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Review of the Gwent Frailty Programme

Gwent Frailty Partnership

Aneurin Bevan Health Board, Blaenau Gwent County Borough Council, Caerphilly County Borough Council, Monmouthshire County Council, Newport City Council, Torfaen County Borough Council

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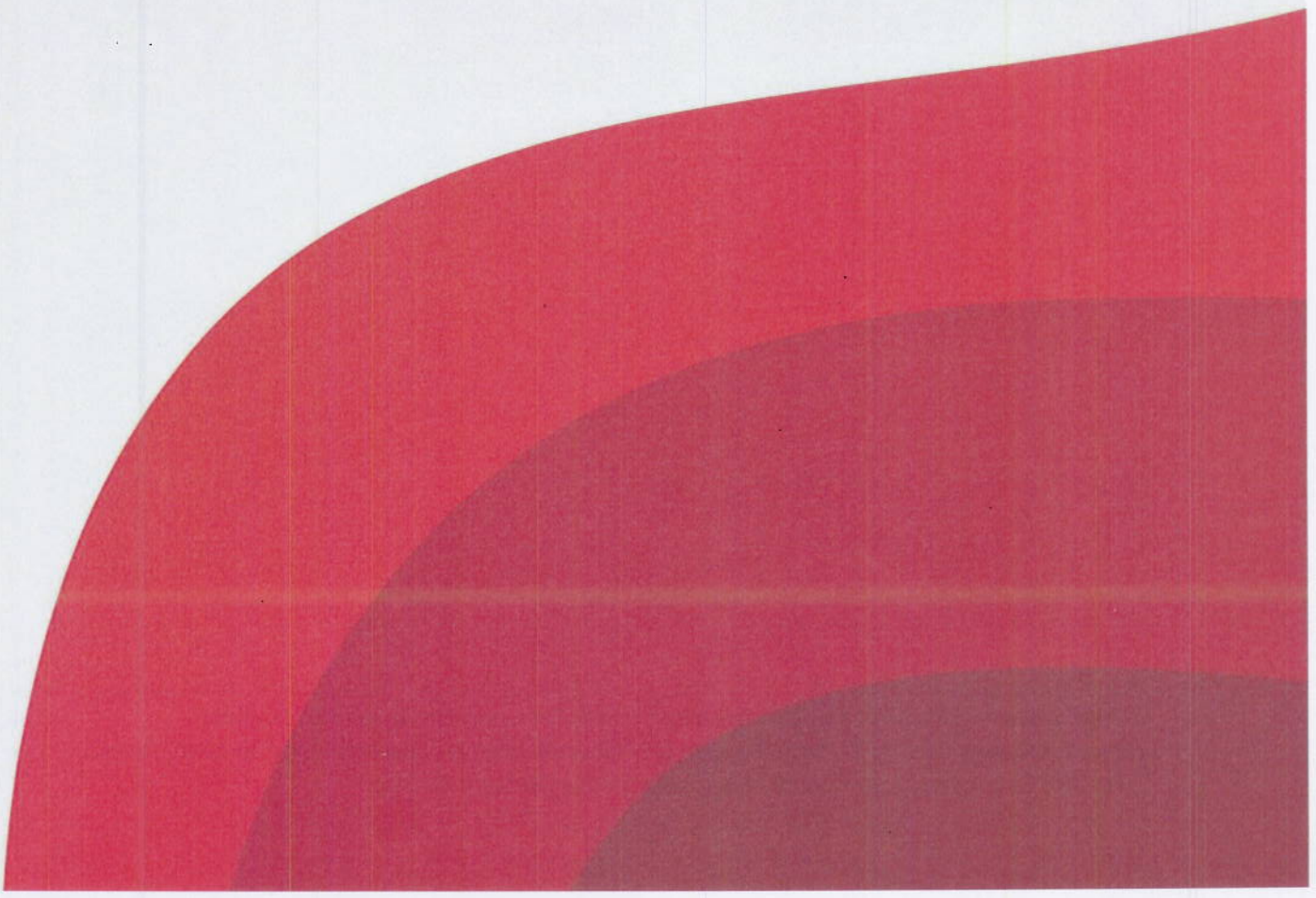

Status of report

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Summary

1. From 4 April 2011 Aneurin Bevan Health Board (the Health Board) and Caerphilly, Monmouth, Blaenau Gwent, Newport and Torfaen Councils began implementing an ambitious integrated model of providing a range of health and social care services to frail people, called the Gwent Frailty Programme (Gwent Frailty). Gwent Frailty has legal status under a Section 33 partnership agreement[1] between the Health Board and the five local authorities and is supported with £6.9 million of Invest to Save Funding from the Welsh Government.
2. Gwent Frailty has been developed in recognition that many aspects of current models of health and social care provision are unsustainable and that more effective whole system working is necessary to address increasing demand for services which meet frail individuals' needs. There is now more pressure to modernise services coming from the unfavourable economic climate, which is placing significant pressure on health and social care budgets.
3. Gwent Frailty brings together health, social care and the main voluntary and independent sector agencies across the region in an integrated approach focused on providing short-term intervention and supporting frail people to remain happily independent. Specifically, Gwent Frailty aims to:
    - ensure people have access to the right person at the right time;
    - focus on preventative care; wherever possible avoiding unnecessary hospital admissions;
    - reduce the length of a hospital stay when admission is necessary;
    - reduce the need for complex care packages;
    - avert crises by providing the right amount of care when needed; and
    - co-ordinate communication by providing a named person for all contact.
4. Gwent Frailty's aims have significant relevance to the way in which the public sector bodies involved use their resources, and are central to the delivery of improvement priorities at all agencies involved. The Wales Audit Office undertook an initial review of the arrangements for Gwent Frailty implementation, focused on providing early assurance in relation to governance arrangements and direction of travel towards achieving intended aims and outcomes. We did not undertake an evaluation of the programme's success, which would be premature at this stage. We sought to answer the following questions:
    - Is there a clear vision of what Gwent Frailty is trying to achieve, jointly owned by all agencies involved?
    - Is Gwent Frailty embedded within localities and underpinned by sound service, financial and workforce planning?

[1] The NHS (Wales) Act 2006 Section 33 provides flexibilities for NHS and local authorities to set up and manage partnership arrangements to help transform delivery of integrated, citizen focused services meeting both local and national priorities.

- Is Gwent Frailty supported by a robust management and governance framework?

5. We concluded that: **Partners are strongly committed to the Gwent Frailty vision and have created a sound programme management framework to underpin it. Gwent Frailty is in the early stages of implementation and challenges remain to ensure it is sustainable, to change established behaviours and to demonstrate its impact.**

6. We reached this conclusion because:
   - whilst there is a clear vision for the Gwent Frailty, which all agencies are strongly committed to, some operational and stakeholder tensions could affect the pace of change and full realisation of potential benefits;
   - the Gwent Frailty is becoming embedded in the everyday working of community teams, although this early progress is not yet consistently underpinned by wider changes needed to support and sustain it, and services to users vary;
   - programme management for implementing Gwent Frailty is sound but some elements of performance management require strengthening to support governance structures and processes; and
   - there are early indications that Gwent Frailty is making some positive progress, although its overall impact will be difficult to evaluate unless its contribution to improving outcomes for frail people can be more clearly defined and measured.

Proposals for improvement

P1	Create a single suite of comparative performance information across Gwent Frailty based upon measures of outcomes for users, costs and sustainability. Develop consistent performance baselines against indicators in order to report and monitor progress; evaluate the impact of different approaches within the franchise; support reductions in unjustifiable variations; identify, assess and share good practice.
P2	Develop a framework for joint scrutiny of Gwent Frailty across councils, supported by the Gwent Frailty dashboard performance reports, which will also support scrutiny by the Health Board.
P3	Agree criteria for referral to and acceptance by Gwent Frailty to target services more accurately at the intended user group. Engage with GPs and hospital clinicians to ensure referral systems are not bypassed and that referrals to Gwent Frailty are appropriate. To ensure medium-term and long-term sustainability of the Programme, clarify the implications of criteria, including profiling: future demand, unit and total costs; hospital admissions, discharges and bed days; benefit realisation; and risks.
P4	Address issues identified in the Gwent Frailty review of Single Point of Access (SPA) first year of operation, including: compliance with referral procedures; improving: SPA functionality; calls handling; records access; information processing; and also training and development for Community Resource Team (CRT) and SPA staff as well as referrers.

P5	Map out financial plans and demand projections beyond the initial three year plan for Gwent Frailty, to ensure it is sustainable.
P6	Undertake the review of Gwent Frailty and CRTs in operation, anticipated for the end of year one, to evaluate the effectiveness of different approaches to delivering the service and identify the impact upon Gwent Frailty and its users of: variations in services within Gwent Frailty; and issues and constraints within the wider health and social care system, including seven day and out of hours working.
P7	Undertake a fundamental review of the IT programme intended to support Gwent Frailty implementation, encompassing issues including: hardware; software; system integration; data capture; reporting; project scope; and progress.

Detailed report

Partners are strongly committed to the Gwent Frailty vision and have created a sound programme management framework to underpin it. Gwent Frailty is in the early stages of implementation and challenges remain to ensure it is sustainable, to change established behaviours and to demonstrate its impact

Whilst there is a clear vision for the Gwent Frailty Programme, which all agencies are strongly committed to, some operational and stakeholder tensions could affect the pace of change and full realisation of potential benefits

The partners demonstrate clear, high-level commitment to the Gwent Frailty vision and Partnership

7. In April 2011, after nearly five years of discussions and joint planning, partners working together to deliver health and social care services across the Gwent region began implementing the Gwent Frailty. Gwent Frailty is a multi-agency collaboration for delivering a short-term intervention service providing integrated health and social care domiciliary support to frail people across Gwent, in order for them to remain happily independent within their community for as long as possible. The partnership, legally constituted under provisions in the NHS (Wales) Act 2006 Section 33, involves the Health Board and Caerphilly, Torfaen, Monmouthshire, Blaenau Gwent, and Newport Councils. Each partner is represented on the Frailty Joint Committee (FJC), a body formed to provide leadership and direction to Gwent Frailty. The Welsh Government has provided support to Gwent Frailty with £6.9 million of 'Invest to Save' grant funding, payable in tranches to 2013–14.

8. The impetus for Gwent Frailty came from widespread acceptance that existing ways of delivering services are not financially or socially sustainable and are not delivering the best outcomes for users. Gwent Frailty aligns with the partners' priorities by shifting focus away from hospital beds to community-based services, avoiding hospital admissions, reducing length of hospital stay and prolonging independence. Nevertheless, building upon this consensus and shared interests to secure the agreement of all the parties to the Gwent Frailty vision and direction represents a considerable achievement. The partners' commitment is consolidated by reflecting Gwent Frailty in the key strategic and operational planning documents across the partnership and within the individual partners, for example the Health Board's *Clinical Futures* strategy. Furthermore, within councils, cross-party consensus should ensure Gwent Frailty is unaffected by any future changes in political administration.

9. From the outset, it has been clear to the Gwent Frailty partners that the relationships between costs and benefits are difficult to quantify and will vary between them, although the Health Board's share will represent the largest proportion of both. Each partner produced a business case, which helped to establish a pooled budget for Gwent Frailty and supported the joint bid for Welsh Government grant funding. Partners identified which services each included within Gwent Frailty, the amount they would contribute to the pooled budget, and estimates of the predicted recurring savings each would contribute towards repaying grant funds by 2017-18. In order to work together and pursue the Gwent Frailty vision collectively, the partners all accepted a level of risk, uncertainty and inequality. In the current climate of reducing resources, the extent and impact of variations in costs and benefits has the potential to cause tension between the partners. So far, partners have been prepared to put aside differences and self-interest but in order to continue to make progress, in future, they will need to confront and manage tensions explicitly and ensure commitment to the vision is maintained.

Stakeholders' levels of awareness of and engagement with Gwent Frailty are variable

10. There is clear high-level, organisational, managerial and political sign-up to Gwent Frailty and widespread commitment to its strategy and vision. Although amongst some staff at lower tiers within the partner organisations, there is less certainty and greater scepticism. Staffs' understanding of Gwent Frailty and its implications is inconsistent, varying from "*whole system transformation*" to "*no change - we're doing it already.*" Levels of awareness of and engagement by GPs and hospital consultants are also variable, which impacts upon referral patterns and commitment to change models of service delivery. The FJC know that there is more work to do in this area, in particular on improving awareness and engagement with the public, service users, hospital doctors, the voluntary sector and GPs. Work with hospital clinicians and GPs, including clarifying the target client group and developing criteria, should help to ensure that referral systems are not bypassed and that referrals to Gwent Frailty are appropriate. There is also a need for better engagement with areas of the health and social care system not encompassed by Gwent Frailty, for example housing.

Achieving transformation in services for frail people relies upon strengthening co-ordination of a range of organisation change programmes and health and social care initiatives beyond Gwent Frailty

11. Amongst stakeholders, some expectations of what Gwent Frailty can achieve are high. Gwent Frailty represents a positive start but cannot deliver modernisation and transformation in isolation. There are significant obstacles in relation to culture and working practices within and between agencies, sectors and professions which Gwent Frailty alone cannot address. These include differences in staff terms and conditions, access to services and hours of operation. Some of these are becoming more apparent as Gwent Frailty progresses because it has exposed a range of deficiencies in existing systems, structures, processes and information. Various project workstreams that support Gwent Frailty implementation have been working on tackling these weaknesses within the context of Gwent Frailty, focused on areas such as finance, performance management, information sharing, technology, and Human Resources.

12. The need to make initial progress with Gwent Frailty implementation means that some problems, such as in relation to working practices and information technology, have been worked around rather than solved. Although in the short-term this approach is pragmatic, ultimately, this expediency may slow progress and compromise success. For example, co-locating multi-agency staff within CRTs has supported progress with implementation but staff in the same offices still work on separate systems and the need for greater integration remains an issue in making further progress. Understandably, the focus of Gwent Frailty working groups has been on finding solutions to support implementation. However, achieving transformation requires wider, longer-term, sustainable improvements to working practices, information and communications technology across health and social care.

13. There is a patchwork of local initiatives beyond the scope of Gwent Frailty aimed at, for example: reducing hospital admissions, length of hospital stay and delayed transfers of care; improving community support for a range of conditions; and strengthening arrangements for sharing information and co-ordinating care. These initiatives are not directly connected to Gwent Frailty but impact upon it. Successful delivery of them is necessary to ensure Gwent Frailty realises its full potential and becomes routine practice; requiring a wider programme of co-ordinated investment and transformative change throughout the health and social care system to more closely match capacity to demand. Although theoretical and intellectual links are being made between these initiatives and Gwent Frailty, particularly at senior levels in the partner agencies, it is important that they are actually co-ordinated in practice and demonstrate what positive impact they are having.

14. The Wales Audit Office's recent report for the Health Board '*Transforming unscheduled care and chronic conditions management*' identified that the Health Board is taking a genuinely whole systems approach to service transformation which is having an impact, although some performance levels remained problematic and services were still experiencing significant pressures.

The Gwent Frailty Programme is becoming embedded in the everyday working of community teams although this early progress is not yet consistently underpinned by wider changes needed to support and sustain it, and services to users vary

Adopting a franchise model has enabled the partners to make some early progress and benefits are starting to emerge

15. The partners recognised that across the Gwent area, there are significant differences in the needs of the population. There were significant differences in all aspects of health and social care services prior to Gwent Frailty implementation, including variations in existing service patterns and ways of working. Therefore, designing and implementing a single, uniform, Gwent-wide service model for Gwent Frailty would be unrealistic because of the time this would take and the urgent need to change how services were delivered. Consequently, the partners pragmatically agreed on a franchise approach based upon consistent values and principles but which recognises the different starting points across Gwent for implementing the Gwent Frailty vision and the necessary changes to services.

16. A benefit of a franchise model, which accommodated variations within a broad framework, was that Gwent Frailty could be launched much more quickly without completely overhauling and re-engineering existing services across Gwent to develop a common starting point. The FJC anticipated that 2011-12, the first year of Gwent Frailty implementation, would be a transition from previous service patterns and ways of working to new, integrated CRTs; driving change, bringing greater consistency and creating a platform for future improvements.

17. To date, Gwent Frailty has focused on simplifying processes so that professions, services and agencies work together better and deliver services to people in their homes, working with them to preserve independence and dignity; including bringing together health and social care teams in CRTs where they were not previously co-located. These foundations should begin to deliver better outcomes for service users and their carers in the short-term. Although there are still inconsistencies in practice and problems with integrating IT systems, a number of benefits are starting to emerge, including:

    - interactions between hospital-based clinicians and community social workers are increasing, which is starting to improve joint working;

- CRTs are beginning to be able to access medical and social care information to get a fuller picture of needs, allowing CRTs to meet needs more effectively, although more progress in this area is necessary;
- a better focus on providing the right services to meet user's need at the first point of contact; and
- referrals to Gwent Frailty are increasing, some hospital beds have closed and hospital-based staff have now moved to community teams.

Some changes necessary to support new structures and ways of working are not yet complete

18. Although there are signs that integrated teamwork is delivering some improvements, Gwent Frailty implementation is highlighting shortcomings in existing information systems, working methods, models of delivery and patterns of services; supporting the need for wider change. Furthermore, the need to continue to deliver services within existing unsustainable structures and processes, whilst simultaneously trying to change them in order to support full implementation, gives rise to some practical problems and tensions, for example:

- difficulties which arise in secondary care as staff are moved from acute hospital to community-based working; and
- issues encountered in primary care during roll-out of the SPA and the CRT information portal which supports it.

19. The Health Board is closing hospital beds and plans to move staff from being located in hospitals to being based in community settings as part of a wider commitment to modernising and rationalising its hospital services. Changes to hospital services involving ward closures and bed reductions are always emotive and politically sensitive within communities and impact upon users and staff. Implementing Gwent Frailty requires staff to work in multi-disciplinary, cross-agency, integrated teams. Inevitably, this process is encountering some issues around variations in terms and conditions of employment within joint teams and across localities, which the partner agencies are working with the Trade Unions to deal with, and which will take time to address. Integration of Blaenau Gwent CBC and Caerphilly CBC social services will aid this process.

20. For Gwent Frailty to successfully refocus services on prevention and shift resources from hospital to community settings, hospital-based clinicians need to accept and adopt changes to the way they work. However, it takes time to change behaviours in secondary care. At present, hospital-based clinicians understand and support what Gwent Frailty is trying to achieve but many have yet to see the direct impact on reducing demand for secondary care, which inevitably raises concerns amongst some clinicians about bed reductions and staffing changes. The Health Board is in the process of remodelling services and as part of this is appointing community-based consultant geriatricians, which will help to change working practices and attitudes.

21. Changes to how doctors, nurses, therapists and social workers work raises a number of issues around clinical governance, professional supervision, training and culture as they move from working within individual professional groups to multi-disciplinary teams and from hospital to community settings. These are recognised and are being addressed but are likely to persist for a while.

22. Increasing the emphasis on supporting frail people in the community impacts not only on hospital ward staff and services but also on a range of support services which need to change in order to avoid hospital admissions, speed up discharges and smooth referral patterns to Gwent Frailty. For example, hospital pharmacy and physiotherapy services, which are outside Gwent Frailty but contribute to its objectives, do not currently operate at weekends or out of hours. Across health and social care, wider changes, such as seven day working, are necessary in order to better match capacity to demand.

23. The vision for Gwent Frailty includes a single telephone-based point of access (SPA) to frailty services across Gwent. The SPA will determine how best to address a frail person's needs and handle an estimated 18,000 referrals per year. The SPA is supported by the CRT Portal, an information capture and sharing system based on information and communications technology. Originally, plans for the SPA included direct access for users and their carers and a fast-track service for professionals, including GPs. At present, SPA does not provide public access or a fast-track for professionals. Limitations in IT affecting CRTs, project slippage introducing digital technology in CRTs, problems with information capture and difficulties accommodating access to professionals by GPs mean that SPA function and CRT Portal operation are not yet supporting Gwent Frailty as anticipated. Currently, SPA records that the Gwent Frailty service receives approximately 1,100 referrals per month but this figure is lower than the actual amount received because not all referrals are being made via SPA. Some referrals are coming via e-mail or by direct contact between professionals, without using the SPA.

24. A Gwent Frailty review of how the SPA operates, aimed at identifying improvements, found:

- that GPs prefer direct communication with professionals within the CRTs rather than contact via a call centre operator;
- difficulties identifying how much information to capture, how to record, store, share and access it and also problems with IT systems and the technology to facilitate this;
- variations in Gwent Frailty services, hours of operation and professional practice across localities, giving rise to complexity which is problematic for SPA call handlers trying to match needs to services appropriately;
- the absence of referral criteria for Gwent Frailty and an algorithm for SPA call handlers to check referrals against, leads to CRT staff time being absorbed in filtering referrals to ensure Frailty services are targeted appropriately;

- much of the technology to support the CRT Portal is not yet fully operational so implementing it is proving to be resource intensive, demanding of CRT managers' time and is criticised as overly bureaucratic and leading to duplication; and
- communication and engagement support for SPA implementation was insufficient, due to capacity constraints.

25. The FJC is committed to continuing with SPA implementation but recognises that addressing the problems encountered so far will take time, involve effective engagement and also require investment in training and technology to improve how the CRT Portal operates. Whilst some GPs prefer to speak directly to a care professional rather than to a call operator, many phone calls to the SPA do not require such contact and the costs of providing sufficient numbers of professional staff to operate in this way are prohibitive.

Across Gwent Frailty, frail people with similar needs do not yet receive consistent services

26. Currently, joint teams across Gwent Frailty are following a model which they modify to meet local circumstances. Gwent Frailty is intended to be a six week intervention service for frail adults aged over 18, 365 days per year, seven days per week, from 8am to 8pm. This can be extended to eight weeks if there is an acute episode at the start of the period. There are no specific eligibility criteria for Gwent Frailty; if users fit within the definition of frailty they will be accepted if they are referred by a professional.

27. There are variations in how Gwent Frailty meets similar needs. Within the franchise, service users should get the same standard of service, although it may be provided in different ways. Currently, Gwent Frailty service users living in different areas but with identical needs do not always receive the same service. This is recognised by the partners and there is a commitment to reduce unjustifiable variations over time, as Gwent Frailty implementation progresses. However, across Gwent there are variations in levels of investment in services, what services Gwent Frailty delivers, services' hours of operation and in CRT functions and priorities:

- In Monmouthshire, two regional CRTs operate Gwent Frailty as part of a wider integrated approach to health and social care.
- In Torfaen, Gwent Frailty is delivered by an integrated CRT but not as part of wider approach. The CRT does not include district nurses and does not provide rapid response nursing. Gwent Frailty operates as a weekday service.
- In Caerphilly, a social care-led team delivers Gwent Frailty and has focused on developing community social care services.
- In Newport, the CRT is health-led, delivers a Gwent Frailty service seven days a week and has focused on working with hospitals to promote discharge and reduce delayed transfers of care.

- Blaenau Gwent's CRT is health-led. So far, existing community services have not changed significantly since implementation. The CRT does not provide urgent assessment and intervention or emergency social care services.

28. Because of service variations within Gwent Frailty across localities, patients who would be accepted in one area would not be accepted in another. This does not mean that they do not receive a service, but does mean that they do not benefit from a minimum Gwent Frailty standard of service. Moreover, outside Gwent Frailty there are different eligibility criteria for social care services across Gwent which will affect the packages of care and support which individuals receive and which impact upon their independence.

29. In addition to pre-existing variations in services, within the general Gwent Frailty framework, partners are approaching implementation differently. So far, in order to reduce acute hospital bed days, some CRTs have been focused on hospital discharge. Although this was deliberate, less progress has been made on community support and admission prevention and, to date, any progress which has been made in avoiding hospital admission is difficult to measure.

30. Overall, Gwent Frailty is not yet operating with a full range of services, at weekends or for its planned hours consistently across Gwent. However, a potential advantage of variation is that different approaches can be evaluated in order to encourage innovation and learning. At Gwent Frailty implementation in April 2011, the FJC agreed to undertake a review after a year to evaluate how well the different models are working in practice. This review has not happened yet. Narrowing the extent of unjustified variations, reducing their impact upon service users and carers and ensuring that all services are improving regardless of variations is important to demonstrating the success of Gwent Frailty. Nevertheless, some differences are likely to persist beyond the grant funded lifetime of Gwent Frailty to 2013-14.

31. The Health Board has decided to abolish the locality structure it has operated since it was established. The localities reflected the previous Local Health Boards which mirrored local authority areas. This helped the locality structure to foster communication and joint working with councils but has perpetuated variations in working methods within the Aneurin Bevan Health Board area. The Health Board senior management team expect that removing the locality structure will support the delivery of more consistent services and streamline existing arrangements by reducing management costs, improving internal communications and encouraging more uniform practice. In addition, Caerphilly CBC and Blaenau Gwent CBC are progressing with fully integrating social care services across the two authorities. Together, these developments should encourage greater consistency in the operation of the Gwent Frailty across the Gwent area. However, it should be noted that some council staff are concerned about how the removal of the locality structure within the health board will impact on local, operational joint working.

Programme management for implementing Gwent Frailty is sound but some elements of performance management require strengthening to support governance structures and processes

Partnership structures and arrangements for programme management appear to be working effectively

32. Governance arrangements within Gwent Frailty, and which support the programme's implementation, appear to be sound and working effectively. Specialist legal advisors and consultants gave assistance to draw-up the Section 33 agreement which sets out clearly the partners' respective accountabilities. The FJC is constituted under the Section 33 agreement as a formal decision-making body with equal representation from each partner organisation. As well as underpinning the partnership, the Section 33 agreement also enabled Gwent Frailty to establish a pooled budget. Arrangements for nominated leads to manage areas such as finance and human resources across Gwent Frailty are working well. A nominated lead from Caerphilly CBC acts as the pooled budget manager, with responsibility for drawing down Invest to Save grant funds and also for organising billing and repayments for individual partners. The Welsh Government monitors Gwent Frailty Invest to Save funding.

33. The FJC is supported by operational decision-making at the Operational Co-ordinating Group (OCG), locality planning and commissioning at Local Implementation Groups (LIGs), and operational delivery by the CRTs. In addition, there are a range of specialist sub-groups and, during implementation groups were established with responsibility to make progress in specific workstream areas. Delivery across these workstream projects, which supported implementation, was variable but all of them made progress. Now, of the initial groups, the group covering finance and performance management is continuing, along with groups covering HR and falls management, the others have concluded and have been dissolved.

34. Each CRT has a commissioning plan which represents an agreement, on behalf of the OCG, between the CRT and the lead commissioner, for how services will be delivered. The commissioning plan sets out how each CRT works, based on operational policies and financial frameworks. It identifies how money will be spent and the payback element, how services will be provided, how teams will be staffed, and the CRTs' focus for the coming year. The plans are instrumental in ensuring that commissioning arrangements are consistent across CRTs and in reducing variations in services across Gwent Frailty.

35. A risk register identifies risks to Gwent Frailty delivery and all risks have identified owners and mitigating actions. The register includes risks to the programme due to a failure to realise expected financial savings and also a failure to achieve the necessary shift from hospital to community-based services. However, other variable factors outside Gwent Frailty, within health and social care and more widely within partners, could impact negatively upon it. For example, access to hospital and community services outside Gwent Frailty's remit, which help to support hospital admission avoidance and early discharge. It is important that such risks are identified and that any opportunities to mitigate their occurrence or impact on Gwent Frailty are not missed.

Better use is being made of available information but performance management is hindered by difficulties in gathering relevant data

36. Across health and social care there are longstanding variations and weaknesses in performance information and performance management systems that affect Gwent Frailty. Shortcomings in availability and comparability of baseline information on needs, demand, demographic changes, services, staffing, activity, costs and outcomes, compounded by data sharing problems, hinder robust performance monitoring. The Gwent Frailty performance workstream identified 60 or so indicators that could be used to monitor Gwent Frailty performance and evaluate success, using results or outcome-based accountability model. Because of difficulties gathering this data or in extracting information which has been collected from systems, in practice a more limited data set is in use and is focused mainly upon health with fewer social care indicators. Although the data set has limitations, the format for reporting performance against this data set has been improved and standardised using a dashboard format which includes:
    - referral rates, origins, patterns and categories;
    - reablement service utilisation;
    - occupied bed days and lengths of stay; and
    - delayed transfers of care.
37. At present, performance management information does not facilitate monitoring of: admission avoidance; repeat admissions; the impact of service variations; or changes in complexity and dependency of people admitted to hospital. The performance management project workstream has been combined with the finance workstream o enhance and co-ordinate financial and performance management information to try and address these gaps in order to demonstrate that Gwent Frailty is contributing to improving service performance, outcomes and value for money.

38. As well as facilitating reporting within Gwent Frailty, the dashboard reports form the basis of reports to the Gwent Frailty partners. The Health Board receive reports outlining performance, risks and progress. At present, levels of performance reporting to councils' cabinet and scrutiny of Gwent Frailty by councils scrutiny function are variable. Improvements to performance information and dashboard formats support greater scrutiny by local authority members and there is an appetite amongst them for undertaking joint scrutiny of Gwent Frailty.

39. Despite shortcomings in relation to performance information, there is clear evidence that the available information is being used to review, adapt and improve Gwent Frailty. This learning will be used to inform year two implementation activity, including reducing unjustifiable variations within the Gwent Frailty model and also improving how the SPA and CRT information portal operate.

There are early indications that Gwent Frailty is making some positive progress, although its overall impact will be difficult to evaluate unless its contribution to improving outcomes for frail people can be more clearly defined and measured

Initial feedback from service users is positive and progress on bed closures supports the financial model

40. Despite difficulties in gathering robust operational and management information for identifying performance baselines and monitoring improvement, there are some early indications that Gwent Frailty is making positive progress. Initial feedback from service users indicates improved satisfaction with services and that they are positive about Gwent Frailty. Referrals to Gwent Frailty are increasing, particularly on weekdays and there is clear evidence that GPs and clinicians are supporting the service and using Gwent Frailty as their first choice. There are also some reported improvements against selected indicators for length of hospital stay, hospital discharges and delayed transfers of care.

41. A financial model is in place to manage payback of Invest to Save funding in line with agreed timescales. The savings needed to accomplish this are linked strongly with reductions in hospital beds and resource shifts from acute to community settings. Alternatives to admission and effective discharge arrangements are necessary to achieve this. Progress on bed closures has been made already with a reduction of 24 beds at St Woolos Hospital and 20 beds within the Royal Gwent Hospital. Some staff have moved from working in-hospital to being community-based. Invest to Save funding is paid by the Welsh Government in tranches based on Gwent Frailty reaching progress trigger points. So far, funds have been drawn down broadly in line with the planned Invest to Save profile. However, the benefits planned for Gwent Frailty implementation year one have not been fully realised yet, due to delays in initial investment and also some recruitment problems. Work is underway to streamline recruitment processes in order to reduce the time taken to get staff into posts.

42. The financial model is based on submissions by each council and the Health Board on: the costs of services eligible to be included in Gwent Frailty; the costs of enhancing services to the level and standard required; and predictions of direct and efficiency savings generated by Gwent Frailty. These figures were used to calculate the level of each partner's contribution to the pooled budget and the amount of Invest to Save funding required to support Gwent Frailty and to be paid back. Across the Gwent Frailty partners the submissions, totalling £8.6 million, were not produced on a consistent basis and were hindered by: variations in services; difficulties in separating the services to be included from those which were not; and variations in calculating costs and identifying activity levels. Efforts to improve information quality are ongoing and there have been some revisions to the original submissions. Nevertheless, each partner knows the amount of savings it needs to make, not only to repay the Invest to Save grant funding, but also to generate sufficient money to support a transformation in how services are delivered.

Robust medium-term demand profiling is necessary to ensure Gwent Frailty's sustainability

43. The financial model anticipates that system efficiencies will be generated and reinvested to drive improvements, but the impact of demographic changes and demand patterns upon anticipated efficiency savings is unclear. Although there is widespread awareness that an increasingly aging population will affect demand for services, medium-term demand profiling and impact assessment to assess Gwent Frailty sustainability has not been undertaken. However, there are indications of developing cost pressures in some areas of social care. But it is unclear whether these pressures are linked to Gwent Frailty implementation; if these pressures will reduce as resources are shifted from hospital to community; or if demand growth will lead to increasing pressures, which would be worse but for Gwent Frailty. The FJC recognise the need to improve measures of service performance and outcomes as well as data quality, alongside Gwent Frailty implementation. It is important that better information is not only used to strengthen performance management but is also used to inform robust medium-term plans. In particular, demand profiling is necessary to ensure sustainability.

Greater clarity about Gwent Frailty's contribution to intended outcomes for frail people is necessary to evaluate its success

44. The Gwent Frailty vision is to support frail people to remain 'happily independent'. Other health and social care services beyond the scope of Gwent Frailty contribute to frail peoples' well-being and independence, as do a range of services outside health and social care, for example; services for housing, transport, benefits, and employment. In order to be able to show that Gwent Frailty is fulfilling its purpose, greater clarity is needed about what 'happily independent' means in practice, how agencies and services work together to support it and what the Gwent Frailty contribution to happy independence is.

45. Addressing the 'happily independent' issue is important for the delivery of effective and sustainable services because, without support in the community, frail people will inevitably be drawn back into services due to isolation, dependency and crisis. Gwent Frailty provides short-term intervention which can avoid unnecessary hospitalisation, but, without better co-ordination of a wider range of services, its impact upon its desired outcome will be limited.

46. The inherent complexity of health and social care systems leads to difficulty establishing cause and effect relationships. Combined with problems identifying and measuring outcomes for service users, this complexity means that Gwent Frailty will be hard to evaluate. Success can only be determined on the basis of associations between actions and results and qualitative information gathered from "stories" of users' experiences. There are some clear measures, such as numbers of referrals, which are difficult to link directly to outcomes and reductions in the number of hospital beds, which it will be difficult to attribute solely to Gwent Frailty. Successfully repaying Welsh Government funding is an important outcome for Gwent Frailty, but does not necessarily mean that service users are better off.

47. Gwent Frailty is a key part of the Health Board and wider community's response to the service changes outlined in their '*Clinical Futures*' strategy. If delivered successfully, the approach places the Health Board and its partners well to meet the challenges outlined in the recent Auditor General's report on '*Health Finances*' and the Institute for Health and Social Care report on the '*Best configuration of hospital services for Wales*'.

48. Although still in its early stages of implementation, to date, Gwent Frailty has generated a great deal of interest across the UK from those involved in developing health and social care policy, planning, delivering and receiving services. In early 2012, Gwent Frailty was nominated for a *Municipal Journal* good practice award and was highly commended as a runner-up.

Appendix 1

Action Plan

Page/para	Issue	Recommendation	Intended outcome/ benefit	Agreed	AIB responsibility and actions	Completion date
	P1 Create a single suite of comparative performance information across Gwent Frailty based upon measures of outcomes for users, costs and sustainability. Develop consistent performance baselines against indicators in order to report and monitor progress; evaluate the impact of different approaches within the franchise; support reductions in unjustifiable variations; identify, assess and share good practice.					

Page/para	Issue	Recommendation	Intended outcome/ benefit	Agreed	AIB responsibility and actions	Completion date
	P2 Develop a framework for joint scrutiny of Gwent Frailty across councils, supported by the Gwent Frailty dashboard performance reports, which will also support scrutiny by the Health Board.					
	P3 Agree criteria for referral to, and acceptance by Gwent Frailty to target services more accurately at the intended user group. Engage with GPs and hospital clinicians to ensure referral systems are not bypassed and that referrals to Gwent Frailty are appropriate. To ensure medium-term and long-term sustainability of the programme, clarify the implications of criteria, including profiling: future demand, unit and total costs; hospital admissions, discharges and bed days; benefit realisation; and risks.					

Page/para	Issue	Recommendation	Intended outcome/ benefit	Agreed	AIB responsibility and actions	Completion date
	P4 Address issues identified in the Gwent Frailty review of SPA's first year of operation, including compliance with referral procedures; improving: SPA functionality; calls handling; records access; information processing; and also training and development for CRT and SPA staff as well as referrers.					
	P5 Map out financial plans and demand projections beyond the initial three year plan for Gwent Frailty, to ensure it is sustainable.					

Page/para	Issue	Recommendation	Intended outcome/ benefit	Agreed	AIB responsibility and actions	Completion date
	P6 Undertake the review of Gwent Frailty and CRTs in operation anticipated for the end of year one, to evaluate the effectiveness of different approaches to delivering the service and identify the impact upon Gwent Frailty and its users of: variations in services within Gwent Frailty; and issues and constraints within the wider health and social care system, including seven day and out of hours working.					
	P7 Undertake a fundamental review of the IT programme intended to support Gwent Frailty implementation, encompassing issues including: hardware; software; system integration; data capture; reporting; project scope; and progress.					

Appendix 2

Information specific to Aneurin Bevan Health Board

Aneurin Bevan Health Board	
Area	**Key Issues**
CRT Services	The franchise model is in operation across five authority areas delivering services in slightly different approaches. The Health Board supports this approach as a pragmatic solution to changing services over the medium to long-term. The different service models have caused some initial implementation problems with staff not always being aware of locality differences. Some clinicians feel it has driven a more conservative approach from their junior staff who have been holding on to the patient for a little longer before discharge. The main focus of CRTs has been pulling patients though the system. This has reduced bed demand and Gwent Frailty services helped facilitate the closure of D2 East at RGH. Staff have been offered retraining opportunities and the majority have taken the offer to work in community and CRTs, which is showing resources can be moved from secondary care to primary care, although in this instance funding has not been directly released to support Frailty services from this closure. Up to now, front-line staff have not seen a step change in admission avoidance. There are encouraging signs with performance data from October onwards showing a decrease in A&E attendances, reducing length of stays and fewer admissions from people with chronic conditions. • The SPA is co-located with the Ambulance Trust and the GP Out of Hours Service (OOH). The Health Board sees a direct benefit of co-locating and having the services in close proximity, although the local authorities are more reserved about the need. The benefits of co-locating have still to be fully realised and there is evidence that more needs to be done with the OOH service redirecting patients to CRTs. Some of the reasons have been the number of temporary OOH GPs who have little direct experience of the service, and building knowledge and confidence with service with local GPs and clinicians. • The OCG in December 2011, identified some issues with complying with agreed recruiting processes, causing delays in receiving vacancy approvals. Frailty posts go to some local authority scrutiny committees which can also slow up the process. Some teams have experienced recruitment delays which have contributed to some local variation in providing planned services. There would appear to be benefits in streamlining recruitment processes to overcome delays.

Aneurin Bevan Health Board	
	• Client satisfaction surveys are undertaken but there is some evidence these are not always distributed and are batched processed which can delay information analysis. Improving these arrangements should be a priority going forward. • OGC has identified some concerns with accuracy and quality of performance information, contributing to this has been the introduction of new technology and aligning IT systems for example, delays in introducing the digi-pen system. The demonstration of the full working system to the audit team showed the potential of the system to manage patients effectively and the potential for good quality performance and outcome information. Therefore, the potential for improving information is good. • Currently, all the CRTs are not the meeting targets for accessing rapid medical and rapid other services.
Invest 2 Save Budget	• No specific I2S issues have been identified with the Health Board's approach although future budget pressures may increase the risks on meeting the commitments across the partners.
Local issues	• The most significant challenge will be delivering sustainable services and keeping people happily independent in the community. The Health Board has shown it can deliver an approach which moves patients through the system and there is evidence admission avoidance strategies are starting to work. Maintaining people in their place of residence requires a much more integrated approach with local authorities and the third sector. Without these services there is a risk of patients coming back into secondary care. Currently, there is little evidence of the partners making progress with services that maintain independence in the community once the medical or social need has been managed. • The current model is a medical/professional one and there are benefits in moving the current arrangements to include patient/carer self-referral, which some services had prior to Gwent Frailty being introduced. • Some services need to be remodelled to support the Frailty arrangements, for example pharmacy is only available until midday Saturday and extended the working day, and discharge and access arrangements in physiotherapy. • The pilot of a CRT manager co-locating in the bed bureau revealed more needs to be done with admission avoidance and service diversion.

Appendix 2

Information specific to Monmouthshire County Council

Monmouthshire County Council	
Area	**Key Issues**
CRT Services	Hours of Operation 8:00am until 8:00pm seven days a week.
	The two Integrated Service Teams (ISTs) (equivalent to CRTs) operate as co-located 'teams without walls', reporting to one manager and providing: • Urgent Comprehensive (Health and Social Care) Needs Assessment (9am until 5pm available at weekends). • Rapid Response to Health and Social Care needs, (referrals 9am until 5pm, available 24 hours seven days a week) which may include: – medical diagnosis, treatment and review; – rapid access to investigations and hot clinics; – nursing intervention; and – emergency home care package. • Reablement (from 9 May seven days a week) • Falls management and prevention (from 9 May five days a week with urgent access only at weekend).
	The two ISTs are located in the North and South of the County. The North service is provided from Mardy Park and the South in Chepstow Hospital: The staffing complement across both teams at declaration was 36.2 FTEs: • Urgent response - 0 FTEs • Falls - 0.81 FTEs • Reablement - 8.53 FTEs • START 26.87 - FTEs The service will increase to 49.93 FTEs at end of Invest to Save period: • Urgent response – 10.71 FTEs • Falls - 0.81 FTEs • Reablement - 11.53 FTEs • START – 26.97 FTEs
	• Cost of declared services • Health - £1,289,009 • Social Care - £970,962 • Total - £1,259,977

Monmouthshire County Council

Invest 2 Save Budget

Amount bid for to fund new services:

- Year 1 (2011-12) - £807,727
- Year 2 (2012-13) - £245,189
- Year 3 (2013-14) - £2,000
- Total - £1,054,916

Amount actually drawn down (Year 1) – £253,419 for Monmouthshire. Central costs - £671,299.

Recurring savings required:

Health

- Year 1 - £677,360
- Year 2 - £205,615
- Year 3 - £1,677
- Total - £884,652

Social Care

- Year 1 - £209,796
- Year 2 - £63,684
- Year 3 - £519
- Total - £273,999

Non-recurring savings 2012-13 to 2017-18:

- Monmouthshire CC – £278,659
- Health – No defined sum for MCC area. The savings will be secured across the Health Board and equate to £5,548,888.

Local issues

Performance

- Measures and reporting templates have been developed but have not yet been fully utilised. Different levels of information are being provided by different teams. Monmouthshire's reports include performance measures for example the work of the IST's can confirm that by the end of the second quarter:
  - 342 people had started a reablement service and 55.6 per cent of these were independent at the end of the six week period and did not need long-term support.
  - Delayed Transfers of care (DTOC) PI recorded 13 delays compared to 20 in the same period last year on track to meet our target of no more than 48 in 2011-12.
  - Reduction in the number of older people being supported in residential/nursing homes at 231 which is a reduction from 244 reported at quarter one.
  - Measurement of service user's satisfaction through the Community Care Questionnaire remains high at 93 per cent, just above the partners target of greater than 92 per cent.
  - Satisfaction amongst homecare service users during the first two quarters is 95 per cent.

Monmouthshire County Council

Role of scrutiny/members

- Recent progress reports on GFP have been presented to both Cabinet and Adult Select Committee in March 2012.
- As a result of more frequent communication there appears to be a good understanding of how GFP links to the work of the Council contributing to its Improvement Objective and key strategy and as such is seen as a priority.
- Cabinet has a strategic overview of GFP performance. It is mindful of costs and commitments but less clear on repayments.
- The Council recognises the need to reengineer the delivery of Adult Social Services and is currently exploring a new model and flow based on the Vanguard 'Systems Thinking' methodology.

Service Issues

- MCC and the Health Board already had integrated services for a number of years before GFP so the issue is less of a leap of faith than for other localities. GFP is considered to be part of a wider approach.
- Joint post in Monnow Vale since 2006 under a S33 agreement covering an integrated service manager and integrated health and social care staff.
- Coterminous boundaries between the 2 IST's and Neighbourhood Care Networks (NCN's).
- One strategic management group which meets monthly.
- GFP plans did not include any consideration of growth in demand for services as a result of changes in demographics such as Monmouthshire's aging population, particularly over the age of 90, associated with complex needs.
- Initial phase of delivery has relied on goodwill and flexibility of staff. IST's accept all referrals within the hours of 9 until 5 and respond to them after those core hours.
- Weekend service relies on blackberry system, no portal in operation so duty nurses respond within blackberry rota.
- Currently have no medical arm within the service, a bid is about to be presented to OCG to fund a consultant.
- Impact of rurality on service specification and transport.
- Major benefits since GFP went live include:
  - improved communication/technology such as the portal;
  - more rapid response work and expectation of teamworking and doing things differently; and
  - expansion of team to even broader multi-agency/disciplined group.

Monmouthshire County Council

Sustainability

- The Adult Service's Budget for 2011-12 at month six is forecast to over spend by £406,000 mainly attributable to continuing pressures within the Community Care budgets.
- Used the I2S monies to fund a rapid response nurse service.
- Expected residential bed (6) and acute bed (7) closure considered reasonable.
- Expected community bed closure considered problematical.

Areas to improve

- ISTs do not consider the SPA to be working effectively, and generally it has provided limited benefit. It is not demonstrating VFM. GPs based in the North are more inclined to use the SPA than in the South. There are still a lot of referrals outside of the system so the data reported from the SPA is incomplete and therefore inaccurate.
- Limited numbers of digi-pens are in use. 25 per cent of the 80 district nurses have received theirs, delays in roll-out have impeded the development of management information, such that staff have to capture referrals manually. The system counts referrals when received but when full assessment is completed the referral may change.
- Need improved Ambulance Awareness to develop the falls pathway.
- Strengthening work with the voluntary sector is seen as important, especially developing approaches to meet changing demands by becoming more focussed on hospital discharge arrangements such as service shopping etc. Recognise that patient needs will become more complex such as managing social isolation and befriending in order to prevent re-admission.
- Need to work more closely with Private Sector to buy in-service flexibly and deliver those services which are not cost effective such as night sitting.
- Organisation of consistent multi-agency training whenever relevant such as infection control and manual handling to prevent members if the same team adhering to different regulations.

Appendix 2

Information specific to Newport City Council

Newport City Council	
Area	**Key Issues**
CRT Services	Hours of operation: • Urgent Assessment & Intervention (Hospital@Home/medical model) - five day working (Monday to Friday between 9am and 5pm). • Rapid Response Nursing – seven day working (8am to 8 pm). • Emergency Social Care – seven day working (8am to 8pm). • Reablement – six day working (Monday to Saturday 8am to 5pm). • Falls management – seven day working (8am to 8pm). Newport CRT is co-located in St Woolos Hospital: • Urgent Comprehensive (Health and Social Care) Needs Assessment. • Rapid Response to Health and Social Care needs, which may include: – medical diagnosis, treatment and review; – rapid access to investigations and hot clinics; – nursing intervention; and – emergency home care package. • Reablement. • Falls management and prevention. Management arrangements: • CRT Manager in Newport is a fully integrated post. • Service at declaration included 52.1 FTEs: – Rapid Response Nursing – 6 FTEs; – Falls – 0 FTE; and – Reablement – 45.09 FTEs. • The service will increase to 88.09 FTEs at end of Invest to Save period: – Rapid Response Nursing – 35 FTEs; – Falls – 5.0 FTEs; and – Reablement – 48.09 FTEs. • Health - £683,179 • Social Care - £1,126,428 • Total - £1,809,607

Newport City Council	
Invest 2 Save Budget	Amount bid for to fund new services: • Year 1 (2011-12) - £1,617,026 • Year 2 (2012-13) - £581,510 • Year 3 (2013-14) - £24,180 • Total - £2,222,716
	Amount actually drawn down (Year 1) - £750,349 for Newport. Central costs - £671,299.
	Recurring savings required:
	Health: • Year 1 - £1,102,380 • Year 2 - £396,434 • Year 3 - £16,484 • Total - £1,515,298 Social Care: • Year 1 - £472,875 • Year 2 - £170,054 • Year 3 - £7,071 • Total - £650,000
	Non-recurring savings 2012-13 to 2017-18: • Newport CC – £661,503. • Health – identified savings across Gwent of £5,548,888 which will be secured across the Health Board and not divided into a contribution by local authority boundaries.

Newport City Council	
Local issues	**Performance** • Measures and reporting templates have been developed but these have not been reported against as internal management systems do not capture the right information to be able to judge outcomes in delivering GFP. The Newport CRT Manager is part of a working group which is developing jointly a performance matrix across the Health Board and the local authority. • There is evidence of benefits from GFP in the form of anecdotal evidence – eg, letters and cards from individuals. • Current reported PIs are mainly health focussed and limited evaluation of the social care impact is available. • A challenge for the future is to develop and report on relevant social care performance measures. • Need also to determine clearly the impact of the GFP on the service user to identify what they have experienced and whether the new approach has resulted in better outcomes. • All patients are issued with a 'patient evaluation pro forma' which informs the 'patient stories' work within the Newport area, designed specifically to monitor outcomes. Data from this process will be included in performance matrices going forward. **Role of scrutiny/Members** • GFP has been reported as a distinct project to Housing and Community Services Overview and Scrutiny committee on 12 January 2012. – The report included some performance information and a summary of on-going operational issues. – Each quarter GFP is reported to Scrutiny.

- Cabinet receives six monthly progress reports on GFP, the most recent of which was presented in February 2012.
  - The report included a detailed analysis of referral activity, case closures and individual stories on the service.
  - No information on service cost has been included.

Service coverage

- There has been a significant growth in staff numbers and service coverage in the last 12 months with the team increasing by 45 per cent. Capacity has been increased in services that pre-existed GFP as well as new services being created (falls).
- Clients needing CRT assistance can access services that were not available 18 months ago.
- The focus in first year has been to prioritise hospital discharge and significant effort has been placed on integrating and working with the Royal Gwent hospital to speed up discharge. In addition, the service has been mindful that 50 per cent of referrals come from primary care and consequently a similar level of emphasis has been placed upon this aspect of the team's work.
- Some services that could have been included within the declaration but were not, which in hindsight has been a missed opportunity – eg, Hospital Social Work team.

Sustainability

- The expansion in services to include weekend working is not being utilised effectively with low referrals over weekends from hospitals being received.
  - There is a consultant on weekend call but very few cases are discharged.
  - Hospitals do not provide a seven day service to match the CRT.
  - Discharge processes are not robust at weekend with the pharmacy and transport, for example, not operating to support weekend discharge.
- CRT established on basis of weekend work but not operating anywhere near capacity and currently discharges are backed up until the next working week day.
- The biggest risk is around the variations in service provided within the five localities which anecdotally is presenting a confused picture for secondary care.
- Dementia cases being dealt with are increasing in both complexity and numbers.
- There has been an increase in demand for social care services and some concern that if this continues in the long-term it will be challenging to accommodate within Newport.
- Estimate £700,000 increase in expenditure on 2011-12 social care budgets.

Appendix 2

Information specific Blaenau Gwent County Borough Council

Blaenau Gwent County Borough Council	
Area	**Key Issues**
CRT Services	Hours of operation: • Urgent Assessment & Intervention (Hospital@Home/medical model) - not available as part of CRT. • Rapid Response Nursing – seven day working (8am to 8pm). • Emergency Social Care – not available as part of CRT. • Reablement – six day working (Monday to Saturday 8am to 5pm). • Falls management – six day working (Monday to Saturday 8am to 8pm).
	Blaenau Gwent CRT: Co-located at Ebbw Vale Health Centre: • Urgent Comprehensive (Health and Social Care) Needs Assessment. • Rapid Response to Health and Social Care needs, which may include: – medical diagnosis, treatment and review; – rapid access to investigations and hot clinics; – nursing intervention; and – emergency home care package. • Reablement. • Falls management and prevention.
	Management arrangements: • CRT Manager in Blaenau Gwent is located within Health. • Service at declaration included 22 FTEs: – Rapid Response – 7.5 FTEs. – Reablement – 14.5 FTEs. • The service will increase to 25 FTEs at end of Invest to save period: – Rapid Response – 7.6 FTEs. – Reablement – 17.4 FTEs.
	Cost of declared services: • Health - £678,891. • Social Care - £425,073. • Total - £1,103,964.

Blaenau Gwent County Borough Council

Invest 2 Save Budget

Amount bid for to fund new services:

- Year 1 (2011-12) - £318,590.
- Year 2 (2012-13) - £30,891.
- Year 3 (2013-14) - £2,000.
- Total - £351,481.

Amount actually drawn down (Year 1) - £76,790 for Blaenau Gwent.
Central costs - £671,299.

Recurring savings required:

Health

- Year 1 - £522,464.
- Year 2 - £50,659.
- Year 3 - £3,280.
- Total - £576,403.

Social Care

- Year 1 - £42,239.
- Year 2 - £4,096.
- Year 3 - £267.
- Total - £46,602.

Non-recurring savings 2012-13 to 2017-18:

- Blaenau Gwent CBC – £47,392.
- Health – Identified savings across Gwent of £5,548,888 which will be secured across the Health Board and not divided into a contribution by local authority boundary.

Local issues

Performance

- Measures and reporting templates have been developed but these have not been reported against as internal management systems do not capture the right information to be able to judge outcomes in delivering GFP.
- There is evidence of benefits from GFP in the form of anecdotal evidence – eg, letters and cards from individuals.
- Current reported PIs are mainly health focussed and limited evaluation of the social care impact is available. A challenge for the future is to develop and report on relevant social care performance measures.
- Need also to determine clearly the impact of the GFP on the service user to identify what they have experienced and whether the new approach has resulted in better outcomes.

Role of scrutiny/Members

- GFP has not been reported as a distinct project to scrutiny and limited information has been provided to members to enable effective overview and challenge on services.
- No report has been provided to Cabinet specifically on the GFP in the last 12 month.

- Focus is given to reporting on progress against Blaenau Gwent CBC living independently in Blaenau Gwent strategy and the quarterly standard performance management report.
  - This includes references to GFP but not a detailed summary or evaluation of current progress, challenges, etc.

Service coverage

- There has been little change in how services operated pre-GFP with many already in place prior to the launch of GFP – eg, rapid response and reablement services were in place.
- Unlike other councils, Blaenau Gwent has not included falls service within the CRT.
- Joint management arrangements is beneficial and supports some growth in capacity and removal of duplication.
- Council elected not to utilise I2S monies to grow the service which has constrained its ability to expand coverage. There has been only one new post introduced, and one remains vacant awaiting recruitment.
- Officers have identified that some services that could have been included were not which has limited service availability – eg, the emergency care at home service.
- To expand further requires the integration of existing services not the development of new within Blaenau Gwent – eg, Blaenau Gwent CBC Occupational Therapists will be moving into the CRT.
- In essence therefore there has been little material change since GFP went live in April 2011.

Sustainability

- Not seen significant savings in Blaenau Gwent CBC to date as a lot of the savings have already been realised under the councils 'Living Independently in the 21st century' strategy – eg, residential home closures, development of extra care housing.
- Anticipation is that there will be no significant savings but resources being used in different ways in the future.
- First year focussed on creating the CRT and focussing on improving integration of the service going forward.
- Both Blaenau Gwent CBC and the Health Board believe there is not a large amount of unmet need within Blaenau Gwent and demand will remain stable going forward.
- Blaenau Gwent franchise model is about consolidating and improving what exists rather than expanding coverage.
- Seen a reduction in number of secondary care beds available in Blaenau Gwent - Ysbyty Aneurin Bevan had 96 beds when opened two years ago but now have two-thirds of patients from out of area.

Appendix 2

Information specific Torfaen County Borough Council

Torfaen County Borough Council	
Area	**Key Issues**
CRT Services	Hours of operation: • Urgent Assessment & Intervention (Hospital@Home/medical model) - five day working (Monday to Friday between 8.00am and 8.00pm). • Rapid Response Nursing –included within CRT. • Emergency Social Care – seven day working (7:30am to 10pm). • Reablement – five day working (Monday to Friday between 8:00am to 8.00pm). • Falls management – five day working (Monday to Friday between 8:30am to 4:30pm).
	Co-located in Mamhilad House initially: • Urgent Comprehensive (Health and Social Care) Needs Assessment. • Rapid Response to Health and Social Care needs, which may include: – medical diagnosis, treatment and review; – rapid access to investigations and hot clinics; – nursing intervention; and – Emergency home care package. • Reablement. • Falls management and prevention.
	Management arrangements: • Joint funded CRT Manager in Torfaen is employed by Health Board and line managed by joint funded head of service employed by the Council. • Service at declaration included 41 FTEs: – Rapid Response – 11 FTEs. – Falls – 7.7 FTEs. – Reablement – 22.28 FTEs. • The service will increase to 69.3 FTEs at end of Invest to save period: – Rapid Response – 20.6 FTEs. – Falls – 8.7 FTEs. – Reablement – 39.98 FTEs.
	Declaration cost; • Health - £1,325,533 • Social Care - £440,088 • Total - £1,744,897

Torfaen County Borough Council	
Invest 2 Save Budget	Amount bid for to fund new services: • Year 1 (2011-12) - £989,865 • Year 2 (2012-13) - £158,776 • Year 3 (2013-14) - £105,612 • Total - £1,254,253 Amount actually drawn down (Year 1) - £169,611 for Torfaen. Central costs - £671,299. Recurring savings required: Health • Year 1 - £785,424 • Year 2 - £125,983 • Year 3 - £83,800 • Total - £995,207 Social Care • Year 1 - £275,433 • Year 2 - £44,180 • Year 3 - £29,387 • Total - £349,000 Non-recurring savings 2012-13 to 2017-18: • Torfaen CBC – £354,934 • Health – Identified savings across Gwent of £5,548,888 which will be secured across the Health Board and not divided into a contribution by local authority boundary.
Local issues	**Performance** • Measures and reporting templates have been developed but these have not been reported against as internal management systems do not capture the right information to be able to judge outcomes in delivering GFP. • There is evidence of benefits from GFP in the form of anecdotal evidence – eg, letters and cards from individuals. • Current reported PIs are mainly health focussed and limited evaluation of the social care impact is available. Local authority dataset needs more work but is in development. • A challenge for the future is to develop and report on relevant social care performance measures. • Need also to determine clearly the impact of the GFP on the service user to identify what they have experienced and whether the new approach has resulted in better outcomes. • Establishing baseline KPIs has been difficult and still not overcome. **Role of scrutiny/Members** • Executive Member sits on the Frailty Joint Committee. • GFP has been reported as a distinct project to Healthier Communities Overview and Scrutiny Committee in November 2011. GFP is on the Scrutiny work programme, reports are presented annually including costs.

- The report included some performance information and a summary of on-going operational issues in the establishment of the CRT service from April 2011.

Torfaen County Borough Council

- Cabinet received reports on GFP in the past but nothing in recent months.
- Performance information and impact of the GFP is not reported in detail at this time. Likewise, no information on service cost has been included.

Service coverage

- Torfaen only CRT where the manager has no control over budget.
- The service is now operating at weekends, previously it only operated on weekdays (with the exception of emergency social care) which was different to the other localities.
- Some services not included in Torfaen – District Nursing – which are represented in other localities – Newport, although rapid response is included.
- Had a well-developed intermediate care service to prevent hospital admission prior to launch of GFP .
- Focus in first year of operation shifted with priority to pull people out of the hospital system which limited CRT focus on prevention approach.
- Major benefit of GFP is the additional staff and increased capacity within the service.
- SPA – GP's used to contacting the CRT directly and built up good relationships over several years. Under SPA lost this dialogue and some GPs did not refer people and numbers fell off. This has required the CRT to introduce an enhanced system to allow clinician contact and accommodate some GPs who will not go through the SPA.
- View within CRT is that SPA has not been successful.

Sustainability

- Social care savings will come from reducing packages of care; move to more apprpriate alternatives with telecare; reducing the use of residential and nursing home placements.
- However, none of the models factored in the impact of demographic change and the likelihood that more people will require social care services in the future.
- There needs to be recognition therefore that GFP is unlikely to realise savings and is about using resources differently.
- The biggest risk is around the variations in service provided within the five localities which anecdotally is presenting a confused picture for secondary care.

Appendix 2

Information specific Caerphilly County Borough Council

Caerphilly County Borough Council	
Area	**Key Issues**
CRT Services	Hours of Operation 8:00am until 8:00pm seven days a week.
	Franchise services provided: • Medical model/Hospital@Home. • One IC Consultant already employed, plus additional Consultant post recruited to (Commence August 2011). Will operate limited service Monday to Friday, 9am to 5pm from 4 April 2011. • Rapid Response Nursing as per current provision plus additional recruitment during April service available 8:00am until 8:00pm seven days a week. • Reablement as per current service provision service available 8:00am until 5:00pm five days a week not available at weekends. • Emergency Social Care 24 hours a day seven days a week. • Falls integrated within current service.
	CRT Manager is a Local Authority employee. CRT co-located at Enterprise House Hengoed. • Service at declaration included 71 FTEs: – Rapid Response Nursing – 12 FTEs. – Falls – 0 FTE. – Reablement – 58.49 FTEs. • The service will increase to 75.2 FTEs at end of Invest to Save period: – Rapid Response Nursing – 16 FTEs. – Falls – 0 FTEs. – Reablement – 59.49 FTEs.
	• Health - £2,705,914 • Social Care - £2,167,667 • Total - £4,873,581
Invest 2 Save Budget	Amount bid for to fund new services: • Year 1 (2011-12) - £885,026 • Year 2 (2012-13) - £845,920 • Year 3 (2013-14) - £324,469 • Total - £2,055,415

Caerphilly County Borough Council

Amount actually drawn down (Year 1) - £394,508 for Caerphilly.
Central costs - £671,299.

Recurring savings required:

Health	Social Care
• Year 1 - £639,222	• Year 1 - £179,122
• Year 2 - £610,977	• Year 2 - £171,208
• Year 3 - £234,352	• Year 3 - £65,670
• Total - £1,484,541	• Total - £416,000

Non-recurring savings 2012-13 to 2017-18:

- Caerphilly CBC – £423,074
- Health – No defined sum for Caerphilly CBC area. The savings will be secured across the Health Board and equate to £5,548,888.

Local issues

Performance

- Measures and reporting templates have been developed but have not yet been fully utilised. Different levels of information are being provided by different teams. At present, do not have the right information being presented to demonstrate Value for Money (VfM).
- There is evidence of benefits from GFP in the form of anecdotal evidence – eg, letters and cards from individuals.
- Current reported PIs are mainly health focussed and limited evaluation of the social care impact is available. A challenge for the future is to develop and report on relevant social care performance measures.
- Need also to determine clearly the impact of the GFP on the service user to identify what they have experienced and whether the new approach has resulted in better outcomes.

Role of scrutiny/Members

- GFP reported to one scrutiny meeting since April 2011.
- A further report was planned for May/June 2012 which has been delayed because of the elections.
- Cabinet received reports on progress in January and March 2011. No update on the project has been provided since this time.

Service Issues

- Between the CRT and Assistant Director for Adults Services works effectively through the line management structures. The manager is employed by Local Government and therefore has adopted their terms and conditions.
- GFP primarily brought teams together resulting in a growth in capacity but not a change in of the availability of services.
- Recognise need to expand the involved stakeholders to increase breadth of service and capacity.

- Officers have identified that some services that could have been included were not – eg, community physiotherapists.
- Caerphilly adopted the lead commissioner role and co-ordinates the invest to save budget for the programme.
- Uncertain whether the increase in expenditure is due to CRT models being rolled out or is it increasing demand as a result of demographic changes, people discharged sooner, numbers of referrals are increasing.
- GFP plans did not include any consideration of growth in demand for services and change in demographics.
- Separate to the GFP, Caerphilly is working on costing the demographic changes and to quantify the estimated additional cost.
- One major challenge is that Caerphilly receives often complex discharges from 12 potential hospitals.

Sustainability

- No reduction in costs is being experienced and likely to increase with more cases now being dealt with.
- Emphasis on reducing use of hospitals and increasing support of more clients with complex needs in the community.
- Able to demonstrate some cost avoidance – eg, 60 per cent of people going through the CRT become independent at the end of the six week intervention.
- Currently looking at demographics in Caerphilly which shows significant pressures coming in the next 10-15 years. If applied. these could see a 40–50 per cent increase in demand but it is not clear if it can be afforded?
- The reality of community-based services is that they are high cost from a Social Care perspective. In five years, predict will see a 20 per cent increase in demand which will increase spend on services significantly.
- Political support remains strong at this time but there are some risks acknowledged if benefits in performance are not realised and current increases in spend continue.
- Premise of the programme is considered sound and further work on strengthening implementation and refining working practices are key priorities.

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