	£635k
Neath Port Talbot	£120k	£248k	£198k	£134k	£700k
Swansea	£222k	£366k	£459k	£144k	£1,191k
TOTAL FUNDING					
Bridgend	£505k	£446k	£477k	£477k	£1,906k
Neath Port Talbot	£241k	£688k	£707k	£675k	£2,312k
Swansea	£267k	£726k	£1,339k	£1,239k	£3,571k
Western Bay	£1,013k	£1,860k	£2,523k	£2,391k	£7,789k

Additional Information
Please use the separate box below for any additional narrative on what any successful application will be spent on (e.g. staffing, expert services, implementation etc.) *(max 200 wds)* The summary figures on expenditure of the revenue and capital elements of the ICF in Western Bay are supported by detailed proposals for the development and enhancement of teams and functions that support the Intermediate Tier in line with the three year strategic Business Case. A full schedule is provided as an appendix to this submission. In summary they include: 1) Health and social care practitioner staffing (including mental health) in the functions of: • Rapid response

- Common Access Points
- Reablement / Intermediate Care
- Medicines Management and medical staffing to support the intermediate tier

2) Investment in the third sector (e.g. Care & Repair, third sector brokerage)

3) Community Equipment and aids and adaptations required to support the increased number of people supported at home

4) Infrastructure developments reflecting the significant increase in the number of community staff and integration of teams across health and social care.

5) Vehicles required for enhanced services

6) Local staffing to support the implementation of these major service developments

7) Academic evaluation of the Intermediate Tier implementation

What funding and other resources, if any, will contributing partners commit to the delivery of the proposal?
The business case for the Intermediate tier constitutes a three year programme of strategic change. Western Bay partners are committed to full implementation of the programme with the ICF monies forming a vital role in developing new services in 2014/15 that will generate benefits (both in service delivery and savings) over the next two years. Local partners are committed to further investment in the Intermediate Tier in 2015/16 to achieve the service configuration required to deliver the improvements identified. Bridging monies will be made available to cover the short term gap between investment required and savings delivered in years two and three of the programme. The Western Bay Partnership has also committed to capital and revenue costs associated with a bid to the Health Technologies Fund (HTF) which is linked to this bid. The HTF bid includes technology that will allow smarter and more efficient working for community staff through the use of remote devices, telehealth and digital pen technology.

Are you applying for other Welsh Government funding to deliver this proposal?
Please provide details of which funding streams and the amount secured

PART 2: FURTHER INFORMATION

For this part of the application you are given the opportunity to expand upon the summary information provided above. This may include further details on the background, governance, rationale and forecast benefits of the proposal.

(max 300 words)

The Business Case for the Intermediate Tier submitted as part of this application provides full details on the work undertaken in Western Bay and development of proposals for the Intermediate Tier upon which this bid is based.

PART 3: CONFIRMATION

Please sign, date and return this completed form to the address shown below:

I confirm that the proposal outlined here has been agreed and authorised and if funding is awarded, it is ready to proceed in the 2014 / 2015 financial year.

Signature:

Name:

Chief Executive and / or Chief Financial Officer:

Date:

Western Bay Community Services

Transforming care through investment in the intermediate tier

3 year business case

27th January 2014

This business case provides details of the investment necessary to develop intermediate care services, as outlined in the Strategic Outline Business Case for Community Services signed off by the Western Bay Programme Board in June 2013. It focusses on Intermediate Care Services because they can act as a catalyst for wider system change at a time of significant pressure across the health and social care system. The focus on intermediate care also recognises the opportunity to bid against the Welsh Government's recently announced Intermediate Care Investment Fund, although further local investment, and a commitment to work together to deliver complex changes, is also necessary to deliver and then sustain this three year programme of transformation.

Contents:

Appendices:

Executive Summary

This is an ambitious, but necessary plan aimed at developing intermediate care services across Western Bay. It is necessary because without a proactive approach to the growing needs within our communities crisis will follow crisis and risks, instead of being managed, will be realised in real people's lives. We have estimated that growing demand for services by 2016/17 would mean, without commensurate increases in resources, that 450 people across Western Bay would be denied the Social Care they need; or, alternatively, every discharge from a post-acute episode of care would be made 5 days earlier, irrespective of need. ***Were we to spend what was necessary to avert these risks it would cost Western Bay partners an additional £1.5M every year cumulatively***.

However, knowing the current pressure on resources, even providing the same levels of support for people's health and care needs will not be possible. It is therefore essential that an 'invest to save' strategy is put in place so that we radically reduce the rate at which people access health and social care services. The Williams report includes recommendations to develop integrated services such as intermediate care, and the recent announcement of the Welsh Government Intermediate Care Investment Fund provides a one-off opportunity to get this transformation programme underway in 2014/15, albeit with the need for other resources to bridge the programme in 2015/16 to a more sustainable footing beyond that.

Intermediate Care across Western Bay is already working, and many people benefit from the services they provide. However, there is ***clear evidence that there are gaps in the focus and size of many of these services***. These services also often operate in isolation, reducing their potential impact and the economies and improved effectiveness that can come from integration.

This business case therefore sets out the vision and ambition for a comprehensive and integrated service model for intermediate care that will match the growing needs of the local population. It describes two broad functions; one that provides immediate support at a time of crisis, wherever you are in the system; and one that provides a planned response, but that is time limited and aimed at optimal reablement.

Current investment in the Intermediate Tier is fairly evening matched between health and social care in each Western Bay locality, even though the make-up of the different contributions is different. ***A total of £8.2M is currently spent on these services***. We have been through an engagement process in which we have mapped out and explored the potential for these services and believe that ***something nearer £14.5M will be needed by 2016/17*** to achieve the transformation, and the ongoing savings from reducing the extent of other long term support needs or dependency on our hospital sector for people whose needs can be met better elsewhere.

By modelling the current intermediate care activity, and understanding the potential for further impact by looking at examples from elsewhere, we have scaled these services in terms of workforce, finance and levels of activity, to arrive at a clear plan for scaling up to achieve the impact necessary.

In terms of workforce we have identified a ***current workforce of 252wte*** across Western Bay. Plans have been drawn up, sensitive to local needs and within the financial envelope identified by the modelling work, to ***increase this staffing by a further 138wte***. The staff required include Nurses, Social Workers, Care Staff, Occupational Therapists, Physiotherapists, Speech and Language Therapists, Dieticians and Pharmacists.

The financial plan translates the activity and workforce profiles into a three year approach to investment and recycling of benefit. ***In the first year c.£6.5M will be invested*** recurrently and non-recurrently from the Welsh Government Intermediate Care Investment Fund. ***This will release £2.3M of in-year savings*** to be reinvested in the service and sustain the recurrent commitments. However, there is a need for ***further bridging in 2015/16 of £3.9M***. Chief Executives will need to consider how to fund this gap as we bridge to 2016/17 where the baseline scenario suggests a more balanced position. Different scenarios have been run to test the sensitivity of the financial model and a full risk management approach has been outlined. The programme is not without risk, but we have set out the implications of the alternative 'do nothing' option, which are clearly unacceptable. We are also conscious of the risk of a half-hearted sign-up that would reduce confidence in the service to address the challenges ahead, for example in being able to recruit high quality staff to a service in which they can see a longer term career development path.

To give clarity and confidence to proceed the plan also sets out the type of reductions in key health and social care activity levels where we expect to see resources released, particularly in the short term. A quarterly profile of reducing numbers of new home care clients, care home admission and post-acute episodes of care will be directly attributable to these service changes. Across Western Bay we will look to ***reduce post-acute episodes of care in a hospital setting from 3,700 to just under 3,000; new home care starts from c.1,600 to c.1,350 and new admissions to care homes from c.1,100 to just under 1,000***. These are achievable targets, but can only be delivered safely and effectively with the best intermediate care services being in place.

To ensure the programme is managed effectively an Implementation Group will be established, answerable to the existing Western Bay Project Board. A team of senior and operational champions and change agents will be identified and provided with dedicated time to deliver this programme. Evaluation and ongoing learning will be built into the programme, as well as commissioning external experts to undertaken formal evaluation.

Finally, it is recognised that there are a wide range of services that will also need to be developed that can contribute to the challenges we face in meeting the needs of a growing older population. Many of these will interface in some way or other with the intermediate tier of services. We have described, in an appendix, the work that is either underway elsewhere or that will need to take place to ensure that community services for people who are frail continue to deliver effective, and value for money solutions that keep people healthy and independent for as long as possible.

Introduction

Our vision

The number of people who are frail or who are vulnerable across Western Bay is increasing, largely because we have become better at treating conditions that might have killed people in previous decades and generations. But those who become vulnerable in this way deserve the very best quality of care that provides genuine choice for frail older people, maximises independence and optimises outcomes.

For many people the conditions that contribute to increasing risk are well understood. Much can be done in the management of long term conditions to slow the rate of progress or to manage these conditions in ways that reduce hospital admissions and other incidents that lead to increased dependency levels. These are important preventative and maintenance strategies that need to dovetail with the development of intermediate care described in this document.

Many frail older people are vulnerable and without the sort of short term support that the intermediate tier can give they are likely to end up being increasingly dependent on ongoing health and social care. These are the words of one such older person who, as well as caring for others in his family, had his own care needs:

> *"I have had various assessments from social care giving me a range of support to help me continue caring. I have been ill myself recently due to being tired and exhausted, and received short term help, which was provided promptly giving me support and peace of mind.* ***I know that without me caring for them, both my mother and brother would almost certainly be in full time residential care. However with the support I have received, we as a family are able to stay together at home."***

However, what is also increasing at a greater rate than simply the number of older people, is the rise in multi-morbidity. These increases require any intermediate care services to become increasingly integrated with 'expert generalists' becoming core to meeting the complex needs of an increasing number of people. Here is a 'before and after' example of what an effective intermediate tier of services meant for one person:

A lady in her 80's with diabetes and a heart problem, lived with her husband but was known to be not eating and drinking properly or taking her medication. She was offered a number of services, many of which were refused. The lady stated that she wanted to die.	
Before: The lady developed an infection that led to her husband calling for an ambulance late one night. She was assessed at A&E and because of the complexity of her case she was admitted. Her mental health meant that it was difficult to co-ordinate all the assessments and treatment necessary. Because there was no significant improvement in her underlying condition she was assessed as needing to be admitted to a care home, but	**After:** The lady developed an infection that led to her husband calling the local access point for health and social care. After gathering the relevant information over the phone a member of the Rapid Response Team visited and arranged for a mental health assessment. This led to her being prescribed anti-depressants, with weekly follow up visits. She is now eating, drinking and taking all necessary medication. Her mood has improved,

delays in finding one with suitable mental health expertise meant that she was in hospital was an extended period of time before finally being transferred.	she states that she no longer wants to die, and has agreed to further services to assist her.

In the work leading up to the development of this business case people expressed the desire to see services for people who were frail that:

- Helped frail older people to stay healthy, for example through support to self-care, improved medicines management, housing adaptations, health screening and community activities that reduced the risk of isolation;
- Was proactive – a pull rather than push approach – that identified those most at need and supported them by identifying key workers and made best use of technology;
- Ensured that people were admitted to hospital only when absolutely necessary, that when they were admitted, their stay in hospital was of the highest quality and when they were ready to be discharged that they were helped to optimise recovery and reablement.

This business case is focussed on a key part of the system that is necessary to deliver this future vision – intermediate care services. These services are largely community based services provided by either health or social care where there is a strong rehabilitation or reablement focus. They are the catalyst for wider system change and help to shift the balance away from institutional care to support at home, sometimes with minimal input from professionals.

Outline and purpose for the Business Case

This Business Case focusses on developing the intermediate tier of services because this is seen as a vital building block for wider whole system change. The intermediate tier consists of short term interventions that address needs at a time of crisis or when people's needs change, with the aim of maximizing recovery and on-going independence. It is linked, but is not the same as on-going support in either health or social care. Developing the Intermediate Tier is a 'first step'. The further development of wellbeing services to reduce future needs from escalating, together with services to support those with complex and high levels of need for ongoing care remain as critical next steps.

The Intermediate Care Business Case is organised in such a way as to clearly identify:

1. The case for change and the service model for the Intermediate Tier that is designed to address the challenge.
2. How we have modelled the local system of health and social care to arrive at the investment and impact described in this Business Case.
3. The business case for additional investment in the intermediate tier for each Western Bay locality to deliver key strategic changes.
4. The governance and monitoring that will be put in place to ensure delivery of the programme.
5. The strategic consequences of this investment on related services in the wider system of care (see Appendix 1).

Strategic context

In June 2013 the Western Bay Programme Board approved a Strategic Outline Business Case for a Transformation Programme relating to the needs of the frail older population across Western Bay. The underlying analysis and modelling work that supported the outline business case has since informed the '*Delivering Improved Community Services – a joint commitment*' paper.

'*Delivering Improved Community Services*' also reflects initial work on dementia, which is still underway. This work identifies the level of need, and the options for strategic redesign for people with dementia. In order to facilitate a local conversation about the overlap and opportunities for integration between services for people with dementia and those who are frail, two further pieces of work have been undertaken:

- A workshop with the C4B programme and the Community Services Project Board was also held in September 2013 to explore the challenges and opportunities for integration. This has subsequently underpinned the options appraisal undertaken, which is reflected in this Business Plan and described in more detail in Appendix 2.
- A high level Investment Plan for the Intermediate Tier was approved by the Community Services Programme Board in December 2013. This Business Case provides the detail to support the Investment Plan.

The case for change

Changes in the older frail population

One of the main, and quantifiable, pressures on current services arises from the growth in the number of people who are frail. People who are frail are also typically, though not exclusively, old and many will therefore have dementia. Identifying the potential impact on services, and resource use, from this group of people, and then focussing our efforts on meeting these needs differently through an enhanced intermediate tier is therefore vital.

The modelling work undertaken has included the development of projections for the change in the older population. These have been used to gain an understanding of the increases in demand that might be expected, were there to be no change in services or in people's access to and expectations from these services.

The projections developed are based on existing research on the prevalence of physical frailty, plus assessments of the varying impact of local health status and local population changes. The headline projected changes in the numbers of older people as a whole, and in older frail people are identified in Table 1. Differences in the expected level of change between the >65s and the frail older population are due to different age distributions in each locality.

	Total >65s			**Est. of frail population**			**Frail per 1,000 >65**
	2012	**2018**	**Change**	**2012**	**2018**	**Change**	
Bridgend	25,880	29,980	+15.8%	2,582	3,001	+16.2%	100
NPT	27,450	31,214	+13.7%	2,837	3,198	+12.7%	103

Swansea	44,290	49,396	+11.5%	4,687	5,226	+11.5%	106

Table 5 Future needs based on demographic projections[1], healthy life expectancy and expected prevalence of frailty

Changes in the population with dementia

The modelling work has also looked at the number of people with dementia, because evidence indicates that people with a range of conditions are twice as likely to be admitted to hospital if they also have dementia. Using the same demographic profiles as above, and applying appropriate incidence and prevalence rates, it has been estimated that by 2018 there will be a total of 2,205 new cases of dementia a year across the Western Bay area – many of whom may go undiagnosed until later in the disease progression. The total number of people expected to have dementia by 2018 across Western Bay will be c 8,009. Table 2 shows the change from a baseline of 2012. It shows that in all three areas the percentage increase in dementia is greater than that for the older population as a whole reflecting an increasingly ageing older population.

Locality	Expected prevalence in 2018	Change from 2012
Bridgend	2,074	+18.2%
Neath Port Talbot	2,239	+13.6%
Swansea	3,696	+13.0%

Table 6 Expected change in the prevalence of dementia

Combining physical frailty and dementia

People with both dementia and frailty have particular needs that can be complex and that therefore require particular attention in our planning and delivery of services. An indication of the levels of co-morbidity also informs where, and to what extent, services would benefit from closer alignment or integration. The approach to determining the extent of co-morbidity is detailed in Appendix 3. In summary, it suggests that across Western Bay:

- 8,050 people who will be frail without having any form of dementia;
- 4,580 people who will have dementia but will not be frail;
- 2,410 people who will have both dementia and who will be frail.

This means that about 16% (1 in 6) of people with either dementia or frailty will experience both. However, when a similar estimate of cost is made across Western Bay we have estimated that £54M out of £110M (i.e. c 49%) is spent on the group who have both dementia and frailty (see Appendix 3).

The financial consequences of 'no change'

From the above demographics it is clear that the demand for care and support will increase by a significant amount in coming years. A system of support that simply delivers the current model of care, to the same kinds of people, is unsustainable particularly in an economic environment that requires savings year on year. The cost of meeting the needs of an

[1] Based on 2008 ONS demographic projections in IPC/ WG Daffodil database: projections derived from the 2011 census will be used to update modelling data once available through this source.

increased number of people using the current reactive service models cannot be met. Indeed, it has not been met in recent years leading to the pressures we currently experience, particularly in the acute hospital sector.

The modelling work underpinning this plan has been used to assess the potential demand on care and support if the number of frail older people increases as identified above, and if rates of access to services remains the same (i.e. general hospital unscheduled admissions per 1,000 frail older people, home care new starters per 1,000 etc.).

Based on current unit costs the modelling suggests increases in expenditure from the 2012/13 baseline as identified in Table 3. If, as we expect, these costs are not met and traditional services are not increased to meet these needs (more hospital beds, a greater number of care home places etc.) then the cost pressures provide an indication of unmet need. For example, the cost pressure of c£3.3M in social care across Western Bay by 2016/17 (compared to 2012/13) would mean that about 450 fewer people could be provided with support at home, without any compensation in prevention, rehabilitation or reablement services. The £2M cost pressures in health would mean the equivalent of discharging everybody in a post-acute bed 5 days earlier irrespective of need, again without any compensating services or support.

The differential change in whole system costs between the three localities, and where these additional costs will fall (health or social care), reflects the differing demographic profiles and differing current rates of usage of health and social care., The figures suggest that in 2016/17 whole system cost pressures across Western Bay will be c£5.8m more than in 2012/13.

Change in annual spend	**2013/14 £000's**	**2014/15 £000's**	**2015/16 £000's**	**2016/17 £000's**
Bridgend				
Intermediate Care	£31k	£65k	£101k	£137k
Social Care	£146k	£349k	£592k	£864k
Hospital Care	£165k	£337k	£515k	£687k
Whole System	£343k	£752k	£1,208k	£1,687k
Neath Port Talbot				
Intermediate Care	£32k	£59k	£85k	£110k
Social Care	£321k	£632k	£871k	£1,086k
Hospital Care	£127k	£244k	£358k	£469k
Whole System	£480k	£935k	£1,313k	£1,665k
Swansea				
Intermediate Care	£89k	£169k	£251k	£328k
Social Care	£391k	£692k	£1,003k	£1,335k
Hospital Care	£206k	£407k	£610k	£810k
Whole System	£686k	£1,268k	£1,864k	£2,473k
Western Bay				
Intermediate Care	£152k	£293k	£437k	£575k
Social Care	£858k	£1,673k	£2,466	£3,285k

Change in annual spend	2013/14 £000's	2014/15 £000's	2015/16 £000's	2016/17 £000's
Hospital Care	£498k	£988k	£1,483k	£1,963k
Whole System	£1,509k	£2,955k	£4,385k	£5,825k

Table 7 Cost pressures using a 2012/13 baseline with 'no change' in service design

Service model for an integrated Intermediate Tier

What do we want the intermediate tier to achieve?

An integrated intermediate tier of services provides a number of functions. These are illustrated in Figure 1. The Intermediate Tier of services needs to make a significant contribution to what the wider health and social care community wish to see at a whole system level and as a result of the joint commitment Delivering Improved Community Services, i.e.

- Support for people to remain independent and keep well;
- More people cared for at home, with shorter stays in hospital if they are unwell;
- A change in the pathway away from institutional care to community care;
- Less people being asked to consider long term residential or nursing home care, particularly in a crisis;
- More people living with the support of technology and appropriate support services;
- Services that are more joined up around the needs of the individual with less duplication and hand-offs between health and social care agencies;
- More treatment being provided at home, as an alternative to hospital admission;
- Services available on a 7 day basis;
- Earlier diagnosis of dementia and quicker access to specialist support for those who need it.

This means that we need:

1. Services that support people to remain confident independent and safe in their own homes for as long as possible and in accordance with their dignity and choice.
2. Services that are coordinated to reduce the number of unplanned admissions into hospital and long term care and support timely discharge when a hospital admission is appropriate.
3. A realignment of capacity, and a shift of resources, into community services to enable more people to receive the right assessment and service in the setting most able to meet their needs.

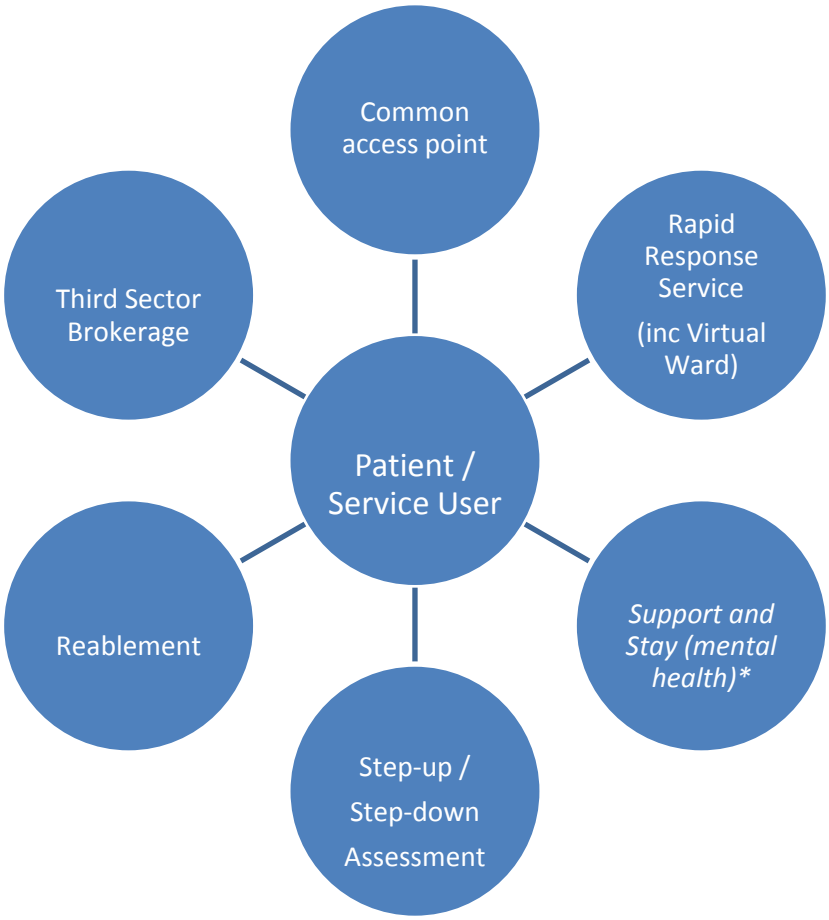

Figure 3 Functions undertaken by the Intermediate Tier

[*Support and Stay provides a dedicated service for older people with mental health needs and is being pursued in the context of the local dementia service development process.]

Together, this service model will help us to achieve significant improvements for services users, including:

- The person, their choice and preferences will be at the centre of every intervention, where appropriate.
- More people remaining independent confident and safe in their own homes for longer.
- Appropriate assessment and intervention carried out in a person's home and realignment of capacity to enable this to happen.
- A suite of support care services are available so less people are asked to consider long term residential or nursing home care, particularly in a crisis.

What will the intermediate tier look like?

The different functions outlined above are described in detail in this section. However, the integration expected within this service means that two broad 'umbrella' functions can be described:

- Those that rely on an immediate response (measured in hours) and where support is typically relatively short lived (measured in days);

- Those where response can be planned (measured in days) and support provided over a longer period (measured in weeks).

These two components of an intermediate tier still need to work closely together with the sharing of assessments and internal referrals between them. An outline of this is provided in Table 4.

	Immediate response (measured in hours and days)	**Planned response (measured in days and weeks)**
Functions	Demand management Rapid response	Reablement functions either at: • 'Intake' to home care • Review whilst being supported at home • Step-up or step-down from hospital
Access	Via Integrated common access point	
Operating Hours	7 days a week – 365 days a year 8am to 8pm	
Response time	Within 2-4 hours (Telecare Mobile response within 30 minutes)	Within 10-12 hours following initial telephone contact
Assessment	Integrated assessment, planning and review documentation	
intervention duration	- Urgent Assessment within 2-4 hours - Short term support (up to 7 days)	Up to 6 weeks of input
Access to	- Frail Assessment Unit / Hot Clinics - Virtual Ward at home - Frailty Case Management - Step-up/step-down beds in residential , domiciliary or hospital setting Hospital diagnostics - Mental Health Liaison workers - End of Life Nurses / workers - Pharmacy	Up to 6 weeks reablement including: - Intake reablement - Review reablement - Residential reablement - Care coordination Telecare - Community Equipment Service - Therapies – SALT/Dietetics/Physio and OT - Pharmacy - Psychology
The team	- Geriatrician – specialist GPs?? - Nurse Practitioners - End of Life Nurses / Support Workers - Therapists – OT/Physio – other therapists? - Pharmacy technician - Mental Health Liaison worker - Social Workers - HCSWs – see new role below - Telecare Mobile response (OOH) **Coordinated with WAST and APPs	- Nurses - Therapists – OT/Physio/SALT/Dietetics - Therapy technicians - Social Workers - Pharmacy technicians - HCSWs ** New role identified here for generic role 'Care Coordinator' - Carer's support worker - [*Support and stay for people with dementia*][2]

Table 8 The core elements of the Intermediate Tier

The team providing the service consists of therapists (e.g. Physio, OT, SALT, Dietetics) and highly trained healthcare support workers (HCSW) and social workers who will in most cases be the care co-ordinators, supported by HCSWs. The HCSWs have a generic set of skills that allow them to care for frail older people, who usually have a wide range of care needs based

[2] Support and Stay services are not included in this business case but are being taken forward in the context of service development plans for services for older people with mental health needs.

on them having a number of illnesses or chronic conditions. The care coordinator for those frail older people and can access a range of services in the community based on the needs of the service user.

The intermediate care teams work closely with long term care managers and case workers in order to determine long term care packages when a person is not responding to time-limited intermediate care packages. The team works closely with community network teams, including District Nursing, Occupational Therapy, Social Work, Chronic Conditions teams and third sector partners. The teams have a mental health liaison worker embedded within them and work closely with specialist mental health teams to ensure people with mental health problems who can benefit from intermediate care receive the service and that there is specialist input and smooth onward referral were necessary.

What different elements make up the intermediate tier?

Common access point

What is it?

Citizens, their Carers and Professionals can access the service via one contact number, (telling the story once). On the basis of that conversation either they are offered a rapid response, advice and information or signposting to another service, where appropriate. Where applicable, a proportionate assessment will be carried out by an appropriate person who will then either refer to or plan for the most suitable response and intervention. The service can be accessed by anyone older than 18 years of age and including those with cognitive and sensory impairment.

How will it work?

- 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). The team can also carry out urgent assessments. The centre operates 8am until 8pm, 7 days a week and has access to both health and social care information systems.
- The multi-disciplinary approach to assessing calls in the SPA will screen referrals and calls based on a risk stratification tool and refer to the most appropriate service and assign a priority.
- A large proportion of frail older people will have a dementia so mental health liaison workers are based in the team to ensure an assessment by a mental health professional is accessible quickly.
- Access to Geriatricians, Nurse Practitioners and Therapists ensure timely clinical response is available.
- Social Workers also work in the team to ensure a person's social needs are assessed quickly and efficiently.
- Third Sector workers are based within the SPA to ensure a quick response to specific needs such as housing adaptations, carer services, etc.

Rapid Response

What is it?

The rapid response service is available either through a rapid clinical response (doctor, nurse and/or therapist) or through a mobile response service linked with assistive technology. Early clinical response will be within 4 hours between 8am and 8pm and mobile response services will respond within 30 minutes (out of hours). This response is coordinated with WAST where appropriate.

How does it work?

The team manages a crisis through the following:

- A 'virtual ward' can be established in a community setting, whether this is in a person's own home, or residential care setting, etc. This 'virtual ward' is exactly the same as a hospital ward, where specialist consultant and nursing staff provide rapid medical assessment and intervention and have access to appropriate diagnostic tests. 24 hour care is provided in the virtual ward and could include assessment by various specialists including mental health professionals, therapists and social workers, as well as personal support to assist recovery at home.
- The Welsh Ambulance Service (WAST) is a satellite link to the team and works in partnership with team members to ensure care is provided as close to or in people's homes as possible and as part of the virtual ward model
- A lead clinician will be responsible for the rapid care needed for the patient and this will either be a geriatrician or a GP
- Specialist nurses are available within the service in order to provide specific procedures and care normally undertaken in a hospital setting, such as IV Antibiotics. Nurses are based within the intermediate tier but do have a particular responsibility for a community network area in the locality, therefore allowing ease of referral from the SPA.
- Access to a Frail Assessment Unit is available if a specialist diagnosis is needed. The aim is to admit the person for that specific assessment and then return home within the same day for their virtual ward based care if needed.
- The service works closely with Welsh Ambulance services, ensuring this includes being a first responder for example for those that have fallen, and is trained to risk assess whether a person's safe to remain at home or needs to be transported to hospital.

Intake intermediate care

What is it?

Intake intermediate care focuses on helping people to regain skills that they may have lost, due to hospital admission or illness, with the objective of minimising the numbers starting to receive a new package of care or entering a care home for the first time.

How does it work?

A package of care lasting up to 6 weeks is planned by the intermediate care team, which may include both health and social care interventions as required to address the client's individual needs.

Services are delivered in most cases in people's own homes, or (where this is not possible) in a short term care home bed.

Review intermediate care

What is it?

Clients currently receiving homecare are assessed at a review as potentially requiring a significant increase in homecare package or transfer to a care home/ extra care housing. They receive a time limited package of intermediate care, delivered in their home, before any changes to the care plan are agreed.

How does it work?

A package of care lasting up to 6 weeks is planned by the intermediate care team, which may include both health and social care interventions as required to address the client's individual needs.

Services are delivered in most cases in people's own homes, or (where this is not possible) in a short term care home bed.

Step down intermediate care

What is it?

Following an admission to hospital for acute treatment, a time limited package of care and support is delivered to people (either at home or in a short term care home bed), to facilitate earlier discharge from hospital and to maximise recovery and reablement

How does it work?

A package of care lasting up to 6 weeks is planned by the intermediate care team, which may include both health and social care interventions as required to address the client's individual needs.

Services are delivered in most cases in people's own homes, or (where this is not possible) in a short term care home bed.

Step up intermediate care

What is it?

People experiencing a temporary increase in their needs as a result of a crisis event receive a time-limited package of care and support with the objective of minimising their need for ongoing care and/or admission to hospital.

How does it work?

A package of care lasting up to 6 weeks is planned by the intermediate care team, which may include both health and social care interventions as required to address the client's individual needs.

Services are delivered in most cases in people's own homes, or (where this is not possible) in a short term care home bed.

Support and stay for people with dementia

This service aims to put in place a rapid response to a person with dementia that needs support from a mental health professional during a crisis.

The service offers an intermediate time limited service to manage crisis and is linked in via the Mental Health Liaison worker based in the common access point who will triage the referral quickly. The support and stay element is provided by a CPN and will usually be within a domiciliary setting to avoid the patient having to go into hospital. The CPN will act as the care coordinator and will provide case management / assessment of ongoing needs. This then improves alignment with Frailty/general service provision.

Other supporting elements for the intermediate tier

Case management

A 'Frailty Caseload' is monitored proactively and closely by the community intermediate tier through a robust risk stratification system (?Prismatic). The caseload is a group of patients that have either been identified as being at risk of hospital admission (due to issues such as irregular prescribing patterns, hospital admission recently, etc.) or have deteriorated whilst on a reablement programme and need some short term care package.

Those being monitored by the community teams as part of the frailty caseload have the benefit of a suite of options within the community in order to respond to any deterioration of their condition – referral to Virtual Ward for assessment and care, referral to Frail Assessment Unit or referral to Reablement teams, etc.

Integrated assessment and review

All Health and social care professionals will use one set of standards and documentation for the assessment and review and planning of patients/service users care and needs. This includes things like Discharge to Assess, where a model of ownership and responsibility will be in place for the referring clinician/therapist/social worker. If the patient is better assessed in the community then they should be discharged from hospital for the assessment to take place – if it is better for the patient for the assessment to be carried out in hospital then it will be carried out in hospital.

Telecare

Telecare equipment is available for service users in their own homes. This equipment raises an alarm if for example the person has fallen, or if there is extreme heat or flood in a person's property, it can also provide reminders to take medication, etc. A mobile response team, of registered care of response workers is in place to respond quickly to the alarms raised by assistive technology equipment and are available throughout the day and night.

The community resource service has seamless links with community equipment services (including third sector), ensuring equipment and adaptations can be put into people's homes quickly and efficiently.

Information systems

It is recognised that each locality has a different information system in place for care management of service users. However, technology will be in place to allow all information systems to talk to each other and share information in a safe and effective way. 'PIMS Community' will be used for more specialist community care (i.e. early response/virtual ward) and local systems (Draig/NPT Bespoke/PARIS) for lower level referrals through the

SPA. PIMS Community has electronic transfer of care (ETOC) ability so all info can be transferred to GP following episodes of care and intervention.

Premises – a community hub

A building with a central location in each locality will be the base of the intermediate tier hub, which houses the team base and the Integrated Referral Management Centre.

How will we know that the service is working as we want it to?

A comprehensive and integrated set of measures will be needed to indicate the Intermediate Tier is actually achieving what we want it to. An initial set of impact measures might include:

- Reduced numbers of people being admitted inappropriately to an acute hospital;
- People having shorter lengths of stay in hospital;
- Reduced numbers of people delayed in hospital or other care settings waiting for the next stage of care;
- Reduced demand for large, complex care packages;
- Increases in the number of people who are enabled to live independently rather than becoming dependant on social care;
- Reductions in the number of people being admitted to a care home;
- Improved patient flow through services, in particular secondary care;
- Improved access to community based services, 24 hours, seven days a week;
- More people being supported through voluntary or third sector organisations;
- More people being helped to live at home confidently & safely or in their own community.

Measuring the demand on the Intermediate Tier itself will also be key to managing the transformation and impact programme. This means that we will need to monitor key activity and indicators of complexity, for example:

- The number of new patients assessed by the Rapid Response team (and number of interventions completed);
- The number of people sign-posted to independent or voluntary sector services;
- The number of people leaving intermediate care with no ongoing social care needs;
- The number of new intermediate tier assessments including all disciplines;
- The number of domiciliary visits by Consultant Physician;
- The number of rapid access appointments made by the Early Response team;
- The number of referrals to hospital for patients in Nursing Homes;
- The number of people deemed to have continuing health care needs.

Timeliness is a key indicator of quality and it will therefore be helpful to ensure that we measure:

- Response times from referral to assessment (in days);
- Number and % of responses within 2 hours and 4 hours;
- Number of mobile response team interventions within 30 minutes;
- Average Length of Stay (ALOS) in the Virtual Ward;
- Number of delayed transfers on to the next stage of care due to waits for package of care;
- Number of delayed transfers on to the next stage of care due to waits for home adaptations.

And finally, there will be the need to ensure effectiveness of the service. The following represents examples of the key indicators in this respect:

- Number of people signposted by the common access point to third sector or other low level support;
- Number of avoided unscheduled care admissions;
- Number of avoided re-admissions to hospital within 14 days of discharge;
- Number of avoided re-admissions to hospital within 6 weeks;
- Number leaving reablement with reduced care needs;
- Number leaving reablement with zero care needs;
- Number and % who were assessed as requiring the same level of care or the need for care was not assessed prior to receiving reablement;
- Number and % of admissions to care homes direct from acute hospital;
- Number of patients returning to usual place of residence direct from acute hospital;
- Number of referrals for carers assessments.

It will be essential that this basket of measures is refined in the context of local service development by those who will be implementing the changes. It is also crucial that the final measures match what is necessary to achieve cash releasing savings on which this plan is dependant. Further work will therefore be carried out through the proposed governance and project management arrangements described later in this document.

Modelling the investment in the Intermediate Tier

Introduction

The importance of the intermediate tier within the new service model cannot be underestimated as it is this range of services that will ensure that people's needs are met speedily with the best possible health outcomes and ongoing independence for people who are frail or who have dementia. This investment plan therefore outlines the development in each Western Bay locality of an optimised and integrated intermediate tier to deliver the functions outlined in section 2.

In building this capacity it has been assumed that implementation will be undertaken during 2014/15 with some part-year effects, whilst full year effect will commence from April 2015. It should be noted, however, that even with the full extent of these services being in place from April 2015 some of the benefits in other parts of the system will not be fully realised until subsequent years.

The intermediate tier now

Activity and costs

Information on current activity and unit costs in the intermediate tier is not consistently collected or reported across Western Bay. Available information has been collected from each locality and best estimates used to generate the baseline analysis shown below. The development of an improved information system and investment in IT Infrastructure for the intermediate tier and core community and social care services is therefore a crucial requirement for the future to support effective delivery and performance management, especially as localities work to develop increased integration.

Improvements in the gathering of intelligence to inform this work going forward should be developed using the Commissioning Activity Tool and the Health Technology Fund bid were that to be successful. In addition there is a national procurement exercise for an Integrated Health & Social Care community information system. Activity information collected to support this baseline analysis includes:

- Unscheduled over 65 medical hospital admissions and subsequent hospital stays, including both the acute and post-acute phase (i.e. time spent in a hospital bed after the end of the acute phase of treatment that may perform an intermediate tier function of active rehabilitation or be for another reason, for example recuperation without active rehabilitation, waiting for assessment, waiting for transfer, etc).
- Home care delivered by the LA's internal provider or by independent sector providers.
- LA funded admissions to permanent care homes (i.e. excluding self-funders).
- Intermediate tier functions delivered by the Community Resource Team in each locality or by other teams or services (e.g. DCAS and ReCAS in Swansea).

The baseline information and assumptions underlying the system model, and used in the development of the projections shown in this business case, are set out in previous versions of the Investment case for the Intermediate Tier with the headlines described in this section.

All information and assumptions will be reviewed as implementation plans are developed to improve baseline understanding of the intermediate tier. The unit costs in the baseline analysis include:

- Bed day costs for hospital based post-acute care;
- Weekly costs of home care and permanent care home admission;
- Cost per case of assessment by a common access point of potential home care clients;
- Cost per case of current intermediate tier functions delivered in the community (excluding medical input).

They exclude costs of medical supervision, diagnostics etc.

Each locality has developed its community intermediate tier functions in a different way. Table 5 shows an analysis of 2012/13 actual spend by each organisation on community intermediate care functions (i.e. excluding post-acute care in hospitals).

	Total spend £000 pa	Health spend £000 pa	Social care spend £000 pa	Percentage spend health:social care
Bridgend	£1,455k	£751k	£704k	52:48
NPT	£1,854k	£882k	£972k	48:52
Swansea	£4,930k	£2,228k	£2,702k	47:53
Total	£8,239k	£3,861k	£4,378k	47:53

Table 9 Actual spend on intermediate tier services (2012/13) as identified in local documentation

The baseline of current costs in community intermediate tier services reflects different availability of services against the standard service model of 7 days a week 8am – 8pm. There are therefore two elements to the 'scaling up' in terms of capacity and availability. Modeling of this change, reflected in this section of the plan, only covers capacity changes. Local implementation plans will need to consider and balance the additional resources invested on this basis and the potential economics of scale that should enable greater availability.

The financial plan underpinning this Business Case will need to be rebased when actual spend on 2013/14 is known. The modelling tool assumes an uplift for demographic change during 2013/14, which is a reasonable modelling position given that even when efficiencies are taken into account evidence suggests that spending on this range of services is growing as its value is recognised.

In order to project future potential costs within the whole systems modelling tools, and to properly take account of proposed changes in different parts of the system and their impact elsewhere, activity and unit costs data has been used to replicate, as far as is possible, the known spend in Table 5. The modelled baseline spend (column 1 in Table 6) differs slightly from actual baseline spend due to the rounding of unit costs, the removal of part year effects, and to allow for an element of baseline spend that would be deployed on other CRT functions, and therefore not forming part of the intermediate tier.

	Community intermediate tier £000 pa	All post-acute care £000 pa[3]	Assumed Post-acute intermediate tier (20% of all) £000 pa	Total intermediate tier £000 pa
Bridgend	£1,289	£1,773	£355	£1,644
NPT	£1,872	£5,656	£1,131	£3,003
Swansea	£4,766	£3,713	£743	£5,508
Total	£7,927	£11,141	£2,228	£10,155

Table 10 Level of baseline spend (by locality of patient/ user in 2012/13) on intermediate tier and related services included in the modelling tool

The spend on post-acute care shown in Table 6 is a reflection of the different levels of reliance on the acute sector in the absence of a comprehensive and optimised range of community intermediate care services. It includes all patients who were admitted for unscheduled medical treatment, assumes that current length of stay for these patients is the same as for all post-acute patients and includes post-acute care for patients admitted for unscheduled, scheduled or surgical care. However, only a proportion of this post-acute activity could be described as intermediate care that could be delivered in the community (i.e.

[3] Based on transferable bed day costs provided by ABMU and the patient's locality of residence.

time limited rehabilitation to maximise independence). This business case estimates that 20% of admissions to post-acute care fall into this category.

Towards an optimised intermediate tier

Introduction

There are a range of examples that demonstrate the potential for intermediate care services, although it is fair to say that no single 'best practice' model for the intermediate tier has emerged. However, practice emerging from areas who have pioneered the development of intermediate tier services have been reviewed (including Pembrokeshire, Torbay and North East Lincolnshire). This has enabled a picture of an optimised intermediate tier to be developed for the intermediate tier functions covered in this business case, although local requirements will continue to inform detailed staffing structures and skill mix.

The optimised intermediate tier is expressed in terms of expected levels of activity, and while it is assumed that it will be delivered on the basis of maximal locality integration it does not assume a particular staffing structure or skill mix: this will be for localities to determine in implementation planning stages.

The sections that follow describe the characteristics of an optimised system, and compare baseline performance in each of the Western bay localities to this 'gold standard'. They set out the projected impact of developing the intermediate tier in each locality to deliver the following:

- Common access point: 100% of all new contacts relating to community health and social care are directed through the common access point.
- Rapid Response: 15% of baseline unscheduled medical admissions for >65 year olds are diverted to Rapid Response.
- Home care intake: 100% of all potential new homecare clients receive intake intermediate care.
- Care home intake: 50% of all potential new care home admissions direct from hospital receive intake intermediate care
- Review: 100% of homecare clients for whom a potential significant change is identified receive review intermediate care.
- Step down care: post-acute care that is suitable for domiciliary intermediate care (20% of sub-acute activity) is delivered at home rather than in a hospital bed.
- Step up care: Step up care provision is expanded proportional to future change in the frail older population.
- Residential intermediate care: provision of intermediate care in residential beds continues to be provided at the current rate in each locality with full utilisation of planned developments.

Demand management (common access point)

Function: enquiries about, and potential referrals to, community health and social care services home care are directed to a single point for initial information gathering and top level assessment, which will signpost some people to alternative forms of support and direct others on to intake reablement/intermediate tier services.

Optimised level: 100% of all new contacts relating to community health and social care are directed through the common access point

The Outline Business Case identified a potential level of optimised spend on this function equivalent to the well developed service in North East Lincolnshire. Assuming comparable cost levels, this would equate to a budget of c.£600k in Bridgend, £640k in Neath Port Talbot and £1,030k in Swansea. It has been assumed in this investment case that 50% of the resources required for this level of SPA are already in social care budgets, and that these would be transferred to the budget for the intermediate tier together with new investment to fund the expansion of the SPA to deliver the full service.

Rapid Response

Function: people are diverted from hospital to the community Rapid Response (RR) service for an intensive period of care.

Optimised level: 15% of baseline unscheduled admissions for >65 year olds are diverted to Rapid Response.

Table 7 shows activity from each of the three Western Bay localities that is consistent with this Rapid Response function. It assumes that half of the current activity is effective in avoiding unnecessary hospital admissions and compares this with actual unscheduled hospital admissions for >65 year olds. This enables us to identify the current level of optimisation in each locality, for example NPT already achieves 11% compared to the target of 15%. (It should be noted here that Swansea provides rapid *access* to intermediate tier but that the service is delivered over an average of 6 weeks and thus does not fit the usual description of a 'rapid response' service.)

	Baseline RR cases pw from diversion	Baseline saved adm'ns pw (@ 50%)	Baseline unsched >65 adm'ns pw	Baseline % of potential admissions saved	Target % of admissions saved	Distance from target
Bridgend	7	3.5	69.3	5	15	-10%
NPT	18	9	73.2	11	15	-4%
Swansea	0	0	128.0	0	15	-15%

Table 11 Estimates of current rapid response function and distance from target

Intake intermediate care (potential new homecare clients)

Function: potential new homecare clients receive a time limited package of intermediate care before a care plan is agreed.

Optimised level: 100% of all potential new homecare clients receive intake intermediate care.

Table 8 shows activity within existing services that perform the intake intermediate care function and distance from target in each locality.

	Baseline intake cases per week	Baseline homecare referrals per week	Baseline % of homecare referrals to intake	Target % of homecare referrals to intake	Distance from target
Bridgend	10	14.9	67	100	-33%
NPT	8	17.4	46	100	-54%
Swansea	30	32.1	93	100	-7%

Table 12 Estimate of current intake intermediate care activity and distance from target

Intake intermediate care (potential new care home admissions)

Function: potential new admissions to a care home receive a time limited package of intermediate care before a care plan is agreed, with a particular focus on people being discharged from hospital.

Optimised level: It is unlikely that all potential new admissions to care homes will be suitable for intake intermediate care: some people will have already spent a long time in the care system and their needs will be well known. It is suggested that the initial focus of intake intermediate care for potential new care home placements should be on people referred for care home placement direct from hospital. This will include a mix of people previously not known to services and those who are known, but whose needs have changed significantly over the course of their hospital admission.

Information on current levels of admission to care home direct from hospital has not yet been analysed in the project to date. As a starting point for further work, it is suggested that a potential aspiration could be that:

- 50% of direct care home admissions from hospital are diverted to intake intermediate care
- 25% of those diverted are diverted to a residential intermediate care bed, and 75% to a domiciliary service
- 50% of care home intake interventions are successful (ie the service user is prevented from admission to a care home on exiting the intake service)
- Any diversions who were not previously receiving home care will need an ongoing package of home care on exiting the intake service if they are not admitted to a care home

It has been assumed that this function is not currently delivered in any of the Western Bay localities at present.

Review intermediate care

Function: homecare clients assessed at a review as requiring a significant increase in homecare package or transfer to a care home or extra care housing receive a time limited package of intermediate care before any changes to the care plan are agreed.

Optimised level: 100% of clients for whom a potential significant change is identified receive review intermediate care.

Table 9 suggests that only Bridgend currently undertakes this type of intermediate care activity and indicates the likely level of activity required to achieve these targets. The targets are based on a conservative estimate that each home care client will have a full review every two years and that in 50% of cases a period of intermediate care is thought to be beneficial (this would be the same as 25% of cases were there an annual review).

	Baseline review cases pw	Baseline homecare reviews pw	Baseline reviews pw IDd as potentially significant	Baseline % of IDd cases to review IC	Target % of IDd cases to review IC	Distance from target
Bridgend	2	6.7	3.4	59%	100%	-41%

NPT	0	7.8	3.9	0%	100%	-100%
Swansea	0	12.3	6.2	0%	100%	-100%

Table 13 Estimates of current review intermediate care activity and distance from target

Intermediate care delivered in hospital

The use of hospital beds for post-acute care has been analysed in detail as part of this work. Providing alternatives to this part of the system is a key area for investment and therefore re-balancing of care over coming years. Great care will be needed to ensure that new services are in place in the community, whether at home or in alternative bed based services, before hospital beds are reduced, but this shift in care and therefore resource is a key ingredient of the future model of service. Appendix 1 outlines some of the consequences of this new service model for the acute sector.

Optimised level: 100% of post-acute care (across all hospital sites) and step up hospital activity that is suitable for domiciliary intermediate care is delivered at home rather than in a hospital bed. Current levels of post-acute episodes of care in hospital are shown in Table 10.

	Baseline new post-acute stays (unsched adm'n) pw	Baseline unsched admissions pw	Baseline IC post ac stays: % of unsched adm'ns	Target IC post ac stays: % of unsched adm'ns	Distance from target	Baseline new scheduled PA stays pw*	Baseline step up admissions pw
Bridgend	11.8	69.3	3.4%	0	+3.4%	2.0	0.3
NPT	21.2	73.2	5.8%	0	+5.8%	9.7	6.3
Swansea	15.6	128.0	2.4%	0	+2.4%	2.3	0.3

Table 14 Assumptions for post-acute activity suitable for intermediate care

Table 10 assumes that:

- 20% of baseline post-acute care and step up community hospital admissions would be suitable for intermediate care, which is an estimate based on local intelligence from CRT operational managers.
- * The split of new scheduled PA activity by locality is an estimate, matching the split of new unscheduled PA activity

Domiciliary step up and step down intermediate care

Function: this covers step down care (packages of intermediate care delivered at home following a hospital admission) and step up care (packages of intermediate care delivered at home, sometimes following on from an initial 'rapid response' intervention, to prevent an admission and/or referral for ongoing packages of care).

Optimised level: The optimised level of step-down intermediate care from hospital is a function of the use of post-acute stays as discussed above. However, the greater the optimisation of hospital diversion the less demand there will be for step-down support. This means that estimating an optimised level for both step-up and step-down intermediate care activity is dependent on the impact of other redesign features of the new service model.

In arriving at these estimates it should be noted that:

- Step down packages may be provided to people following an admission for any reason (i.e. for planned/ surgical care as well as for unscheduled medical care).
- Step up packages are shown in Table 11 as a rate per 1,000 modelled frail older people.
- The Swansea step up figure includes those identified locally as referred into the service via rapid access (but who do not receive an intervention of the type normally identified as Rapid Response).

The proportion of step down care currently being delivered in hospital and community is discussed later in this section.

	Baseline new step down cases pw	Baseline unscheduled admissions pw	Baseline new step down % of unsch admns	Baseline new step up cases pw	Baseline new step up cases pa per 1000 frail
Bridgend	6	69.3	8.7%	2	37
NPT	4	73.2	5.5%	4	115
Swansea	18	128.0	14.1%	47	514

Table 15 Estimates of current domiciliary intermediate care

Residential step up and step down intermediate care beds

Function: beds in residential care homes used for intermediate care.

Optimised level: provision of intermediate care in residential beds continues to be provided at the current rate in each locality with full utilisation of planned developments. Table 12 provides an estimate of current activity in this area. [4]

	Baseline admissions to residential IC beds pw	Percentage of admissions step up: step down	Average length of stay in days	Baseline bed days pa	Baseline bed days pa per 1000 frail
Bridgend	1.25	20:80	35.4	2301	826
NPT	0	-	-	0	0
Swansea	2.5	60:40	17.9	2327	489

Table 16 Estimate of current activity in bed based intermediate care

*The impact of developing **the intermediate tier***

Introduction

This section sets out the projected impact of implementing a transformation programme, in the context of rising demographic pressures, assuming the following system changes:

The implementation of an optimised intermediate tier including the following the functions:

- Common access point
- Rapid Response
- Intake intermediate care (potential new homecare)
- Review intermediate care
- Domiciliary step up and step down intermediate care
- Residential step up and step down intermediate care

The provision of alternatives to hospital based 'step-down' or post-acute care by re-providing all step down intermediate care currently delivered as post-acute care in a hospital bed as a community-based function.

The projected impacts of the transformation programme are presented in the sections below, with the 'do nothing' scenario as a comparator. This section therefore sets out the projected impact of implementing a transformation programme, assuming demographic change, including all the proposed changes in the intermediate tier described in section 4 above. The projected impacts of the transformation programme are presented in the sections below, with the 'do nothing' scenario as a comparator.

The 'do nothing' comparator assumes:

- Projected increases in the numbers of older people, and within that in the numbers of frail older people;

[4] NPT will have 7 residential intermediate care beds from April 2014.

- No change in current rates of access to unscheduled hospital care, home care, permanent care homes, and intermediate tier services by older people;
- No change in current models of service for older people (i.e. assessment criteria, lengths of stay, levels of input per unit time, and relative flows between services remain unchanged from baseline values);
- No change in unit costs over time (there is no allowance for inflation);
- Staffing for intermediate tier functions is able to be increased proportionately to the rise in demand.
- Spend on intermediate tier functions therefore rises proportionately to increases in demand;
- Spend on hospital and social care core services therefore rises proportionately to increases in demand due to demographic changes and the cost increase is proportional to the demand rise;

Impact within the intermediate tier

The development of an optimised intermediate tier will have a significant impact on activity and associated resource requirements in each locality:

- Referrals and new admissions to services delivering intermediate tier functions will increase;
- Staffing requirements for services delivering intermediate tier functions will increase.

Because each locality currently has a different model of service delivery, working at varying levels of integration and different access times/days the development of an optimised intermediate tier on the basis of maximal locality integration will have a differential impact on staffing models and associated staffing costs. The financial modelling and the indicative workforce numbers include the projected costs of scaling up activity within the intermediate tier on an as-is basis in each locality. They therefore take no account of the potential increases in productivity, and consequent efficiency savings, achievable through increases in integration at local level. These will be modelled in detail at the next stage of locality implementation planning between January and March 2014.

Impact elsewhere in the system

Developing the intermediate tier will also have impacts on demand for ongoing community support, including, in ongoing community services:

- Reducing new homecare packages via signposting by a common access point and increased levels of intake intermediate care;
- Reducing escalation in existing homecare packages via increased levels of review intermediate care;
- Reducing new permanent care home placements via increased levels of review intermediate care.
- And, in the hospital sector:
- Reducing unscheduled admissions to hospital (and therefore bed days) via increased diversion to Rapid Response;

- Reducing post-acute hospital stays for unscheduled, scheduled and surgical patients via increased step-down domiciliary intermediate care.

The nature and potential scale of these impacts are described in the Strategic Consequences appendix. The financial impact of the whole system change resulting from investment in the intermediate tier is included below.

Projected changes in intermediate tier activity

Table 13 shows the impact of the proposed development of the intermediate tier on average caseloads, compared to the do nothing comparator. These are presented as year-end 'snapshots' of domiciliary intermediate tier patients/ service users, across all functions (ie Rapid Response + intake + review + step up + step down). They exclude occupancy of residential intermediate care beds.

	March 13	March 14	March 15	March 16	March 17
Bridgend	128	131	212	218	224
Do nothing comparator	*128*	*131*	*135*	*139*	*143*
Neath Port Talbot	142	144	269	274	278
Do nothing comparator	*142*	*144*	*147*	*149*	*151*
Swansea	581	592	692	704	715
Do nothing comparator	*581*	*592*	*602*	*612*	*622*

Table 17 Projected caseloads for intermediate tier by locality: year-end snapshots

The workforce plan

Baseline intermediate tier staffing and projected impact of changes

Current community-based staffing figures for the intermediate tier have been estimated for each locality (note that this represents the majority of the work delivered by the CRT in each area, plus in Swansea the staffing establishments for DCAS and ReCAS). These have been used to develop initial projected staffing requirements for delivering future intermediate tier activity for the recommended option.

	Community intermediate tier staffing
Bridgend	39.8 WTE
NPT	65.1 WTE
Swansea	147.1 WTE

Table 18 Baseline intermediate tier staffing by locality

The scale of change in activity will have major implications for future staffing requirements, especially (but not exclusively) in those community services delivering intermediate tier functions. The tables below show an indication of the potential impact of implementation of the proposed developments on WTE staffing for these services at year end. It should be noted that:

- These projections are based on current identified staffing within Community Resource Teams, plus (in Swansea) DCAS and ReCAS.

- These projected staffing numbers should be treated as indicative only because they assume no change in working hours skill mix or productivity. In practice, increasing levels of integration would be expected to deliver staffing efficiencies, for example as duplication is reduced and/or back office functions rationalised. The extent of potential productivity gains will also depend on the current scale of integration and planned extension of working hours to deliver 7-day working, additional evening access etc.
- Projected staffing requirements are therefore proportional to the increase in activity for the relevant function compared to the baseline (and note that this baseline is derived from best local estimates of activity where robust data is not available).
- Swansea Rapid Response staffing projections are based on baseline staffing ratios in Bridgend.
- These figures exclude staffing requirements for the common access point/intake functions for potential new care home admissions.

Bridgend	**March 13**	**March 14**	**March 15**	**March 16**	**March 17**
Rapid Response WTE staffing	8.4	8.6	21.4	28.2	29.0
Other intermediate tier staffing (intake + review + domiciliary intermediate care)	31.4	32.2	43.7	48.5	49.7
Neath Port Talbot					
Rapid Response WTE staffing	13.2	13.4	16.1	17.5	17.8
Other intermediate tier staffing (intake + review + domiciliary intermediate care)	51.9	53.0	95.3	113.8	115.3
Swansea					
Rapid Response WTE staffing	0.0	0.0	20.5	30.9	31.5
Other intermediate tier staffing (intake + review + domiciliary intermediate care)	147.1	150.0	162.4	169.1	171.9

Table 19 Impact on WTE staffing levels of proposed investments in the intermediate tier

Developing a workforce plan

Further work has been undertaken starting with a more bottom up approach to determine the precise number, grading and mix of staff required to deliver the intermediate tier functions described in the service model underpinning this business case. This has involved local nursing, therapy, integrated community service managers, mental health managers, medical and medicines management staff from health and social care and ABMU corporate workforce managers. The work was undertaken through an initial workshop and then subsequent confirm and challenge to align broadly with the expected changes from the systems modelling work.

Attendees were provided with details of the projected changes in activity at March 2017 (end of the modelling period) for each function and asked to confirm these and to provide an initial assessment of the additional staffing requirement for these functions. Additional input

was provided of plans being developed for the medical workforce in Swansea that will support the intermediate tier and plans developed for medicines management, although funding for medical staff are not included in this business case.

Attendees were encouraged to consider innovative ways of delivering services, to take account of skill mix, and the potential efficiency and productivity gains that could be achieved through integration. There was a general consensus that the extent of service enhancement envisaged by the plan was consistent with the potential unmet need for intermediate care and that real impact could be achieved through this additional investment. However, this was not without its challenges and workshop participants identified some of the key issues in delivering these additional staffing requirements, including:

- A shortage of Advanced Nurse Practitioners and general nurses;
- Timescale for skills development;
- Difficulty in recruiting AHPs at higher skill levels;
- Potential for destabilising private provider workforce – domiciliary care, care homes, nursing;
- Crucial requirement for medicines management skills across all elements of the workforce.

Participants also identified opportunities in working with education and training providers to accelerate workforce development and also noted that levels of unemployment might suggest that there are some skills available in the workforce from which to recruit. There are also opportunities over time for encouraging the workforce to reskill and transfer to new areas of work, for example from some acute settings to the community.

Considerable further work needs to be undertaken on these in the next few weeks to develop them further, to test robustness and sense check. They do, however, provide an overall framework and shape of the workforce required by 2016/17 to deliver the new service model and changes in activity. A number of areas were identified where further scoping of the detailed service model is required to inform workforce requirements. These include:

- Determining precise hours of operation;
- Clarification of operational practice;
- For some functions the quantity of care to be provided in a domiciliary setting and in a residential setting;
- Determining the interfaces with other public facing services and the Common Access Point;
- Confirming how mental health expertise will be provided in/to the intermediate tier;
- Scaling up of identified staff numbers to 24/7 working

Workforce requirements

Since the workshop detailed work has been undertaken in each locality to specify the workforce that needs to be recruited in the first year of the programme. In determining these account has been taken of the local priorities for service development, reflecting on current gaps and areas of potential biggest impact, and the potential for speedy recruitment. It is recognised that in some professions such as Advanced Nurse Practitioners there is a

significant training / lead in time and plans are being put in place now to grow capacity to come on stream in future years.

The additional workforce proposed for 2014/15 for each locality are detailed in the following tables. As implementation progresses these may be refined further in light of learning and experience.

Bridgend

Intermediate Care function	Staff Group	WTE	Grade	Cost £000's FYE	Cost £000's 2014/15
Rapid Response					
(a) Rapid Response	Advanced Nurse Practitioner	1	A4C 7		
	Qualified Nursing	2	A4C 6		
	Qualified Nursing	1.5	A4C 5	£286k	£200k
	Occupational Therapist	0.5	A4C 6		
	Physiotherapist	0.5	A4C 6		
	Social Worker	1	LA 9		
(b) Mobile Rapid response	LA Care Staff	7	LA 3	£265	£186k
	Team Leader	1	A4C 7		
Planned Care					
(a)Bridging service extension	LA care Staff	14	LA 3	£426k	£299k
(b) Residential reablement	Occupational Therapist	0.5	A4C 6	£96k*	£67k
	Physiotherapist	0.5	A4C 6		
Pan Intermediate Care					
	Pharmacist	1	A4C 8b		
	Pharmacy technician/ MMN	2	A4C 6		
	Speech & Language Therapist	1	A4C 6	£269k	£208k
	Dietician	1	A4C 7		
	Dietician	0.5	A4C 6		
Contingency (10%)				£134k	£95k
Bridgend Total				£1,476k	£1,044k

* Includes LA loss of income for 2 residential Care beds

NB: Staffing based on band / grade midpoint including on costs and non-pay (mainly travel)
7 day working and nights enhancements included where appropriate

Swansea

Intermediate Care function	Staff Group	WTE	Grade	Cost £000's FYE	Cost £000's 2014/15
Common Access Point					
	Advice officers	10.0	LA 5	£468k	£234k
	Supervisor	01.0	LA6		
Rapid Response					
	Occupational Therapist	4.0	A4C 6	£648k	£364k
	Speech & Language Therapist	1.0	A4C 6		
	Physiotherapist	4.0	A4C 6		
	Dietician	0.5	A4C 6		
	Admin	1.0	LA 2		
	Advanced Nurse Practitioner	1.0	A4C 7		
	Qualified nurse	2.	A4C 6		
Planned Response					
	CCA/HCSW	15.0	LA 2	£828k	£646k
	Senior CCA	3.0	LA 6		
	Speech & Language Therapist	0.5	A4C 6		
	Dietician	0.5	A4C 6		
	ReCAS Carers (CCA/HCSW)	12.0	LA 2		
	Social Worker	1.0	SW grade		
Pan Intermediate Care					
(a) Medication Management	Medication Management Nurse	2.0	A4C 6	£197k	£148k
	Pharmacy Technician	20.	A4C 6		
(b) Peripatetic response Team	CCA/HCSW	4.0	LA 2	£172k	£86k
	Supervisor	1.0	LA 6		
Contingency (10%)				£232k	£162k
Swansea Total				£2,544k	£1,638k

NB: Staffing based on band / grade midpoint including on costs and non-pay (mainly travel)
7 day working and nights enhancements included where appropriate

Neath Port Talbot

Intermediate Care function	Staff Group	WTE	Grade	Cost £000's FYE	Cost £000's 2014/15
Planned Care					
(a) Review Reablement	Therapist	3	A4C6		
	Reablement Support Worker	16	LA 4	£1,094k	£766k
(b)Bridging service extension	Qualified nurse	2	A4C5		
	HCSW	10	A4C 3		
Rapid Response					
(b) Care Home preventative model	H&SC Professionals	4	A&C 6	£174k	£122k
Common Access Point					
	Third sector Broker	1			
	Mental Health Worker	1	A4C 6	£120k	£84k
Pan Intermediate Care					
	Pharmacist	0.6	A4C 8b		
	Pharmacy technician/MMN	1	A4C 6	£136k	£100k
	Mental Health Worker	1	A4C 7		
Contingency (10%)				£152k	107k
NPT Total				£1,830k	£1,408k

NB: Staffing based on band / grade midpoint including on costs and non-pay (mainly travel)
7 day working and nights enhancements included where appropriate

Costing the workforce growth & reconciling the workforce plans

The whole system capacity modelling undertaken to determine the scale of the challenge for this Business Case remains the indicative, high level estimate of funding required, and of savings from the impact of this investment. The financial assumptions underpinning this modelling work has been based on unit costs for service interventions rather than staffing levels. It is therefore necessary to reconcile these two approaches, using the strategic modelling outputs as the 'touch-stone'.

The workforce profiles represent the conclusions arrived at by service leads through a process of:

1. Considering the full complement of workforce required for an optimised service (by 2016/17).
2. Targeting year 1 investment at recognised service gaps where the greatest impact can be achieved.

3. Scaling the investment, at a locality level, to broadly match the modelling outputs for 2014/15 only, whilst leaving flexibility for local implementation plans.

This has enabled us to arrive at a strategic workforce plan that is consistent with the high level modelling outputs, allows for flexibility in local implementation, and is targeted at achieving the greatest impact.

The financial plan

Financial context

This Business Case is not being implemented in isolation from a range of pressures, inclusion ambitious and challenging cost improvement programmes. Both Health Board and Council financial plans currently require savings to go to the bottom line, e.g. care homes (LA) and Continuing Health Care (Health). No assumptions are therefore made about re-directing these savings where they are not the result of the changes being implemented in the Intermediate Tier.

However, due to the strategic importance of this transformation programme, and the inherent risks of 'business as usual' (£6.2M recurrent cost pressure by 2016/17 compared to 2013/14) financial modelling has been undertaken, and will be illustrated here, to warrant such reinvestment.

The financial plan outlined in this section therefore assumes the achievement of anticipated impact from the intermediate tier, particularly on post-acute activity, home care starts and care home admissions. It recycles this and identifies the extent of further bridging required after any initial investment from the Welsh Government Intermediate Care Fund. A local policy about using reserves, invest to save and/or to make different decisions about wider contributions to the bottom line will be required to address the bridging required after the first year of WG monies.

Modelling the financial impact

In order to model the financial impact arising from the proposed service redesign we have estimated the combined spend on health and social care for the Western Bay frail older population (i.e. existing intermediate care, emergency hospital admissions for the >65 and social care spend) at £91M (2012/13). Cost pressures within the system from demographic change amount to c.£6.2M by 2016/17 – but budgets are being reduced meaning that efficiencies, changes in eligibility and/or developing more effective services are essential.

The modelling undertaken to support this Business Case suggests that the pressures will be addressed with full implementation such that by 2016/17 the cost pressures noted above will have been fully absorbed, with a small saving of £125k. The level of additional investment over the 2012/13 baseline indicated by the modelling work amounts to £6.5M by 2016/17. The tables in this section show projected investment requirements and projected shifts in spend on the basis of the service modelling tool developed with the engagement of local stakeholders.

Bridgend	**2013/14**	**2014/15**	**2015/16**	**2016/17**
Intermediate care costs over 2012/13 baseline	32	1,140	1,687	1,761
Change in annual spend on social care over 2012/13 baseline	**153**	**-16**	**-400**	**-863**
Do nothing comparator	153	364	620	909
Change in spend on hospital services - acute	133	16	12	140
Change in spend on hospital services - post acute phase	48	-146	-394	-479
Change in annual spend on hospital care over 2012/13 baseline	**181**	**-130**	**-382**	**-339**
Do nothing comparator	181	369	563	752
Change in annual spend over 2012/13 baseline - whole system	**366**	**-146**	**905**	**559**
Do nothing comparator	**366**	**799**	**1,287**	**1,801**
Neath Port Talbot	**2013/14**	**2014/15**	**2015/16**	**2016/17**
Activity costs over 2012/13 baseline	32	1,440	2,110	2,162
Change in annual spend on social care over 2012/13 baseline	**276**	**-17**	**-619**	**-1,210**
Do nothing comparator	276	566	841	1,078
Change in spend on hospital services - acute	77	57	77	142
Change in spend on hospital services - post acute phase	109	-424	-1,171	-1,464
Change in annual spend on hospital care over 2012/13 baseline	**186**	**-367**	**-1,094**	**-1,322**
Do nothing comparator	186	353	514	670
Change in annual spend over 2012/13 baseline - whole system	**494**	**-384**	**397**	**-369**
Do nothing comparator	**494**	**978**	**1,440**	**1,858**
Swansea	**2013/14**	**2014/15**	**2015/16**	**2016/17**
Activity costs over 2012/13 baseline	89	1,727	2,571	2,687
Change in annual spend on social care over 2012/13 baseline	**356**	**52**	**-946**	**-1,409**
Do nothing comparator	356	641	957	1,311
Change in spend on hospital services - acute	159	-156	-419	-457
Change in spend on hospital services - post acute phase	66	-334	-932	-1,176
Change in annual spend on hospital care over 2012/13 baseline	**225**	**-490**	**-1,350**	**-1,633**
Do nothing comparator	225	445	667	886

Change in annual spend over 2012/13 baseline - whole system	**670**	**-438**	**274**	**-355**
Do nothing comparator	**670**	**1,255**	**1,875**	**2,525**

Table 20 Outline investment plans for each locality – compared to 'do nothing'

The revenue financial plan underpinning the business case

Outline of the approach

The approach to the financial plan underpinning this business case, applied in a consistent way in each Local Authority but scaled and targeted appropriate to local need, is:

1. A 'one-off' resource for 2014/15 is secured from the Welsh Government Intermediate Care Investment Fund to enable the expansion of key services, as well as to make the necessary non-recurrent investment in infrastructure and training.
2. Service and financial monitoring is undertaken alongside implementation in order to refine current assumptions about financial benefits secured in other areas of the system as a direct result of the Intermediate Care investment, and that these resources are transferred to a pooled budget in 2015/16.
3. That partners identify the extent and sources for any necessary bridging required in 2015/16 (and potentially in 2016/17 in some scenarios).
4. That the pooled budget arrangements are extended during 2015/16 to include on-going support in the community for health and social care so as to manage risk and secure future flexibility to secure the appropriate level and mix of on-going community support.

The 3-year plan

Table 17 shows the 3-year plan that arises having applied the above approach. In summary it indicates that:

- The sum total of spend on intermediate care for 2014/15 would amount to £14.5M, of which £6.5M (£4.2M of which is revenue) would come from the Welsh Government Intermediate Care Investment Fund;
- In 2015/16 a transfer of £0.8M from social care and £1.6M from health would be made to the pooled funds that is directly attributable to savings and efficiencies in services where the intermediate Care developments have had an impact during 2014/15;
- To meet the ongoing requirements of the developing intermediate tier further bridging in 2015/16 would be required totalling £3.9M;
- The total recurrent budget for the Intermediate Tier in 2015/16 would then be £14.3M (£2.3M capital funding from Welsh Government Intermediate Care Investment Fund is not re-provided in the pool);
- In 2016/17 a transfer of £2.0M from social care and £1.8M from health would be made to the pooled funds that is directly attributable to savings s in services where the intermediate Care developments have had an impact during 2015/16;

- The total recurrent requirement for the Intermediate Tier in 2016/17 would be £14.5M;
- A further requirement for bridging in 2016/17 is then identified for Bridgend of c.£0.6M whilst Neath Port Talbot and Swansea return a small surplus;
- In 2017/18 a transfer of £1.5M from social care and £0.5M from health would be made to the pooled funds that is directly attributable to savings and efficiencies in services where the Intermediate Care developments have had an impact during 2016/17. This would mean that the Pooled Fund totals £16.2M;
- In 2017/18 Bridgend remains slightly in deficit (£0.2M), although the overall surplus for Western Bay amounts to £1.7M.

2014/15 budget	Bridgend	NPT	Swansea	**TOTAL**
Welsh Government Int Care Investment Fund for recurrent spend	£1,108	£1,408	£1,638	£4,154
Baseline spend - health	£751	£909	£2,301	£3,961
Baseline spend - social care	£704	£1,002	£2,414	£4,120
Total recurrent budget placed in pooled arrangement	**£2,563**	**£3,319**	**£6,353**	**£12,235**
Welsh Government Int Care Investment Fund for non-recurrent spend	£621	£722	£959	£2,302
Pooled budget (including non-recurrent spend)	**£3,184**	**£4,041**	**£7,312**	**£14,537**
IMPACT:				
In-year direct social care savings from impact of IC	£169	£293	£304	£766
Absorption of social care cost pressures	£211	£290	£285	£786
In-year direct health savings from impact of IC	£311	£553	£715	£1,579
Absorption of health cost pressures	£188	£167	£220	£575
Savings from mainstream budgets	**£879**	**£1,303**	**£1,524**	**£3,706**
Cash releasing	£480	£846	£1,019	£2,345
Cost avoidance	£399	£457	£505	£1,361

2015/16 budget	Bridgend	NPT	Swansea	**TOTAL**
Baseline health and social care spend for IC	£1,455	£1,911	£4,715	£8,081
Transfer of savings from mainstream budgets	£480	£846	£1,019	£2,345
Total recurrent pooled budget	**£1,935**	**£2,757**	**£5,734**	**£10,426**
Actual recurrent commitment	£2,563	£3,319	£6,353	£12,235
Gap (+ive figure requires bridging, -ive is a saving)	£628	£562	£619	£1,809
Additional investment to optimise IC service	£547	£670	£844	£2,061
Level of budget spend required to optimise IC service	£3,110	£3,989	£7,197	£14,296
Further bridging required for 2015/16	**£1,175**	**£1,232**	**£1,463**	**£3,870**
IMPACT:				
In-year social care savings from impact of IC	£384	£602	£998	£1,984
Absorption of social care cost pressures	£256	£275	£316	£847
In-year health savings from impact of IC	£252	£727	£860	£1,839

Absorption of health cost pressures	£194	£161	£222	£577
Savings from mainstream budgets	**£1,086**	**£1,765**	**£2,396**	**£5,247**
Cash releasing savings	£636	£1,329	£1,858	£3,823
Cost avoidance	£450	£436	£538	£1,424

2016/17 budget	Bridgend	NPT	Swansea	**TOTAL**
Baseline health and social care spend for IC + 2014/15 recurrent savings	£1,935	£2,757	£5,734	£10,426
Further transfer of savings from mainstream budgets (2015/16)	£636	£1,329	£1,858	£3,823
Total recurrent budget available	**£2,571**	**£4,086**	**£7,592**	**£14,249**
Final investment needed to optimise IC service	£74	£52	£116	£242
Level of recurrent budget spend required to optimise IC service	£3,184	£4,041	£7,313	£14,538
Gap (+ive figure requires bridging, -ive is saving)	**£613**	**-£45**	**-£279**	**£289**
IMPACT:				
In-year social care savings from impact of IC	£463	£591	£463	£1,517
Absorption of social care cost pressures	£289	£237	£354	£880
In-year health savings from impact of IC	-£43	£228	£283	£468
Absorption of health cost pressures	£189	£156	£219	£564
Savings from mainstream budgets	**£898**	**£1,212**	**£1,319**	**£3,429**
Cash releasing savings	£420	£819	£746	£1,985
Cost avoidance	£478	£393	£573	£1,444

2017/18 budget	Bridgend	NPT	Swansea	**TOTAL**
Baseline health and social care spend for IC plus recurrent savings	£2,571	£4,086	£7,592	£14,249
Further Transfer of savings from mainstream budgets (2016/17)	£420	£819	£746	£1,985
Total recurrent pooled budget	**£2,991**	**£4,905**	**£8,338**	**£16,234**
Actual recurrent commitment	£3,184	£4,041	£7,313	£14,538
Gap (+ive figure requires bridging, -ive is a saving)	**£193**	**-£864**	**-£1,025**	**-£1,696**

Table 21 Three year financial plan

The implications arising from the plan

Variations on the plan

Alternative scenarios and assumptions can be made to inform local risk management. For example, if the resource equivalent to the absorption of cost pressures in the services directly impacted by the Intermediate Tier were included in the annual transfers alongside cash releasing savings then the level of bridging required in 2015/16 would reduce from £3.9M to £2.5M. However, if this were not adopted and only 60% of the cash releasing savings were achieved then this bridging requirement would increase to £4.8M.

Implications for each partner

It has been acknowledged from the start of this work that intermediate care services are at different levels of development and integration in each of the three Western Bay areas. The development path, and financial consequences are also therefore different and need to be spelt out. Table 18 provides the headline messages for each organisation party to this transformation process.

	Bridgend LA	NPT LA	Swansea LA	ABMU
Baseline spend on intermediate care (2012/13)	£704k	£1,002k	£2,414k	£3,961k
'Do nothing' increase in spend by 2016/17 arising from demographic pressures on social care or unscheduled and post-acute medical hospital admission	£909k	£1,078k	£1,311k	£2,308k
Proposed investment in the intermediate tier by 2016/17 (split 50:50 LA/HB for illustrative purposes)	£880k	£1,081k	£1,343k	£3,305k
Savings in other services by 2016/17 with investment in the intermediate tier	£863k	£1,210k	£1,409k	£3,294k
Expected bridging requirement for 2015/16 (split 50:50 LA/HB for illustrative purposes)	£588k	£616k	£731k	£1,935k

Table 22 Partner financial benefits arising from investment

Bridging requirements

Because the resource available from the Welsh Government is for one year only, and the scale of the implementation challenge and timing of future financial benefit will accrue over a three year period, it is necessary to find other resources to bridge the gap. The final row of Table 18 adds up to £3,870k of bridging required for 2015/16. The precise split between organisations may differ but on the basis of current 50:50 funding of the service we have used this as an indicative basis for estimating the bridging requirement. Potential ways of filling this gap include:

- Assuming that each organisation's Long Term Financial Plan includes funding earmarked to cover cost increases for demand growth (including that due to demographic changes), each organisation could agree to earmark a sum of that funding for Intermediate care that equates to the costs avoided in those mainstream services directly affected by the Intermediate Tier (under the do nothing comparator this is the impact of demand growth due to demographics). These costs avoided are identified in the Financial Plan summary as circa £1.4M (£0.8M Social Care & £0.6M Health) across Western Bay in 2014/15;
- Additional savings being achieved through the intermediate care not currently factored into the modelling, for example savings in acute medical admissions in addition to post-acute episodes of care. During 2014/15 the impact of the intermediate tier on acute bed occupancy is estimated as resulting in a real reduction (including the impact of demographics) of 24 beds. At a bed day cost of £120 this would equate to £1,051k, although two factors would reduce the availability of this sum, namely that there would only be a part-year effect and that some of these costs would be fixed;
- Achieving further efficiencies in the Intermediate Tier of services, without affecting their capacity to deliver the necessary impact. A 5% efficiency in a service valued at £14.3M would equate to £715k;
- Local Authorities accessing organisational reserves;

- Making further ‘spend to save’ bids against Welsh Government funds.

Taking these opportunities together there is the potential to bridge the gap and realise a more sustainable financial position from 2016/17.

Non-recurrent spend and capital

The Welsh Government has made indicative capital resources available as part of the investment fund recently announced of £2.3M across Western Bay. A separate process is underway to ensure that these resources are targeted at the necessary infrastructure and associated non-recurrent spend. The Governance and project management section of this plan identifies a sum of £427k for project management and evaluation that will be part of this non-recurrent bid. Measures will be taken to ensure that the final bid to the Welsh Government will not duplicate the bid against the Technologies Investment Fund process.

Impact and service reconfiguration

Overview and approach

Whilst there are a wide range of strategic consequences arising from this Business Case (see Appendix 1) across the health and care system, the plan depends on the identifiable impact, and therefore release of appropriate resources in three key areas:

1. A reduction in the use of post-acute beds and their substitution with community based, time limited, episodes of intermediate care.
2. A reduction in the commissioned packages of care for people with ongoing needs for social care as a result of the extensive reablement and rehabilitation activities carried out within the new and expanded services.
3. A reduction in the number of new placements in care homes for the same reasons as above, including a key focus on discharges from hospital that currently result in care home admissions but where targeted intermediate care activity can enable people to return home (the support they need is netted off the second element above).

The intermediate tier will also be impacting on medical unscheduled admissions to hospital. However, the evidence of impact from integrated community services such as intermediate care remains unclear in this respect. Our modest assumptions within the modelling result in the system managing to address underlying demographic pressures but not making a significant impact on reducing these admissions. No assumptions of cost savings and future transfer of resources from acute admissions to intermediate care is therefore currently being made. However, monitoring of ‘step-up’ services, i.e. saving hospital admissions, will be included in the reporting mechanisms. It is therefore proposed that where direct impact is evidenced a potential transfer of resource is considered in future years.

To arrive at the financial impact indicated in section 6 the modelling tool has made assumptions about local unit costs and activity in the key services where impact is expected. Building on 2012/13 data (which should be updated when a full set of 2013/14 data is available) we have made an initial estimate of the baseline activity for 2013/14 using underlying demographic changes as the key driver. The tables in the following sections identify, at an average Western Bay unit cost, the reductions in activity in the three areas noted above that would be required to meet the savings and reinvestment targets.

Impact on sub-acute activity and beds

The intermediate tier will have a significant impact on post-acute episodes of care. The financial plan estimates £1.6M across Western Bay of cash releasing savings in 2014/15 from this reduction in activity. At an average length of stay of 28 days, and an average bed day cost of £110, with two thirds of this cost being variable and therefore being released, the number of episodes for 2014/15 would need to reduce from 3,724 to 2,972. A possible profile of this per quarter is shown in Table 19.

Post-acute episodes of care	2013 /14	Ave per qtr	Qtr1	Qtr2	Qtr3	Qtr4	Total
Admissions	3724	931	892	750	680	650	2972
Reduction in admissions from 13/14			39	181	251	281	752

Table 23 Reductions in post-acute episodes of care to achieve financial savings

Appendix 1, section 2 identifies the impact expected from this reduction in activity on bed numbers in the 'sub-acute' sector. It indicates an underlying demographic pressure across Western Bay for sub-acute capacity that would otherwise see it grow between April 2014 and March 2017 from 290 occupied beds to 305 (+15 beds). The one-off impact of the intermediate tier during 2014/15 is expected, subject to the reductions in admissions outlined above, to release 93 beds (12 in Bridgend, 38 in Neath Port Talbot and 43 in Swansea). The modelling assumes that the investment in the Intermediate tier also enables the increased demand on the hospital sector due to demographic changes to be dealt with. This underlying demographic impact is estimated to equate to an additional 40 beds (15 post-acute & 25 acute).

Packages of home care

Through the work of the intermediate tier, particularly through the home care reablement functions, the number of new packages of care being commissioned will reduce. This reduction will occur over the year so early diversions will have a greater financial impact on the Business Case projection for 2014/15 than those occurring later in the year.

The average weekly cost of a home care package is £138 and an estimate of the new starts in 2013/14 is 1,578. Table 18 shows the profile of reduced home care starts per quarter to achieve a reduction to 1,356 new starts, which is the output from the modelling tool having applied the assumptions outlined regarding impact earlier in this business case.

Home Care	2013 /14	Ave per qtr	Qtr1	Qtr2	Qtr3	Qtr4	Total
New home care starts	1578	395	386	350	320	300	1356
Reduction in new starts			9	36	30	20	
Weeks in year with reduced cost			45	32	19	6	
Weekly saving per client week	£138						
Savings			£52,785	£158,976	£78,660	£16,560	**£306,981**

Table 24 Reductions in new home care starts to achieve financial savings

Supporting people in care homes

The work of the intermediate tier, particularly through the step-down functions, will impact on care home admissions. As with home care, the number of new care home admissions will occur over the year so early diversions will have a greater financial impact on the Business Case projection for 2014/15 than those occurring later in the year.

The average weekly net cost of a care home place is £346 and an estimate of the new admissions across Western Bay in 2013/14 is 1,108. Table 19 shows the profile of reduced care home admissions per quarter to achieve a reduction to 991 new admissions, which is the output from the modelling tool having applied the assumptions outlined regarding impact earlier in this business case.

The combined savings from social care identified in Tables 18 and 19 is c.£734k compared with £766k in the financial plan. These profiles of quarterly activity are therefore sufficiently close to the financial savings targets to inform the next stage of locality specific targets that can be owned and monitored at this level.

Care homes	2013 /14	Ave per qtr	Qtr1	Qtr2	Qtr3	Qtr4	Total
New care home admissions	1108	277	265	250	240	236	991
Reduction in admissions			12	15	10	4	
Weeks in year with reduced cost			45	32	19	6	
Weekly net saving per client week	£346						
Accrued savings			£186,840	£166,080	£65,740	£8,304	**£426,964**

Table 25 Reductions in new care home admissions to achieve financial savings

Governance and Implementation arrangements

Governance structure

A governance structure to ensure delivery of the Intermediate Tier developments and identified benefits detailed in this business case will be put in place, building on existing Western Bay arrangements. This is illustrated below:

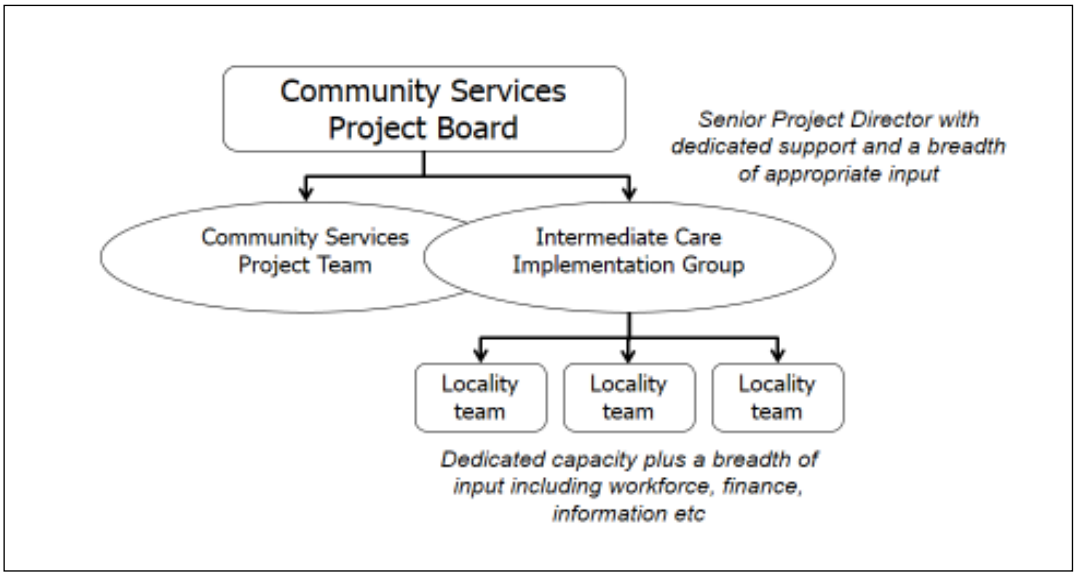

Figure 4 Overview of governance structure

The key elements of this arrangement are:

Senior Responsible Owner

Dr H Laing, ABMU Medical Director is the current SRO for the Western Bay Community Services Project and will continue in this role.

Western Bay Community Services Project Board

Function: The existing Board currently oversees and is responsible for the delivery of the Improving Community Services Programme of which the Intermediate Tier developments are one key element. It is accountable to the Western Bay Programme Board. The Community Services Project Board will have delegated responsibility from the Western Bay Programme Board to implement this Business Case. Quarterly reporting of progress, or more frequently if the implementation plan varies significantly from this Business Case, will be provided from the Community Services Project Board to the Western Bay Programme Board.

Membership: The current Board has membership from service functions at ABMU (Localities and Mental Health Directorate), the three Local Authorities and the third sector. To ensure it is fit for purpose in its enhanced role, this service membership will be reviewed both in terms of seniority and size for effective decision making. In addition it is proposed to further strengthen the Board with senior finance, corporate and legal representation.

Chair: The Head of Service Neath Port Talbot will continue to chair the Board and retain their ongoing role as project lead for community services.

Programme Director: The recent appointment of a Western Bay Programme Director will ensure significant dedicated time at a senior level is available to the Intermediate Tier Business Case implementation.

Western Bay Community Project Team

Currently there is a Community Services Project team who have co-ordinated the development of the Intermediate Tier service model and this Business Case. This group will continue to have a role alongside the implementation of this Business Case and will continue to develop other community services project areas. They will also ensure that the wider community services work is coordinated with the intermediate tier developments.

Western Bay Intermediate Tier Implementation Group

Due to the size and significance of the investment and the risks associated with it, a dedicated Project Implementation Group will be established to drive forward the Intermediate Tier programme. We recommend that membership should include:

The Western Bay Programme Director	Locality Intermediate Care Change Agents
A senior finance manager	A senor workforce manager
A representative from each of information and performance, communications / engagement, legal and corporate services. These members will have a role in linking with and as appropriate co-ordinating work across colleagues in their respective functions across Western Bay	
ABMU Mental Health Directorate representative	
Two existing Community Services Project team support staff to undertake discrete tasks within the plan and to ensure continued linkage across the range of community service development	

The Implementation Group will be chaired by the Western Bay Programme Director working closely with the Community Services Project lead.

Locality Implementation Teams

A local implementation team will be put in place in each locality supported by the Locality change agent and chaired at a senior level. The precise make-up of these teams will be determined locally but will cover all relevant organisations and functions. Their overarching remit will be to develop and implement a Local Implementation Plan.

Project Management & evaluation

The scale and pace of change requires that there is a dedicated support in place to deliver the service changes, system and behavioural change and secure the financial benefits identified. The project will be coordinated and driven forward through a Western Bay Programme Office comprised of the staffing identified in the table below:

Staff	WTE	Grade	Cost
Project Manager	1	A4C 8b	£60k
Project Support	1	A4C 5	£30k
Locality Change Agents*	3	A4C 8a	£155k
Senior Finance	0.5	A4C 8a	£26k
Senior Workforce	0.5	A4C 8a	£26k

Table 26 Proposed project management resource

* Drawn from social care, community health and mental health

The proposed cost of this support is therefore proposed as being £297k. This represents just under 7% of the investment being sought from the Welsh Government in year 1 of the programme. In addition there will need to be provision for accessing legal services.

Establishing the baseline and monitoring impact from day 1 of the project will be a key requirement of the project team. This essential part of any evaluation process will then be supplemented by an externally commissioned evaluation of the programme. A further indicative sum of c.£130k (3% of year 1 investment) is suggested. The costs associated with this work will, in year 1, be a call on the non-recurrent element of the Welsh Government Intermediate Care Fund. Means of providing continuing support to this infrastructure will need to be factored into the second and third year of the programme, albeit at a reducing level toward the end of the programme as the new services become part of normal business.

Financial Governance

If the bid to the Welsh Government Intermediate Care Investment Fund is successful it is a requirement that these resources are delegated to the relevant Local Authority. Deployment and monthly monitoring of this fund will be overseen jointly by identified Local Authority and ABMU senior finance staff with regular reporting to the Western Bay Community Services Project Board. Existing financial agreements for the virement of funds held by Local Authorities for spend on health components of the Intermediate Tier will be used to enable draw down. This will facilitate risk sharing and will dovetail with other required processes. The Western Bay Programme Board will need to satisfy themselves that appropriate existing mechanisms are appropriate for this purpose in the context of the Intermediate Tier investment outlined in this business case.

During 2014/15 detailed work will be undertaken by finance leads on the mechanisms necessary for the use and management of the fund in future years. Sustainability of the programme is reliant on the identification of direct savings emerging from the programme, which will enable other resources, including in particular cost savings in health and social

care as a result of the investment in the intermediate tier, to be incorporated into a future pooled fund arrangement from April 2015. A formal agreement will be put in place signed off by the Western Bay Programme Board.

Impact monitoring

As noted above, the identification of direct impact and savings from investment in the intermediate tier has been identified and a value determined for this benefit. This is described in section 7 of this Business Case. What will be required from day 1 of implementation is a clear framework that reflects these assumptions and a weekly monitoring process for activity levels in each component of the intermediate tier at a locality level. Critical to the sustainability of the work, therefore, is the impact that this activity achieves. At six months the programme will be reviewed so as to indicate the extent of the impact and savings with a view to informing 2015/16 savings transfers to ensure ongoing support for service development.

Risk management

The implementation programme is not without its risks. The table below provides an initial risk assessment and the management approach to each.

Risk	a) Likelihood (scale of 1-6)	b) Impact (scale of 1-6)	Score (a x's b)	Risk management (where the risk score is 8 or higher)
Political				
That LA members and ABMU Board members will not give full support	2	6	**12**	Briefings have been prepared and clarity of message is being worked on.
That the Williams report causes a reluctance to proceed	1	4	**4**	
Financial				
That the new services, whilst achieving the necessary increased activity will, nonetheless, not achieve the impact, i.e. the improved outcomes for people	2	4	**8**	Care has been taken to evidence impact from similar schemes elsewhere and to be conservative in the impact anticipated.
That the anticipated savings cannot be identified	2	5	**10**	Existing modelling work has provided clear targets for quarterly impact. The business case therefore clearly identifies the unit cost/benefit of each unit of impact. These have also been varied to provide an indication of the implications of not achieving the full impact anticipated. The approach to performance management will ensure a tight grip is maintained on this.
That savings cannot be released	3	5	**15**	Engagement of finance leads and operational managers in the implementation process will retain a focus on the need to release savings.

Risk	a) Likelihood (scale of 1-6)	b) Impact (scale of 1-6)	Score (a x's b)	Risk management (where the risk score is 8 or higher)
That LA CIPs and HB savings plans make the provision of additional bridging money unachievable.	2	4	**8**	The business case clearly identifies the level of further bridging and a variety of sources are being explored for this to cover the possibility of a longer time to achieve savings and impact than envisaged.
That agreement cannot be reached between all parties on the 'rules' for recycling of savings from health and social care to sustain the intermediate care developments	2	4	**8**	During the first year of the programme existing arrangements for the virement of funds will be relied upon. Work will be undertaken to determine common ground as to when a piece of activity results in a cash releasing saving.
Service				
That it will take longer than envisaged to establish links with the wider system to enable new referrals to be made	2	2	**4**	
That confidence in the enhanced intermediate care services is lacking within the consultant and primary care workforce	2	5	**10**	Involvement of key clinicians in the development of the service model and aligning the intermediate care developments with proposed developments in medical staffing.
Inconsistency in medical leadership across ABMU could stall implementation	4	2	**8**	A medical workforce plan is being developed as a priority.
That the level of behavioural and cultural change required across the whole system is such that it cannot be fully achieved on the required timescale to deliver the service changes and financial savings	2	4	**8**	The implementation programme will be accompanied by a workforce development and training programme to be agreed by all parties.
That there will be an adverse impact on core community services	3	3	**9**	Alignment of project teams across Community Services with a remit to continue the development of on-going services in the community in such a way as to dovetail with the intermediate care implementation

Risk	a) Likelihood (scale of 1-6)	b) Impact (scale of 1-6)	Score (a x's b)	Risk management (where the risk score is 8 or higher)
That patient pathways, having been redesigned for increased intermediate care activity, will find other bottle-necks in the system	3	3	**9**	The ongoing use of a systems modelling approach to understanding and mapping patient pathways and the needs of patient cohorts will support the learning and understanding necessary to recognise and address this risk.
That new services will attract unmet demand rather than those most in need of intermediate care	4	2	**8**	Criteria for access to intermediate care services will be clearly defined and the expectation of significantly improved outcomes through the impact monitoring will reinforce this requirement.
Implementation				
That project management capacity is not adequate or senior enough to enable the changes	2	4	**8**	An additional 5% is being invested in project management capacity at a levels with the most senior position being answerable directly to the W Programme Board
Workforce				
That recruitment to key roles is not possible	4	3	**12**	Previous experience in recruiting to stepped changes in services will be drawn on and discussions entered into with the local education provider to secure fast track training or development for cohorts of staff to fill key roles
That recruitment will have a detrimental impact on other providers (private dom care, nursing, residential homes)	2	3	**6**	
That the plans do not dovetail with Health Board medical workforce plans	2	2	**4**	

Appendix 1: Strategic Consequences

Introduction and scope

The wider impact of proposed intermediate tier investment

Doing things in one part of the system will have inevitable consequences elsewhere. Figure 3 provides an illustration of the wider context in which the investment in intermediate services is expected to have an impact. This appendix details the impact (activity and cost) and strategic consequences of the proposed investments with regards to the following sectors:

- General hospital
- Care Homes
- Homecare
- Ongoing community support
- Specialist mental health services

It draws on the modelling work undertaken across Western Bay in relation to frail older people and people with dementia. Whilst highlighting the specific impact of the proposed investment it also identifies where further impact could be achieved through the implementation of further developments as part of a broader programme of transformation for community services.

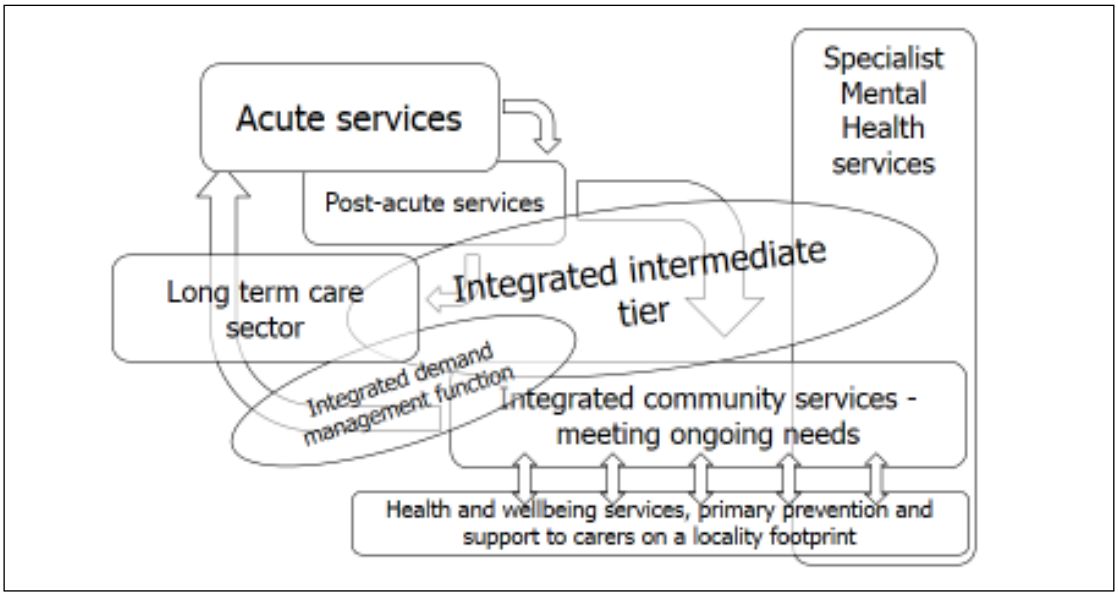

Figure 5 The wider system on which changes in the intermediate tier will impact

The development of the intermediate tier cannot be seen in isolation and sits within a broader context. Nationally and locally other policies, plans and service redesign will also impact on the health and social care system. These are identified in this paper to reflect the many other factors that will impact on local activity, cost and system design. Developing the intermediate tier will have impacts on the demand for care and support, including:

<u>In ongoing community services</u>:

- Reducing new homecare packages via signposting by a common access point and increased levels of intake intermediate care;

- Reducing escalation in existing homecare packages via increased levels of review intermediate care;
- Reducing new permanent care home placements via increased levels of review intermediate care.

In the hospital sector:

- Reducing unscheduled admissions to hospital (and therefore bed days) via increased diversion to Rapid Response;
- Reducing post-acute hospital stays for unscheduled, scheduled and surgical patients via increased step-down domiciliary intermediate care.

As each locality currently delivers intermediate care to varying levels then the investment proposed will have a differential impact on the whole system in each locality.

The impact of community and mental health programmes other than intermediate tier services

Planned investment in the intermediate tier will deliver significant reductions in demand for other parts of the whole system in each locality compared to the 'do nothing' scenario. These changes in demand will be experienced by both health and social care services, but to varying degrees. Integration will be required to maximise the extent to which resources can be released by the investment made. However, optimising the intermediate tier cannot, on its own, deliver the level of savings currently required for the system as a whole (especially if investment funding is only available on a non-recurring basis, meaning that recurring funding for the intermediate tier must be found from elsewhere in the system).

The planned service changes detailed in the investment plan form part of a broader transformation programme for community services that will be detailed in a full business case in January 2014. Implementation of these will be crucial to contributing to the savings required. The modelling work to date has included developing estimates of the impact across the system of a number of specific service developments which form part of this transformation programme. These are:

- Reducing lengths of stay in general hospital for acute unscheduled care;
- Reducing lengths of stay in general hospital for post-acute care;
- Delivering enhanced home care for 6 months to delay admissions to permanent funded care home placements;
- Increasing the provision of extra care housing for new clients and for clients transferring from permanent funded care home placements.

Detailed modelling work has also been undertaken across Western Bay with regard to people with dementia and the services to support them. Areas identified for possible development would impact on:

- Reductions in general hospital unscheduled admissions for people with dementia;
- Reductions in general hospital lengths of stay for people with dementia;
- Reductions and delay in care home admissions for people with dementia;

- Reduction in care home admissions direct from general hospital for people with dementia.

Impact of Wider System Changes

Other factors outside the development of the Intermediate Tier will impact on the health and social are system, the key areas are outlined below. The modelling work has not taken these into account explicitly although it is clear that they will be significant in taking this programme forward.

Welsh Government

Three key current Welsh Government policies will shape the future of health and social care provision locally:

The Social Services and Wellbeing Bill currently going through the Welsh Assembly. This will introduce national eligibility criteria, a national outcomes framework and equal rights for carers to those they care for.

A framework for delivering integrated health and social care for older people with complex needs – which sets out the essential requirements re the standard model for Wales.

Integrated assessment, planning and review arrangements for older people (December 2013). To be implemented immediately, this sets out the duties and responsibilities on health and social care services to provide integrated arrangements for assessment and care management for older people. It replaces 'Creating a unified and fair system for assessing and managing care in respect of people aged 65 years and over'.

In addition **the *Commission on public service governance and delivery*** due to report early in the new year will potentially impact on the local government organisational arrangements in Western Bay. This could facilitate the development of an integrated intermediate tier but at the same time might lead to short term planning blight.

These set the current context for the development of an integrated intermediate tier of services. Local implementation will have implications and impacts across the sectors covered in this paper beyond those identified in relation to the development of the Intermediate Tier. The consequences of developing the intermediate tier should not therefore be considered in isolation but forming a part of a bigger jigsaw.

Western Bay

Locally a number of factors will also impact on the delivery of services and have consequences for the local system beyond those identified in this paper. Key areas include:

Changing for the Better programme that incorporates 9 work projects. Key projects pertinent to the development and impact of an integrated intermediate tier relate to Rapid Access, Hospitals usage and outpatient modernisation. These will impact on hospital and community activity levels and costs and have broader consequences for the health and social care system.

South Wales Programme is looking at the future of hospital sites across South Wales. This will potentially have implications for the nature of the services delivered by Bridgend in the future.

Financial Constraints Across the health and social care system in Western Bay there is a requirement for financial constraint and budget reductions. This means organisations will be making individual decisions as to how to manage this situation. This will mean some reductions in current services presenting a significant risk to the local health and social care economy. There is a danger that any service / staff reductions in current services will impact on the ability of the intermediate tier to deliver the activity and cost changes identified in this paper.

Strategic consequences for the Acute General Hospital

Changes in activity

In analysing current patterns of hospital usage across Western Bay, it has proved helpful to consider each patient's journey in two stages:

- The acute phase - the period from admission to a DGH until the end of active treatment
- The post-acute phase: time spent by the patient in a hospital bed after the end of the acute phase. This is likely to be in a different location from the acute phase, and may involve more than one transfer between hospital sites or wards. It may take place in a DGH, a community hospital, or a combination of both.

Post-acute care may be delivered after a planned or surgical admission. It is important to note that, at this stage, these have been excluded from the analysis below.

Unscheduled admissions to general hospital

The table below (based on over 65's unscheduled care activity for the 7 month period September 2012 – March 2013) illustrates the variation in the number and rate of unscheduled general hospital admissions for the residents of each of the three localities.

Locality	Admissions pa	Rate pa per 1,000 over 65s	Rate pa per 1,000 frail older people
Bridgend	3,603	139	1,294
NPT	3,807	139	1,203
Swansea	6,661	150	1,400

Table 27 Current unscheduled over 65's general hospital admissions

The proposed intermediate tier developments will have an impact on unscheduled over 65 admissions as detailed in the table below. This compares the number of admissions under the 'do nothing' scenario with the number the modelling work estimates if the proposed changes in the intermediate tier are implemented.

	2012/ 13	2013/14	2014/ 15	2015/ 16	2016/17
Bridgend					
With IT developments	3603	3700	3605	3612	3704
Do Nothing	*3603*	*3700*	*3800*	*3904*	*4004*
NPT					
With IT developments	3807	3877	3855	3876	3936
Do Nothing	*3807*	*3877*	*3941*	*4003*	*4065*
Swansea					
With IT	6661	6778	6399	6273	6374

developments					
Do Nothing	*6661*	*6778*	*6893*	*7009*	*7122*

Table 28 Unscheduled over 65 admissions (annual at year end) with and without planned intermediate tier developments

Whilst unscheduled admissions are a little higher in 2016/17 than currently in both Bridgend and Neath Port Talbot, as a result of the investment in the intermediate tier, they are well below those pertaining under the do nothing scenario. For Swansea the modelling suggests an absolute reduction in the number of unscheduled admissions in 2016/17 over the 2012/13 baseline but by then they are again on a slightly upward trend.

Impact of Intermediate tier development on hospital bed occupancy

The modelling suggests that the implementation of the planned changes to the intermediate tier will have the impact on 'average' occupied beds relative to the do nothing scenario as detailed in the table below. The figures represent snapshot occupancy at the end of March each year.

The figures suggest that, with enhanced intermediate care in place, the number of acute phase occupied beds will remain broadly the same over the period to 2016/17, mitigating the impact of demographic growth. As a result of the implementation of increased step down intermediate care the modelling suggests total Western Bay average post-acute bed occupancy will fall in absolute terms.

Bridgend	**March 13**	**March 14**	**March 15**	**March 16**	**March 17**
Acute phase beds occupied (over 65 unscheduled medical)	115	118	112	115	118
Do nothing comparator	*115*	*118*	*121*	*124*	*127*
Post-acute and step up beds occupied (all sources of acute admission)	44	45	31	32	33
Do nothing comparator	*44*	*45*	*46*	*48*	*49*
Neath Port Talbot	**March 13**	**March 14**	**March 15**	**March 16**	**March 17**
Acute phase beds occupied (over 65 unscheduled medical)	97	98	97	98	100
Do nothing comparator	*97*	*98*	*100*	*102*	*103*
Post-acute and step up beds occupied (all sources of acute admission)	150	152	109	110	112
Do nothing comparator	*150*	*152*	*155*	*157*	*159*
Swansea	**March 13**	**March 14**	**March 15**	**March 16**	**March 17**
Acute phase beds occupied (over 65 unscheduled medical)	209	212	193	196	199
Do nothing comparator	*209*	*212*	*216*	*219*	*223*
Post-acute and step up beds occupied (all sources of acute admission)	91	93	61	62	63
Do nothing comparator	*91*	*93*	*94*	*96*	*97*

Table 29 Occupied hospital beds (over 65 unscheduled medical acute, all-cause over 65 post-acute, and step up) with and without intermediate tier developments by locality of residence of patient

Acute sector cost changes

The projected reductions in admissions, and the shift of post-acute care from hospital to the community, resulting from investment in the intermediate tier provides the potential for reductions in hospital costs, or alternatively for the redeployment of resources to other parts of the hospital system. The extent to which potential cost savings can be realised depends on the ability of resources to be released or shifted. The investment case assumes an average delay of 6 months between any reductions in activity resulting from improvements in the intermediate tier to the release of costs for savings or redeployment.

The table below summarises the projected change in spend in the hospital sector, by locality, on this basis, compared to the 'do nothing' position. Note that this table includes only those costs assumed to be transferrable (hotel costs and ward staffing costs).

Change in spend	**2013/ 14 £000's**	**2014/ 15 £000's**	**2015/ 16 £000's**	**2016/ 17 £000's**
Bridgend				
With Intermediate Tier development – acute phase	£125k	£15k	£11k	£132k
With Intermediate Tier development – post acute phase	£40	-£123k	-£331k	-£402k
With Intermediate Tier development – total hospital sector	**£165k**	**-£108k**	**-£320k**	**-£271k**
Do Nothing	*£165k*	*£209k*	*£447k*	*£622k*
NPT				
With Intermediate Tier development – acute phase	£71k	£52k	£70k	£130k
With Intermediate Tier development – post acute phase	£56k	-£234k	-£641k	-£798k
With Intermediate Tier development – total hospital sector	**£127k**	**-£182k**	**-£571k**	**-£668k**
Do Nothing	*£127k*	*£122k*	*£301k*	*£413k*
Swansea				
With Intermediate Tier development – acute phase	£151k	-£148k	-£396k	-£432k
With Intermediate Tier development – post acute phase	£55k	-£285k	-£790k	-£994k
With Intermediate Tier development – total hospital sector	**£206k**	**-£432k**	**-£1,186k**	**-£1,426k**
Do Nothing	*£206k*	*£203k*	*£508k*	*£710k*

Table 30 Projected change in spend in the hospital sector by locality compared with the do nothing scenario

For Western Bay as a whole, investment in the development of the intermediate tier is projected to generate a cumulative reduction in hospital costs of £5.2 million over the 3 years from April 2014 to March 2017. This compares to additional cumulative costs of £3.5 million in the equivalent period in the 'do nothing more' scenario, i.e. assuming that hospital activity would otherwise have risen in line with demographic change in each locality.

Further potential changes to the hospital sector

It is only through implementation as a whole of all aspects of the identified programme of transformation for community services that full benefit identified through the modelling work is to be achieved across the system. Within the Business case currently under development further specific changes that have an impact on length of stay in general hospital have been identified and modelled. These are:

- A reduction of 2 days in the average stay in the acute phase (note that if all hospitals matched the current 'best' this would equate to a reduction of 1.4 days);
- A reduction of 5 days in the average stay in the post-acute phase (note that if all sites matched the current 'best' this would equate to a reduction of 4.5 days in DGHs and 6.9 days in community hospitals).

Changes in activity, and potential savings realisable through these system changes, are not included in this paper. The modelling work to date however indicates that these savings could amount to £1.1M across Western Bay in 2014/15 rising to £1.8M by 2016/17. Some of these savings may, however, be double-counted in existing hospital redesign programmes and/or work on managing long term conditions differently.

Two potential developments for services and support to people with dementia are being considered. These are:

- Enhancing memory assessment and associated ongoing support to increase the proportion of people with dementia with a diagnosis and in touch with services
- Enhancing general hospital and care home mental health liaison.

If implemented they will impact on general hospital admissions, length of stay and care home admissions. The modelling undertaken suggests the impact could be significant.

It needs to be noted that at this point no explicit modelling work has been undertaken to scale the potential double counting in savings identified between interventions to support fail older people and those to support people with dementia. As identified earlier there is a significant overlap between these cohorts of people.

Other programmes of work underway within the acute sector locally will impact on hospital admissions and bed occupancy over and above those described in this Intermediate Tier Investment Plan. Key areas are:

- Hospital services redesign to reduce bed occupancy to 85% which will necessitate changes in clinical approaches away from admission and increases in those supported in the community;
- Programmes of work around unscheduled care and patient flows.

Changes in activity, and potential savings realisable through these system changes, are outside the scope of the modelling work undertaken.

Strategic consequences of developing the intermediate tier for the acute sector

- Investment in the intermediate tier will produce a requirement for additional community-based staff. Locality implementation planning will include skill mix analysis and the identification of the mix of staffing required for an integrated intermediate tier service. This will lead to a significant need for the redeployment, and potential training and re-skilling, of some hospital ward staff.
- Shifting a proportion of post-acute care from hospital to community will require a change in clinical approach which will facilitate earlier discharge and a 'discharge to assess' mentality.
- Local culture and patient/ carer expectations may currently regard hospital care as 'the safe option' given the long stays that are the norm for many older people.

Increased diversion to community services and reduced lengths of stay may challenge this view. Communications will need to be developed to reassure patients, carers and potential referrers that the new ways of working represent safe, effective practice and to provide a clear picture of what people can expect from the transformed system.

- It will require patients receiving post acute care in the community to have access to the same range of diagnostics, medical and/or therapy inputs etc as is currently the case for post-acute patients in hospital. This will require changes in working patterns, referral systems and so forth.
- As an increasing proportion of people are supported in the community the overall acuity of patients who are admitted to general hospital will increase with implications for staffing and skills requirements.
- Longer term projections of demographic change will continue to exert upward pressure on demand for hospital beds for years to come. The proposed transformation programme represents a one-off shift in the service model and should not be seen as a panacea for managing long term demand. Commissioning strategy for hospital services will need to incorporate additional measures to set against this demographic pressure. Current examples include:
  - The development of 'hospital at home' services to support people with enhanced input from community health services
  - Work on future hospital capacity requirements which models the potential impact of other changes in hospital egg improved medicines management, improved bed management etc.

Strategic consequences for Care Homes

The information and projections in this section refer to total levels of LA funded long term care placements. Figures for each locality are for all funded placements, including both those delivered by internal provider arms of the Council and those delivered through contracts with external providers for the private and/or voluntary sector. Neither continuing health care patients nor people self-funding their long term placement are included.

Baseline activity

The three local authorities each fund people in long term care home placements according to their local policies on eligibility. The number of placements in long term care homes at March 2013 and the rate of admissions per 1,000 frail older people are given in the table below.

	People supported in a care home	**People supported in a care home per 1,000 frail older people**	**Admissions to long term care per 1,000 frail older people**
Bridgend	494	177	1.36
NPT	624	197	1.90
Swansea	996	209	2.12
Western Bay	**2,114**		

Table 31 **C**are home admissions and placements by locality

Impact of intermediate tier development on long term care home activity

There are two potential levels of impact on care home admissions, dependent on the functioning of the intermediate tier.

- The impact of review reablement on the rate of admissions to care homes, leading to a marginally lower rate of care home admissions and a small downward pressure on funded care home places
- More significantly, the introduction of care home intake for a proportion of people currently admitted to a care home following a hospital admission.

The modelled intermediate tier development programme results in a reduction in new admissions to care homes, which will feed through over time into a reduction in average occupancy.

The table below shows projected year end occupancy levels by locality, compared to the 'do nothing' scenario:

Bridgend	**March 13**	**March 14**	**March 15**	**March 16**	**March 17**
Funded care home placements	495	499	486	471	463
Do nothing comparator	*495*	*499*	*505*	*513*	*523*
Neath Port Talbot	**March 13**	**March 14**	**March 15**	**March 16**	**March 17**
Funded care home placements	626	632	600	568	553
Do nothing comparator	*626*	*632*	*639*	*646*	*654*
Swansea	**March 13**	**March 14**	**March 15**	**March 16**	**March 17**
Funded care home placements	998	1005	960	916	894
Do nothing comparator	*995*	*1005*	*1014*	*1025*	*1037*

For Western Bay as a whole, the projected impact by March 17 of intermediate tier development on the care home population is a reduction of 205, compared to an increase of 96 for the 'do nothing' scenario.

Changes in costs associated with the impact of intermediate tier development on care homes are included in the overall modelled financial impact for social care set out below.

Further potential changes to the care home sector

The overall transformation programme includes a proposal to introduce enhanced homecare in order to delay care home admission which, when implemented, will impact further on the number of placements. The modelling work has been used to assess the impact of an increased level of home care (150% of existing weekly contact hours) to people at the point where they would otherwise transfer to a long term care home, thereby delaying the transfer to a care home, and reducing the time supported in a care home, by 6 months.

Further, the transformation programme includes the potential development of additional extra care housing placements in order to reduce new care home placements, and to allow for the transfer of some people currently in a care home. The modelling work has been used to determine the potential impact of the provision of extra care housing placements for 25% of

people who would otherwise enter long term care homes for the first time, and the transfer of 5% of existing residential care home clients to an extra care housing placement.

The impact of these changes is not included in this paper but will form part of the overall business case.

The dementia modelling work has assessed the impact of a number of service interventions. Of the development proposals increasing diagnosis through memory assessment and provision of ongoing support, and the introduction of general hospital mental health liaison will impact on the number of people with dementia admitted to a care home. These impacts are not included in this paper.

Whilst the developments in the Intermediate Tier will have some impact on the overall number of people supported in care homes there are other factors that will have an influence. There is already evidence locally that the national policy to place a £50 cap on homecare charges has resulted in fewer people going into long term care as families recognise the financial benefits of people being supported to remain at home . The potential impact of this policy is outside the scope of the modelling work undertaken.

Strategic consequences

There are a number of consequences for the care home sector resulting from the proposed development of the intermediate tier:

- Changes to the care home market as demand and usage change with placement numbers decreasing but increases in complexity, and a shift to short term models of care through residential reablement;
- The potential for providers to seek increases to fees as the mix of clients and service delivery changes;
- An increase in the quantity and nature of equipment required by care homes to support clients with more complex needs ;
- The potential for changes in the behaviour of self-funders in terms of long term placements as they have access to intermediate care will require a further analysis of likely changes in levels of self-funding;
- A need for effective liaison between the intermediate tier (who will act as gatekeepers to new long term care placements through the review function) and care home providers, to enable the right 'fit' between client and placement and the minimisation of moves between placements over time;
- There is the potential that families and carers will still perceive an admission to a care home as the 'safe option'. The 'story' around intermediate tier will need to be communicated effectively to service users, families and carers and the public at large.

These changes bring significant consequences for the commissioning and contracting of long term care with the need for:

- Development of a proactive approach to market management to encourage providers who are able to support complex clients for longer and deliver new models of care;
- A strategic approach to commissioning and the development of flexible contracts that can adapt to changing requirements over time;
- Rigorous approaches to quality assurance, monitoring and the escalation of concerns to ensure that all care delivered is of an appropriate standard and quality as specified in contracts. There has been an increase over time in challenges and litigation, serious case reviews and safeguarding issues with regards to care home placements; the potential for further escalation of these as the demands and expectations of care home providers increase needs to be mitigated;
- A strategic approach to workforce development across all providers, both independent and in house, so that staff have the skills and competencies required to

deliver the new models of care, meet the more complex needs of clients and attain the quality standards that will be required. The scale of the challenge this creates should not be under estimated.

Strategic consequences for homecare

The information and projections in this section refer to total levels of homecare provision. Figures for each locality are for ongoing packages of homecare, including both those delivered by internal provider arms of the Council and those delivered through contracts with external providers from the private and/or voluntary sector.

Baseline homecare activity

The three local authorities each fund support to people at home provided in house or from independent providers in line with their local policies on eligibility. The number of people supported at home at March 2013 and the baseline rate of new starts per 1,000 frail older people is given in the table below.

	People supported at home	People supported at home per 1,000 frail older people	Annual new home care starters per 1,000 frail older people
Bridgend	721	259	166
NPT	772	244	132
Swansea	1,282	270	133

Table 32 People supported at home and new homecare starts

Impact of intermediate tier development on homecare activity

The modelling suggests that the implementation of the planned changes to the intermediate tier will tend to reduce the number of people supported at home, through a combination of increased signposting by a common access point, increased intake intermediate care with a resulting decrease in new homecare packages, and an optimised review function which will end homecare packages that are no longer required to support the client's ongoing needs. The table below shows projected end of year snapshots of homecare clients, and compares them to the do nothing scenario.

For Western Bay as a whole, the proposed investment in the intermediate tier would result in a reduction of 161 homecare clients between March 2013 and March 2017, compared to an increase of 187 under the 'do nothing more' scenario.

In addition to the change in overall numbers, investment in the intermediate tier would be expected to deliver a change in the average level of homecare package delivered to clients. If the outcome of optimised review function is (as expected) to reduce levels of ongoing care where appropriate, this would be expected to result in a lower average package of care across all clients than would be the case in the 'do nothing more' scenario.

Bridgend	March 13	March 14	March 15	March 16	March 17
Total home care clients	726	738	696	679	679

Do nothing comparator	*726*	*738*	*756*	*776*	*798*
NPT	**March 13**	**March 14**	**March 15**	**March 16**	**March 17**
Total home care clients	776	784	755	748	747
Do nothing comparator	*776*	*784*	*794*	*806*	*817*
Swansea	**March 13**	**March 14**	**March 15**	**March 16**	**March 17**
Total home care clients	1287	1299	1304	1325	1345
Do nothing comparator	*1287*	*1299*	*1314*	*1333*	*1352*

Table 33 Home care clients all providers with and without intermediate tier developments

Changes in costs associated with the impact of intermediate tier development on homecare are included in the overall modelled financial impact for social care set out below.

Strategic consequences of developing the intermediate tier for home care

There are a number of consequences in relation to homecare that result from the proposed development of the intermediate tier.

- Changes to the provision of home care as a result of investment in the intermediate tier will require a robust homecare commissioning strategy to be developed in each locality. This would need to specify the scale and nature of home care provision required from both in house and independent providers. There will a need for proactive market management to develop the home care market to meet the more sophisticated requirements demanded by the new service model. Ways of incentivising the market need to be developed;
- Changes in homecare requirements will necessitate a review of both the fees paid to providers and of charging to clients ;
- Rigorous approaches to quality assurance, monitoring and the escalation of concerns to ensure that all care delivered is of an appropriate standard and quality;
- There will be an increased demand and associated cost for assistive technology and the need for specialist equipment advice and support to be available to providers. The additional costs of using assistive technology to support people with dementia needs to be recognised;
- There will need to be a major up skilling of staff across all providers to meet the changing requirements of homecare delivery;
- Care managers will need to move to developing care plans that are outcome focused rather than based on hours of service provision;
- The will be a need for improved processes for matching clients with providers, aimed at minimising delays (and consequent bottlenecks in discharging clients from the intermediate tier);
- Effective communication with home care providers will be essential if the benefits of the development of the intermediate tier are to be achieved. Providers will need to change their approach to the ongoing provision of support, identifying potential changes in needs and timely referral for review Intermediate Care.

Strategic consequences for wider social care costs

Note on this section

This section brings together the projected change in costs for social care associated with the proposed investment in the intermediate tier. This projected change is made up of three elements:

- Changes associated with long term LA funded care home activity.
- Changes associated with homecare activity.
- Changes associate with the transfer of costs for existing activity to form part of a new common access point function within the intermediate tier: the assumption in the investment plan is that 50% of the costs of a full service SPA are already within social care budgets and will be transferred to the intermediate tier alongside the extra investment required to fund the SPA.

Social care cost changes

The table below summarises the projected change in spend in the social care sector, by locality, compared to the 'do nothing' position.

	2013/ 14 £000's	2014/ 15 £000's	2015/ 16 £000's	2016/ 17 £000's
Bridgend				
Change in annual spend on social care	153	-16	-400	-863
Do nothing comparator	*153*	*364*	*620*	*909*
NPT				
Change in annual spend on social care	-17	-619	-1210	-17
Do nothing comparator	*566*	*841*	*1,078*	*566*
Swansea				
Change in annual spend on social care	356	52	-946	-1409
Do nothing comparator	*356*	*641*	*957*	*1,311*

Table 34 Projected change in spend for social care compared with the do nothing scenario

For Western Bay as a whole, investment in the development of the intermediate tier is projected to generate a total decrease in social care costs of £5.4 million over the 3 years from April 2014 to March 2017. This compares to additional costs of £6.8 million in the equivalent period in the 'do nothing' scenario, i.e. assuming that care home and homecare activity continues to rise in line with demographic change in each locality.

Strategic consequences for Ongoing Community Support

Service changes

Within this context ongoing support covers as wide range of services and support functions available in the community through universal services, community networks, the third sector etc. Some aspects of these services will require reshaping as explicit intermediate tier

functions are developed. The modelling work undertaken has not explicitly estimated the impact in activity terms of changes in the intermediate tier to these services / functions.

The planned transformation programme will see this support complimenting primary care at a locality level in case finding and care management for those needing support due to increasing frailty or dementia (i.e. district nursing, chronic disease management). They will take full advantage of the opportunities created by assistive technology and advise and support people to access additional support from the independent and voluntary sector.

Strategic consequences of developing the intermediate tier for ongoing community support

There are a number of consequences in relation to ongoing community support that result from the proposed development of the intermediate tier:

- There will be a significant increase in the number of people with complex needs supported to remain in their own home. Maintaining them at home will require a greater use of assistive technology. Community staff will need to understand the role these technologies can play and have easy access to them. The development of a local approach to the development and implementation of these technologies and appropriate funding will be required;
- The requirement for community equipment, beds, hoists and more advanced equipment will increase. This will require funding but also effective processes to be in place to ensure equipment is provided and, where necessary, installed promptly if hospital admission is to be avoided and early discharge facilitated. Effective links will need to be in place with the third sector for any housing adaptations necessary;
- The effectiveness of an integrated Common access point in managing demand will be influenced by the extent to which non-public sector support and services are available within the local community to which people can be signposted. Currently third sector support is relatively underdeveloped. An approach to stimulating and, as necessary, investing in the third sector to provide low level support will be required;
- The development of the intermediate tier will necessitate changes in the working practices of the District Nursing Service, for example in new areas such as medicines management. There is already a shortage locally of District Nurses and the need to recruit and train will create issues for implementation timing;
- Increasing numbers of frail older people will require some short term assessment / reablement to be undertaken in a domiciliary setting in the future rather than in a hospital or care home bed. Review reablement will be crucial to prevent gridlock in the system and will require a change of approach by professionals with 'review' becoming part of their day to day activities;
- There will be a need to enhance the workforce and recruitment of additional staff as the intermediate tier is developed. An approach to the recruitment and transfer of staff will be required that can overcome the current delays experienced in recruitment. This is critical due to short term additional investment being available for one year only;
- The development of explicit intermediate tier functions will necessitate changes in current services, teams and staffing. The potential for 'disruption' as changes are introduced are high and for performance to temporarily dip. A robust approach to organisational development as part of the programme of implementation will be required;
- The service developments create the opportunity for enhancing community based therapy services. The longer term goal would be to see therapy services as part of the locality networks.

Specialist Mental Health Services

Specialist support to the intermediate tier

As identified in the Investment Plan there is a significant cohort of older people who are both frail and have dementia. There are also significant levels of other mental health problems (depression, anxiety, alcohol issues etc) in the older population. The proposed service model for the intermediate tier will see mental health link workers based in the Common access point. This will facilitate signposting to the broad range of support available in the community, the spread of knowledge and expertise within the staff team and reduce inappropriate referrals and admissions. It will allow for timely assessment of older people with mental health needs and onward referral as necessary to specialist services.

A support and stay team will also be in place for people with mental health problems as part of the Rapid Response function. These changes will have an impact on the work of the Older Peoples CMHTs strengthening their focus on those with the most complex needs.

The developments will be implemented in a phased approach starting initially with mental health professional expertise being available to the Common access point and moving over time to mental health workers embedded within the intermediate tier. Development of the current support and stay service will initially focus on a levelling up of current provision to those with complex needs across the Western Bay area before further extension to cover those with mild to moderate mental health problems.

The impact of these developments on activity and costs in mental health services has not been modelled explicitly to date.

Proposals for developing further specialist support to people with dementia

Detailed modelling work on dementia has adopted a similar approach to the work on frail older people looking at the impact of demographic change and thus the prevalence of dementia on service activity and costs if no new action is taken and assessing the impact of specific service interventions. The outputs from this work are detailed in full in the report that has been prepared for Western Bay Partners on the dementia project.

The dementia modelling work has identified in particular the impact of:

- Increasing the number of people with dementia with a diagnosis and the provision of ongoing community based support to them and their carers;
- The implementation of general hospital and care home mental health liaison across Western Bay.

These suggest there are potential savings to be made compared with the do nothing scenario in terms of hospital and care home admissions and reductions in hospital length of stay if these services are developed further.

Beyond these financial savings, specialist support to care homes should assist in improving the quality of care provide as staff become more able to meet the requirements of people with dementia, particularly those with behavioural difficulties. Locally the lack of the development of the care home market and its poor response in meeting the needs of people

with dementia is reflected in the number of extended assessment beds for people with dementia who meet Continuing Health Care criteria that are provided by ABMU. Over time improvements in care home quality through liaison may allow the market to develop to the extent that it is possible to commissioning more specialist dementia beds from within the community and so reduce the number of people who are staying long term in an extended assessment beds within a hospital setting.

Strategic consequences

There are a number of consequences in relation to specialist mental health services that result from the proposed development of the intermediate tier:

- In the shorter term (up to 2 years) there is the potential for increasing demand on mental health support services as mental health professionals supporting the intermediate tier identify unmet demand (depression, anxiety, alcohol issues etc) and additional support to carers (e.g. respite). However, in the longer term this may be balanced by the effect of increases in preventative and early intervention work;
- There is the potential for increasing the proportion of people with dementia who are diagnosed and in touch with services as a result of mental health expertise being available to services focused on the physical health of older people;
- Investment in mental health professionals in the intermediate tier will facilitate the process of CMHTs delivering Part 1 of the Mental Health Measure. It should improve links between mental health services and primary care and facilitate access to primary care mental health services. This will then potentially prevent escalation to secondary care services.

Primary Care

Overview

There are a number of consequences in relation to primary care that result from the proposed development of the intermediate tier:

- Development of the intermediate tier and maintenance of an increased number of people with complex needs in the community will require changes and enhancements to the medical workforce. A medical workforce plan will be required to be developed along with associated additional investment;
- There is a need to review and develop a commissioning approach for primary care services that will support the development of the intermediate tier and the care of frail older people living in the community and in care homes;
- The critical interplay between the development of the medial workforce to support the intermediate tier developments and work currently underway in locality networks with primary care needs to be recognised.

There will be a specific impact in terms of increasing the volume of work being undertaken through intermediate care, as well as growing pressures on "core" primary care services as a result of changing demographics and an increase in the number of patients with complex and co-morbidities.

Proposed changes to the GMS contract that will take effect from 1st April 2014 will support the development of new care models and to encourage practices to work together. There will be a specific focus on the development of care pathways that address emergency admissions and unscheduled care admissions. A local service development programme will require GP practices to participate in three national care pathways covering the early detection of cancer, end of life care and the frail elderly, which is pertinent to the development of this business case.

Capacity

A joint report produced by the Wales Deanery and the National Leadership and Innovation Agency for Healthcare in July 2012 summarised work undertaken to model the anticipated future supply of new GPs in Wales and to compare it against the most likely levels of future demand. The conclusions of the review indicated that there is likely to be a shortfall in the supply of GPs in the near future.

As a result of the Deanery report, a local workforce analysis has been undertaken within the Health Board. Since the Deanery report was published, there are other factors that are also likely to impact on the supply of GPs including pension and tax changes that are beyond the control of NHS Wales. Other factors that are relevant include an increase in part time working.

Our initial assessment has highlighted the potential shortfall in the number of GPs given predicted retirement patterns and on the basis of the 'known' shortfall in the number of GPs being trained. Earlier retirement patterns, and changes to the GP training programme could result in a markedly worse situation. New workforce models may therefore need to be considered, both to address the 'core GMS work' as well as to address some of the demand

factors, such as complexity, increasing number of frail older people, and the need to address the widening gap in health inequalities.

In terms of the development of the intermediate tier there will be a need to consider whether there is sufficient medical manpower available in the community to provide the level required. There is potential to develop new ways of working, and new roles, to support the expanded intermediate tier including the following:

- 'Expert' GPs working across practices in network arrangements or within the CRT framework to provide medical support for rapid response services, in particular;
- Practices collaborating to strengthen input into fixed settings of care, e.g. step up/step down provision, particularly support into care homes (partly addressed by proposed to change the current arrangements for providing enhanced care to care homes);
- GP champions at a locality network level – to provide a source of expertise and advice – particularly about the potential alternatives to admission and a source of knowledge about intermediate care services;
- Effective case management and care coordination and the appropriate use of risk stratification tools that will help to identify frailty and put a proactive support plan in place – the potential to look at risk identification in the context of a network model needs to be explored further, and the resourcing of GPs becoming engaged in proactive and anticipatory care planning needs to be considered further.

Links with GP Out of Hours

As services develop on a 7 day basis, it is important that there is a clear pathway and good communication between a range of unscheduled care services. Maximising the opportunities to keep people within their own homes, avoiding the need for a conveyance to hospital and potential admission will require there to be absolute clarity on the alternative services available (particularly over the weekend) and clear and simple processes to divert or signpost patients to the most appropriate service, as well as the ability to share relevant information in a timely way.

Governance

It will be essential that arrangements for care co-ordination and medical responsibility are addressed in line with the new model of care. GPs will retain responsibility for the provision of general medical services. New models of community based geriatrician support will provide valuable expertise and advice to GPs. Ensuring an effective interface so that there is clarity about the responsibility for prescribing, care planning, , support for step up/step down provision, information sharing, discharge communication and effective handover of care following intervention is critical.

As new models emerge, for example, GPs supporting the Community Resource Team in an 'expert GP role, more nurse practitioners working in community settings, the overall governance and responsibility framework will need consideration to ensure that it remains fit for purpose. A lead clinician who is most appropriate to provide the level of support should be identified, this could be a geriatrician, a specialist GP or the patient's own GP if specialist medical input is not required.

Integrated Assessment and Review

The role of the GP in supporting the integrated assessment and review process (whether at a locality or CRT level) will need to be explored. The potential for moving towards shared health and social care records will require further consideration, as well as the potential for existing systems to be used to better effective to improve coordination between primary, community and acute settings.

Access to specialist support

The enhancement of rapid response models, and the move to develop services on a 7 day basis will also have a requirement to ensure that there can be rapid access to assessment and investigative support to enable patients to receive appropriate diagnosis and treatment, avoiding the need for an admission. This work is being taken forward through the rapid access project (within the C4B Programme).

The potential for patients to be seen in ambulatory care setting should also be explored. This is a key strand in the modernisation plans being taken forward within the Health Board to ensure that there are pathways in place for access to specialist advice, when required. The role of the traditional day hospital and links with intermediate care services need to be further explored.

An effective medicines management plan is also required to ensure that older people can be supported safely at home. This is important as:

- 4 in 5 people over 75 take at least one medication with 36% taking 4 or more;
- Up to 50% of patients do not take medicines as intended;
- Adverse drug events are attributed to 5-17% of hospital admissions;
- Capacity to manage medication becomes complicated by disease states and increasingly complicated regimes;
- Older people have increased adverse drug events;
- Poor medicines management contributes to an increase in unscheduled care and admissions, as well as delayed transfers of care;
- Cost avoidance through improved medicine management and reduced wastage, could potentially free up resources to invest in improved services.

A separate analysis of the potential to enhance existing pharmacy models has been scoped and a discussion on resourcing these plans will need to be taken forward.

Overarching strategic consequences

The sections above have detailed the strategic consequences for individual sectors. There are however a small number of common themes that emerge for the Western Bay system as a whole and for commissioning and contracting.

Workforce

Without the right staff, in the right place, with the right skills and competencies the new service model and its expected impact across the system will not be secured. Co-ordinated workforce planning and workforce development needs to be an essential element of the change programme.

Cultural change

For the new system to work it requires behavioural change across sectors in the approaches adopted to supporting individuals (enabling, rehabilitation, discharge to assess and so forth), integrated working (more than simply co-location), recognising the role and capability of the community as opposed to hospital care. Changing behaviour is not easy and will require significant investment in time and energy and needs to be supported by appropriate underpinning frameworks including risk management.

Behavioural change also relates to families and carers. Hospital care and care home placements can be seen as the 'safe' option. An explicit and comprehensive approach to communication will be required to inform people of what they can expect from the changed system and that it represents safe, effective practice.

Rebalancing of financial resources

As more people receive their care outside a hospital setting there is a requirement for a rebalancing of financial resources between hospital and community services. Unlocking hospital resources for reinvestment in the community will be key to delivery of the change programme.

Developing the market

The revised system of care places new requirements and expectations on service providers (both independent and in house). A proactive approach to market management is required to encourage providers who are able to support complex clients for longer and deliver new models of care. A fragile local and regional market with its own drivers for change means that without market stimulation and direction it may not be capable of delivering the changes required. This could include stimulating the growth of smaller social enterprises to deliver care, who pay above the minimum wage helping to foster a more stable staff group, crucial for the delivery of out of hospital care.

Commissioning, contracting, quality assurance

A strategic approach to commissioning is required with a move away from spot contracts and the development of flexible contracts that can adapt to changing requirements over time. The move to more people with complex needs being cared for in the community emphasises the need for rigorous approaches to quality assurance, monitoring and the escalation of concerns to ensure that all care delivered is of an appropriate standard and quality as specified in contracts. Changed requirements of providers may require a review of fees and of charges.

Appendix 2: Options appraisal for integration

What options have we explored?

Introduction

An option appraisal for determining the nature of the transformation programme for frail older people was included in the Outline Business Case. It considered a short list of options from 'do nothing more' through to a substantial transformation programme that sought to deliver a fully optimised system of care.

However, to support this Investment Plan a further formal options appraisal has been undertaken by members of the Western Bay Community Services Project Board. This has been focussed on determining the future arrangements for the implementation of proposed service changes with a particular emphasis on the nature and extent of integration, including the presence of pooled budget arrangements.

In this section we therefore describe the options and the weighted criteria against which they were scored. The relative scores for each option are detailed and a preferred option identified. Through the process of the options appraisal a number of issues and comments were raised which will need further consideration in taking forward the proposals for community services and these are noted. The option appraisal was undertaken as part of the Community Services Project Board meeting on 7th November. The details of the scoring is included as Appendix 1 whilst the options and the outcome from this work is detailed here.

The options

The options considered were built up using four components as indicated below:

- The service functions to which integration might apply – Demand management, intermediate tier, ongoing community support;
- What part of the system will be integrated, i.e. community health services, social care professionals and mental health staff;
- The footprint for a Section 33 pooled budget Agreement i.e. None, by locality or across Western Bay;
- The extent of any pooled budget agreement i.e. transformation programme only or also including business as usual.

These components can be combined in a variety of ways to create a wide range of options. However, eight options were identified and assessed in the option appraisal as being representative of this wider range of possibilities. Whilst not covering all possible options they constitutes a short list of the most likely combinations that matched the expectations from the integration workshop and discussions at a Changing 4 The Better community services workshop held on 1st November and attended by some Board members.

The options appraisal considered the three key community service components within the service model, namely:

i. Demand management function

ii. Intermediate tier

iii. Ongoing support function

Integration

A key focus of the option appraisal was to determine whether the service functions detailed should be integrated, and if so to what extent. Integration can be across health and social care older peoples services or across health and social care including mental health. For the purposes of the option appraisal an integrated service was taken to mean:

- A Multi professional team with specialist and generic staff appropriate to meet the needs of the client;
- Co-location with single management, joint training and a single budget;
- Joint care planning and coordinated assessments of care needs;
- Named care co-ordinators acting a navigators;
- Recording on single clinical record.

Pooled Budgets

This component within the options included using the opportunity to establish pooled budgets under the national Health Service Wales Act 2006. Pooled budgets could be established for each of the three local areas or a single pool across the Western Bay area. In addition a pool (whether 3 or 1) could apply to the transformation funding only or also include 'business as usual' funding.

Appraisal process

The options

The eight options considered in the appraisal are detailed in Appendix 1. They are:

1. Delivering transformation through the existing mechanisms with no additional integration or pooled budget arrangements.
2. Delivering transformation through existing mechanisms except for the intermediate tier where reablement support and short term interventions would be delivered in an integrated health and social care service using pooled budgets for the transformation funding.
3. Delivering transformation through integrated health and social care services in all three elements of community services using pooled budgets for the transformation funding.
4. Delivering transformation through integrated health and social care services in all three elements of community services using local pooled budgets for transformation and business as usual.
5. Delivering transformation through integration of health, social care and mental health services for the intermediate tier and ongoing support, but without any pooled budget arrangements.
6. Delivering transformation through integration of health, social care and mental health services for all three components of community services using local pooled budget arrangements for transformation funding.
7. Delivering transformation through integration of health, social care and mental health services for all three components of community services using local pooled budget arrangements for transformation funding and ongoing business.

8. Delivering transformation through integration of health, social care and mental health services for all three components of community services using a single Western Bay pooled budget arrangement for transformation funding and business as usual.

Domains, questions and weightings

At the 'Changing 4 the Better' workshop participants had discussed, agreed and ranked the criteria against which the options presented at that point should be assessed. These were subsequently developed into five domains with three or four specific questions within each. The domains were then weighted (points out of 100) based on the ranking. Then the questions were weighted within each domain to sum to the domain total. The domains and weighting used in the appraisal are as follows:

Criteria	C4B Ranking	Weighting
Patient Experience	1	30
Independence	2	25
Patient Journey	3	20
Finance	4	15
Implementation	5	10

Table 35 Ranking and weightings for the options appraisal around integration

The full set of domains, questions and weightings are included at Appendix 1.

Appraisal process

Participants were asked to score each of the options against each question on a scale of 1 to 5 where 5 represented 'meets entirely' and 0 represents 'does not meet at all'. The exercise was undertaken as a group with individuals developing their personal scores followed by a group discussion to secure a 'group' score.

Option Score analysis

The option scores and preferred option

The final weighted scores for each of the eight options are given in the table below. The scores for each question are given in Appendix 3.

	Option							
	1	2	3	4	5	6	7	8
Weighted score	150	234	242	297	282	359	437	325

The highest scoring option overall was Option 7:

> ***Delivering transformation through integration of health, social care and mental health services for all three components of community services using local pooled budget arrangements for transformation funding and ongoing business.***

The current understanding of the extent of Mental Health Integration under this option is that there will be co-location and alignment of Mental Health teams within the intermediate Tier,

with link posts. Further, the term 'local' indicates a preference toward subsidiarity, i.e. doing things at the most local level consistent with delivering value for money and improved outcomes.

The weighting used in the scoring (based on the C4B discussion) gives greater weight to the patient experience, promoting independence and the patient journey, than to financial matters and the feasibility of implementation. After the option appraisal a set of revised weightings have been applied to the scores recorded at the event for the purposes of sensitivity testing. These place much greater emphasis on the finance and implementation domains. Whilst changing the total weighted scores Option 7 still retains first position scoring 389 with option 6 in second position scoring 340.

Score analysis

There are common features in the top three highest scoring options (numbers 6, 7 and 8), indicating the importance of these to local partners, namely:

- Integration of mental health along with community health and social care;
- The inclusion of all three service functions – demand management, intermediate tier and ongoing community support;
- The use of a pooled budget.

There is a 78 point difference in the scores between options 6 and 7(the highest scoring) but the only variance between them is the inclusion of 'business as usual' funding in the locality pooled budgets in option 7. A review of the scoring indicates that there is a strong perceived benefit in the impact on the patient experience, independence and the patient journey domains when 'business as usual' funding is pooled.

Option 8 proposed a pooled budget across Western Bay for both transformation funding and 'business as usual'. Compared with option 7 it received lower scores for the patient experience, promoting independence and improving the patient journey. This reflects comments made by some members during the process of the importance of localism, having services that are a tuned to local needs and a view that this could not necessarily be secured under a pan Western Bay arrangement. However, with the development of commissioning by localities it was suggested this may not be such an issue.

Option 8 also scored lowest of all options on the implementation domain, which may be a reflection of current uncertainty regarding local government boundaries. When greater clarity emerges on the future direction this option may be more deliverable and scores can be revisited. Whilst scoring maximum points for delivering consistency across the localities it scored zero in terms of deliverability, high level leadership commitment and being able to be delivered without undue disruption and risk to patient safety. It did however score highly for cost containment, with the debate suggesting that a Western Bay approach could drive out inefficiencies, duplications and deliver reductions in back office functions.

Issues to be considered

Through the option appraisal process a number of issues emerged that will require careful consideration by Western Bay partners.

Specialist Mental health

Whilst it was considered by many that it was essential for mental health professionals to be an integral part of the three service functions – demand management, intermediate tier and ongoing community support, significant concern was raised by ABMU mental health members. Whilst acknowledging the benefit of mental health involvement in these functions

for people with physical and mental health problems their concerns were that if resources were to be deployed in this way, they would not be able to adequately support those people with complex needs as the specialist service would be diluted. Potentially there would also be some misalignment with their developing all age tiers of service under the Mental Health Measure. Currently there is a national requirement for a specific proportion of health funding to be spent on mental health. Any pooled budget arrangement would need to be cognisant of this

Finding a means of addressing the mental health needs of older people in general as well as those with complex needs as the transformation programme is developed further now appears to be a priority issue to be resolved. A phased approach that initially focusses on liaison posts, co-location and alignment of boundaries will be pursued alongside the delineation of team criteria in line with part 1 and part 2 of the Mental Health Measure.

Business as Usual funding

Within the options appraisal the term 'business as usual' funding was used. It became clear as the process and discussion progressed that there were different perspectives on what constituted 'business as usual'. This ranged from a fairly narrow definition incorporating current funding in Community Resource Teams and others involved in intermediate care through to all community and social care funding for both direct service provision (e.g. district nursing) and commissioned services (e.g. residential care). Given that the preferred option would see such funding in a locality pool it is important that local partners reach a common agreement on the precise definition of 'business as usual. The timescale for developing pooled budgets based on business as usual also needs to be considered. It may be appropriate for transformation funding to be pooled from April 2014 with work undertaken during 2014/15 to establish further pooled budget arrangements from April 2015.

Demand management

Of the three service functions being considered for an integrated arrangement the importance of the demand management function and in particular a Common access point were emphasised. From an implementation perspective it was thought that these needed to be put in place first as well as being the priority for initial levels of integration and alignment with mental health services.

Localism v's Western Bay

A number of issues were raise during the appraisal process regarding having a pooled budget across Western Bay and the potential difficulties associated with this. Apart from the localism mentioned earlier there were concerns over governance and potential additional layers of bureaucracy. From the third sector perspective considerable advantage was seen in a Western Bay approach streamlining commissioning / contracting arrangements and giving the opportunity to re-commission third sector services in a coordinated way. There is current political uncertainly in terms of the future footprint for local authorities and it is important to recognise therefore that the questions, particularly those relating to implementation, are set within this context. Option 8 could potentially score higher were the footprint to be known.

The options

The options:		Integration	Functions	Section 33 Pooled Budget
1	Delivering transformation through the existing mechanisms with no additional integration or pooled budget arrangements	No	Demand Management Ongoing support Intermediate tier	No
2	Delivering transformation through existing mechanisms except for the intermediate tier where reablement support, and short term interventions to prevent admissions to hospital and long term care, as well as to speed discharge from hospital, would be delivered in an integrated health and social care service using pooled budgets for the transformation funding.	H&SC	Intermediate Tier	3 separate pooled budgets for transformation
3.	Delivering transformation through integrated health and social care services in all three elements of community services using pooled budgets for the transformation funding.	H&SC	Demand Management Intermediate tier Ongoing support	3 separate pooled budgets for transformation
4	Delivering transformation through integrated health and social care services in all three elements of community services using local pooled budgets for transformation and business as usual.	H&SC	Demand Management Ongoing support Intermediate tier	3 separate pooled budgets across Western Bay for transformation & business as usual
5	Delivering transformation through integration of health, social care and mental health services for the intermediate tier and ongoing support, but without any pooled budget arrangements.	H&SC including mental health	Ongoing support Intermediate tier	No
6	Delivering transformation through integration of health, social care and mental health services for all three components of community services using local pooled budget arrangements for transformation funding.	H&SC including mental health	Demand Management Ongoing support Intermediate tier	3 separate pooled budgets for transformation
7	Delivering transformation through integration of health, social care and mental health services for all three components of community services using local pooled budget arrangements for transformation funding and ongoing business.	H&SC including mental health	Demand Management Ongoing support Intermediate tier	3 separate pooled budgets for transformation & business as usual
8	Delivering transformation through integration of health, social care and mental health services for all three components of community services using a single Western Bay pooled budget arrangement for transformation funding and business as usual.	H&SC including mental health	Demand Management Ongoing support Intermediate tier	Single pooled budget across Western Bay for transformation & 'business as usual' funding

Domains and weightings

1- Patient Experience	Relative weighting within domain
1.1 To what extent will the option deliver care that is ***personalised***?	7
1.2 To what extent will the option deliver better ***outcomes for patients*** allowing them to live the life they want to the best of their abilities?	10
1.3 To what extent will the option deliver better ***co-ordinated seamless care*** with fewer barriers between services, multiple assessments, multiple information giving etc	6
1.4 To what extent will the option deliver improved ***outcomes for families and carers*** through recognition of their needs and provision of support?	7
Weighting of domain	30

2- Independence	Relative weighting within domain
2.1 To what extent will the option contribute to the ***early identification*** of people's needs?	13
2.2 To what extent will the option help to ***minimise the risk*** to people's independence?	6
2.3 To what extent will the option increase the proportion of people who are ***supported at home***?	6
Weighting of domain	25

3- Patient Journey	Relative weighting within domain
3.1 To what extent will the option deliver ***improved access*** to services and support (e.g. Common access point, 24/7 services)	5
3.2 To what extent will the option ***reduce handoffs*** between professionals and teams and the current gaps between services?	5
3.3 To what extent will the option improve the ***timeliness*** of service delivery (e.g. provision of equipment)?	5
3.4 To what extent will the option maximise the ***staff time available*** for direct patient care?	5
Weighting of domain	20

4- Finance*	Relative weighting within domain
4.1 To what extent will the option contribute to the ***containment of cost increases*** over the next 10 years?	10
4.2 To what extent will the option facilitate flexibility ***in the deployment*** of financial resources to meet needs?	5
Weighting of domain	15

* Two additional questions were included in this domain, namely:

1. To what extent can the option be implemented without the need for significant ***investment in new / redesigned se***rvices?
2. To what extent can the option be implemented without the need for significant ***investment in local infrastructure*** (e.g. premises, Information Technology etc?

However, participants found it impossible to score these and it was therefore agreed during the workshop to give them '0' weighting and therefore leave them outside the process.

5- Implementation	Relative weighting within domain
5.1 To what extent could the option ***actually be delivered*** across Western Bay over the next 3 years	3
5.2 To what extent could the option be ***delivered in a consistent manner*** across the three localities?	2
5.3 To what extent could the option be delivered with the current level of high level ***leadership commitment*** within the Western Bay partnership?	2
5.4 To what extent could the option be delivered without causing undue ***disruption and therefore risk to patient safety*** in the system?	3
Weighting of domain	10

Scoring

1 Patient Experience	Option							
To what extent will the option deliver	1	2	3	4	5	6	7	8
1.1 Care that is personalised	1	1	1	2	2	3	4	3
1.2 Better outcomes for patients	1	1	1	2	2	3	4	3
1.3 Better coordinated seamless care	1	1	1	2	2	3	4	3
1.4 Improved outcomes for families and carers	1	1	1	2	2	3	4	3
Weighting of domain = 30								

2. Independence	Option							
To what extent will the option	1	2	3	4	5	6	7	8
2.1 Contribute to the ***early identification*** of people's needs	1	3	3	3	4	4	5	3
2.2 Help to ***minimise the risk*** to peoples independence	1	3	3	3	4	4	5	3
2.3 Increase the proportion of people who are ***supported at home***	1	3	3	3	4	4	5	3
Weighting of domain = 25								

3 Patient Journey	Option							
To what extent will the option deliver	1	2	3	4	5	6	7	8
3.1 ***Improved access*** to services & support	3	3	3	4	3	4	5	5
3.2 ***Reduce handoffs*** between professionals & teams & gaps in services	3	3	3	4	3	4	5	4
3.3 Improve ***timeliness*** of service delivery	3	3	3	4	3	4	5	4
3.4 Maximise the staff time available for direct patient care	3	3	3	4	3	4	5	4
Weighting of domain = 20								

4. Finance*	Option							
To what extent will the option be implemented	1	2	3	4	5	6	7	8
4.3 Contribute to containment of cost increases	1	2	3	3	2	4	4	4
4.4 ***Facilitate flexibility*** in deployment of financial resources	1	2	3	4	2	3	4	5
Weighting of domain = 15								

5 Implementation	Option							
To what extent could the option be implemented	1	2	3	4	5	6	7	8
5.1 Actually be delivered	5	4	3	3	3	3	2	0
5.2 Be delivered in a ***consistent manner***	0	4	3	3	4	4	4	5
5.3 Be delivered with current high level of leadership commitment	1	5	4	4	3	4	3	0
5.4 Without undue disruption & risk to patient safety	1	3	3	3	3	3	3	3
Weighting of domain = 10								

Appendix 3: Identifying frailty and dementia co-morbidity and associated costs

1. Introduction

Much work nationally and locally has been done to understand the progression of dementia and, separately, the onset of frailty in a population, and to identify the services that are needed to meet these needs in as effective and efficient way as possible. However, less is known about the extent of co-morbidity between dementia and frailty, although it is clearly a relatively common occurrence.

More work is needed to understand how we meet the needs of such people in a way that avoids duplication but retains access to appropriate specialist care but this appendix builds on the ambition reflected at the Western Bay engagement event for integration and provides a provisional estimate of:

1. The number of people experiencing dementia and frailty separately and together, and therefore the different population cohorts of need.
2. The total spend on services to meet these needs across health and social care, avoiding double counting wherever possible.

Considerable further work will be necessary to refine our understanding of these areas of need. One way of doing this is through the use of the SAIL database at Swansea University[5], which provides an opportunity to match data from across several different sources. The first questions that are being asked of this database are:

1. Is the rate of unscheduled hospital admissions for people with a diagnosis of dementia higher than for people without a diagnosis?
2. What is the proportion of people receiving home care support/care home residents with a positive diagnosis of dementia?

It is recognised that as well as co-morbidity between dementia and frailty other factors or conditions can contribute to increasing needs within the population. Many of these will have contributed to a person's frailty but at this stage no attempt is made to identify the single conditions, apart from dementia, that contribute to the wide range of long term healthcare needs prior to people becoming frail. However, there is clearly a strong link between advancing dementia and frailty. One of the key areas of overlap for these client groups is the nature of support required toward the end of life, for which we will also provide an initial estimate in this appendix.

2. Estimating cohorts of need for frailty and/or dementia

Using local demographic profiles from GP networks and expected prevalence rates for frailty and dementia we can estimate that there were approximately 10,460 people who were frail and 6,990 who had dementia in April 2012[6]. However, we know that some people will fall into both cohorts – and that supporting these people in a holistic and integrated way is of critical importance. In order to estimate the number of people who might experience both frailty and dementia a brief literature search has been undertaken. This has identified an

[5] See http://www.biomedcentral.com/1472-6963/9/157

[6] Based on GP registered population for ABMU constituent GP practices, drawn from the Exeter system, as at the 1st of April 2012.

initial sample of research that suggests that if you are frail then you are twice as likely to also have dementia[7]. Using this intelligence we have:

1. Identified the expected prevalence of frailty by 5 year age bands in each local network.
2. Applied the expected population prevalence for dementia to each of these age bands and doubled this to reflect the research noted above.
3. Netted this cohort of people expected to have both frailty and dementia from the expected prevalence of frailty and of dementia respectively.

At a Western Bay level this methodology provides an estimate of 2,409 people who will have both frailty and dementia. This is illustrated below in Figure 3. At a local network level the breakdown of needs is illustrated in Figure 4. The 15,040 people suggested in Figure 1 represent 14.6% of the over 65 population, with a range from 13.6% in Bridgend North to 15.6% in Swansea Bay.

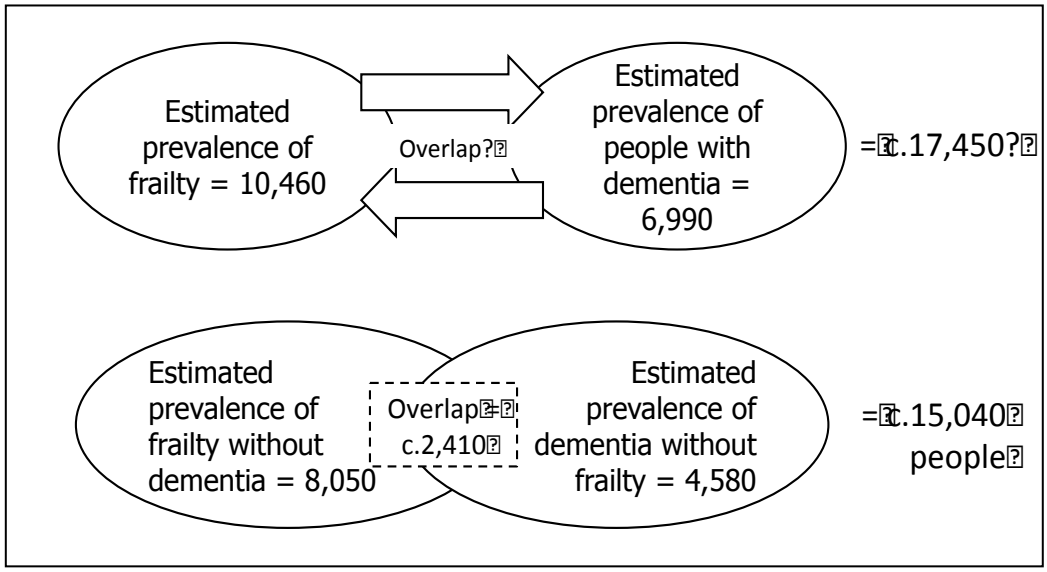

Figure 6 Estimate of population cohorts of need for dementia and frailty

[7] The J Am Med Dir Assoc (2013) Jul;14(7):518-24 article entitled "*Combined prevalence of frailty and mild cognitive impairment in a population of elderly Japanese people*" found a significant relationship between frailty and MCI with an odds ratio adjusted for age, sex and education of 2.0.
Alzheimer's Dement. 2013 Mar;9(2):113-22. doi: 10.1016/j.jalz.2011.09.223. Epub 2012 Dec 12. article entitled "*Frailty syndrome and the risk of vascular dementia: the Italian Longitudinal Study on Aging*" identified an overall hazard ratio of 1.85 for the risk of dementia when someone is frail.
J Gerontol A Biol Sci Med Sci. 2013 Sep;68(9):1083-90. doi: 10.1093/gerona/glt013. Epub 2013 Feb 18 article entitled "*Frailty and incident dementia*" identified a similar hazard ratio of 1.78.

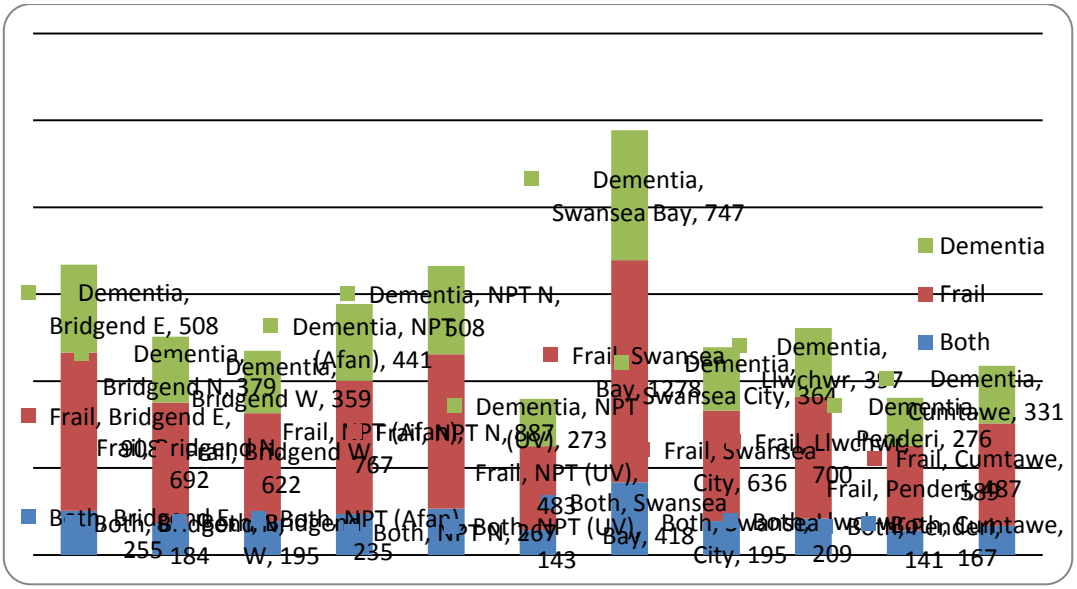

Figure 7 Cohorts of need at a Network level estimated for April 2012

3. Estimating the costs of services

The modelling tools developed to support the current strategic redesign programmes for frailty and dementia identifies baseline activity (either at April 2012 or for the full year 2012/13) and unit costs. The purpose of this data was to estimate the capacity and resource impact of different redesign options, i.e. a change from baseline spend. The results of this are covered extensively in the reports for the frailty and dementia projects respectively.

The primary reason for collecting this information was not therefore to construct a budget or to reconcile back to overall spend, in part because a lot of the services included were non-specialist meaning that spend on people with dementia or frailty could not be identified precisely. However, using this data it is possible to provide an indication of the costs associated with these clients, and once again to identify any overlap so as to avoid double counting.

The estimate of gross spend on these two client groups by both health and social care is:

- £72.6M for dementia, which includes spend on admissions to hospital for people with dementia (for all causes); specialist mental health services for this client group; home care services for people expected to have dementia; and care home spend, again for that proportion of residents expected to have dementia.
- £91.6M for frailty, which includes spend on the proportion of acute and post-acute hospital admissions expected for frail older people; Intermediate Care services; all home care services; and all Local Authority supported care home residents.

There is clearly an overlap between these two sets of costs and we have therefore identified duplication and estimated total spend on these two clients as set out in Table 1. A further illustration of this overlap is provided in Figure 5.

Element of spend	Estimate	Balance or split of spend
General acute	£15.7M	Of which just over half will be for people with dementia
Intermediate care	£5.6M	Of which the majority will be spent on people who are frail
Home care	£13.6M	Of which c 60% will be spent on people with dementia
Care homes	£22.1M	Of which about two thirds will be spent on people with dementia
Specialist MH services for people with dementia	£18.0M	All of which will be spent on people with dementia
TOTAL	£109.7M	

Table 36 Estimate of total costs for people with dementia and/or that are frail

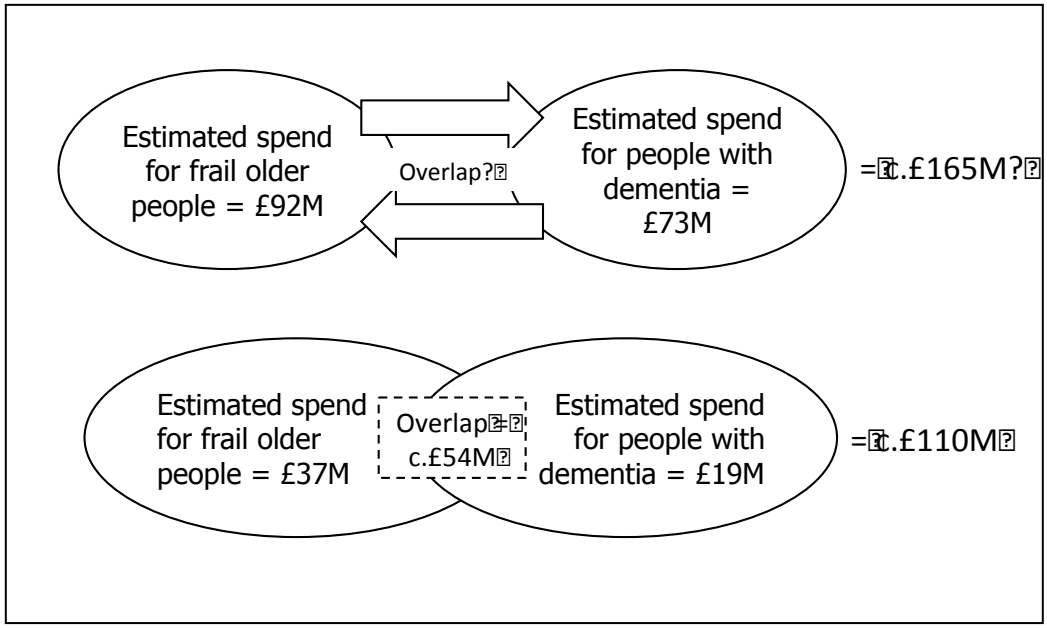

Figure 8 Estimate of health and social care spend on people with dementia and/or frailty

4. End of Life Care

End of Life Care has not been a specific focus of the work commissioned by the Western Bay Partners to date. However, the tools used to develop the dementia and frailty simulations rely on an underpinning demographic that also, as a consequence, identify the number of people who will die each year. The modelling work on frailty estimates 5,600 deaths each year, which is 1.03% of the GP lists across Western Bay[8]. The number of people who die with dementia can also be estimated from the modelling tool associated with this work. It suggests

[8] This is consistent with the Gold Standard Framework which suggests that 1% of people will die in any one year of all causes.

that 1,770 people will die each year with dementia, which means that just under one third of people who die will have some level of dementia.

To arrive at an estimate of deaths for people with dementia and/or frailty we have applied the same methodology as set out in section 2. Figure 6 provides a breakdown of these estimates by locality. It suggests that frailty and/or dementia will be a part of people's needs during the last year of life in 63% of all deaths (3,600). When compared to the total combined prevalence of frailty and/or dementia this also means that 24% (1 in 4) of people with frailty and/or dementia can be expected to be in their last year of life.

The Welsh End of Life Care Strategy stresses the importance of providing an integrated care plan for people at the end of life, as well as other aims for improving choice at the end of life. The estimates in this paper therefore provide a useful starter to explore service redesign and its impact on this area of strategy.

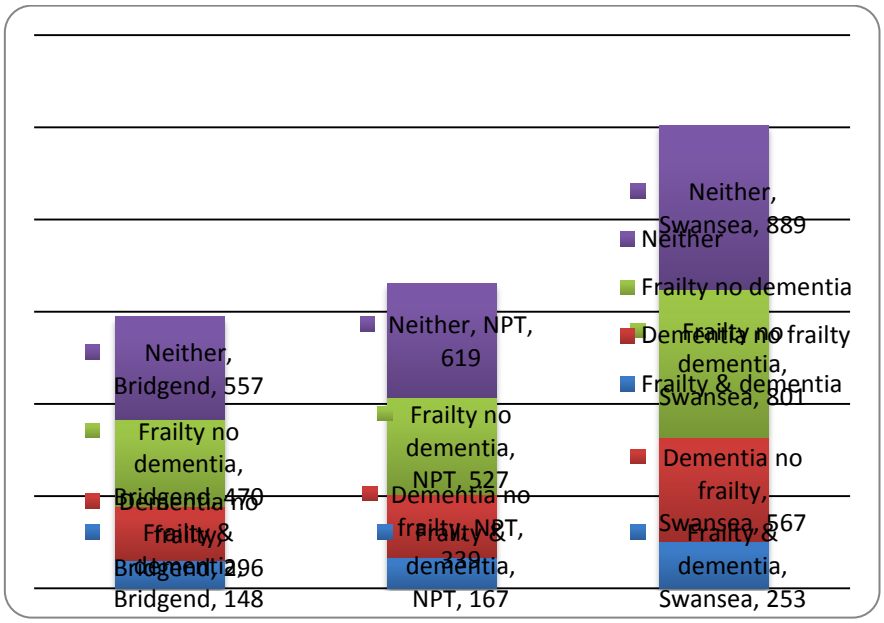

Figure 9 Estimate of deaths where frailty or dementia are present

Definitions for Figure 4:

A. People whose last year of life will be characterised by frailty with dementia and potentially other conditions.

B. People who will have dementia and potentially other conditions but will not be frail.

C. People who will be frail, potentially with other conditions, but will not have dementia.

D. People who will not have dementia and will also not be frail.

Appendix 4: Statement of Intent

caring together
gofalu gyda'n gilydd

Delivering Integrated Health and Social Care for Older People with Complex Needs across Western Bay

Statement of Intent
March 2014

1. Introduction

This document sets out our commitment to deliver integrated health and social care for older people with complex needs across Swansea, Neath Port Talbot and Bridgend. The document has been developed through a process of discussion and collaboration with partners in health and local government, through the *Western Bay Health and Social Care Programme* which was initiated in 2012.

The Western Bay Programme was established to deliver integrated care models across older people, mental health and learning disability services. Significant progress towards this goal has already been made, and our organisations have agreed to work together progress the development of joined up care for older people signalling our intent in a document agreed by ABMU Board and Cabinets within each of the three Local Authorities during the Autumn of 2013.

Multi agency and multidisciplinary community teams will continue to be the mainstay of mental health services with work carried out to develop integrated teams within older people's mental health services across the three local authority areas and this has also been agreed by partners. A third element of the overall Western Bay Programme is focussing on learning disability services. Increasingly it is recognised that having age appropriate models of care will be an important issue for learning disability services.

The Western Bay Partnership is committed to transforming care provision, particularly in terms of moving the delivery of care from institutionalised models to independent living and community based care. ***Delivering Improved Community Services*** brings together two strategic programmes, ABMU's *Changing for the Better* and Western Bay in order to build a collaborative approach to service transformation from the beginning. It is based on extensive public engagement and dialogue with the third sector and primary care in addressing local health and social care issues.

The overarching aim of the programme is to deliver integrated health and social care services that will ensure:

Support for people to remain independent and keep well
More people cared for at home, with shorter stays in hospital if they are unwell
A change in the pathway away from institutional care to community care
Less people being asked to consider long term residential or nursing home care, particularly in a crisis
More people living with the support of technology and appropriate support services
Services that are more joined up around the needs of the individual with less duplication and hand-offs between health and social care agencies
More treatment being provided at home, as an alternative to hospital admission
Services available on a 7 day basis
Earlier diagnosis of dementia and quicker access to specialist support
Ensure that the needs of carer's are included in the development of new service models.

Delivering Improved Community Services sets out three key priorities that have been and will be the focus over the next three years. They are:

1. **Wellbeing and keeping healthy** – making sure older people who are frail and those with long term conditions are given the opportunities and support to take care of themselves and be independent, for example through innovative community resilience initiatives
2. **Strengthen community teams** – making sure people default to the community for assessment and if necessary care rather than hospitals and institutional care, for example by investing more in CRTs, community networks, older people's mental health services, etc.
3. **Sustainable services** – ensuring the enablers are in place to allow community services to be the best they can be for the long term future, for example through better technology, better workforce planning, etc

The aims of the programme are in line with the key principles underpinning the proposed Social Services and Well Being (Wales) Bill particularly in terms of:

- Moving to a 'strengths based' approach – focussing on helping people to live independent lives
- Shifting the emphasis towards prevention and working with third sector and other partners on innovative approaches such as Local Area Coordination to help people to be supported in different ways, within their own communities
- Developing consistent services available across the 7 day period across our Health Board area
- Using technology to support people more effectively.

2. Policy context

The Welsh Government policy framework is set out within ***Together for Health*** **(2011**),and confirms its commitment to improve the health of people in Wales, and to take tough action on health inequalities over the next 5 years by creating a 21st century healthcare system.

The key challenges are:

- Demographic changes leading to more older people and increasing frailty
- Rising number of people with chronic ill health and long term conditions
- Lifestyle choices that are worsening population health
- Widening health inequality between rich and poor
- Difficulties in recruitment in a number of key areas including, but not restricted to medical manpower several groups of clinical staff, particularly some doctors
- Falling real terms revenue available each year to the NHS and Local Authorities in Wales.

Shared Purpose – Shared Delivery (Single Integrated Partnership Plans (SIPP)) is the guidance issues by Welsh Government in June 2012 that states each local authority area, through its Local Service Board, will produce a single integrated plan that replace the following:

- Community Strategy
- Children & Young People's Plan
- Health, Social Care & Wellbeing Strategy
- Community Safety Partnership Plan.

SIPPs are 5 year plans and are a statutory requirement. Local Service Boards are not statutory bodies so the duty lies with the Local Authorities to implement these important plans with support and sign up from partner organisations.

Setting the Direction, the vision for primary and community services, issued in 2010, paved the way for the development of locality working and was seen as the cornerstone of the new model for primary and community care. A particular focus is on those individuals who are frail, vulnerable and who have complex care needs, with key themes as follows:

- Confidence to self manage
- Sharing information

- Health and social care alignment
- Local clinical leadership and engagement
- Flexible working
- Principles of public health
- Joined-up and easily navigated services
- Seamless between in and out of hours services
- Service excellence & accessibility

Sustainable Social Services: A Framework for Action sets out the action needed to ensure care and support services respond to rising levels of demand and changing expectations, bringing consistency, for example in standard contracts for care homes. Frail older people are one of three priority areas for greater integration of delivery:

- Placing reablement at the heart of the approach
- Maximising recovery for people with long term care needs
- Addressing the needs of people with dementia
- Using technology effectively
- Ensuring a confident and competent workforce.

Designed to Add Value (2008) outlines the key role the Third Sector plays in supporting health and social care to make a real difference to the health of individuals and the community ensuring:

- That the right services are delivered at the right time and in the right place, to the right person across the care pathway.
- The integration of the contribution of volunteers, Carers and the third sector in better health.
- Engagement of the public, including vulnerable groups, in identifying needs and determining how best they can be met.
- Volunteers also bring considerable value to the daily lives of people and to health and social care services in a variety of ways. They support and enhance services to patients provided by statutory services with little or no cost but significant gains for people, patients and professionals.

The Social Services and Wellbeing (Wales) Bill, published in January 2013 will provide the legal framework to support the transformation of care and support in Wales.

The *Bill* focuses on three key themes:

- Identifying those in need of support;
- Promoting wellbeing;
- Earlier targeted support (aimed at reducing demand for long term care).

The new legal powers will include:

- Strengthened powers for safe-guarding;
- Increasing services covered by direct payments;
- National eligibility criteria and portable assessments;

- Equivalent rights for carers.
- Strengthening duties on Health Boards and Local Authorities to work together to develop integrated services.

The Bill provides the legislative framework for implementing the vision set out in *Sustainable Social Services.* It focuses on empowering people and recognises that Social Services need to move from crisis management and deliver earlier intervention to be sustainable. The Bill, therefore, requires local government and partners in the NHS to understand the dimensions and shape of the population in need in their areas, to make this public and to use its powers to make arrangements to provide a range of services to meet these needs.

Some people will require an intensive and comprehensive range of services. The Bill makes it clear that local authorities have a duty to provide, or commission, social care services and will bring forward a definition of these types of services that will draw on the existing definitions and take account of proposals put forward by the Law Commission. This will include the development of social enterprise and co-operatives as delivery agents.
The legislation will also provide individuals with a stronger voice and real control. The starting point is enabling individuals to understand fully how care and support may help them. The proposals give individuals a right of access to an assessment of their needs and will require those assessments to be carried out in a way that focuses on the outcomes that people.

In the summer of 2013, two further policy documents reinforced the need for urgent and transformational change. The first of these – *Delivering Local Health Care* – required Health Boards, working with partners, to focus on the development of community (locality) networks as a means of securing a different approach that brings together primary, community and social care services, in geographical networks serving 30-50,000 population. This policy 'refreshed' the vision set out within Setting the Direction. The Bevan Commission also provided advice to the Minister on the development of health and social care services during the autumn of 2013. A policy document published in mid 2013 set out *A Framework for Delivering Integrated Health and Social Care for Older People with Complex Needs* which required partners to accelerate the development of integrated services. Partners were also required to publish this 'statement of intent' setting out how they would respond to the key requirements by the end of January 2014.
The development of the new ***Integrated Assessment, Planning and Review*** framework provides a timely opportunity to review existing systems and processes to streamline access into services and ensure that assessments are proportionate to need.

3. Where are we now?

In response to both national policy frameworks and strategic and operational pressures at a local level, ABMU and the three Local Authorities have worked hard over recent years to build local community services. These include:

Community Resource Teams (CRTs)
The aim of CRTs was to provide integrated and co-ordinated care management including specific admission avoidance and supportive discharge schemes, chronic condition case management, enhanced preparation for scheduled care, enhanced medicines management and advanced access to diagnostics.

In the Western Bay area, CRTs have been established in Swansea, Neath Port Talbot and Bridgend to provide specialist care to people in the community. As well as other services in the community, the teams include nurses, therapists and social workers with advanced skills in assessment and management of complex needs. These teams provide a strong, multidisciplinary approach focused on the maintenance of more complex cases in the community.

A recent baseline assessment of the three CRTs highlighted the lack of pace in implementing these specialist community services. The following were key findings from the analysis:

- Each CRT has been established differently in response to local pressures and historical ways of working within each Locality.
- Service provision differs in each area due to differences in population size, resource allocation and strategic priorities, making it difficult to provide a comparative analysis of the three teams.
- Integration between health and social care is at varying stages of development in each area.

    - **Bridgend**
        - 3 community network health and social care teams bringing together social workers, district nurses and occupational therapists are co-located in community hubs working within an integrated management structure
        - A single point of access to intermediate care and adult social work through the development of an Integrated Referral Management Centre (IRMC) providing a gateway to services
        - An integrated Community Resource Team with a full range of intermediate and reablement services together with rapid response nursing service, and an innovative mobile response team which enhances the telecare service
        - A joint residential reablement service is in place to provide step down beds for patients who require additional support before being able to return home from hospital.

    - **Swansea**
        - A joint Community Resource Team is in place with a single manager
        - Integration of Occupational Therapy services has begun to be integrated with the CRT therapy services.
        - The next phase of work will move to using a single IT system for referral, work allocation and as a single record.
        - The role of Gorseinon Hospital as a 'step down' facility operating as part of the CRT is in place. There are step down beds available in Local Authority homes across Swansea. Innovative approaches being tested to bring together reablement, domiciliary care and health care support workers into an integrated team in Gower to overcome issues of hard to reach areas that were impacting on the recruitment of domiciliary care staff.

    - **Neath Port Talbot**
        - The CRT is a joint team with a single management structure for all health and council employees in place.

- The NPT Community Gateway provides a common access point for the CRT and Adult Social Care. A multidisciplinary team of staff work within the Gateway to ensure that referrals are managed in the most appropriate way. Allocation of work from the Gateway to the CRT is all managed electronically.
- Residential Reablement and Step up/down beds are currently being developed.
- The Reablement and Acute Clinical Team in NPT CRT were already using a single paper based client record and work is well advanced to move all of this onto a IT system.
- The CRT are co-located on the same site (Cimla Hospital) and this is proving to be highly supportive in terms of integrating work practices and pathways for service users.

There are however recognised issues and limitations cross the Western Bay area that have been identified through the local review work undertaken. These include:

- The majority of services operate on a 5 day basis (with notable exceptions in the Neath Port Talbot area)
- ABMU is unique in Wales in that there are 4 information systems in use across the ABMU footprint: Draig in Bridgend, a bespoke system in NPT, PARIS in Swansea and the Health Board has adopted Myrddin as its patient administration system. The evidence base is clear in that a key success factor in developing integrating services is the ability to access a single record so the current infrastructure presents significant barriers, and pragmatic solutions are needed to overcome the lack of a single integrated system being in place
- The medical model differs across ABMU with differing levels of input being provided across the Health Board area
- Telecare has developed differently - Bridgend has the strongest model with an innovative and flexible mobile response service, with a high uptake of telecare because of its history of being developed as a core function within the CRT.
- Core community service models have emerged differently in each of the three areas, with Swansea having a strong chronic conditions management model in place that complements the delivering of primary, community and intermediate care services.

Community Mental Health Teams

The Older People's Mental Health Teams within ABMU include staff from both health and social care. There are good examples of joint working between the health and social care teams, including joint visits, assessments, care and treatment plans and joint team meetings to discuss cases and allocation. However, this is not standardised and improvements need to be made. There is a commitment from all services to achieve full integration of these teams to deliver responsive and equitable service for older people with mental health needs and to develop systems for monitoring performance.

The success of integration will be measured against its achievement of improved outcomes for people and carers who need care and support including:

- Improved support in the community, reducing unplanned admissions to hospital and enhancing discharge planning following admission
- Reduced duplication between health and social care services by removing the need for multiple assessments which recommend the same outcome;

- Delivery of ongoing services in a more timely manner by reducing the number of assessments that need to be undertaken to access health or social care services;
- Improved outcomes of Carers Assessments that are undertaken and individual support plans specifically for Carers;
- Engagement at an earlier stage with Service Users and Carers to offer more timely advice and support to reduce admissions to residential or nursing care homes;
- Agreed contingency plans to reduce crises in the community and avoidable hospital and care home admissions.

Community Networks

Based on GP Practice populations of between 30,000 and 60,000, eleven community networks have been established across ABMU to plan, co-ordinate and ensure delivery of services that meet the needs of people living in the local community. Three networks have been established each in NPT (discussions underway about reshaping the networks into two) and Bridgend and five in Swansea (due to the population size).

The networks have a diverse membership ranging from GPs, community nurses and health visitors to social workers and third sector representatives. The teams have clinical leadership in the main and are supported by dedicated resources provided by ABMU Health Board staff, including management support, administration and business planning functions. Since their inception, networks have identified service development priorities that are important to the practices in meeting local health needs and challenges. Each network meets regularly, with educational sessions provided and the opportunity to share information. Regular newsletters are produced and this is supported by dedicated websites for the local community to access information on the work of each of the networks.

Since their inception, community networks have done a considerable amount of work to address local needs. During the autumn of 2013, the Health Board has engaged widely with partners and community networks to discuss proposals to strengthen their role.

The Health Board has committed to strengthening the role of community networks and has identified a number of functions that networks could undertake in future, including:

- Improving population health and tackling health inequalities
- Developing and expanding primary care services
- Managing community health services
- Shaping service integration with social care
- Developing pathways between primary and secondary care

In principle, the Board have agreed to explore more innovative organisational arrangements that maximise the autonomy and flexibility of networks to carry out these functions. At this stage, it is recognised that further discussion with partners will be required to look at the balance of service delivery across networks and more specialist services, including the CRT. A detailed plan is being developed for 2014/15.

All partners have committed to a service model that integrates health and social care services using community networks as a footprint to integrate primary, community health and social care services.

Local Authorities

In the three Local Authority areas there has been considerable innovation in tackling the pressures on long term care services and meeting need in ways which maximise independence and reduce dependency. All three areas have reviewed or are reviewing care home provision with a view to delivering a clear and sustainable future for current or former Local Authority care home provision, to improve the quality and provision of independent sector care home provision, particularly for people with dementia, and to continue a move to care for people in their own homes, where appropriate in extra care settings in the community.

All three Authorities are also reviewing strategically their long term domiciliary provision and particularly the balance between directly provided services and services commissioned from the independent sector. Key questions in this approach include the balance between specialist, for example for people with dementia, and more general domiciliary support, how to commission for outcomes, rather than inputs, and the balance between quality, sustainability and cost of service.

Third Sector

There are over 2000 third sector organisations operating across the Western Bay area. The services offered range from, for example, befriending and mental health services through to prevention, carers and bereavement services. They offer flexible and professional services that also aim to complement those provided by the statutory agencies, which together ensure that there is choice and diversity for a host of service users.

The third sector operate a health and social care network in the Western Bay area where organisations come together to share information and discuss local health and social care developments. The network continuously identify areas where they can add value and provide services that prevent ill health, ways they can bolster health, social care and well being services and support for carers' and local communities.

Third sector brokerage models are in place within each Local Authority area which are a significant step towards helping to support people within their own communities, by identifying and matching the needs of individuals with potential support systems or organisations locally. During the early part of 2014, more formal arrangements around Local Area Coordination are being explored. A feasibility study into tier zero services has been commissioned, and investment will be made into this area during 2014. Both Local Area Coordination and Tier zero (as well as a complementary Health Board programme focussing on 'Staying Healthy') will help to drive new service models and approaches that are intended to strengthen the preventative agenda and deliver services in line with the Social Services and Well Being Bill.

There is a strong relationship with Care & Repair across Western Bay who provide flexible, timely support to enable people to remain independent within their own homes, and also in supporting hospital discharge schemes.

Current Pooled Budget Arrangements

The following table highlights the current pooled budget arrangements active for the financial year 2012/13.

Table 1

Type	Service Area	Parties	Parties
Pooled Budget	Community Equipment	ABMU Health Board (Swansea & Neath Port Talbot localities)	City and County of Swansea/Neath Port Talbot County Borough Council
Pooled Budget	Assisted Recovery in the Community (ARC)	ABMU Health Board (Mental Health Directorate)	Bridgend County Borough Council
Pooled budget	Community Equipment	ABMU Health Board (Bridgend locality)	Cwm Taf Health Board, Merthyr & RCT Local Authorities, Bridgend County Borough Council

Although the number of pooled budget arrangements is limited, there are broader arrangements for joint working that include:

- Joint management arrangements – in Bridgend and Neath Port Talbot, with plans in place to integrate management arrangements in Swansea well advanced
- A number of pre-existing financial arrangements and grant funding between health and social care.

Through the Western Bay Programme, all partners have committed to a full and detailed review of existing financial arrangements that will take place during the final quarter of 2013/14 to inform future service development.

4. Transforming our services: what we intend to do next

At the beginning of this document we set out the three key priorities for the Delivering Improved Community Services programme, they were:

- Wellbeing and keeping healthy
- Strengthening Community teams
- Making services sustainable

Since September 2013, the main focus has been on strengthening community teams through development of the Intermediate care function. This was as a result of the Western Bay Programme Board approving a Strategic Outline Business Case in June 2013 for a Transformation Programme relating to the needs of the frail older population across Western Bay. Following the submission of a strategic outline case, it was agreed to proceed to the development of a detailed business case. The business case focusses on developing the intermediate tier of services because this is seen as a vital building block for wider whole system change.

The intermediate tier consists of short term interventions that address needs at a time of crisis or when people's needs change, with the aim of maximizing recovery and on-going independence. It is linked, but is not the same as on-going support in either health or social care. Developing the Intermediate Tier is a 'first step'. The further development of wellbeing services to reduce future needs from escalating, together with services to support those with complex and high levels of need for ongoing care remain as critical next steps for the Delivering Improved Community Services Programme.

An integrated intermediate tier of services provides a number of functions. These are illustrated in Figure 2. The intermediate tier of services needs to make a significant contribution to what the wider health and social care community wish to see at a whole system level and as a result of the joint commitment *Delivering Improved Community Services*, i.e.

- Support for people to remain independent and keep well;
- More people cared for at home, with shorter stays in hospital if they are unwell;
- A change in the pathway away from institutional care to community care;
- Less people being asked to consider long term residential or nursing home care, particularly in a crisis;
- More people living with the support of technology and appropriate support services;
- Services that are more joined up around the needs of the individual with less duplication and hand-offs between health and social care agencies;
- More treatment being provided at home, as an alternative to hospital admission;
- Services available on a 7 day basis;

- Earlier diagnosis of dementia and quicker access to specialist support for those who need it.

This means that we need:

- Services that support people to remain confident independent and safe in their own homes for as long as possible and in accordance with their dignity and choice.
- Services that are coordinated to reduce the number of unplanned admissions into hospital and long term care and support timely discharge when a hospital admission is appropriate.
- A realignment of capacity, and a shift of resources, into community services to enable more people to receive the right assessment and service in the setting most able to meet their needs.

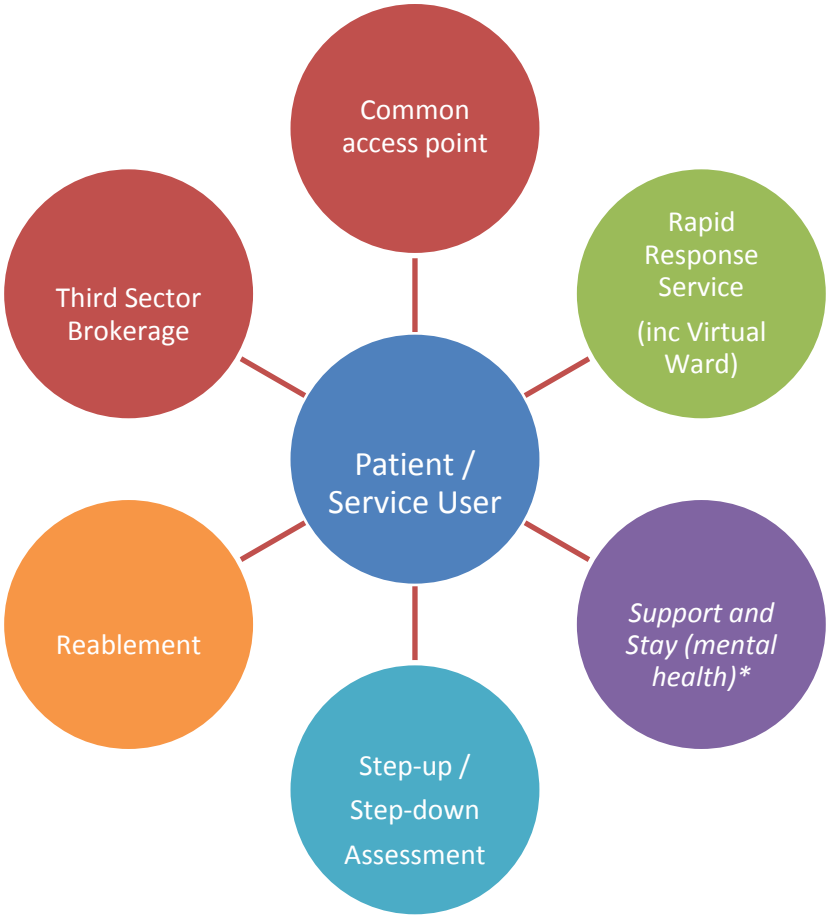

Figure 1 Functions undertaken by the Intermediate Tier

Together, this service model will help us to achieve significant improvements for services users, including:

- The person, their choice and preferences will be at the centre of every intervention, where appropriate.
- More people remaining independent confident and safe in their own homes for longer.
- Appropriate assessment and intervention carried out in a person's home and realignment of capacity to enable this to happen.

- A suite of support care services are available so less people are asked to consider long term residential or nursing home care, particularly in a crisis.
-
- Whilst the main focus has been on developing the business case for intermediate care, there has been work ongoing to ensure the other priorities are developing. In particular:
-
- Wellbeing and keeping healthy
    - The programme team has been working with Welsh Government and Third Sector partners with regards an innovative model for community resilience linked to issues of social isolation and loneliness amongst older people. A proposal is currently being developed using the principles of co-production and linked to the concept of social finance. A series of scoping sessions have taken place to plan this innovative approach to service provision.
- Sustainable services
    - A comprehensive bid to the Health Technologies Fund has been developed over several months and is detailed more in the 'Enabling' section below.

Assessing Need

One of the main, and quantifiable, pressures on current services arises from the growth in the number of people who are frail. People who are frail are also typically, though not exclusively, old and many will therefore have dementia. Identifying the potential impact on services, and resource use, from this group of people, and then focussing our efforts on meeting these needs differently through an enhanced intermediate tier is therefore vital.

The modelling work undertaken has included the development of projections for the change in the older population over a 5 year period. These have been used to gain an understanding of the increases in demand that might be expected, were there to be no change in services or in people's access to and expectations from these services.

The projections developed are based on existing research on the prevalence of physical frailty, plus assessments of the varying impact of local health status and local population changes. The headline projected changes in the numbers of older people as a whole, and in older frail people are identified in Table 2and Figure 2. Differences in the expected level of change between the >65s and the frail older population are due to different age distribution in each locality, for example Neath Port Talbot has a 'younger old' population whilst Bridgend will have a higher proportion of its older population in the 'old old' age bands.

	2012	2016	Change	2012	2016	Change
Bridgend	25,860	28,580	+10.5%	2,784	3,157	+13.4%
Neath Port Talbot	27,450	29,940	+9.1%	3,163	3,383	+7.0%
Swansea	44,290	47,621	+7.5%	4,756	5,126	+7.8%

Table 2 Future needs based on demographic projections[9], healthy life expectancy and expected prevalence of frailty

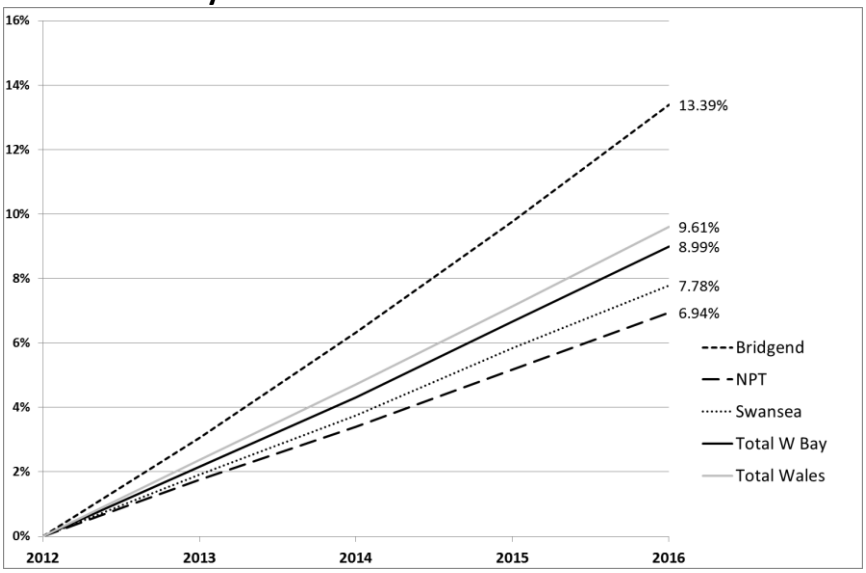

Figure 2 Projected change in frail population, 2013-2016, compared to 2012 baseline

Changes in the population with dementia

The modelling work has also looked at the number of people with dementia, because evidence indicates that people with a range of conditions are twice as likely to be admitted to hospital if they also have dementia. Using the same demographic profiles as above, and applying appropriate incidence and prevalence rates, it has been estimated that by 2016 there will be a total of 2,098 new cases of dementia a year across the Western Bay area – many of whom may go undiagnosed until later in the disease progression. The total number of people expected to have dementia by 2016 across Western Bay will be c 7,590, with just under 3,000 of these having a severe dementia. Table 2 shows the change from a baseline of 2012.

Locality	Expected prevalence in 2016	Change from 2012
Bridgend	1,943	+10.8%
Neath Port Talbot	2,125	+7.8%

[9] Based on 2008 ONS demographic projections in IPC/ WG Daffodil database: projections derived from the 2011 census will be used to update modelling data once available through this source.

Swansea	3,522	+7.6%

Table 3 Expected change in the prevalence of dementia

Combining physical frailty and dementia

People with both dementia and frailty have particular needs that can be complex and that therefore require particular attention in our planning and delivery of services. An indication of the levels of co-morbidity also informs where, and to what extent, services would benefit from closer alignment or integration. The approach to determining the extent of co-morbidity is detailed in Appendix 3. In summary, it suggests that across Western Bay:

- 8,050 people who will be frail without having any form of dementia;
- 4,580 people who will have dementia but will not be frail;
- 2,410 people who will have both dementia and who will be frail.

This means that about 16% (1 in 6) of people with either dementia or frailty will experience both. However, when a similar estimate of cost is made across Western Bay we have estimated that £54M out of £110M (i.e. c 49%) is spent on the group who have both dementia and frailty.

Development of a Frailty Model

The Community Services Project has made a commitment to develop a Frailty Model as part of the implementation of *Delivering Local Care*. This will be a key piece of planning work during 2014/15 in order to be in a position to implement by March 2015 in line with the timescales set out by Welsh Government.

Western Bay has already made significant progress in articulating the frailty model, with the detailed service model and business case produced for intermediate care. The work in 2014/15 will focus on aligning this work with the development of community networks and core community services. It will also include core primary care and hospital services, ensuring frailty is addressed as a system of care and all are working to a common set of principles with regards the management of this complex group.

Work on the model will begin with a Frailty Symposium in the Spring 2014, which will invite a wealth of experienced specialists and academics in the care and research of frail older people. The conference will set the scene for the development of the model and to ground the work in a foundation of best practice and innovation.

Summary of Next Steps

During 2014/15 we intend to:

- Use the Intermediate Care Fund to strengthen intermediate care services in line with the business case outlined to provide a core and consistent set of services across ABMU, moving towards those services being available on a 7 day in line with the year 1 investment plan
- Develop a detailed implementation plan to support community networks having more responsibility for shaping and delivering care within their areas, and using networks as the key organising platform for a range of health, social and third sector services
- Develop a 'frailty model' ensuring this is system-wide design of services in line with Welsh Government directives
- Align / pool resources across health and social care to deliver integrated care
- Develop a common performance management framework with a suite of whole system measures that operate across health and social care
- Agree how we will formally evaluate the transformation programme of change
- By implementing the business case, begin to shift the delivery of care from institutional models (eg hospital beds and care home placements) to community models by extending rapid response and reablement services that will support people to live within their own homes and allow the health and social care system to deal with the impact of an ageing population
- Develop a broader approach to consider how we can influence and support people to live independently including tackling broader issues of social isolation, loneliness and developing community resilience by taking forward the principles of co-production and prudent health care.
- Develop joint market position statements and progress the development of joint commissioning functions within each of the three areas, aligned to the overall Western Bay commissioning and contracting project.
- Begin implementation of the 'Integrated Information in Integrated Care' agenda as part of the Health Technologies (once approved by WG)
- Agree a consistent model of 'support and stay' as part of a comprehensive review/strategy for Older People's Mental Health Services
- Consider how to better integrate housing and other support plans into the development of integrated health and social care models for the future and progress other initiatives that maximise the ability of people to live within their own communities (for example, progressing 'Dementia Friendly' communities).

5. Our approach to Integration

An option appraisal for determining the nature of the transformation programme for frail older people was included in the Outline Business Case. It considered a short list of options from 'do nothing more' through to a substantial transformation programme that sought to deliver a fully optimised system of care.

However, to support this Investment Plan a further formal options appraisal has been undertaken by members of the Western Bay Community Services Project Board. This has been focussed on determining the future arrangements for the implementation of proposed service changes with a particular emphasis on the nature and extent of integration, including the presence of pooled budget arrangements.

The options considered were built up using four components as indicated below:

- The service functions to which integration might apply – Demand management, intermediate tier, ongoing community support;
- What part of the system will be integrated, i.e. community health services, social care professionals and mental health staff;
- The footprint for a Section 33 pooled budget Agreement i.e. None, by locality or across Western Bay;
- The extent of any pooled budget agreement i.e. transformation programme only or also including 'business as usual'.

These components can be combined in a variety of ways to create a wide range of options. However, eight options were identified and assessed in the option appraisal as being representative of this wider range of possibilities.
A key focus of the option appraisal was to determine whether the service functions detailed should be integrated, and if so to what extent. Integration can be across health and social care older peoples services or across health and social care including mental health. For the purposes of the option appraisal an integrated service was taken to mean:

- A multi professional team with specialist and generic staff appropriate to meet the needs of the client;
- Co-location with single management, joint training and a single budget;
- Joint care planning and coordinated assessments of care needs;
- Named care co-ordinators acting a navigators;
- Recording on single clinical record.
-
- In total, 8 options were appraised with criteria identified in a workshop session at one of the Changing for the Better events that included service users, carers, representatives from third sector as well as statutory partners.
-
- The preferred option that emerged from this process was:
-

- Delivering transformation through integration of health, social care and mental health services for all three components of community services using local pooled budget arrangements for transformation funding and ongoing business. (The 3 components being common access point, intermediate tier and ongoing community support.)
-
- Partners also agreed that the extent of mental health integration under this option is that there will be co-location and alignment of mental health teams within the intermediate tier, in the first instance, building from a point of having link posts within each of the 3 CRTs. The term 'local' indicates a preference towards subsidiarity, ie. doing things at the most local level consistent with delivering value for money and improved outcomes.
-
- In line with this agreement, detailed discussions on financial and governance models required. Partners have agreed to begin discussions on pooling/aligning budgets in each of the three local areas across the Western Bay area. The pool could apply to the transformation funding only or also include 'business as usual' funding. Further discussion on the range of budgets that could be considered as part of this pooling arrangement will be considered as part of the finalisation of the business case.

Commissioning

There has been recent agreement to establish a formal commissioning and contracting workstream under the auspices of the Western Bay Programme. Some initial preparatory work has already been taken forward, and a number of commissioning leads have been appointed to take forward the next phase of work.

Each of the Western Bay projects has commissioning as a priority and are developing common service models that will be delivered in each Authority area. For older people, work is progressing to develop a common vision and service model for frailty and also one for dementia, recognising there is a significant number of older people who will experience frailty and dementia.

An integrated contracting and procurement project has been established and work has progressed to develop a common quality framework for care homes and a market position statement and costing model for domiciliary care. Dedicated capacity is now in place for this project and the principal of a regional contracting and procurement hub agreed.

6. Supporting people to live in their home of choice

People want a home that they can afford, that is safe, warm and secure, that meets their needs whether that be owned or rented and is in an area where they want to live and are supported to do so. Housing has a huge impact on a person's quality of life, wellbeing, health and life chances. People's homes are the focus for the delivery of many services including health and social care.

The aspirations and expressed preference of people with care and support needs is that placement in a care home is the least preferred care option.

It is critically important that where a care home is the preferred option of an individual that this is a positive choice, planned for and not made at a time of crisis, and that the care home is of a high quality in terms of the care provision, the homeliness of the environment and integration with the community. People in residential and nursing care can feel part of the community and retain as much independence as possible in well designed and sensitively managed care homes.

Supported housing is able to meet particular needs including 'own front door' options like sheltered and extra care (for older people) and independent or supported housing to meet other needs. Increasingly, there are people who in the past would almost certainly have been in residential care but who can now retain a large degree of independence if they are in well designed and supported accommodation housing is outcome focused, based on the needs and abilities of the individual, and people are not 'over supported' in an alternative setting.

People may need at certain times of their life accommodation based support in their own homes, wherever they live, which may be funded through the Supporting People Grant programme. They also may require aids or adaptations to enable them to remain in their home of choice. People who are becoming progressively frailer as they get older can stay at home much longer if that home has no stairs (or can take a stair-lift), has a bathroom big enough for a wheelchair to turn in, wide doors and appropriate equipment to live at home safely. Assistive technology provides huge potential for supporting people with complex needs within the community, including younger people with learning disabilities, and older people with mental health difficulties or dementia. Developing 'dementia friendly' communities is a priority across the Western Bay area.

Each Local Authority, working with the Health Board, will be ensure that housing remains integral to the development of services that maximise people's independence and ability to live within their own community, preferably in their own home, for as long as possible.

7. Governance

A governance structure to ensure delivery of the Intermediate Tier developments and identified benefits detailed in this business case will be put in place, building on existing Western Bay arrangements.

A Community Services Board currently oversees and is responsible for the delivery of the *Delivering Improved Community Services* Programme of which the Intermediate Tier developments are one key element. It is accountable to the Western Bay Programme Board.

The current Board has membership from ABMU (Localities and Mental Health Directorate), the three Local Authorities and the third sector. To ensure it is fit for purpose in its enhanced role, membership will be reviewed both in terms of seniority and size for effective decision making. Local governance arrangements (at an individual local authority level) will be shaped as required. Formal partnership boards are being established in each area to oversee developments at a local level and ensure that there are appropriate governance and scrutiny arrangement in place.

8. Learning and Development

There is a growing evidence base within the UK which identifies the critical success factors required to deliver integrated care, and these present opportunities to identify learning from elsewhere.

As part of the development of the business case, we will be commissioning a formal evaluation of the development of intermediate care locally to supplement the local performance management. We will also be building in patient experience measures locally to ensure that we are making progress towards delivering high quality, patient centred care.

Partners locally have benefited from the shared learning opportunities provided through the re-ablement learning network, and would be keen to see the establishment of a similar network having a broader remit around integrated care. This is an area that has been flagged as an issue to the Integrated Care workstream reporting to the Unscheduled Care Board as an opportunity.

9. Performance Management

Partners within the Western Bay Programme have committed to the development of an integrated performance management approach, using a set of joint measures and metrics that look at performance across the health and social care system. It is recognised that the business case for intermediate care will require very tight performance management to ensure that the benefits realisation framework is delivered. This will need to operate at both a Western Bay and local level and will be developed further as part of the work with Swansea University to develop an evaluation framework for the programme as a whole.

10. Other Enablers

Health Technologies Fund

The vision set out in *Delivering Improved Community Services* is ambitious but recognises that community teams cannot achieve these aims without transforming the way they work. Community services will need to adapt quickly and effectively ensuring they are fit for purpose, safe and sustainable, with the following technology priorities:

- Information and new technology is used to its maximum affect and acts as the enabler for coordinated care, shared records and innovative solutions to care and support in the community
- Widespread use of telecare, assistive technology and telehealth, where appropriate, to support frail and older people to be independent in their own homes and to provide additional confidence and support for carers
- Community teams will have access to the electronic equipment needed to make their work more efficient and effective, such as hand held devices and remote capability for working away from their team base.

The bid to the Health Technologies fund seeks to address the availability and use of new technologies within community care settings in order to improve efficiency and safety and increase productivity. It also seeks to increase the quality of services in the community and provides a bridging effect to enable these services to embrace future technological changes as part of national ICT programmes.

The technology will include:

- Digital pen and tablet technology for staff in the community to enable point of care recording of information, digital care documentation and the piloting of information sharing between community and secondary care.
- Telecare and telehealth technologies for patients and service users to feel safe and for their care to remain in their own homes. This will include the development of an out of hours service across Western Bay following the successful evaluation in the Bridgend locality.
- Remote clinical management capability for staff in the community using the same digital pen and tablet technology, along with state of the art telehealth to monitor patients with long-term conditions, including care home 'Skyping' to replace traditional clinical consultations.
- Simplified access to citizens' health and social care information by utilising existing integration software within the Health Board to bring together data from disparate systems in partner organisations

Information Sharing

The provision of integrated health and social care services will rely on an ability to share information. In fact, without the ability to do this the programme of integration will only be realised in a limited and clumsy manner. IT systems can make this process of sharing information more efficient and opportunities to develop this should be taken. Information sharing will allow for:

- Improved health and social care outcomes
- Improved wellbeing
- More effective and efficient service provision
- More effective and efficient service planning

The legislative framework with Wales supports information sharing across statutory and non statutory providers. Work to develop Information Sharing Protocols across the Western Bay community will need to be undertaken to advance this across the Western Bay area.

Information System Development

A joint forum bringing together the ICT Heads from each of the local authorities and the Health Board meets regularly. There is a reporting mechanism to the Western Bay Programme Team. The initial focus of the work has been on discussing practical arrangements to facilitate joint working at a locality level (for example, access to respective IT systems for health and social care staff who are co-located). Work has also shaped a proposal submitted under the Health Technologies Fund. The potential options to develop a more strategic approach to ICT are being explored, and the potential benefits of procuring the Community Care Information Solution (CCIS) across Western Bay needs to be considered in this context.

Workforce Planning & Development

Similarly the respective Heads of Workforce across Western Bay also now meet to consider both practical and strategic workforce issues. There are opportunities to explore innovative workforce models, as well as opportunities to look at more sustainable workforce solutions in key areas – for example, development and skilling up of the non qualified support worker role – an area where both health and social care struggle to recruit.

Regulatory Issues

Current organisational models govern the regulation of health and social care separately and this can be a barrier to progress. Whilst pragmatic and flexible solutions have been put in place to try and address individual service issues, it would be helpful for Welsh Government to assist in ensuring that regulatory arrangements reflect the need to support new care models.

11. Measuring Success

As part of the development of the business case for intermediate care, a range of performance indicators will be used to judge the success of the integration programme. These are currently being refined. In addition a clear programme of research and evaluation will be agreed to support the wider transformation programme

12. Conclusion

ABMU Health Board and the City and County of Swansea, Neath Port Talbot County Borough Council and Bridgend County Borough Council are committed to the development of integrated health and social care services. A major transformation programme is underway across Western Bay to realise our ambitions and deliver joined up care for older people with complex needs.

Appendix A

Examples of Integrated Services developed within the ABMU Area

Swansea: Integrated Gower Team

In August 2013, there was little way of provision in community domiciliary care for the rural Gower area of Swansea. This problem was leading to delays in hospital discharge for patients requiring packages of care within the home setting. There were also difficulties in establishing packages of domiciliary care for those people at home requiring extra support in care, this included, palliative care, continuing care, rehabilitation and long term care.

The rural nature of the Gower area necessitates long driving distances between patient calls and therefore, there has been a long standing problem of maintaining domiciliary care services in this area. There were 4 different health and social domiciliary care teams working within the area. These teams were criss-crossing one another when visiting patients and there was an obvious waste of resources and an inefficient way of working. Something different had to be done with the winter season looming.

Working in a collaborative and efficient way with the local authority, a small Integrated Gower Team was formed with a selection of health and social care staff from all four existing teams.

The team which is comprised of health care support workers (HCSW), nursing and team leaders, is based with the Gower community nursing team and they deliver highly skilled care to all people living in the Gower area. Duplication and driving times have been significantly reduced and capacity has been created to allow domiciliary care provision to all residents requiring support in this rural area.

In the three months since the creation of the Integrated Gower Team has:

- There is currently no waiting list for any care within the Gower Area
- No patients are waiting unnecessarily in an acute hospital bed for care provision
- Patients within the hospital and home setting now have access to a responsive domiciliary care service
- Response times are range from 2 hrs to 2 working days.
- There is continuity, quality and safety in care provision.
- Patients requiring palliative care and wishing to die at home can do so without delay.

The importance of following a change process has been key to the success of the new integrated team. Involving all stakeholders early on in any key change was also important in gathering support.

The key lesson learnt was that not all problems can be solved at the outset; many issues follow a PLAN, DO, STUDY, ACT (PDSA) cycle of change. All members of the team are still learning and implementing changes as the service evolves over time.

Bridgend: Integrated Community Resource Team

The following client case study illustrates a complex programme of intervention from CRT services.

We received a referral for a young man living with his partner and young family who was independent with all aspects of his personal care and family life. He was admitted to hospital following a CVA with a dense left sided weakness and spent 14 weeks at hospital. He experienced low moods as he coped with major life changes and adjustments; he was discharged home with Reablement. His support on discharge consisted of 4 double handling calls 7 days per week.

All personal reablement goals were achieved and his ongoing support needs drastically reduced.

Incontinence was an issue initially, but with the provision and optimal siting of the appropriate equipment this ceased to such a problem.

Once home, his mood improved, he received intense Social Work support and his partner was offered and accepted a carers assessment. There were access issue to the first floor in the privately rented house rendering access the toilet and bathroom as challenging. The Social Worker was able to refer the family to housing services to facilitate the identification of more suitable housing through the Accessible Housing scheme.

He had also developed problems with his eyesight following the CVA for which he received support from the Sensory Impairment Team within the CRT. The Team made applications for support to the RNIB and Servicemen Associations.

Skin problems that were affecting both his and his partners' sleep were reviewed by a CRT Nurse and the advice and intervention resolved the acute symptoms.

Telecare service and Mobile Response Team support was arranged to enable his partner to feel more confident about returning to work, knowing that help would available should it be needed in her absence.

As the Reablement intervention progressed the service linked in with the Hospital Physiotherapist to consider the most appropriate on-going Therapy following Reablement and a referral for Outpatient Neuro physiotherapy was arranged.

The Stroke Association offered excellent support and the family were planning to join the local groups. He was definitely feeling more positive about the future.

At the end of CRT intervention, the feedback from the young man was *"The service was fantastic and an enormous support for my partner. I was originally sceptical but the service was inspiring, motivating and gave my confidence back that there is light at the end of the tunnel."*

Neath Port Talbot –Integrated Community Resource Service

A 76 year old lady who suffered a stroke about 25 years ago which had left her with weakness down her right side though she lived independently in England until a few years ago when her general health started failing and she came to live closer to her family. During this period she had a prolonged admission to a community hospital . She returned home but due to her increasing frailty she had to have a large package of care to maintain her at home. She was coping reasonably well which in part was due to the excellent family support that she received. She became unwell October 2012 and was taken to the Emergency Department at Morriston Hospital. It was felt that she had a urine infection and she was discharged with antibiotics. These proved unsuccessful and she was admitted to a Community Hospital where she spent about 6 months. Due to her general condition and dependency it was felt that she needed to be looked after in a nursing home (NH). In addition to her above problems she also suffered from poor swallow, a mood disorder, diabetes, and had some cognitive problems.

She became unwell in the NH and was seen by her GP who thought it was a urine infection and treated her with antibiotics. She was subsequently seen by 2 on call GPs and given more antibiotics with no improvement, eventually the out of hours GP asked the staff to admit the patient her to hospital. Nursing home staff asked the GP to refer to the on call nurse practitioner (NP) from the Acute Care Team (ACT) who provide in-reach services into care homes.

He did this and the patient was examined by the NP who undertook an assessment. It was 4.30pm by the time the NP had a good picture of the patient and following liaison with the consultant, family and nursing home it was agreed that we could look after the lady in the community.

Regular and frequent care and treatment from Nurse Practitioner, District Nurses and Consultant Physician was provided into the care home. This included intravenous fluids and antibiotics. End of life care was discussed with the family and the Consultant and a do not resusitate agreement was made. Through discussion with the family it was felt that the most appropriate way forward was to keep her in the NH and not to proceed with artificial feeding. There was a feeling that she may require end of life care including a syringe driver (to give drugs for symptom control) district nurses were happy to support as nursing home staff felt that they would not be able to manage it.

This was a frail lady who was comfortable and well looked after in a NH and who with the support of the CRT was able to remain at her home with appropriate levels of skilled and caring staff. Without the intervention of the CRT she would have most likely been put through the whole process of an unscheduled admission to a hospital.

Appendix 5: Joint Statement of Intent on Integrated Care

Neath Port Talbot County Borough Council/ Neath Port Talbot Locality ABM UHB

Integrating Health and Social Care

Older and Disabled People

Joint Statement of Intent on Integrated Care

Table of contents

Integration - Our Strategic Intentions

1. Introduction

This document sets out the shared vision and commitment of ABMU and NPT CBC to work in partnership to deliver integrated care and support to older people with complex needs. It is the means by which the longer term goals and aspirations for future integration are articulated.

The document provides a baseline assessment of the current levels of integration between NPTCBC and ABMU, evaluates the readiness of both organisations for further integration and sets out a road map for the realisation of the partnerships' longer term ambition for a fully integrated health and social care system.

2. Summary

NPTCBC and ABMU Health Board, Neath Port Talbot Locality, have made significant progress in the development of integrated health and social care in recent years resulting in the development of an integrated Community Resource Team (CRT). We have achieved full operational integration and a single management structure for the intermediate tier. January 2014 saw the launch of the Gateway which is a common access point for advice, information and community health and social care. CRT staff are co-located, with shared access to information systems, assessment and care plans.

It is our intent to accelerate the integration of health and social care across NPT CBC in areas where it makes sense to do so in the interests of citizens and service users. The key areas we have identified for the next phase of development are:

- Taking forward the recommendations of the Western Bay / Changing for the Better Business Case for the further development of intermediate tier services;
- Integration of health and social care long term services at a community network level;
- Integrated governance arrangements
- Integrated planning and commissioning of long term care including contract monitoring and review
- Further integrating financial arrangements, ICT, information systems and estate strategies.

3. NPT perspective on integration.

Partners in NPT, are part of the Western Bay Health and Social Care Partnership. We have agreed the following principle to underpin integration:

> *'..an organising principle for care delivery with the aim of achieving improved user and patient care through better coordination of services provided. Integration is the combined set of methods, processes and models that seek to bring about this improved coordination of care'.*[10]

[10] Sara Shaw, Rebecca Rosen and Benedict Rumbold (June 2011) What is integrated care? An overview of integrated care in the NHS Research Report, Nuffield Trust

The vision for service provision within NPT's Social Care Policy for Transforming Social Care is

….to deliver a model of social care that puts the individuals needs and aspirations firmly at the centre, which minimises dependency and enables people to live as independently as possible within their own homes and communities[11]

In terms of what this will look like to the individual the framework for delivering integrated care suggests that the person will identify that their…

…Care is planned by [them] with people working together to understand [them], [their] family and carer(s), giving [them] control, and bringing together services to achieve the outcomes important to [them].'[12]

In NPT this principle is manifest in the partnership working between NPTCBC and AMBU and in the delivery of a model for Intermediate tier services that delivers: -

- a common access point
- coordinated case management
- multi disciplinary assessments
- signposting
- supported discharge form hospital
- reablement
- Telecare
- Acute response services to prevent unnecessary hospital admissions.
- Bridging Service to facilitate early discharge from hospital.
- Third sector brokerage
- Sensory Support Team
- Community Occupational Therapy

In addition, within NPT, significant progress has also been made in the following areas:

- Collaboration to develop Long Term Care joint contract monitoring, quality assurance, safeguarding, and joint commissioning
- Pooled fund arrangements for Integrated Community Equipment.

4. NPT Vision for Integrated Services

- Both NPT and ABMU are fully signed up to the intermediate tier business case developed by the Western Bay Health and Social Care Partnership.
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[11] Connecting People and Communities: A Social Care Policy for Transforming Social Care In Neath Port Talbot 2013 - 2018

[12] A Framework for Delivering Integrated Health and Social Care For Older People with Complex Needs

- Locally, integration will take the form of the further expansion of the multi professional team comprising specialist and generic staff, building on the co-location, single management structure, and jointly trained staff. Currently budgets are aligned. We will deliver a single / pooled budget. A joint care planning and assessment approach will provide people with care and support needs with a named care co-ordinator who will record all assessment and treatment plans on single record.
-
- Full integration al this level will allow NPT and ABMU to manage the demand for and reduce the level of dependency on long term packages of domiciliary care, unplanned hospital admissions and post acute hospital stays, and care home placements, by maximising the use of its intermediate tier services and promoting ongoing community support services. This approach is also articulated in the preferred option set out within the Western Bay Outline Business Case as '*delivering transformation through integration of statutory health, social care and mental health service for all three components of community services using local pooled budget arrangements for transformation funding and ongoing business*'. (The 3 components being demand management, intermediate tier and ongoing community support.)

Having built on the foundations of previous collaboration, NPT CBC and ABMU partners are well placed to clearly deliver both the vision of fully integrated services within NPT.

The overarching vision within NPT is to deliver integrated health and social care services that will deliver:

Vision

- Support for people to remain independent and keep well
- More people are cared for at home, with shorter stays in hospital if they are unwell
- A change in the pathway away from institutional care to community based care
- Less people being asked to consider long term residential or nursing home care, particularly in a crisis
- More people living at home with the support of technology and appropriate support services
- Services joined up around the needs of the individual with less duplication and hand-offs between health and social care agencies
- More treatment being provided at home, as an alternative to hospital admission
- Services available on a 7 day basis, with essential services available outside of office hours.
- Earlier diagnosis of dementia and quicker access to information, advice, and specialist support for those who need it.
- Improved, person centred outcomes, achieved by organisations working across traditional boundaries.
- A well-coordinated approach to community health and social care services, with emphasis on out of hospital support.

Principles

- Services will share the values and outcome aspirations for the people who use the

service.

- There will be a common access point into integrated services.
- Resources will be shared for the benefit of the service user, and staff will work in a person centred way so that people using services are able to maximise their potential to remain independent.
- Services will be delivered in a way that ensures there is a clear flow between care settings, and that gaps in services are recognised and addressed.

In addition to the above, we are committed to the following service objectives.

Joint Strategic Intentions

- To work together across the local authority, NHS, independent and voluntary sector boundaries to respond the needs of people in NPT.
- To provide good information and advice, in a timely, responsive and proportionate way.
- To prevent crisis and inappropriate admissions to hospital or long-term care, by delivering health and social care interventions at home where appropriate.
- NPT's unpaid carers will be recognised for the care and support they provide. They will be supported to stay as mentally and physically well, to remain economically active and have opportunities for accessing training, education and employment, and will be given information when they need it and in a way which meets their needs
- To work in partnership with carers and service users to design and deliver support which promotes choice and control over their lives, ensures they are treated with dignity and respect and their wishes and preferences are listened to.
- To develop appropriate pathways, and interventions to support people affected by frailty, or complex long-term conditions, including dementia that promotes independence and wellbeing in the most appropriate setting.
- To further strengthen our primary and community services to develop clinically led operational management units within community networks. Networks will focus on preventing illness and co-producing health alongside generalist and specialist care.
- That those experiencing acute illness requiring specific medical interventions will have those needs met within a hospital setting where appropriate.
- To ensure a clear and consistent approach to developing, monitoring and benchmarking of services across the NPT health and social care community.
- To ensure that all staff are well trained and working in the right job to make best use of their skills and experience.

6 Readiness of partners for further integration

There is a record of successful service collaboration within the CRT and Gateway services. However, further development work is required in the areas of financial frameworks and governance to facilitate full integration of health and social care systems between NPT CBC and ABMU, some of which will be achieved through the Western Bay Regional Collaboration, and some of which will be delivered locally.

To achieve these strategic intensions over the next 3 years NPT plan to move forward in the following strategic directions:

1. Further development of intermediate tier in line with Western Bay Business Case:
2. Full Integration of long term health and social care teams within Community Networks

3. Building on joint contract monitoring, planning and commissioning for long term care services
4. Development of joint governance arrangements
5. Integration of finance, IT, information systems and estates.

7 Strategic Direction 1: Further development of intermediate tier in line with Western Bay Business Case

NPTCBC and ABMU have had success with the development of a model of intermediate care that incorporates a multi disciplinary CRT unit and a common access point through the Gateway service.

The Community Resource Team (CRT) consists of 5 main service areas: - Assistive Technology, Acute Clinical Care, Community Occupational Therapy Service (COT), Reablement, Care Management, and the Sensory Support Team (SST) and Nurse Practitioner led admission avoidance schemes.

Four elements of the service are collocated at the Cimla Hospital site, which has allowed new professional relationships to be established. The fifth element, Assistive Technology unit will also be collocated at Cimla Hospital

The Homecare Enabling and Assessment Team (HEAT) and the reablement element of the CIIS team have merged, and the CRT is now in the process of re-commissioning Residential Reablement in partnership with Grwp Gwalia in a new care home as part of the Reablement provision year 2014 / 15.

The NPT Gateway has replaced the two existing contact points by merging the functions of both the Contact and Access team and the Community Integrated Intermediate Care Service (CIIS), and will be taking more 'proportionate' information at the first point of contact before deciding on the correct place to refer someone onto. This will avoid people being the subject of multiple referrals and ensure that people receive the right intervention, at the right time, from the right professional. The service started on the 20th January 2014.

There has been a significant recruitment programme to complete the multidisciplinary team of nurse, social worker, occupational therapist and third sector broker. The nurse and third sector broker are in post, and working alongside the team of contact officers.

The Community Occupational Therapy (COT) and Sensory Support (SST) Teams are now managed by a Community OT manager, who is being supported by a deputy in delivering support to the staff in the Sensory Support Team. Both teams are working with other elements of the CRT to develop pathways that improve the outcomes.

The Acute Clinical Team has developed service that 'bridges' the gap between referral for a domiciliary package of care, and its actual date of commencement. This has enabled NPT residents to be discharged from hospital earlier with the support of the CRT behind them. It's success is demonstrated by a considerable reduction in the number of delayed transfers of care in Neath Port Talbot, The

Bridging Service was originally commissioned by ABMU, but in December 2013 NPT CBC funded (on a short term basis) additional workforce to support 'double staffed' calls.

There is agreement from the Older Persons Mental Health Multi Disciplinary Team for integrated working. The following team members are co-located in Tonna Hospital and Port Talbot Resource Centre

- Care Managers.
- CPN's.
- Support workers.
- OT's.
- Dementia Coordinators.
- Consultants.

Plans for further integration focus on embedding and extending the use of the single integrated assessment tool, and establishing criteria for the flow between parts II and III of the Mental Health Measures. Integration between locality and the mental health service through the creation of mh link workers as part of the CRT. A service specification for the Support and Stay Service as part of the intermediate tier is under development.

ABMU / NPT partnership have made good progress with fully integrated systems and intend to build on the information systems development work undertaken to date. Similarly, the introduction of a single, multi agency, assessment tool will be tested and reviewed for efficacy.

Further investment in both physical and human resources, will therefore be required in order to achieve the outcomes within the Business Case. A proposal for investment in the ICT infrastructure to deliver the modernisation of community teams has been made to Welsh Government Health Technology Fund. The Western Bay Partnership is developing a financial model to support the expansion of the intermediate tier to provide the optimal service to manage the increasing need for service and deliver the best outcomes for frail older people.

7.1 Redesign common arrangements for integrated assessment and care planning

Specific pathways will be developed for integrated provision for people who have sight problems and who are falling, and between the Community OT and the OTs within the reablement service. Co-location on the Cimla Hospital, NPT Hospital and Resource Centre sites is a core facilitating factor in the development of an integrated and cohesive care and support planning process.

Welsh Government states that by April 2014, suitable arrangement must be in place for the integration of information, assessment and planning for older people's services. In NPT this will entail: -

- Locating services in community settings;
- Smooth transitions between mainstream and more specialised services;
- Creating fully integrated referral pathways;

- Capturing information once, and addressing all the needs of the service user;
- a balanced set of services operating 7 days a week;
- full engagement all people with care and support needs and carers

NPT has already reviewed the systems, arrangements, protocols and skills needed for integrated, assessment and planning for service for people under the auspices of the Transforming Adult Social care (TASC) project's social work systems work stream. As a result, social work assessments and protocols have been realigned, and staff will continue to develop their practice throughout 2014-15. The next phase is to develop more integrated assessments, planning and review through commonly networked services.

7.2 Develop information sharing protocols, and improve patient / service user data sharing arrangements

Progress has been made to allow CRT staff to access appropriate information systems. All of the CRT staff (ABMU and NPT CBC) now use a single electronic case file.

These developments will deliver significant benefits for service users and staff from across council and health services and will enhance the integration of services.

The partnership has developed a proposal for the Health Technology Fund for the introduction of Digi Pen and electronic call monitoring systems that will ensure more effective ways of working, improve productivity and efficiency of community teams and ensure information systems are joined up around the needs of the person.

7.3 Enhance arrangements for managing the interface between specialist and community care

NPT will deliver a programme of service developments that strengthen the range and scope of community services to further reduce demand for hospital, care home and long term domiciliary care.

The care home contract with Grwp Gwalia allows for the adjustments to the capacity required and bed usage. Within these parameters NPTCBC and ABMU have negotiated with Gwalia, to establish a ten residential reablement beds within a new build scheduled to be opened in the summer of 2014. The Gwalia new builds scheduled for development over the next three years will be built to nursing care standards.

NPT is developing an enhanced reablement service to cover 7 day hospital discharges, work towards 100% of people accessing reablement prior to the commencement of a long term care package. This will reduce the need and demand for long term care and improve the 'flow' from hospital to community services.

7.4 Place prevention, well-being and early intervention services at the fore, and expand the role of the third sector broker.

The Gateway service will be expanded to include both housing and mental health support alongside third sector brokerage, to ensuring a wide range of expertise at the triage point. This supports better decision making at point of entry, and ensure that there is choice and diversity for a host of service users.

As well as high quality information and advice to respond to needs more effectively, and in a more timely manner, information systems to underpin the effective shared use of information discussed, NPTCBC and ABMU will also undertake an exercise to review current resources across the health and social care interface with a view to:

- Develop more 7 day community nursing, therapy and social care services with a focus on recovery.
- Invest more in AT services to help people stay at home whenever possible, through the Health Technology Fund.
- We will work collaboratively with Public Health Wales and other Local Service Board partners to address and develop a range of early intervention and preventative services.

8 Strategic Direction 2: Integration of Community Networks

NPT and ABMU are developing plans to fully integrate long term health and social care teams within Community Networks. This will involve in phase one the co-location and alignment of: -

- Social Work Teams
- Review and Monitoring Team
- Homecare Services
- District Nurses Teams
- Continuing Health Care

A pilot will be taken forward in the Swansea Valley area to link homecare and other care providing teams to understand the benefits of working as an integrated locality team.

In 2014 / 15 we will also

- Integrate with third sector organisations
- review management structures
- Improve links with housing and community development, fire service and other partner and community services to promote inclusion and well being

Successful implementation of the above will produce the following outcomes:

- Improved support in the community, reducing unplanned admissions to hospital and enhancing discharge planning following admission
- Remove duplication between health and social care services by applying a singe assessment process.
- Timely delivery of services by applying a singe assessment process to access health or social care services;
- Engagement at an earlier stage with Service Users and Carers to offer advice and support to reduce admissions to residential or nursing care homes;
- Agreed contingency plans to reduce crises in the community and avoidable hospital and care home admissions;
- Improved community resilience and infrastructure to reduce demand for managed care services

9 Strategic Direction 3: building on joint contract monitoring, planning and commissioning

Delivery of integrated services needed to meet future population needs in NPT will require effective arrangements for:

- Needs analysis
- Service analysis
- Strategic planning
- Budget and resource management
- Commissioning and market management plans
- Procurement and contracting processes
- Business cases and performance management

Whilst progress has been made in integrating service planning and contract monitoring of long term care, further work is needed to undertake all these activities collaboratively and to fully integrate them.

There is a formal commissioning and contracting work stream under the auspices of the Western Bay Programme. Work plans have been developed, and a number of commissioning leads have been appointed to take forward the next phase of work.

Work has commenced to produce joint ABMU and NPT CBC Dementia Care, and Care Homes Strategy Commissioning strategies. The dementia strategy will result in greater levels of integration between ABMU's Support and Stay dementia service and intermediate tier and long term care services. This will provide both organisations with a consistent approach to the delivery of services to people with complex care needs and dementia. The joint care homes strategy will deliver the right mix of nursing care, residential care and extra care placements required within NPT CBC, and will reflect the positive effect that fully integrated services will have on

people level of independence, and therefore their ability to remain at home for longer.

9.1 Establish a joint planning, performance and commissioning function across NPTCBC and ABMU.

NPT and ABMU will undertake a review of planning, and commissioning activities, so that new arrangements for a single commissioning function for the delivery of the strategic directions described in this document can be established. There will be a need to:-

- Build a shared delivery plan for the implementation of clear service strategies
- Engagement with stakeholders in the delivery plan
- Building a communications strategy to staff and the public about integrated services
- Developing aligned and pooled budget arrangements where needed
- Delivery of robust joint performance management arrangements.

We aim to have achieved this by September 2014, and any changes to posts, management arrangements and pooled budgets required, will be completed by September 2015.

9.2 Market engagement

NPT has deployed considerable innovation in tackling the pressures on long term care services and the Council is reviewing its care home provision with a view to delivering a clear and sustainable model that will continue to improve the quality and provision of independent sector care home provision, particularly for people with dementia. The Council has engaged with Grwp Gwalia on issues relating to residential reablement already discussed in section 7 of this document.

NPT is also reviewing its longer term domiciliary provision and particularly the balance between directly provided services and commissioned services to ensure that the market retains sufficient capacity to meet increasing demands. This will include

- Realignment of the balance between specialist domiciliary care for people with dementia or complex care needs and more general domiciliary support.
- Commissioning for outcomes, rather than inputs.
- Engaging the support of consultants to develop a sustainable domiciliary care market within NPT.
- Review commissioning of third sector floating support services to ensure we are focusing on need, not tenure of accommodation.

A joint Market Position Statement will be completed by April 2014 to give providers clear steer on how to develop their businesses. This will form the basis for regular ongoing dialogue about future needs and services

Joint Commissioning Strategies and Market Position Statements for Dementia and Care homes will be completed by April 2014

Individual MPS will be produced for the following:-

- Learning Disability Services

- Mental Health Services
- Domiciliary Care
- Floating Support
    - Housing Related Support
    - Lower Tier Support

10. Strategic Direction 4: Develop joint governance arrangements

10.1 Agree governance, planning and commissioning roles for community based, clinically led networks across NPT

Arrangements to support the development of integrated community services have been developed successfully in NPT and the overall governance of the programme is established. There have been a number of successful groups who have led the development of integrated services in the past but these need to be refreshed in preparation for the future developments outlined in this paper.

The Health, Social Care Executive Board will oversee the planning and governance of integrated service developments in the future.

The Board will establish projects, to address the core priorities identified within this statement.

11. Strategic Direction 5: Integration of finance, IT, information systems and estates

11.1 We will develop robust joint financial management and audit arrangements

We will develop robust joint financial management and performance management arrangements for our integrated community services, clarifying those resources which are jointly funded and the performance framework underpinning the outcomes expected of the service. We will ensure arrangements are robust by developing appropriate governance.

Although there are number of broader arrangements in place to support joint working, other than the MICE, there are no formal section 33 agreements in place.

12. Summary of key actions

The following table summarises the key actions over the next period:

Priority	Activities	Period	Lead
Strategic Direction 1: Further development of intermediate tier in line with Western Bay Business Case:			
Establish arrangements for further integrated assessment and care planning	Establish flow between COT and Reablement OT's	June 2014	Andy Griffiths/Sara Foster
	Develop specific pathways for visually impaired older people	June 2014	Andy Griffiths
	Embed use of single integrated assessment tool and Mental Health Measures tool – shared access for all team from both Health and LA systems	April 2014	Adam Greenow
	Shared responsibility for all OPMH integrated team to undertake carers' assessments.	April 2014	Louise Barry
	Establish criteria for flow between part II and III of Mental Health Measures with other community teams.	April 2014	Louise Barry/Petrina Thomas
Develop information sharing protocols, and improve patient / service user data sharing arrangements	Embed single integrated assessment and electronic case file	April 2014	Andy Griffiths
	Develop proposal for introduction of Digi Pens and Electronic Scheduling and Call Monitoring.	April 2014	Rhodri Davies
	Extend single integrated assessment tool across community networks.	April 2014	Adam Greenow
Enhance arrangements for managing the interface between hospital and the community	Establish ten residential reablement beds within Grwp Gwalia new build	June 2014	Andy Griffiths
	Work towards 100% of people accessing reablement prior to the commencement of a long term care package.	April 2015	Andy Griffiths

Priority	Activities	Period	Lead
Place prevention, well-being and early intervention services at the fore, and develop the role of the third sector broker	Inclusion of housing and mental health support within Gateway Team	June 2014	Louise Barry
	Develop more 7 day community nursing, therapy and social care services with a focus on recovery.	June 2014	Andy Griffiths
	Increase usage of telehealth and telecare services to support people to be independent at home with minimal intervention	June 2014	Carla Dix
Strategic Direction 2: Integration of Community Networks			
integrate long term health and social care teams within Community Networks	Co- location of below within CN's. • Care Managers • Adult Mental Health Team • Review and Monitoring Team • Homecare • District Nurses • Continuing Health Care	June 2014	Lyndsay Davies
	Integrated CN team to be piloted for six months in the Upper Valleys Community Network,	Sept 2014	Louise Barry/Shan Tanner
	link with the third sector in the pilot area	Sept 2014	Louise Barry/Shan Tanner
	review management structures	Sept 2014	Louise Barry/Shan Tanner
	Roll out of integrated CN team Neath and Afan networks	April 2015	Louise Barry/Shan Tanner
Strategic Direction 3: building on joint contract monitoring, planning and commissioning			
Establish a joint planning, performance and commissioning function across NPTCBC and ABMU	Develop joint Dementia Care Strategy	April 2014	Julie Duggan
	Develop joint care homes strategy	April 2014	Liz Griffiths-Hughes
	Building a shared delivery plan for the implementation of the strategy	June 2014	Julie/Liz
	Review commissioning of third sector floating support services to ensure we are focusing on need, not tenure of accommodation	Sept 2014	Claire Jones

Priority	Activities	Period	Lead
Market engagement	Develop MPS for care homes	April 2014	Liz Griffiths-Hughes
	Develop Market Position Statement (MPS) for Dementia services	April 2014	Julie Duggan
Strategic Direction 4: Develop joint governance arrangements			
Agree governance, planning and commissioning roles for community based, clinically led networks across NPT	Review of priorities for Health and Social Care Executive Board	April 2014	Karen Jones
	Agree governance of integrated service developments in the future	June 2014	
	engage stakeholders in the health and social care sector to contribute fully to the planning and delivery of integration agenda	June 2014	
Strategic direction 5: Integration of finance, IT, information systems and estates.			
Develop robust joint financial management and audit arrangements	Develop and agree financial model to implement WB intermediate tier business case.	last quarter of 2013/14	Claire Marchant

Equality Impact Assessment Questionnaire

1. Identify aims and objectives

1.1 What is the name of the function/policy/procedure?

Delivering Improved Community Services sets the foundation for improving community services as a whole by focussing on the integration of intermediate tier community services and to deliver the vision for fully integrated health and social care services for older people with complex needs. The proposal will :-

- Strengthen the 'demand management' function undertaken by common access points into the intermediate tier of services.
- Support 3rd sector involvement in brokerage and short term support as an integral part of the intermediate tier.
- Optimise services, and provide the necessary housing adaptations, equipment and support, in order to provide genuine alternatives to a hospital or long term care admission.
- Provide the context, physical estate and care pathways for integrated services between health and social care and, where appropriate, with mental health services.
- Act as a catalyst for the transformation of services for frail older people and achieve, over time, a shift in how and where this care is delivered.

1.2 What are the main aims and objectives?

- To deliver an optimal service model, at scale, for intermediate tier services.
- To establish a pooled fund for intermediate tier services in accordance with Section 33 of the National Health Service (Wales) Act 2006 by 2015/16 financial year.
- To develop recruitment programme to appoint the workforce required to deliver the intermediate tier services, on a permanent basis.

1.3 What are the main areas of activity?

the key areas of impact are:-

- Rapid response at times of crisis.
- Introduction of review reablement to maximise independence before a care package is agreed or increased.
- Support people to remain independent and keep well, and reduce the need for large, or long term packages of domiciliary care.
- Ensuring that more people are cared for at home, with shorter stays in hospital if they are unwell;
- Changing typical pathways away from institutional care to community care;
- Ensuring that less people are asked to consider long term residential or nursing home care, particularly in a crisis;
- Providing more people with the support of technology and

associated services;

- Joining up services around the needs of the individual with less duplication and hand-offs between health and social care agencies;
- Providing more treatment at home, as an alternative to hospital admission;
- Ensuring that services are available on a 7 day basis;
- Encouraging earlier diagnosis of dementia and quicker access to specialist support for those who need it.

1.4 Who is responsible for it?

- AMBU HB
- Director of Social Services – NPT CBC
- Director of Social Services – CCS
- Director of Social Services – BCC

1.5 Who is the policy intended to benefit, and how?

- The business case sets out a vision for enhanced integrated community services for older people which will support them to remain in the community. It will ensure a consistent service so that residents will be offered a similar service no matter where they live in the Western Bay area
- The wellbeing of older people is improved by keeping them healthy in their own communities so they enjoy happy and independent lives; – which is a strong message emanating from a raft of consultation exercises with older people
- Strengthening community teams, making sure people default to the community for assessment and care rather than hospitals and institutional care, will enable the Council to deliver the above.
- Making community services sustainable, ensuring community teams are the best they can be through better technology and better financial and workforce planning models.
- Citizens of NPT CBC by more effective use of resources.
- Fewer people will be admitted to hospital in crisis due to a more coherent approach to integrated health, and social care and support at home.
- Those that do need the level of care and attention only available in a hospital setting, will spend less time there, and be able to continue their recovery either in a step down placement (for a period of recovery and convalescence) or with support in their own home, as soon as they are medically fit to leave hospital.
- The Council by reducing costs.
- ABMU by reducing number of bed days and DToC's
- ABMU and NPT CBC by implementing section 33 agreement on pooled budgets to maximise the use of resources.
- Care home sector by minimising expenditure on future building costs

and allow them to develop their businesses from a robust evidence base.

- Residents of care homes by providing more appropriately sized homes.
- Domiciliary care sector, by having robust information upon which to build their businesses.
- Social care workforce will be up-skilled.
- NPT citizens – as new employment opportunities will be created.

1.6 How will you measure the expected outcomes?

- Increase percentage of new contacts relating to community health and social care directed through the single point of access.
- 15% of baseline unscheduled admissions for >65 year olds are diverted to Rapid Response.
- 100% of all potential new homecare clients receive intake intermediate care.
- 100% of homecare clients for whom a potential significant change is identified receive review intermediate care.
- 100% of post-acute care that is suitable for domiciliary intermediate care is delivered at home rather than in a hospital bed.
- Step up care provision is expanded proportional to future change in the frail older population.
- Provision of intermediate care in residential beds continues to be provided at the current rate in each locality with full utilisation of planned developments.

2. Evidence and data used for assessment

2.1 What evidence and data have you used?

- Demographic profiling.
- Evidence form the Western Bay Regional Partnership Programme projecting a decline in demand for residential care and a concomitant increase in the provision of integrated community based services for older, frail people.
- Evidence provided by the Whole Systems Partnership consultancy on the regional frailty and dementia projects including: -
  - Strategic Case for Change produced for the Western Bay Programme Board in June 2013
  - Western Bay Business Case for people with Dementia
  - Western Bay Business Case for Frail Older People
- Annual Performance Management Team returns to Welsh Government
- NPT Financial Assessment section monthly returns
- Academic evaluation of the Intermediate Tier implementation

2.2 Could any of the equality groups be affected differently from the original aim of the function/policy/procedure? • None apparent
2.3 Is there evidence that any equality groups could be discriminated against unlawfully, either directly or indirectly? • None apparent.

3. Assessing the impact

3.1 Are there any gaps in the evidence and data that need to be addressed and incorporated into actions for further consultation and/or review? • None apparent
3.1 Could the function/policy/procedures lead to unlawful direct discrimination? If yes the function/policy/ procedure must be abandoned. • No
3.2 Is the function/policy/procedure indirectly discriminatory? • No **3.3 Can it be justified under legislation?** • Yes
3.4 If the function/policy/procedure is not directly or indirectly discriminatory, does it have an adverse impact for any of the equalities groups? This work is likely to have a positive effect for NPT citizens, as the business case is centred around strengthening community services to enable older people (including those with dementia) to remain at home, be active citizens, and remain independent for as long as is possible.
3.4 Is the adverse impact unavoidable? If not, can it be justified? • No adverse affects anticipated for equalities groups
3.5 Are there alternative measures that could still achieve the desired aim? Provide justification if the alternative have not been accepted. None apparent
3.6 Could damage to relations between the Council and the equalities groups, and between groups themselves, be caused due to the adverse impact? • No
Is there potential for the function/policy/procedure to conflict with the public sector duties and /or the Council's equality principles? • No

4. Consultation

4.1 Who are the relevant stakeholders?

- *All members of the public within NPT CBC*
- *Existing care home residents.*
- *Existing domiciliary care service users.*
- *Residential care home providers*
- *Domiciliary care providers*
- *NPT CBC, CCS and BCC senior officers*
- *ABMU senior management*
- *Voluntary, not for profit / third sector / NGO's*
- Social care workforce
- ABMUHB workforce
- Political leadership

4.2 What consultation has taken place on the function/policy/procedure or similar issues with relevant stakeholders?

Engagement with:

- Primary Care,
- Third Sector colleagues via the Third Sector Network
- A variety of participants at the Western Bay Launch event (July)
- Swansea, Bridgend and NPT Cabinets (Sept – Oct)
- ABMU Board (Sept)
- GP networks
- Community Networks

4.3 Have there been any comments/criticisms/alternatives made in relation to equalities? Please list.

- No

4.4 Has an adverse impact been identified by consultees? Does it differ from that already identified?

- No

4.5 What steps can be taken to mitigate the impact?

- N/A

4.6 Are there ways in which the function/policy/procedure can be improved?

Further development of strategy should be based on: -

- *Most up to date research and data.*
- *Use of local intelligence.*
- *EIA repeated periodically to support local context of proposal*

5. Decision making

5.1 Has the decision been based on:

- The aim of the function/policy/procedure - **yes**
- The evidence collected on possible adverse impact - **yes**
- The results of consultation - **yes**
- The relative merit of different approaches and/or actions to mitigate negative impact? - **yes**

6. Monitoring arrangements

6.1 How will the function/policy/procedure be introduced e.g. pilot scheme, phased in etc?

The process will ensure the involvement of all staff in understanding and evaluating the impact of the new services to ensure early feedback of lessons learnt and any adjustments necessary in the implementation process.

To ensure the programme is managed effectively an Implementation Group will be established, and will report to the existing Western Bay Project Board.

Key Milestone	Indicative delivery date
Governance arrangements in place HR recruitment team operational Performance Framework in place and operational Appointment of early posts (tranche 1) Evaluation commissioned Third sector contracts in place	End June 14
Appointment of tranche 2 posts (the majority)	End Sept 14
Remainder of posts recruited (tranche 3)	End Dec 14
Section 33 arrangements developed for pooled fund for implementation 1/4/15	End March 15

6.2 How will progress be measured?

Formal monitoring and governance arrangements will consist of:

- Local weekly reporting of key activity & impact by practitioners gathered by team managers in 'real time';
- Monthly reports to the Community Services Programme Board prepared by locality managers, supported by the central Intermediate Care Programme Office. These will be linked to budget reporting and will include an alignment with budgets and the planned investment profile;
- Quarterly reporting to the SSHH Scrutiny/ Cabinet Board, Western Bay Programme Board with external validation and comment, prepared by the Intermediate Care Programme Office.

The process will ensure the involvement of all staff in understanding and evaluating the impact of the new services to ensure early feedback of lessons learnt and any adjustments necessary in the implementation process.

6.3 Is the monitoring system sufficient to provide reliable and appropriate equalities information?

- Yes

6.4 How and when will results of monitoring be used to assess any impact and/or modify the function/policy/procedure in light of experience?

- As per governance arrangements
- Use of existing contract monitoring arrangements of other residential care home providers
- Population measures will be identified to track the long term implications of reducing the numbers of residential care home placements.
- Service level performance measures will be identified to track the success of the policy..

6.5 How often will the function/policy/procedure be reviewed and who will be responsible for this?

- The Project Manager will provide monthly budget monitoring and progress reports to the Head of Service and Project Board

7. Publishing the results

7.1 Has a report been prepared for publication? How will it be made accessible to the public?

- It will be published at the appropriate time. External evaluation will also be commissioned to ensure the full impact of this change is understood.

7.2 Has the assessment and report been signed off by your head of service equalities champion?

- Yes

8. Actions Identified

8.1 Actions to address gaps in information and/or service improvements

Further information gathering to support a detailed business case to deliver the strategy is ongoing on a 'whole systems' basis and a report with recommendations for investment in local intermediate tier community services will be produced throughout the life of this programme.

8.2 Actions to be included in business plan.

Signed: …Julie Duggan……..

(Officer undertaking assessment)

Date: 07.05.14……

Signed off by:Angela Thomas……

(Head of Service Equalities Champion)

Date:…07.05.14……