Cyngor **Abertawe**
Swansea Council

Cabinet Office
The Guildhall,
Swansea, SA1 4PE
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Cllr Peter Black
Convener, Adult Services Scrutiny Panel

Please ask for: Councillor Mark Child
Direct Line: 01792 63 7441
E-Mail: cllr.mark.child@swansea.gov.uk
Our Ref: MC/HS
Your Ref: ref
Date: 5 April 2018

Dear Cllr Black

Thank you for your letter of 12 March 2018.

In response to the matter of Hospital Admissions:

The number of admissions avoided through the Acute Clinical Response Service between June 2017 and January 2018 were 1,787. For the preceding 12 months, 1,546 admissions were avoided so there has been a significant improvement in performance this year which demonstrates that this relatively new service is bedding in and a range of professionals and services are working with it to support people in the community wherever possible.

I have attached the latest Western Bay Intermediate Care Scorecard which gives the data asked about in terms of the before and after figures in terms of people supported in the community. However, we do not collect data to the level of detail requested in your letter. As ever, if there is a data set that you think we should be collecting, it can be discussed when the Panel next considers the Adult Services Performance report at its meeting in May. However, it should be noted that the scorecard reflects the agreed dataset as per the Western Bay model.

I believe the Optimum Model has been sent to Liz Jordan for circulation to the Panel.

Cont'd.....

Please note, a response to the issues raised on the proposed budget in relation to Adult Services was sent by The Leader on the 26 March 2018.

Yours faithfully

Councillor Mark Child
Cabinet Member for Health & Wellbeing

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Swansea Council

WB Intermediate Care Performance January 2018
Community Resource Team – *Swansea Council* Area

Intermediate Care Business Case:

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

The following table outlines our progression towards the optimal model of intermediate services including the baseline status.

Key Feature of Optimal Model	Baseline	Established	Optimised
Multi-disciplinary triage in common access point	N	Y	Y
Mental Health provision within common access point	N	Y	D
Third Sector Brokerage in common access point	N	Y	Y
Acute Clinical Response	N	Y	Y
Therapy led reablement service	N	Y	Y
Intake & review reablement	N	Y	Y
Therapy led residential reablement	Y	Y	Y
Access for people with dementia	N	Y	D
Step up / down intermediate care (residential or community)	Y	Y	Y
Key; *Y(yes) N(no) D (in development)*			

Programme Outcomes:

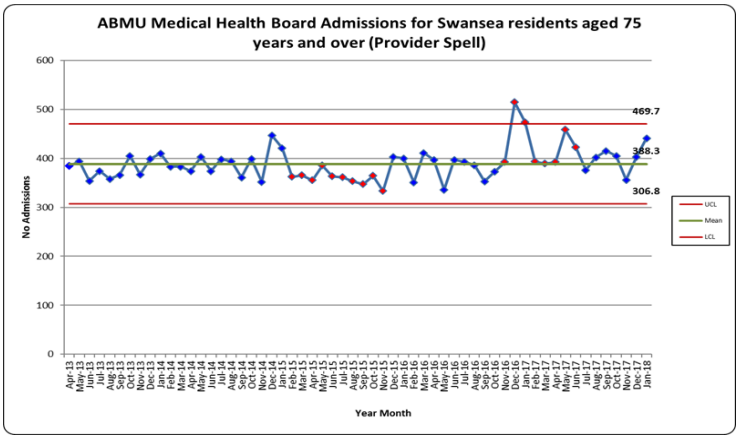
- Reducing new homecare packages via signposting by a common access point and increased levels of intake intermediate care
- Reducing escalation in existing homecare packages via increased levels of review intermediate care
- Reducing new permanent care home placements via increased levels of review intermediate care
- Reducing unscheduled admissions to hospital and (therefore bed days) via increased diversion to rapid response services
- Reducing post– acute hospital stays for unscheduled, scheduled and surgical patients via increased step down intermediate care
- More older people are supported to live independently with the support of technology
- More frail and older people are supported to remain independent and keep well, as well as to have improved quality of life
- More frail and older people to become cared for at home rather than in institutional care, i.e. in hospitals / care homes.

Performance Measure: Hospital Admissions between April 2014— January 2018

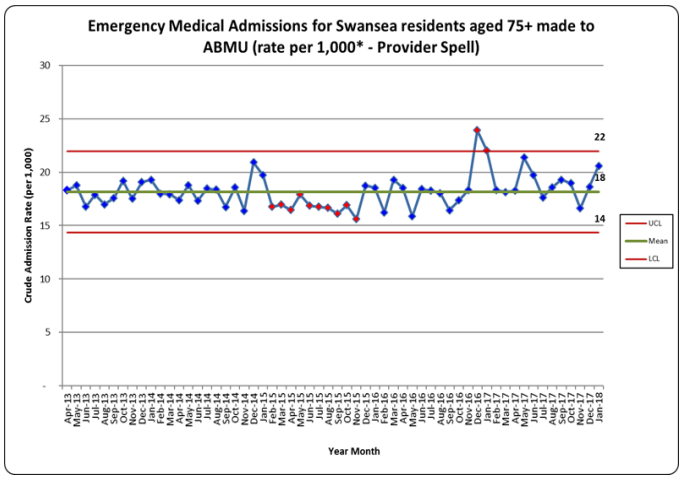
Emergency Unscheduled Hospital Admissions 65+ and 75 + For Jan Month by Month comparison between 2014—2018.

Year	65 Yrs and over		75 Yrs and over	
	Jan	Variance +/-	Jan	Variance +/-
2014/15	604	Baseline	427	Baseline
2015/16	575	-29	402	-25
2016/17	657	**+53**	477	**+50**
2017/18	631	**+27**	446	**+19**

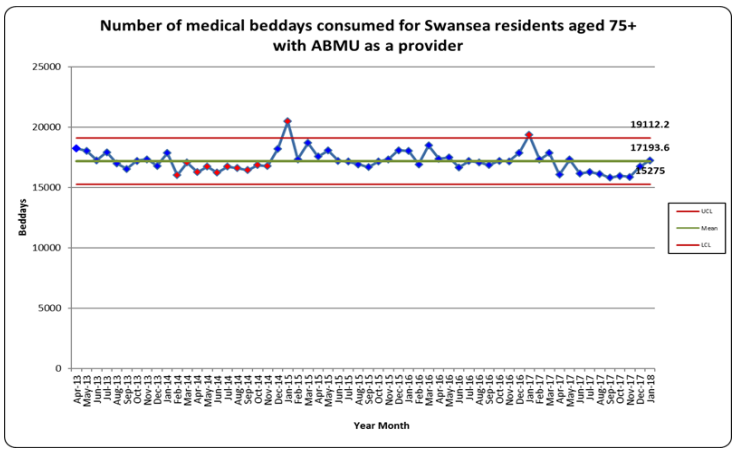
Hospital Admissions Rates (>75) Per 1000 Population Locality between April 13—January 18



Emergency Unscheduled Hospital Admissions (>75) made by Resident Patients between April 13—January 2018



Total Bed Days Consumed (Age 75+) originally admitted as an unscheduled care medical admission April 2013—January 2018



- Unscheduled admissions continue to increase and the length of stay is starting to show an upward trend.
- To try and manage the issue the reablement team's interventions continue in all hospitals to facilitate discharges, however, as mentioned in previous months this is largely due to the reablement service operating a 'bridging' function. This has continued but capacity is an issue.
- Work is ongoing to maximise capacity within the external domiciliary care sector so wherever appropriate bed days are not increased due to a placement being sourced. The brokerage list has been greatly reduced through process changes and close working with the review team to target areas of need.

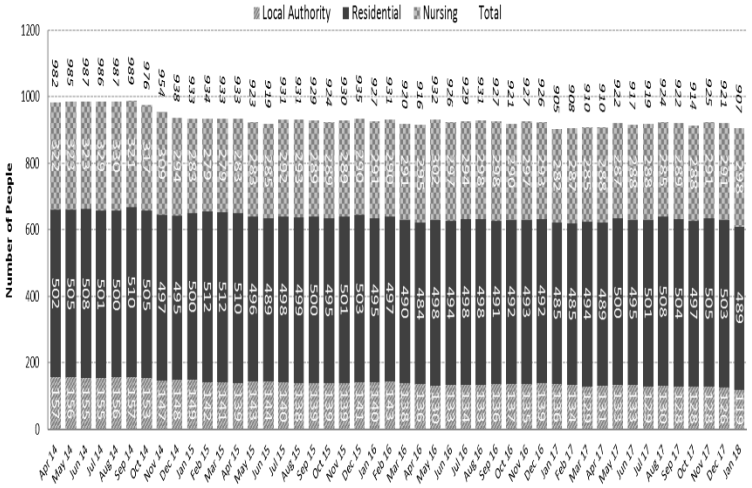
Data source: ABM UHB

Performance Measure: Care Home Admissions April 2015 – January 2018

Total* Number of People Support In a Care Home Aged 65+ between Apr 2015— January 2018 (Nursing Included).

	Jan 2015 (Baseline)	Jan 2016	Jan 2017	Jan 2018
Total No. of People Supported	933	927	905	907

At request of WB, data for those nursing placements supported in a care home have been included.

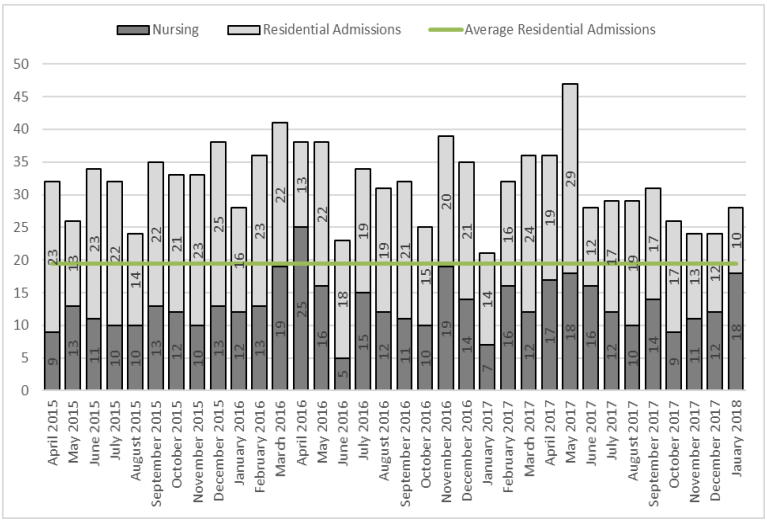


Total* Number of New Care Home Admissions Month by Month Comparison between 2015—2018

	Jan 2015 (Baseline)	Jan 2016	Jan 2017	Jan 2018 (Actual)
Total No. of New Care Home Admissions	22	28	22	28

At request of WB, data for those new starters in nursing placement have been included.

Care Home Admissions aged 65> within Month between April 2015 and January 2018 (Including Nursing)

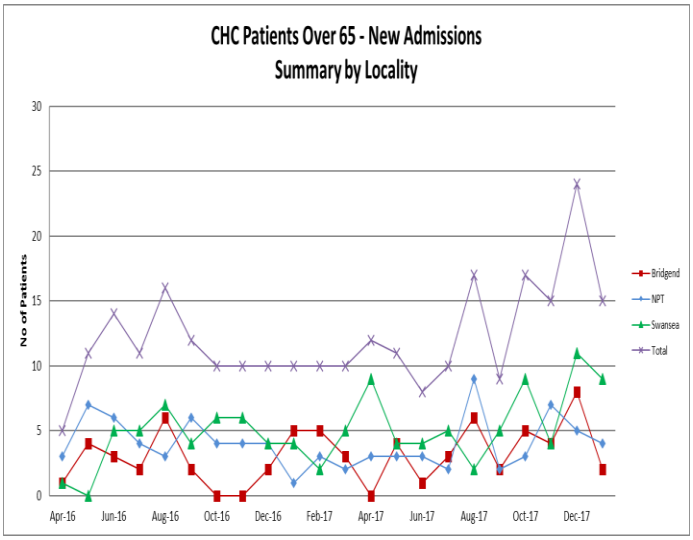


- Both of the graphs above have been adjusted to show nursing placements as well as Residential placements
- The number of people supported in a care home in Swansea has risen approx. 17% from previous month (December 2017).
- Figures for January 2018 show **28** admissions. This has increased from 24 in December 2017.
- In comparison to previous years January 2018 admissions are up 33% on January 2017 the same compared to the same month in 2016.

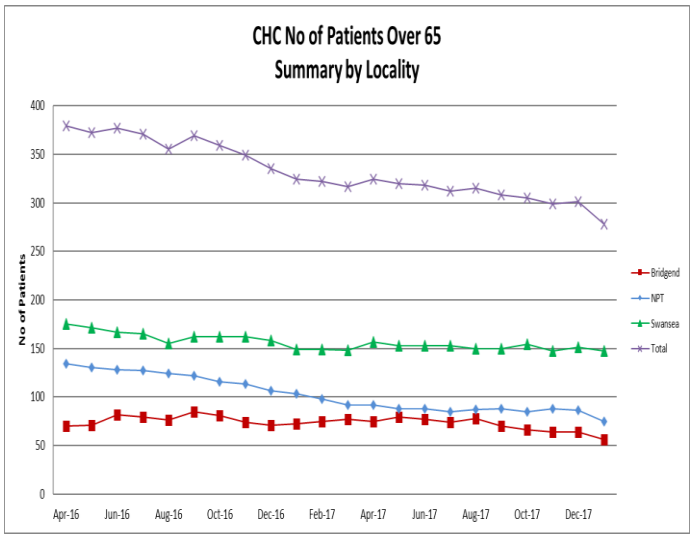
Data source: Local Authority

Performance Measure: FNC and CHC Admissions April 2016 – January 2018

Total Number of CHC new starters
April 2016 - January 2018



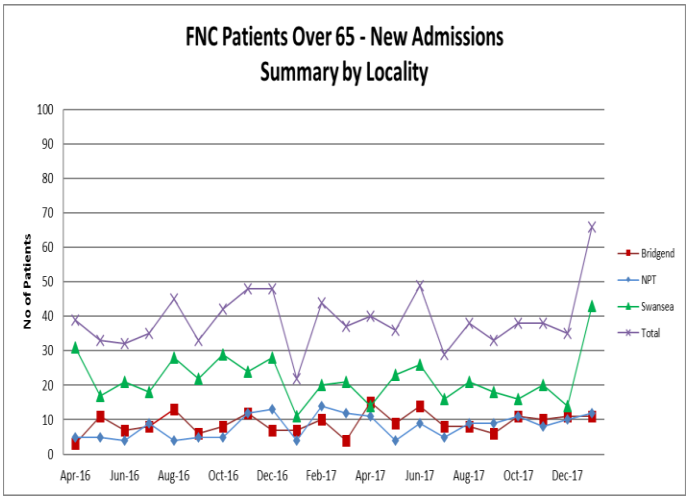
Total Number of people supported By CHC
April 2016 — January 2018



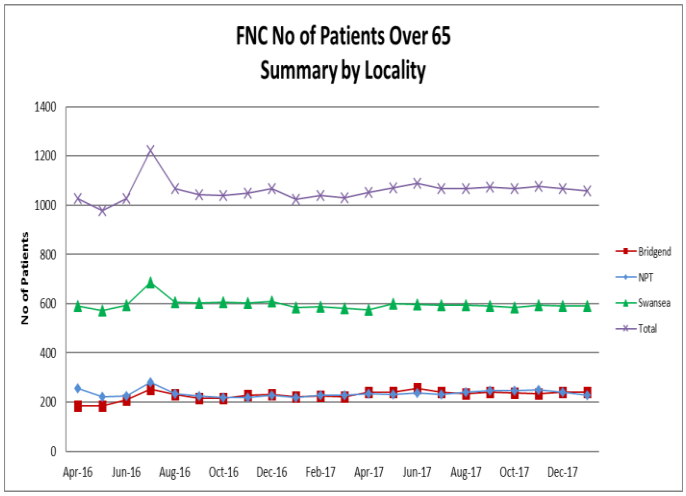
NHS Funded Continuing Healthcare (NHS CHC) is a complete package of ongoing care arranged and funded solely by the NHS for a person aged 18 or over to meet physical or mental health needs which have arisen as a result of disability, accident or illness and where it has been assessed that the individual's primary need is a health need.

Narrative CHC: Swansea is currently undertaking a piece of work to better understand the CHC process. Initial observations of the process do suggest that fluctuations in "new starters" reflect a process issue.

Total Number of FNC new starters
April 2016 — January 2018



Total Number of people supported by FNC
April 2016 – January 2018



NHS Funded Nursing Care (NHS FNC) is the contribution paid by the NHS to individuals for their registered nursing care when resident in care homes with a nursing requirement that is not the primary need. Patients can be self-funders or funded by the local authority.

Data source: ABM UHB

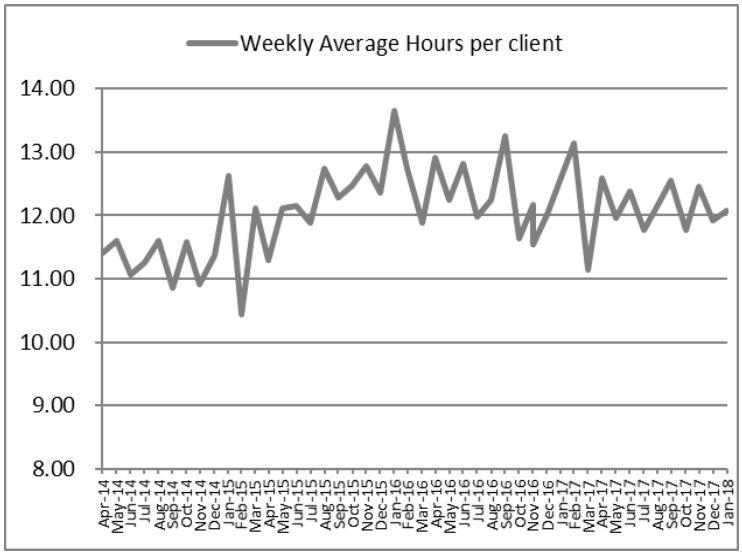
Performance Measure: Domiciliary Care Starts April 2015 – January 2018

Total Number of New Domiciliary Care Starts within January aged 18+, Quarter by Quarter comparison 2014—2018

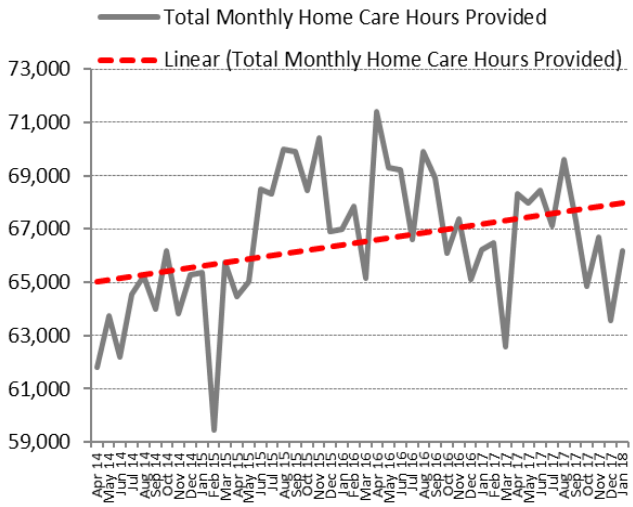
Year	January	Running Total	+/- Running total compared to baseline
2014/15	44	44	Baseline
2015/16	37	37	-7
2016/17	51	51	+7
2017/18	27	27	-17

Data includes those aged 18 and over, who have not previously had a domiciliary care package.

Average Domiciliary Care Hours per Client Per Week between April 2014—January 2018



Total Number of Domiciliary Care hours provided between April 2014 and January 2018



- The average hours of care provided per week has remained relatively static since April 2015, with most months showing an average of between 11 and 13 hours per week (since January 2016).
- There has been an increase in Total Domiciliary Hours in January compared to the previous month.
- We are currently working on demand for Dom care by optimising our CAP MDT, and installing new processes to challenge and review new referrals for Dom care.
- Work is in progress to optimise the Dom care review team, in order to develop effective and robust processes around reviewing existing care packages.
- The service has started to record 'bridging' clients. To date, we have excluded these cases from the count of those starting / receiving domiciliary care. We will establish whether to adjust the analysis to include these individuals.

Data source: Local Authority

The Community Resource Team** contributed to the outcomes in the following way:

ACT

ACT	2014/ 2015	2015/ 2016	2016 Jul 2017 Jun	June 2017	July 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Running Total for 2017
No. New Starters	N/A	N/A	1702	142	136	144	190	199	197	177	256	2003
No. Admissions avoided (stayed at home)	N/A	N/A	1546	128	126	132	171	178	184	145	220	1787
No. of Facilitated Discharges	N/A	N/A	**156**	14	10	12	15	15	8	7	9	153
No. Hospital bed days avoided	N/A	N/A	Unknown	863	802	1019	1904	2043	2029	*810	1069	10,539
Bed day costs avoided	N/A	N/A	Unknown				380,800	408,600	405,800	*101,250	133,625	

Number of hospital bed days avoided has been revised and is now calculated as the duration of days *avoided admission* patients remain in their own homes throughout the reporting period.

**Bed day costs recalculated at £125. This number has recently been confirmed via Pete Hopgood, Finance department and is used to calculate bed days saved across health and Local Authority.

Intake Reablement (Community Reablement)

Intake Reablement	2014/ 2015	2015/ 2016	2016/ 2017	January 2018	Running Total for 2017/18
No. New Starters	1,008	991	904	55	548
No. Community starters	*	*	*	*	*
No. Hospital Discharges Facilitated	399	394	331	50	286
No. Hospital bed days avoided	1,197	1,182	987	150	858
Bed day costs avoided	131,670	130,020	108,570	21,000	120,120
No. Domiciliary care hrs avoided	N/A	N/A	N/A	N/A	N/A
Weekly Domiciliary care costs avoided	N/A	N/A	N/A	N/A	N/A

- For this month No. of Hospital bed days avoided has been calculated as **hours saved for a single week** following reablement end, compared to hours recorded at start of reablement. Other organisations may calculate this differently but we will work to standardise this for future scorecards. Bed day costs are calculated at £140 per day (Previous years used Bed Day Costs at £110).

- Work is currently being done to improve back office processes in relation to Community Reablement data, to ensure we are getting the complete data set.
- We have optimised this function (see page 1). Action has been taken to have OTs screening for patients entering into the integrated domiciliary care team, with the therapist leading on an outcome focussed care plan, achievable within a 6 week period.

The Community Resource Team contributed to the outcomes in the following way:

Intermediate Beds (Residential Reablement)

Intermediate Beds	2014/ 2015	2015/ 2016	2016/ 2017	Running Total for 2017/18	Jan 2015	Jan 2016	Jan 2017	Jan 2018
No. New Starters	219	217	195	118	13	16	18	22
No. Hospital Discharges Facilitated	88	81	69	48	4	3	5	7
No. Discharged to own Home	87	116	129	52	6	15	10	16
No. Discharged to Long Term Placement	75	73	25	13	9	6	3	1

- We are developing a new gathering method for Residential Reablement
- Note: No of new starters does not currently include the bridging that the reablement service are undertaken with hospital patients.
- There have been improvements in the number and proportion of people discharged home.
- Number of new starters in December 2017 is the highest since January 2017.
- Bonymaen House are reviewing criteria for referrals in order to improve pathways in.
- An ICF Capital fund is being utilised to improve facilities in Bonymaen House, and further facilitate staff in the reablement of patients

Common Point of Access

Common Point of Access	Base -line 2014	December 2015	January 2017	January 2018	Running Total for 2017/18
No. calls responded to and closed by contact officers	NA	NA	**1933**	**2486**	20,633
Total no. people referred to MDT	NA†	NA†	89	359	2709
No. people responded to and closed by MDT	—	—	—	—	—
No. of people referred to CRT	NA	NA	85	90	861
No. of referrals to 3rd sector broker	NA† †	NA††	19	13	152

- † Service did not exist in Swansea prior to 2016/17
- ††No useable data exists before 2016/17.
- Please note the CRT figures DO NOT include Community Continence
- Calls in January increased significantly, which is a typical trend for January.

**** Swansea does not have a separate CRT, instead operating a Hub model. We will class CRT as the OT/Physio input from the three community hubs combined with the Specialist Integrated Community Health team (Speech & lang, continence etc.).**

The Community Resource Team contributed to the outcomes in the following way:

Community Dementia Support Services

Community Dementia Support Service	2016/ 2017	January 2018	Running Total for 2017
Number of new referrals	-	44	220
Number seen within 7 days	-		
Numbers seen within 14 days	-		
Number of cognitive assessments undertaken Cantab	-		
Other cognitive assessments	-		
Number triaged in (for further investigation)	-		
Number triaged out no further investigation/ signposted to other services	-		
Number of referrals that declined an assessment	-		
Number of cases 'open' for follow up	-	217	217

Swansea recording of Community Dementia Support Services is emerging. To date, only information about enquiries has been recorded. The ability to report assessment data is dependent on data being recorded.