Confidential

Gwent Frailty Programme

Review of the Gwent Frailty Programme

September 2014

CordisBright
Consulting

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1 Executive summary

Introduction

This is the final report of the review of the Gwent Frailty Programme (GFP) undertaken by Cordis Bright between March and June 2014. It incorporates comments and suggestions made by members of the Operational Co-ordinating Group and Joint Committee on a first draft report, and includes actions agreed by the OCG and JC for taking the programme forward following the review.

This section presents a summary of the findings, recommendations and OCG and JC response. We have used our findings to attempt to answer the four key questions posed by the Frailty Joint Committee, and to present our recommendations for further improvement of the programme.

Is the service effective?

Based on the views of service users and our analysis of 44 cases, it is clear that people are receiving a very good service, which is timely, responsive and helps them to achieve their aspirations for remaining independent. The GFP initiative also seems to have gone some way towards eliminating what was perceived as a 'postcode lottery' across Gwent, despite concerns about the variations in service provision enabled by the 'franchise model'. It is clear, however, that there is considerable scope for more effective targeting of services for frail people.

It is unclear how cost effective the service is, since no systematic data has been collected on outcomes for individual service users. There are concerns that the programme has not achieved cashable savings as envisaged in the Invest to Save application, and that the funds needed to pay back the investment have not yet been identified.

At the moment management of the service is not nearly as effective as it could be, with confusion over lines of accountability, decision-making and setting the direction. This is a key area for improvement, from which we believe that the benefits of better outcomes, including cost savings, will follow.

What is the impact on other systems?

The impact of the GFP on hospital admissions, length of stay and delayed transfers of care, residential and nursing care admissions and intensive home care packages is not yet proven.

In the report we have recorded and discussed qualitative and anecdotal evidence of avoidance – in terms of cost, hospital admission, transport and rapid discharge. Overall, stakeholders think that the service has reduced pressure on acute services and is effective at both avoiding hospital admissions in the first place and reducing length of stay. However, it is currently not possible to compute quantitative values for the impact on 'avoidance' because:

- There are no reliable records or secure data submitted across the GFP areas on this.

- The portal is inconsistently completed both in specific fields and overall. Neither outcomes nor location are recorded for around 39% of patients on the GFP on the portal.

- No financial records of any savings or cost transfer were submitted, other than the calculations in the business case.

We make a number of recommendations for implementing demand modelling and performance management, which would enable the GFP to better understand the impact of the programme on other systems.

Throughout the report we have stressed the importance of:

- Improved executive leadership focussed on outcomes and quality recording.

- Consistent completion of the recording for every patient.

- Named individuals having responsibility for capturing the data concerning avoidance, cost shifting, cost control and savings.

Is the direction of travel right?

Stakeholders are overwhelmingly of the view that the direction of travel is right. The aims and objectives of the programme match national policy and there is evidence that integrated care can be effective in helping the health and social care system to manage demand whilst providing the outcomes that service users want. We recommend that the GFP should focus on achieving all the objectives originally set for the programme, and not being deterred by the fact that cost savings have not materialised as quickly as originally hoped.

Is information currently collected fit for evidence-led decision-making and service planning?

There is considerable room for improvement in this area as recognised by stakeholders consulted. Information is incomplete in that there is no comprehensive means to ask the right questions, and the data sets themselves contain too many gaps. An improved and multi-faceted performance dashboard is a vital precursor to achieving the desired aims. We have provided suggestions as to how this can be improved in the report.

Recommendations

Recommendations, together with reference to where they appear in the report, are set out in Figure 1 below, which also includes a summary of the OCG/JC response to each recommendation and the actions agreed.

We suggested, and this was accepted, that the top three recommendations that the GFP should prioritise are:

- Adopting the means to provide current evidence of improved outcomes for patients and service users.

- Strengthening leadership and ensuring it is focussed on a) improved outcomes for service users, b) avoidance of admission or early discharge and c) cost-shifting to demonstrate any real savings.

- Each area having a named person with responsibility for achieving a – c above, with clarity on how the dashboard will have reliable data to demonstrate progress.

Figure 1: Summary of recommendations

	Recommendation	Section(s) of the report where this topic is discussed	Rationale and OCG/JC response
1	Continue to implement the GFP as originally planned rather than allow the programme to stall. Re-set target levels of activity and financial savings for the programme after modelling medium term demand. Re-focus the programme more fully on avoiding admission or speeding up discharge. This was the key indicator supporting the health affordability modelling for the business case. Identify where any cost shifting will come from (e.g. closing beds or reducing acute services) and agree specific targets for each organisation and a named lead person to take responsibility for achieving this.	6.9, 5.6	The programme fits with national policy objectives; stakeholders generally agree that the direction of travel is right; people value the service provided, and there is evidence that integration is increasingly effective over time. Response: This was agreed.
2	Appoint a senior leader (effectively a Frailty Programme Director), employed by ABHB. Designate ABHB as the lead agency for the programme. The priority for them is to focus on a) improved outcomes for service users b) avoidance of admission or early discharge and c) cost-shifting to demonstrate any real savings	6.11	The programme is in danger of stalling unless there is clear accountability and strong leadership. It makes sense on a number of fronts for ABHB to be the lead organisation. Response: This recommendation and actions to implement it were agreed. These are detailed in section 6.11.
3	Review the governance structure, including terms of	6.11	The current governance structure is unwieldy; senior

Recommendation		Section(s) of the report where this topic is discussed	Rationale and OCG/JC response
	reference and membership of the Joint Committee and OCG. Suggested structure described in the body of this report.		staff and political leaders need to oversee the programme in different ways, and operational staff need to be able to share learning and formulate proposals for practice. Response: This recommendation and actions to implement it were agreed. These are also detailed in section 6.11.
4	Implement the 'medical model' across all local authority areas.	6.11	There is evidence that the presence of doctors in community teams leads to better outcomes, particularly in the triage stage and in using pathway approaches. Response: It was agreed that the GFP would work towards being able to offer the same level of clinical service across all localities, although the posts employed to deliver it would not necessarily be identical. A working group will be set up under the leadership of a new clinical director to consider how to implement this.
5	Ensure that all areas are providing a consistent service with a similar skill mix and available at a	6.11	We are not advocating complete standardisation, as there has to be some room for local flexibility, but all

	Recommendation	Section(s) of the report where this topic is discussed	Rationale and OCG/JC response
	minimum at the times set out in the core standards.		services should at least be open for referrals until the same times and use shared protocols and templates. Response: This recommendation was modified to make clear that each locality should adopt consistent service principles, but not necessarily a uniform service model. It was agreed that the new programme director would oversee a thorough review of the service model.
6	Develop revised workforce plans across localities and recruit to vacant posts in the newly agreed structure.	8	Recruitment of staff needs to be expedited to ensure that the programme can meet its objectives, with the right people in the right place doing the right things. Response: This was agreed.
7	Adopt a common frailty assessment tool.	3.4, 8	Use of a tried and tested frailty assessment tool would ensure a better understanding of people's needs and facilitate comparison of outcomes across the programme.

Recommendation		Section(s) of the report where this topic is discussed	Rationale and OCG/JC response
			Response: It was agreed that this recommendation concerns operational detail, and should be considered once the new leadership and governance structure is in place.
8	Adopt a case finding approach and tools.	3.4, 8	Case finding of people at risk of hospital admission has been proved to be an effective way of reducing admissions. Response: It was agreed that this recommendation concerns operational detail, and should be considered once the new leadership and governance structure is in place.
9	Ensure referral criteria are explicit and clear.	6.11	This is linked to recommendation 7 above and recommendation 11 below. Response: The recommendation was agreed in principle. Again, the details will be worked though when the new

Recommendation	Section(s) of the report where this topic is discussed	Rationale and OCG/JC response
		director is in place.
10	Be clear within the GFP and with other partners about the 'frailty care pathway' and the role of the GFP within it. 3.4, 8 and Appendix 2	Introducing a clear care pathway, and training staff on its implications, is an effective way of ensuring that people are treated by the right service at the right time. Response: The recommendation was agreed in principle. Again, the details will be worked though when the new director is in place.
11	Introduce triage at the point of referral (SPA) using the frailty assessment tool and employing staff at the appropriate level to do this 6.11 and Appendix 2 Sec 1.2	It is suggested that a Band 7 nurse ought to be available in the SPA to triage calls and carry out an assessment before passing on the referral. Having a common assessment tool would enable the SPA to be used as a triage point rather than as a service which simply passes on calls. Response: This recommendation was rejected. It was agreed that a smaller group would be convened to look at what is needed and how the technology currently in place can best be used.

	Recommendation	Section(s) of the report where this topic is discussed	Rationale and OCG/JC response
12	Continue to embed the IT system and ensure that all partners are using it consistently	6.11	It is vital that the information system is used consistently if data is to be useful for informing performance. Part of the resistance to using the system is likely to be cultural. Response: It was agreed that all staff would be expected to use the Frailty IT system consistently and to report any issues with it. There would be a full review of its use after six months.
13	Introduce a consistent performance reporting framework, covering the various objectives of the GFP, including improving quality of life and avoiding hospital admission, delayed transfers of care and unnecessarily long hospital stays	5.6	This is an essential component of performance improvement. Response: This recommendation was accepted and will be taken forward by a smaller group.
14	Model expected demand for hospital based care over the next five and ten years, using a bed census and demographic information and setting targets for the impact of the GFP on conditions which are amenable to hospital avoidance.	5.6 and Appendix 2 Sec 1.3	If modelling is done, it needs to be rigorous and based on as much service specific data as possible, rather than being based on high level population trends.

Recommendation	Section(s) of the report where this topic is discussed	Rationale and OCG/JC response
		Response: This recommendation was accepted and will be taken forward by a smaller group, with support from the ABHB statistician.
15	Set revised savings targets for the GFP which equate to reductions in LoS, DToC and spells for the identified cohorts, but do not assume closure of hospital beds, which are outside the control of the programme. 5.6	Targets are important, but they need to be achievable in the context of other initiatives and owned by named people who are accountable back to the GFP board. Response: This recommendation was accepted and will be taken forward by a smaller group.
16	Develop a revised marketing and communication strategy aimed particularly at hospital doctors, GPs and social services. 8	External communication has tailed off somewhat as the programme has reconsidered its position, and stakeholders need to be reminded of its role and benefits. Response: This recommendation was accepted and detailed work

Recommendation		Section(s) of the report where this topic is discussed	Rationale and OCG/JC response
			will begin in November.
17	Introduce more consistent communication with all stakeholders, for example regular newsletters for CRTs and other health and social care staff; update the Frailty website.	6.11	There is a general feeling that internal staff do not know enough about the programme and would like to feel part of a greater whole. Involving staff in this way is likely to lead to better professional integration._Response:_This recommendation was accepted and detailed work will begin in November.
18	Introduce a well-publicised structured programme of staff training and learning opportunities	8	Similarly, it is important for staff to feel part of a coherent whole, and for new ways of working to be embedded into practice through training and sharing learning._Response:_This recommendation was agreed and a full programme will be worked out under the guidance of the new Frailty director.
19	Work towards the physical co-location of all staff in each CRT where practical.	8	This may not be appropriate for all services, but does help the process of cross-boundary working where it

Recommendation		Section(s) of the report where this topic is discussed	Rationale and OCG/JC response
			can happen. Response: It was agreed that further co-location of services would be implemented where possible, bearing in mind the constraints of existing buildings.
20	Use Frailty as a starting point to work towards the further integration of primary healthcare and social care in all five local authority areas.	8	There is no reason why the GFP approach cannot be applied across all community-based services, enabling a significant shift from hospital-based to community care. Response: It was noted that this is already happening, and confirmed that this is the desired direction of travel.

2 Introduction

Overview

The Gwent Frailty Partnership (GFP) commissioned Cordis Bright to undertake a review of the Gwent Frailty Programme, a partnership between Aneurin Bevan University Health Board (ABHB) and Blaenau Gwent, Caerphilly, Monmouthshire, Newport and Torfaen local authorities. This report sets out the findings from the review, which took place between March and June 2014, and makes a number of recommendations for taking forward the project.

On the basis of the work we have done, we have made 20 recommendations to the GFP, which are intended to help partners get to a position of consistency, effectiveness and sustainability. The recommendations have already provided a springboard for honest conversations between partners and consideration of the actions needed to take forward this important work. This report has been updated from the first draft to reflect the response of the Operational Co-ordinating Group and Joint Committee to the report and the actions agreed by both groups in response to the review.

Aims and objectives of the evaluation

2.2.1 Aims

The overall aim of the review was to answer the question: *'Is the Gwent Frailty Programme delivering the objectives set out in the original Business Case and are they still fit for purpose?'* The GFP also wanted to know:

- Is the service provision effective?

- What is the impact on other systems?

- Are we going in the right direction?

- Do we have the correct information for decision-making and service planning?

2.2.2 Objectives

The objectives of the review, as set out in the invitation to tender, were to:

- Provide a rapid review/synthesis of the existing evidence of effectiveness of integrated care projects.

- Establish and describe the level and nature of current service provision across the five localities and compare consistency of the care pathways provided by each Community Resource Team (CRT) / Integrated Services Team (IST) in relation to the agreed Frailty Franchise model.

- To measure the relative effectiveness of the models across the localities, in terms of:

  - Service users receive, the right service, from the right person at the right time

  - Reduction in acute and community beds

  - Reduction in packages of care

  - Reduction in residential and nursing placements

  - Number of Frail people presenting at A&E

  - Reduction in the number of WAST Conveyances to hospital

- Establish the current level of professional and service integration, across the whole system.

- Ascertain reasons for unnecessary hospital admission for the GFP cohort of patients and what is needed to prevent admission and support the person in a community environment.

- Consider how the raising ageing population will impact on the future development of the programme.

- Understand the impact of the increasing age of patients who are being admitted to hospital and / or to long term care.

- Understand if the service is being managed effectively and efficiently, including communication, timely service delivery, capacity management and coordination of care.

- Provide recommendations with regards to the effectiveness of the services and future direction of travel.

- Produce an evaluation progress report for the Gwent Frailty Joint Committee summarising the findings and implications for the future development of the Gwent Frailty Programme.

Methodology

The methodology proposed for the review and agreed with the Programme Joint Committee (JC) comprised:

- A rapid review of the evidence of effectiveness of integrated care projects across the UK and a selection of other countries with comparable systems.

- Quantitative analysis of activity, financial, outcome and other data provided by the GFP and accessed by Cordis Bright via GP Cluster Profiles for ABHB and the DAFFODIL population database.

- An on-line quantitative survey of 248 key professional stakeholders, including staff working in the programme, other health and social care staff and senior leaders.

- A hard-copy quantitative survey of 200 service users distributed via existing Community Resource Team networks, to ascertain their views about the effectiveness and appropriateness of the service they received.

- Semi structured face to face interviews with a sample of fifteen senior staff from all participating agencies.

- Outcomes focused case studies of the patient journey and outcomes achieved for 44 service users.

- A day long workshop with members of the Operational Co-ordinating Group (OCG) to test and refine the recommendations and to come up with an action plan for implementation.

- Discussion and sign-off by the Joint Committee of the recommendations put forward by the OCG.

Challenges and limitations

2.4.1   Limitations of the available data

There has been an understandable focus on whether or not the GFP has resulted in cost savings, but no reliable way to measure these and, critically, be able to attribute them to the impact of the GFP. In addition, because some partners are reluctant to use the common information portal, there are gaps in the data on service activity.

In the report we have recorded and discussed qualitative and anecdotal evidence of avoidance – in terms of cost, hospital admission, transport and rapid discharge. However, it is currently not possible to compute quantitative values for the impact on 'avoidance' because:

- There are no reliable records or secure data submitted across the GFP areas on this.

- The portal is inconsistently completed both in specific fields and overall. Outcomes nor location are recorded for 39% of patients on the GFP on the portal.

- No financial records of any savings or cost transfer were submitted, other than the calculations in the business case

Throughout the report we have stressed the importance of:

- Improved executive leadership focussed on outcomes and quality recording

- Consistent completion of the recording for every patient

- Named individuals having responsibility for capturing the data concerning avoidance, cost shifting, cost control and savings

2.4.2   The challenge of leadership

The key and underlying issue for the GFP has been a lack of clear leadership over the past two years. This has led to uncertainty and indecision, as partners are unsure to whom they are accountable and who is driving the project. Meetings are inefficient, as time is taken up discussing issues, but actions are not consistently followed up. The Programme does not have a clear performance management framework by which to measures all aspects of the effectiveness of the programme. These issues have created a context in which, to draw conclusions about the effectiveness of the GFP, we have had to rely on literature on good practice and analysing respondents' perceptions, rather than hard quantitative evidence.

Report structure

The remainder of this report is structured as follows:

- **Section 3** contains a review of studies of the effectiveness of integrated care.

- **Section 4** describes the Frailty programme and the services provided in each locality.

- **Section 5** contains a review of performance of the programme so far against its original objectives.

- **Section 6** present stakeholders' views on and our analysis of governance and management in the GFP.

- **Section 7** explores the experiences of service users.

- **Section 8** contains concluding remarks and a summary assessment of the progress the GFP has made against the 'success factors' identified in the literature.

3 The effectiveness of integrated care projects: rapid evidence review

Introduction

As a starting point for understanding how the GFP is performing, we conducted a review of the literature on integrated care. The purpose of the review was to: (a) find evidence of "what works" in integrated care for frail people and, in particular, which interventions are most effective in reducing hospital admissions, and (b) to be able to measure the effectiveness of the GFP against evidence of good practice.

We developed a bibliography using the following search terms, agreed with the GFP, in Google Scholar:

Primary search terms	Secondary search terms
"Integrated care"	"Evaluation"
"Organisational integration"	"Research"
"Integrated services"	"Frailty"
"Integrated health"	"Older People"
"Integrated health and care"	"Cost"
	"Benefits"
	"Effectiveness"
	"Cost effectiveness"
	"Savings"
	"Outcomes"
	"Impact"
	"Best practice"
	"Typologies"
	"Models"

Each primary search term was searched in combination with each secondary search term (e.g., "integrated care" + "evaluation"). This resulted in 70 distinct searches. We looked

at the first 50 articles for each combined search term, for a total of 3,500 articles. Abstracts were scanned for all potentially relevant, publicly available articles, and the most appropriate articles were chosen for the bibliography. A regular Google search was also conducted using the primary search terms to make sure key UK literature not found in journals was also included in the bibliography.

We also included relevant Welsh policy documentation in this literature review.

Appendix one contains a list of documents reviewed. Numbers in brackets in the text in this section refer to sources listed in Appendix one[1].

Definitions

3.2.1   Frailty

Frailty is a term which is used widely to describe a physical or mental state, but also has a specific clinical definition. A useful and up-to-date working definition of frailty and its relationship with integrated care appears in a recent guide by NHS England:

> *Our starting position has to be an understanding of frailty as a distinctive state related to the ageing process, as multiple body systems gradually lose their in-built reserves. This means the person is vulnerable to sudden changes in health triggered by seemingly small events such as a minor infection or a change in medication. A person therefore typically presents in crisis with the 'classic' frailty syndromes of delirium, sudden immobility or a fall (and subsequent unsafe walking). There is strong evidence that medical assessment within two hours, followed by specific treatment, supportive care and rehabilitation, is associated with lower mortality, greater independence and reduced need for long-term care.*

NHS England (2014). Safe, compassionate care for frail older people using an integrated care pathway: Practical guidance for commissioners, providers and nursing, medical and allied health professional leaders

The GFP is aimed not only at older people but at anybody who presents as 'frail'. However, the reality is that frailty is closely associated with older age, and the vast majority of individuals receiving a service from Community Resource Teams (CRTs) are aged over 65.

A care pathway for frail older people reorganises services around the patient and provides care at all stages of the patient journey from healthy, active ageing through to end-of-life care. If frail older people are supported in living independently and understanding their long-term conditions, and educated to manage them effectively, they are less likely to reach crisis, require urgent care support and experience harm. When a frail older person requires admission to hospital, best practice models will help to ensure timely discharge. These include 'discharge to assess' where patients are discharged once they are medically

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[1] This is available as a separate report.

fit and have an assessment with the appropriate members of the social care and community intermediate care teams in their own home.

3.2.2 Integrated care

The Integrated Care Network (quoted in 13[2]) defines integrated care as '*a single system of needs assessment, service commissioning and/or service provision'*, whilst the World Health Organisation recognises the different models that exist and describes a range of vertical and/or horizontal integration happening across organisational boundaries. In the Welsh Government's framework for delivering integrated care (45), integration is defined from the perspective of the service user: *My care is planned by me with people working together to understand me, my family, and carer(s), giving me control, and bringing together services to achieve the outcomes important to me.* (p.4)

Financially, there is a growing body of evidence which points to the need to have an integrated care pathway in place to prevent harm and additional costs to the system (48). Currently costs can be quantified in terms of harm related to pressure sores, urinary catheterisation, urinary-tract infection and falls that lead to increased morbidity, suffering, extended length of stay and increased risk of not returning to usual place of residence, with the subsequent cost of care home placements.

National policy context

One of the determinants of effective integrated care is a supportive policy context (13). The Welsh Government has made clear its intention to encourage the health and social care system to move towards greater integration in order to achieve better outcomes for individuals and to address rising demand from an ageing population.

Policy in Wales has been dominated by a desire to prioritise public health and tackle health inequalities, and promote the benefits of collaboration between public services – and especially the NHS and local government – in joint efforts to improve well-being and to deliver seamless services which place the citizen at their heart. With 22 unitary authorities, responsible for all local government services, Wales has a relatively large number of small local government services, with the attendant difficulties in ensuring critical mass and avoiding inefficiency. Until 2009 local health boards (LHBs) were coterminous with local authorities. LHBs commissioned services from more than a dozen NHS trusts, a situation which was eventually recognised as untenable. The formal merger of commissioning and providing functions into seven new LHBs was intended, in part, to incentivise the system locally to review all aspects of the patient pathway to ensure that care and support were provided where they best met the needs of the citizen.

In terms of overcoming organisational barriers to collaboration, one theoretical advantage enjoyed in Wales is the existence of integrated health bodies, having responsibility for the totality of health care provision for substantial populations. Since each LHB receives a single allocation for primary, community, secondary and public health provision, and holds the contracts for all staff, it is therefore relatively unconstrained by external factors

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[2] Appendix one contains a list of documents reviewed. Numbers in brackets in the text in this section refer to sources listed in Appendix one. The appendices to this report are available as a separate document.

in its ability to shift or reshape services. Clearly, however, there are still challenges for the LHBs in collaborating with a number of local authorities and in working with acute services which are not coterminous.

The Social Services and Wellbeing (Wales) Act 2014 includes provision for co-operation between local authorities and other bodies, and requirements on local authorities to promote the integration of health and social care services. The accompanying notes to the Act mention that partnership arrangements between local authorities and between them and Local Health Boards may be prescribed through regulations.

The Welsh Government has also published a range of reports and guidance on integrated care (see for example 13, 44, and 45). Alongside this, a draft national outcomes framework for people who need care and support (47) has recently been published. This represents a significant step in measuring progress towards transforming services so that they meet the needs of the individual. It is expected that a final outcomes framework and measurement tools will be ready to support the Social Services and Wellbeing (Wales) Act going live in 2016, although there is no reason why local partnerships should not begin to adopt the approaches suggested to measure outcomes for current service users.

The Welsh Government's intentions are summarised in its *Framework for Delivering Integrated Health and Social Care for Older People with Complex Needs* (45). These outcomes could be generalised to all who fall into the category of 'frail', not only older people. Ministers say that they want integrated services that enable older people and their carers to:

- Be well informed and supported to actively engage in decisions relating to their care and support – with coproduction being the way services are designed and delivered.

- Achieve and maintain good health and well-being.

- To have easy access to services, care and support that is integrated and co-ordinated and easy to use.

- Get the help they need, when they need it and in the way they want it.

- Have access to services, care and support, at home or in the community setting.

- Receive high quality services, care and support, ensuring their rights are respected and individual circumstances considered.

- Only access hospital services when they are required – not because of a lack of other community services.

- Find services are well planned and organised, where they live in Wales.

- Have more options for accessing services, care and support (including face to face and electronic access).

Key success factors for integrated care projects

3.4.1 Introduction

It is clear from the literature that turning the aspirations of policy into reality on the ground is not easy. However, a number of research studies from the UK and elsewhere have identified the factors which determine the success of integrated care projects, and we have summarised these under the following headings:

Overarching factors:

- Starting from a focus on individuals

- A supportive legislative and policy context

Service factors:

- A clear care pathway for frail people (incorporating comprehensive services across the continuum of care and standardised care delivery)

- Physician integration

- Case finding

- Comprehensive geriatric assessment

Organisational factors:

- Clear and effective leadership

- Effective communication of aims and objectives

- Governance structure

- Performance management (including measuring outcomes and financial management)

- Information systems

- A culture of collaboration

- A culture of learning

- Solution focussed thinking and 'how to' leadership

- Organisational development and workforce planning focussed on integrated care

The remainder of this section looks at the evidence for each of these success factors and explores how the findings from the literature can be translated into practice at a local level.

3.4.2   Starting from a focus on individuals

The King's Fund, Department of Health, Welsh Government and others (3,4,5,10,11,13) emphasise that integrated care projects must be driven by the needs of patients and service users rather than the needs of organisations and professions. Conversely, organisations that fail to place the patient or service user at the centre of their integration efforts are unlikely to succeed.

In practice, patient focus is reflected by population-based needs assessments that drive service planning and information management, and the desire to redesign internal processes to improve patient satisfaction and outcomes. Services demonstrate market sensitivity and responsiveness to changing needs of the population, ensuring – as the GFP recognises - the person receives the *'right care at the right place at the right time'*. This requires a thorough understanding of the way in which people move within and between different health and social care providers.

Integrated health systems should be easy for patients to navigate, and the importance of involving the communities served in the design of services, as well as getting feedback from users, has been stressed (11). Put simply, service users and carers do not care about the structures and processes adopted by health and social care agencies; what they do care about is the timeliness, flexibility, responsiveness and suitability of the services they receive.

3.4.3   A supportive legislative and policy context

Much of the commentary on integrated care highlights the importance of a legislative and policy framework that consistently supports and encourages integration (see 45 for a summary of evidence). Ham and Oldham (2009) recommend that government encouragement should be *'tight on ends and loose on means'* (4), noting that this is the approach most likely to deliver the desired outcomes.

As noted in the section on policy context above, the Welsh Government plans to go further in providing incentives for integration in health and social care, in addition to the existing 'Invest to Save' and 'Intermediate Care Fund' incentives. This aspiration is also reflected in initiatives from other countries, for example, the UK Government's 'Better Care Fund', which will compel health and social care commissioners to pool budgets to provide preventative, integrated services. It should be noted, however, that at the time of writing the implementation of the Better Care Fund is being reviewed, following Cabinet Office concerns that the financial savings claimed in draft Better Care Fund plans do not appear credible.

3.4.4   A clear care pathway for frail people

Practitioners and policy makers agree on the need for a clear care pathway, which includes all elements of the health and social care system. The King's Fund have set out the essential stages in an end-to-end pathway of care for frail older people (10), and these are summarised in Figure 2 below. NHS England (48) notes that frailty is a complex and fluctuating syndrome. Patients will enter the pathway at different levels, or may require identification in primary care in order to access appropriate services along the pathway. However, identification of frail people and the level of frailty can be a challenge. If possible, integrated

care projects should bring together all stages of the care pathway within a defined locality, and should include not only statutory health and social care but also third sector agencies (4).

Figure 2: Essential elements of an end to end care pathway for frail older people
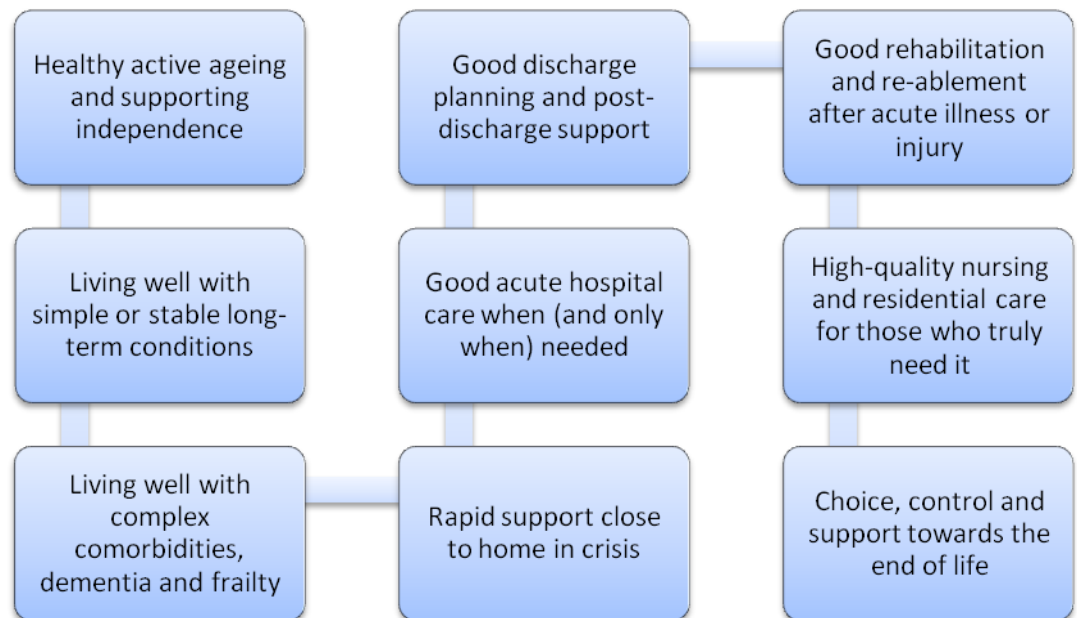
Diagram developed using care pathway set out in David Oliver, Catherine Foot, and Richard Humphries. (2014). Making our health and care systems fit for an ageing population. *The King's Fund*

All the studies we reviewed recognise that the needs of frail people may be met in a variety of settings and by a range of agencies, with the overall aim of providing care as close to home as possible and giving people as much responsibility for their own care as possible. These aspirations are summarised succinctly in Figure 3, which depicts care for frail people as a continuous process.

Figure 3: Summary of a model integrated care pathway
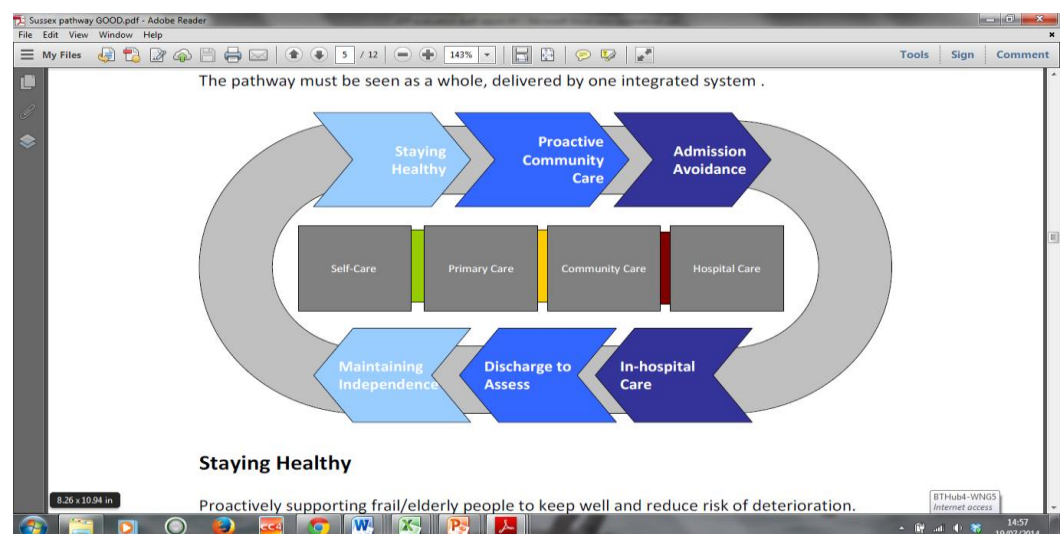
Source: Dr K Armstrong (2012). Proactively Caring for the Elderly and Those with Complex Need in Sussex.

3.4.5 Physician integration

Suter et al (2009) note that: *physicians need to be effectively integrated at all levels of the system and play leadership roles in the design, implementation and operation of an integrated health system* (11). They also point to findings from the literature which suggest that integrating physicians into care teams is not always easy, with shared decision making and inter-professional teams the key difficulties for doctors. However, they also conclude that integration of doctors at all levels of the care pathway is a key success factor in making sure that integrated care works for the patient and that more care is delivered away from hospital settings.

3.4.6 Case finding and case management

As noted in the King's Fund's report in 2010 (6), evaluations of preventative services and integrated care consistently show that case finding and pro-active case management - particularly of people with complex conditions – are effective tools for helping to avoid hospital admissions.

At present, clinicians do not formally 'diagnose' frailty or identify it with a specific 'code'. This makes systematic case-finding and proactive care difficult. Older people with frailty can be readily identified and are usually known to local professionals. They usually have weak muscles and, often, conditions like arthritis, poor eyesight, deafness and memory problems. They typically walk slowly, get exhausted easily and struggle to get out of a chair or climb stairs. However, there are many screening tools available to identify frail people. NHS England (48) gives examples of the following tools:

> *The gait speed test (Studenski et al, 2011) is a valid predictor, and can be used to support carers, relatives and volunteers in identifying frail people to health and social care services. The Edmonton Scale (Hilmer et al, 2009) can be used in primary and community care. An electronic frailty index (EFI) (Trueland, 2013) is under development by Dr Andrew Clegg and colleagues at Leeds University; it uses indicators of frailty coded on general practice systems to identify frail people for further screening and assessment.*

The Frailty Index[3], summarised in Figure 4, developed by researchers at Dalhousie University, Canada, is a useful tool, in that enables an individual to be assessed according to continuum of states of frailty by a suitably qualified person trained in the use of the tool. The Frailty Index categorises people into one of nine 'frailty states', and is already being used in Newport to help determine which services people need.

Figure 4: The Frailty Index

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[3] http://geriatricresearch.medicine.dal.ca/clinical_frailty_scale.htm last accessed 21 July 2014.

Risk prediction models have been used successfully by integrated teams elsewhere, notably in Cornwall (see Appendix two for details), for example, PARR++ (The King's Fund). These use patient-based data to predict future likelihood of admission. They can be valuable to GPs and community services in identifying at-risk patients.

3.4.7   Comprehensive geriatric assessment

NHS England (49) gives a clear steer on the use of comprehensive geriatric assessments for people identified as frail (British Geriatrics Society, 2010). This is defined as a *'multi-dimensional interdisciplinary diagnostic process focused on determining a frail older person's medical, psychological and functional capability in order to develop a coordinated and integrated plan for treatment and long-term follow-up'*. Comprehensive Geriatric Assessment (CGA) has a very strong evidence base for effectiveness and has been shown to increase patients' likelihood of being alive and in their own homes after an emergency admission to hospital. This is associated with a potential cost reduction compared with general medical care (Ellis et al, 2011). In terms of Numbers Needed to Treat (NNT), to avoid one long-term care placement, for CGA the number is 20.

The domains of a CGA are summarised in Figure 5.

Figure 5: domains of a Comprehensive Geriatric Assessment

Organisations may wish to develop their own assessment templates and documentation; however, the domains described above must be included as a minimum in an effective CGA. In addition, a multi-disciplinary team should deliver the CGA. This must include as a minimum:

- A competent specialist physician in medical care of older people.

- A coordinating specialist nurse with experience.

- A senior social worker or a specialist nurse who is also a care manager with direct access to care services.

- Dedicated appropriate therapists.

- The older person and their family, carers or friends (BGS, 2010)

3.4.8 Clear and effective leadership

Leadership from the top – at board and elected member level – is cited as a success factor in the majority of evaluations which have looked at how integrated care projects work (45,7,11,15,24). But there also needs to be a clear clinical vision and someone who is responsible for driving the programme. This is sometimes achieved through organisational structures, e.g. care trusts in England, but may be achieved through the creation of a senior post, e.g. a joint director of social care and health in a locality (4). Critically, the King's Fund (4) and Nuffield Trust (24) find that devising new organisational structures is less important than collaborative behaviour.

3.4.9 Effective communication of aims and objectives

A literature review by Cameron and Lart (2003) (cited in 15) highlighted the importance to successful joint working of clear, realistic and achievable aims and objectives, understood and accepted by all partners. Good communication improves the ability of teams to work together successfully, while clear communication structures are needed to keep all staff aware of, and involved in, the processes surrounding integrated care, design and implementation. (11)

3.4.10 Governance structure

Governance and management of funds are also critical success factors. Pooled funds are a key driver of integration, but the governance structures underpinning them need to be clear.

3.4.11 Performance management

Measurement is critical to the effective evaluation of any commissioning intervention; it is crucial that good measures are identified and reviewed from the beginning of the commissioning process. This is not only important in the context of final evaluation, but also in identifying areas for improvement and evidencing whether a change or intervention is a success. Outcome measures are of key importance, but process and balancing measures should not be excluded. These can be very useful in determining effective change and action in the short term, especially where an intervention is particularly complex or where outcome measures can take a long time to determine. It is recommended that measures to evaluate the implementation of any frail older people's pathways are based on the following categories (24):

- **Patient experience:** where patients themselves have provided feedback on the quality or effectiveness of the service they have received.

- **Harm reduction:** where outcome measures indicate whether harm to frail older patients has occurred.

- **Quality of life:** whether or not frail older patients are able to maintain reasonable quality of life after contact with health services.

- **Systems supporting older people:** where measures relate to the systems that treat frail older patients, and whether these support improvements in care.

- **Financial:** where indicators show any savings released as a result of changes to the pathway.

3.4.12 Information systems

When implementing new ways of working which have challenging financial targets attached, it is critical to be able to track progress. Studies (for example, 11) have found that success depends on robust information systems for rapid communication between sectors and organisations and within teams, including using a single record gathered from shared assessments. This is only possible with an IT system that allows data management and effective tracking of activity and outcomes.

Quality information systems also enhance communication capacity and information flow across integrated pathways. Electronic health records link users, commissioners and providers across the continuum of care and provide relevant information to these stakeholder groups. It is essential that information can be accessed from anywhere in the health and social care system, even in remote locations, to facilitate seamless communication between providers. The information system should also enable system wide patient registration and scheduling coordination as well as management of clinical data. The ability to integrate clinical and financial information is viewed as important for monitoring cost-effectiveness and facilitating service planning.

Developing and implementing integrated electronic systems is time-consuming, complex and costly. Poorly designed electronic information systems, systems that are not used by providers, lack of a clear business plan, lack of common standards, inadequate training and incentives for providers to participate, poor technology solutions and ineffective leadership all contribute to failure of information integration (11,13).

3.4.13 A culture of collaboration

Clashing cultures, such as differences between providers of medical services and long-term care services, or between physicians and other service providers, is one of the reasons named for failed integration efforts. Another cultural barrier to integration is an acute care mind set, which places the hospital at the centre of the integration process (see 11 and 13).

To make integrated services work, staff must be able to put the interests of service users before professional cultural norms, and must be prepared to work in different ways. There are examples from some of the integrated care pilots in England (33) of projects which have floundered because of professional protectionism and failure of teams to be able to work in a truly collaborative way.

3.4.14 A culture of learning

For staff to become comfortable in integrated teams there needs to be a culture of learning and practical opportunities for staff to share experiences of what has and has not worked. Where this is not present, silo working tends to persist, despite structural organisational change. In particular, cross-disciplinary teams need to be brought together for training and learning (15).

Barriers to effectiveness

In addition to the success factors described above, possible barriers to the implementation of effective integrated services can be summarised as:

- **Time**: Integrated care typically can take five years or more to deliver on the planned objectives and become self-sustaining. However, service leaders and policy makers are keen to see change happen at scale and pace. There is a risk that if projects do not deliver immediate financial benefits they may be deemed unsuccessful and abandoned. As the Welsh Government acknowledges (13), in some parts of Wales, services are reluctant to embrace integrated working, often either because they are nervous about the ability of other services to deliver for

their clients or they are worried about the possible reduction in their own resources. Persuading them of the desirability of change takes a long time and requires major cultural change.

- **Distractions**: such as structural re-organisation imposed by central government. Helpfully, there is no prospect of further structural reorganisation of health services in Wales, which avoids one major possible source of turbulence, although there is some exploration of mergers between social services departments and local authority reorganisation.

- **Misaligned performance indicators and financial incentives**: typically, financial savings through integrated care projects are realised in the acute sector, while the majority of the services provided are based in primary and social care. The evaluation of the English integrated care pilots found that reluctance to shift resources across the system was a key barrier to integration.

- **Reluctance to learn from elsewhere**: there is a considerable body of evidence of what works in integrated care, and independent organisations such as the Nuffield Trust, King's Fund and Health Foundation have collated much of this into accessible documents for practitioners. It is important for projects to be able to learn from what has happened elsewhere and to introduce continuous evaluation into their work to ensure that formative learning also happens.

Is integrated care cost effective?

Initiatives to integrate care are frequently driven by a need to contain cost, yet, investing in integrated care does not necessarily imply an economic gain. This will depend on the part of the cost associated with the level of need that can be averted or reduced through the intervention set against the cost of carrying out the initiative in question (46). The development of integrated care teams needs to occur in parallel with decommissioning of services or facilities for there to be any cashable savings, otherwise the gain is largely in quality and timeliness of service delivery.

One of the key challenges to assessing the economic impact of complex interventions such as integrated care is the need to have a robust comparison strategy to isolate effects that can be attributed to the intervention from those that would have occurred without it (the counterfactual). The most reliable way to do this is through a randomised controlled trial (RCT). Essentially this involves identifying a group of people using the Frailty service and 'matching' them with people with similar characteristics who are not using the service, to see whether there is any difference in outcomes and use of health and social care services over time. The Nuffield Trust have used this method to evaluate integrated care projects in England (24), and identified small financial savings for some patient groups, but it is expensive and time-intensive to implement in the context of one local evaluation.

Nolte and Pitchforth (2014) (46) have carried out a review of 19 studies on the economic impacts of integrated care. They found that, due to the design of the studies, it was difficult to draw definitive conclusions about the financial benefits. They also noted, however, that it is difficult to identify a direct causal link between integrated care projects and the economic outcomes sometimes claimed for these projects.

They suggest that there may be a need to revisit our understanding of what integrated care is. It is important to come to an understanding as to whether integrated care is an intervention that, by implication, ought to be cost-effective and support financial sustainability, or whether it is a complex strategy to innovate and implement long-lasting change in the way services in the health and social care sectors are being delivered and that involve multiple changes at multiple levels. Nolte and Pitchforth suggest the latter, and propose that initiatives and strategies underway will require continuous evaluation over extended periods of time to enable assessment of their impacts on both economic and health outcomes. They also note that the complexity and variability of related interventions and programmes calls for the use of mixed-method research methods.

4 Current service provision

Introduction

This section looks at the aims and objectives of the GFP, the context in which it is operating and the configuration of services across the five localities which have been set up to meet the objectives. It is based on information provided by the GFP; information supplied to Cordis Bright by CRTs in the five localities, and analysis of demographic data drawn from GP cluster profiles[4] and the DAFFODIL[5] population database.

Overview of the Gwent Frailty Programme

The overarching aim of the GFP is to redesign health and social care services around the interests of frail service users with the key outcome of frail people being 'happily independent'[6]. The Programme aims to change the current system so that:

- More people remain independent in their homes and communities for longer.

- Services are timely and responsive and avert crisis and promote independence.

- Individuals and carers are listened to and worked with.

- People are pulled out of hospitals and institutional settings, rather than being pushed into them.

The GFP is based on listening to and seeing people as individuals in the context of their own lives. The service re-design programme aims to develop a model for delivery of health and social care service that:

- Brings together professionals in each locality into a Community Resource Team (CRT) to ensure there is access to the right professional and/or service at the time when it is most needed.

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[4] Public Health Wales Observatory (2013) GP Cluster Profiles: Aneurin Bevan HB

[5] www.daffodilcymru.org.uk www.daffodilcymru.org.uk

[6] 'Happily Independent ': Gwent Frailty Programme Communication and Engagement Strategy

- Co-ordinates communication so that service users have one key person who can guide them through the system and be their main point of contact.

- Delivers the right level of response that can change according to how much support a service user needs at any particular time.

- Helps users of the service to remain independent where this is a realistic expectation.

- Delivers care in or close to people's own homes, and avoids unnecessary hospital admissions.[7]

The GFP aimed to adopt an outcomes-based approach. The CRTs focus on delivering the following user experiences which require an integrated health and social care response:

- Being able to remain living in their own home with support.

- Receiving services in their home.

- Being listened to by people who are responsible for providing services to assist them.

- Having their health and social care problems solved quickly and considered as a whole rather than individually.

The integrated Community Resource Teams are designed to intervene to support an individual to:

- Avert pending health and/or social crisis wherever possible.

- Operate a 'pull system' away from hospital admission to support through the crisis and restore/maintain independence.

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[7] Gwent Frailty Programme - Community Resource Teams Operational Policy (2011)

- Provide a smooth transition with core services or longer-term care where required.

End of life care will usually fall under the remit of core services working with palliative care services. There will be cases however where referral to and from the CRT will support an individual to remain in their own home and achieve their choice of place of death.[8]

Intended impact

The intended measures of the impact of the programme are:

- Better outcomes for frail people and their families

- Fewer acute hospital admissions

- Shorter stays in hospital

- Fewer delayed transfers of care

- Improved flow through secondary care services

- Reduced hospital acquired infections

- 24/7 access to community services

- Reduced demand for complex care packages

- Reduced demand for Continuing NHS healthcare

- Better use of public money[9]

Data is not consistently collected to inform all of these measures and, where it is possible to quantify activity, it is difficult to attribute outcomes to the GFP (Frailty), due to the incomplete data on activity within the programme. These issues are discussed further in the following section on programme performance, where we make recommendations for improving impact measurement.

Demographic profiles of the five areas

4.4.1   Drivers of demand for health and social care

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[8] Gwent Frailty Programme - Community Resource Teams Operational Policy (2011)

[9] Delivery Group Frailty Brief 2011

A growing number of frail, elderly people are living with one or multiple long-term conditions. Older people are far more likely to have immediate or chronic health problems, more likely to need to go to an Accident and Emergency (A&E) department and more likely to be admitted into hospital once in A&E. The admission of an increasing number of older patients to hospital creates additional pressures on the system, as they typically spend much longer in hospital once admitted.

The UK has seen an increase in emergency admissions over the last 15 years, which has come almost entirely from patients being admitted from major A&E departments who have a short hospital stay once admitted. The causes of the increase in emergency admissions include: systemic issues, policy changes, changing medical practices, demographic changes and the fact that A&E departments are under increasing pressure. It is not possible to say what contribution each factor has made because they are interlinked, but the main factors are increased demand from an ageing and increasingly frail population and the lack of effective alternatives to hospital admission, particularly for older people[10].

4.4.2   Current population

Gwent has a total population of almost 600,000 people, of whom 18% are over the age of 65. Caerphilly has the highest number of older people, while Monmouthshire has the highest percentage of the population aged over 64.

Total population by local authority and numbers aged over 65 are shown in Figure 6 and Figure 7 below.

Figure 6: Population and number of people aged over 65 by local authority

Local authority	Total population	People aged > 65	Percentage of population aged over 65
Blaenau Gwent	73,330	13,450	18%
Caerphilly	184,150	31,560	17%
Monmouthshire	97,720	20,810	21%
Newport	148,250	24,830	17%
Torfaen	94,230	17,150	18%
Gwent total	**597,680**	**107,800**	**18%**

Source: Public Health Wales, GP Cluster Profiles (2013)

Figure 7: total population and number of people aged over 65 by local authority

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[10] Source: National Audit Office (2013), *Emergency admissions to hospital: managing the demand*
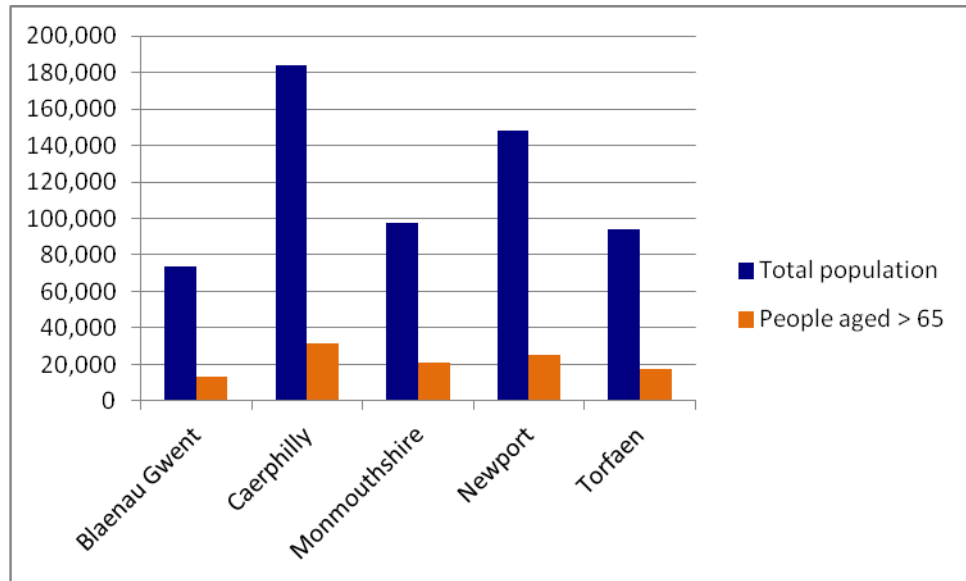
Over 200,000 people in Gwent are living with a long term condition which puts them at risk of unplanned hospital admissions. Figure 8 below shows that the profile of long term conditions amongst the Gwent population is broadly consistent with that across Wales. Caerphilly have almost 60,000 people with a long term condition, which suggests that there are more people resident in Caerphilly who are at risk of hospital admission than in other areas (see Figure 9 below).

Figure 8: Prevalence of long term conditions by local authority in Gwent

Indicator	Blaenau Gwent	Caerphilly	Monmouth shire	Newport	Torfaen	Total	% Health Board	%
Hypertension	12,860	26,350	13,540	21,610	15,410	89,770	15%	
Asthma	4,650	10,370	5,670	9,760	6,830	37,280	6%	
Diabetes	4,870	9,470	4,740	8,210	5,730	33,020	6%	
CHD	3,380	6,720	3,450	5,610	4,040	23,200	4%	
COPD	2,210	3,500	1,330	2,780	1,910	11,730	2%	
Epilepsy	600	1,240	530	1,060	770	4,200	1%	
Heart Failure	950	1,390	830	1,280	940	5,390	1%	
Total	29,520	59,040	30,090	50,310	35,630	204,590		

Source: Public Health Wales, GP Cluster Profiles (2013)

Figure 9: Number of people with long term conditions by local authority
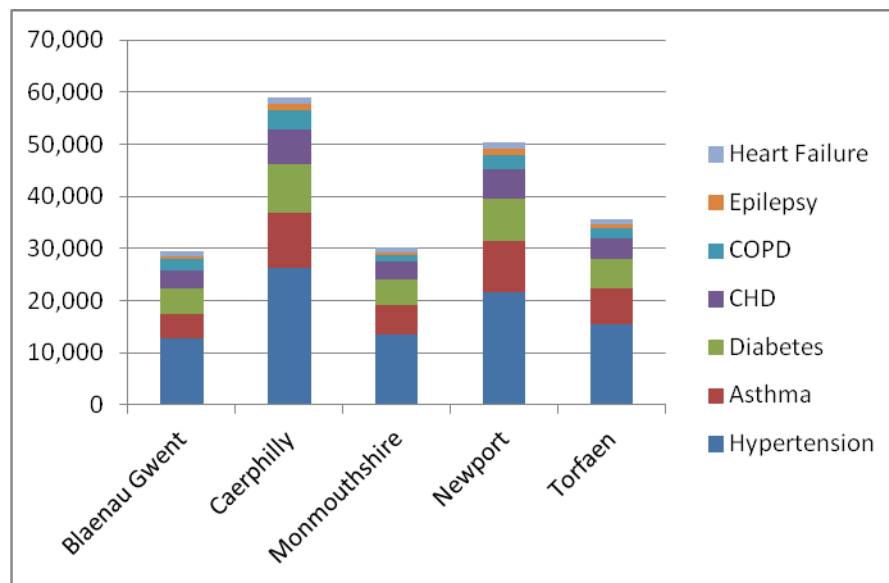
The health of people in Wales reflects its post-industrial economy. Life expectancy overall has increased in recent years, rising by 4.4 years for males and 3.0 years for females since 1991, reflecting a substantial decrease in deaths from circulatory disease in men under 75. But there remain substantial geographical and socio-economic variations in all types of life expectancy (Public Health Wales Observatory 2011). For example, healthy life expectancy in males ranges from 57.1 in Blaenau Gwent to 68.2 years in Monmouthshire, and for females the largest difference is around 10 years. National inequalities are particularly wide in healthy life expectancy. The gap between the most and least deprived areas is 18.9 years for males and 17.8 years for females.[11]

4.4.3   Projected population change

The Gwent Frailty Programme has been developed in the context of a population which is expected to contain a higher percentage of older people and more people with long term conditions likely to require hospital treatment. This is not the dramatic 'demographic time bomb' which is often referred to in analysis of the issues facing health and social care, but more a slow change which will gradually begin to create a bottleneck for services if changes to the system are not made.

According to projections accessed from the DAFFODIL database, the population of people in Gwent aged over 65 is expected to grow by approximately 37,000 by 2030 (a 34% increase from 2010). Figure 10 shows the population in 2013 and the projected profile in 2030, while Figure 11 illustrates the extent of the change expected to take place.

Figure 10: Projected Gwent population profile 2013 to 2030

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[11] Chris Ham, Deirdre Heenan, Marcus Longley, and David R Steel. (2013).Integrated care in Northern Ireland, Scotland and Wales: Lessons for England. *The King's Fund*
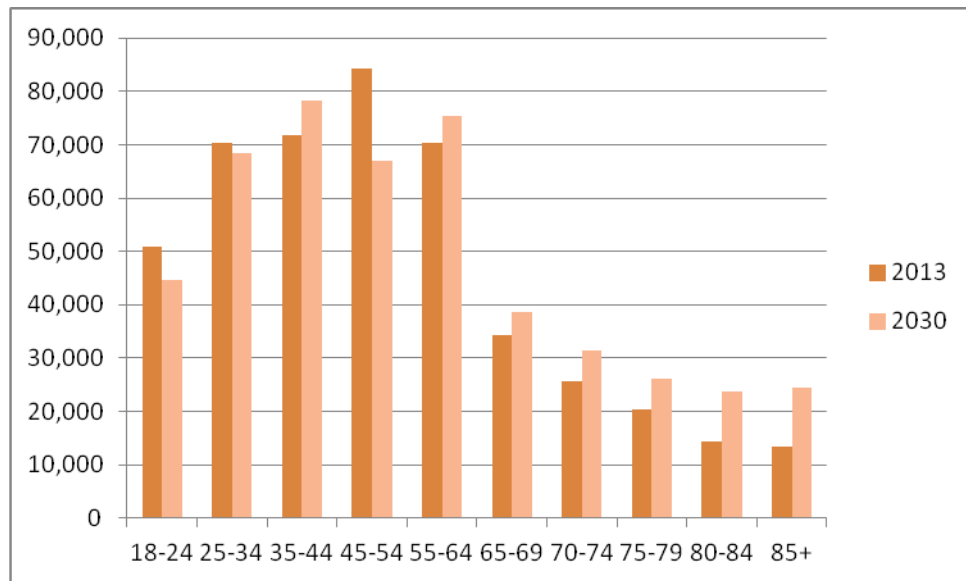
Figure 11: Change in Gwent population profile 2013 to 2030
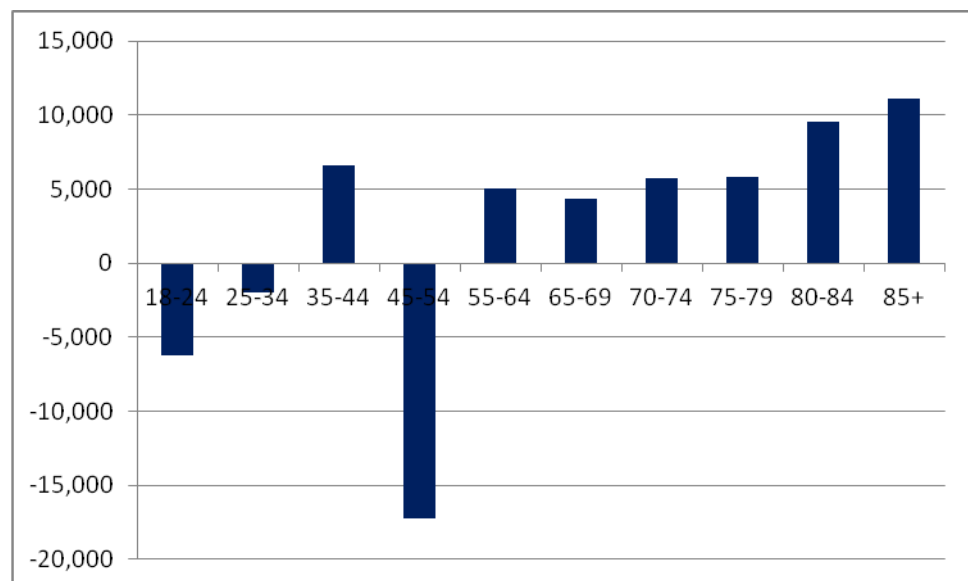
DAFFODIL also contains projections of the numbers of people living with a condition which is likely to increase their chances of a hospital admission; the total across Gwent is likely to rise from 18% to 23% of the population by 2030, with the associated increase in demand on health and social care services. Figure 12 shows a breakdown for Gwent for conditions projected by DAFFODIL.

Figure 12: Projected growth in the number of people in Gwent with long term conditions 2013 to 2030
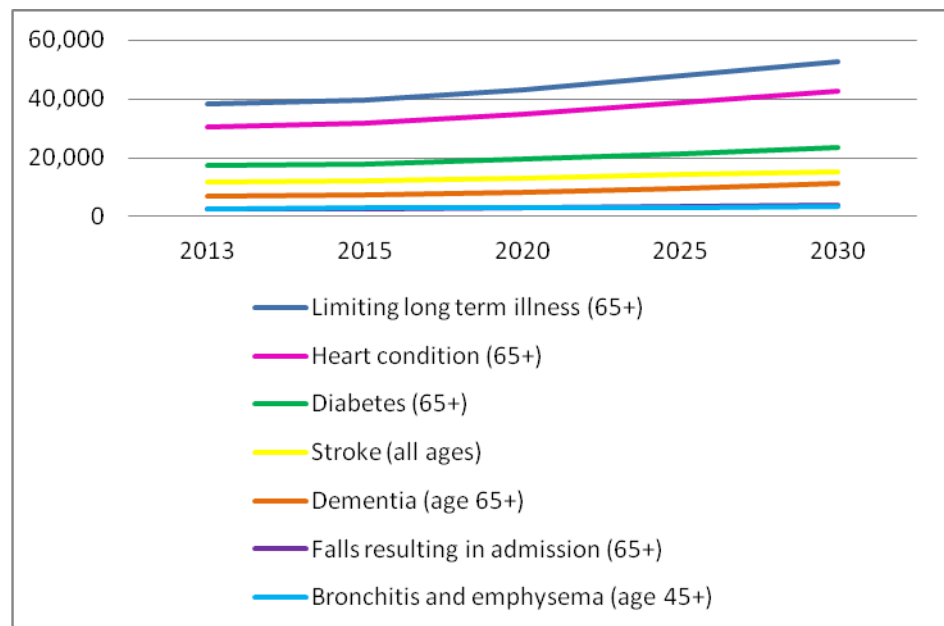
The Gwent Frailty Model

The GFP consists of integrated Community Resource Teams (CRTs) operating in each of the five local authorities in the Gwent area (Blaenau Gwent, Caerphilly, Monmouthshire, Newport and Torfaen). Broadly, it was intended that the CRTs would consist of:

- Administrative support

- A team of Support & Wellbeing Workers

- Registered General Nurses

- Registered Mental Nurses

- Social Workers

- Pharmacist

- Specialist Doctors

- Occupational Therapists

- Physiotherapists

- Dietetics/SALT/podiatry (a possible development for the future)

- Consultant Physician/appropriate medical input

There is currently some variation in the make-up of the teams, the implications of which are discussed further in sections five and six. Common service standards for Community Resource teams were agreed at the outset of the GFP (see Figure 13 below).

Figure 13: Common integrated standards for CRTs

Component	Description
Access to the service	Single Point of Access
Core hours of operation	7 days a week 365 days a year 8am to 8pm
Response time	2 - 4 hours for urgent response and intervention. Rest to be determined by assessed need (within 24 hours)
Method of assessment	Agreed common assessment framework
Services provided (Pick and mix options to be co-ordinated to meet individual need)	Urgent Multidisciplinary Assessment Rapid response health intervention Emergency Home Care package Carers Assessment & signposting Re-ablement Access to rapid diagnostics & 'hot clinics' Equipment, minor aids and adaptations Onward referral & support where required Management/Hospital at Home – up to 14 days in response to assessed need. Reablement – up to 6 weeks rehabilitation and reablement.
Single Point of Access	The SPA will comprise a number of call handlers within Vantage

Component	Description
(SPA)	Point House who will work alongside other call management services from WAST[12], NHS Direct and GP Out of Hours Service (GPOOHS).
	This service will be available 24/7 and staffing levels will need to flex with demand though we will seek to share the resource from GPOOHS between 11pm and 7am.
	Only calls from professionals and Local Authority (LA) call centres (transfer) will be dealt with in the first instance and clinical triage will not be undertaken for Frailty Referrals as this will be provided from the CRT Bases. As the service become established then the public will also gain direct access and it is highly likely that all call management services for Health and Social care will all merge into a communications hub for Gwent in the medium term.

Delivery models in the five local authority areas

Elements of the model remained unresolved at the time of implementing CRTs, with agreement on use of the medical model, in particular, proving challenging and sensitive. Three localities opted for a model with Intermediate Care Consultants and staff grade physicians. The remaining two have proposed the testing of alternative models, one being using GPs with special interest, the other operating an in-reach/outreach model from the local hospital. The GFP has accommodated flexibility to test different solutions in other areas of implementation, for example Caerphilly is trialling extended hours of operation, and Monmouthshire has two Integrated Service Teams to address its issues with rurality[13].

Consequently, there are variations in how the GFP meets similar needs. Within the franchise, service users should get the same standard of service, although it may be provided in different ways. The Wales Audit Office review in 2012 found that GFP 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 implementation progresses. However, across Gwent there are variations in what services the GFP delivers, services' hours of operation, and in CRT functions and priorities. Because of service variations within the GFP across

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[12] Welsh Ambulance Services Trust

[13] Frailty-Programme-Report-August-2011-v1

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 GFP standard of service. Moreover, outside GFP 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.[14]

As Figure 14 shows there is currently variability in the service provided across the five localities. In particular, the hours of opening, times when referrals are accepted and availability of medical assessments vary across authorities.

[14] Welsh Audit Office (2012) Review of the Gwent Frailty Programme

Figure 14: Summary of services provided and times of availability by local authority

Service component	Blaenau Gwent	Caerphilly	Monmouthshire	Newport	Torfaen
Medical assessment	Intermediate care consultant Mon-Fri 9:00 – 17:00 Sat-Sun 10:00 – 13:00 as part of Gwent wide model	Intermediate care consultant x 2 Speciality doctors x 2 Mon-Fri 9:00 – 17:00 Sat-Sun 10:00 – 13:00 as part of Gwent wide model	No consultant available Service is GP-led	Intermediate care consultant Speciality doctors x 2 Mon-Fri 9:00 – 17:00 Sat-Sun 10:00 – 13:00 as part of Gwent wide model	Intermediate care consultant Speciality doctor Mon-Fri 9:00 – 17:00 Sat-Sun 10:00 – 13:00 as part of Gwent wide model
Rapid response nursing	8:00 – 20:00 7 days per week	7:00 – 22:00 7 days per week	8:00 – 20:00 7 days per week (new referrals only taken between 9:00 and 17:00)	8:00 – 20:00 7 days per week	8:00 – 20:00 7 days per week
Reablement	8:00 – 20:00 7 days per week	7:00 – 22:00 7 days per week for care delivery 8:00 – 18:00 7 days per week for assessment	8:00 – 20:00 Mon – Fri (new referrals only taken between 9:00 and 17:00)	7:00 – 23:00 7 days per week for care delivery 8:00 – 18:00 7 days per week for assessment	8:00 – 20:00 7 days per week
Emergency care at home	None in CRT at present (although workers are being appointed)	24 hours a day, 7 days a week	8:00 – 20:00 7 days per week (new referrals only taken between 9:00 and 17:00)	8:00 – 18:00 Mon – Fri for care provision 8:00 – 14:00 Mon – Fri for assessment	8:00 – 20:00 7 days per week
Falls	8:00 – 20:00 7 days per	7:00 – 22:00 7 days per	9:00 – 17:00 Mon - Fri	8:00 – 20:00 7 days per	8:00 – 20:00 7 days per

	week (tier 2 only)	week		week	week

Local variations in service delivery

Some variation in the services provided is to be expected, since each local authority started from a different place and it was agreed at the start of the programme that authorities would not be expected to standardise services in the short term. It was hoped that the GFP would be able to learn from the experience of each authority area to help determine which are the most effective models.

The key difference between areas, and one which programme members and external partners find most problematic, is the operation of the 'medical model', which has a consultant-led, community-based medical component. Only Monmouthshire has no medical staff employed within the CRT, although Blaenau Gwent has no speciality doctors, while Newport, Torfaen and Caerphilly have both intermediate care consultants and specialists within their teams. The impact of this on performance and experiences of the programme in different areas is discussed in the next section and in section six.

There have also been variations in service provision because authorities have drawn down different amounts from the agreed Invest to Save funding and because there have been delays in getting new staff into post. This would suggest that there may be some reluctance on the part of individual authorities to fully commit to investing further resources – which carries some risk – into a programme whose economic benefits not guaranteed.

Modelling of demand for CRT services is discussed in the next section. However, it is worth noting that demand modelling happened fairly quickly at the start of the programme and may not have been fully understood or owned by all partners. This may have resulted in a reluctance to scale-up services to meet expected demand.

5 Programme performance

Introduction

This section is based on an analysis of monitoring and finance data provided by the GFP and covering the period from 1 April 2011 to 31 March 2014.

The evaluation tender brief included a requirement to measure the relative effectiveness of the models across the localities, in terms of:

- Whether service users receive the right service, from the right person at the right time

- Reduction in acute and community beds

- Reduction in packages of care

- Reduction in residential and nursing placements

- Number of frail people presenting at A&E

- Reduction in the number of WAST[15] conveyances to hospital

We have tried to assess the extent to which it is possible to measure the relative effectiveness of the localities on the basis of data collected by the programme and publicly available information. There are some limitations to being able to do this, for the following reasons:

- **Data on CRT activity is incomplete, as the Frailty Portal has not been used consistently.** This means that we are unable to link activity to outcomes. It is critically important to be able to link activity to outcomes in this way to ensure that the causal link between the GFP and a reduction in service activity can be identified. As noted in section three above, there are various methods of evaluating cost effectiveness, with randomised controlled trials commonly accepted as the gold standard in providing a methodologically robust approach for 'proving' cost savings.

- **Recent data from social care on packages of care and residential and nursing placements has not been provided.** This data would need to be linked to individual users of the Frailty service to enable us to draw meaningful conclusions. (It is also important to note that it is doubtful whether use of social care services will reduce as a result of the GFP, as (a) more people may enter the system, and (b) social care may be used as an alternative to hospital based care).

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[15] Welsh Ambulance Service Trust

- **A consistent clinical definition of frailty would need to be agreed and consistently applied, for analysis of A&E data.**

Data has been collected to inform key performance measures relating to emergency hospital admissions, length of stay and delayed transfers of care. The data covers all three complete years of the GFP. This does enable an analysis of trends compared to the original GFP targets, however, it is difficult to draw any firm conclusions about the causes of those trends and their link to the GFP without either robust patient outcomes data or complete activity data.

This section presents an analysis of the GFP's performance against its original objectives, in as far as it is possible to draw robust conclusions from the available data.

The business plan

5.2.1 Modelling of demand

Modelling of demand for the service and the likely impact on other services – and in particular efficiency savings - takes as its starting point an assessment of the needs of the population, now and in the medium term future (five to ten years).

We understand that the GFP has estimated increased demand for the services provided by the CRTs, but not what the demand for usual care would be in the medium term. The Welsh Audit Office (WAO) report recommended doing this, but we understand that the work has not yet been undertaken; in reality this is a task to be undertaken not only by GFP but across ABHB.

From the documents provided, we understand that:

- Caerphilly, Newport and Torfaen have undertaken bed censuses and this has been used as a basis for calculating potential demand for Reablement.

- Monmouthshire and Blaenau Gwent have not undertaken the same local bed censuses, although Blaenau Gwent has reviewed bed requirements as part of the business case for the new Ysbyty Ystrad Fawr (YYF) hospital. For the purposes of the modelling exercise the same methodology has been applied across the five Gwent localities.

- The calculation of potential demand for Aged Care Assessment Team (ACAT)/Rapid Response type services is based on the ACAT data and scaled up/down for population size, with an additional 30% added to take account of the increase required to provide a service from 8am to 10pm, seven days per week.

At the end of this section we make some recommendations for completing a more comprehensive demand modelling exercise to inform future service planning and performance targets.

5.2.2   Planned activity (inputs, activities, outputs)

The Strategic Outline Case for the GFP contains target levels of activity for each service component and each locality (see Figure 15 below)[16].

It was expected that the service would accept around 22,000 referrals per year, with the majority of people receiving a rapid response (either social care or health based) or reablement service.

Figure 15: Target levels of activity included in the Strategic Outline Case

Locality	ACAT/Rapid Response	Reablement	Falls	Total
Caerphilly	3,360	3,048	624	7,032
Blaenau Gwent	1,380	1,356	264	3,000
Monmouthshire	1,740	1,332	324	3,396
Newport	2,772	1,908	492	5,172
Torfaen	1,776	1,596	360	3,732
Gwent Total	**11,028**	**9,240**	**2,064**	**22,332**

Funding for the GFP comprises monies already committed by ABHB and the five local authorities to fund existing services which transferred into the CRTs and 'Invest to Save' money secured to fund further development of these services. The total annual funding of £15.5m comprises:

Base declaration:

- £3.5m per year ABHB localities

- £5.1m per year LAs

- Total £8.6m

Invest to Save funding:

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[16] 'Happily Independent': Strategic Outline Case for the Gwent Frailty Programme (2011)

- £4.6m year 1

- £1.9m year 2

- £0.4m year 3

- Total £6.9m

The Invest to Save funding is repayable over six years, and in theory the repayments will come from savings achieved by the programme. However, as cashable savings depend on closure of services, specifically hospital beds, there is serious doubt over where these savings will come from, given that hospital admissions and spells are currently above target and GFP is being implemented in the context of a range of initiatives around management of demand for hospital care.

5.2.3   Planned outcomes for service users

High level outcomes are described in the Strategic Outline Case. It appears that the GFP has had difficulty in translating these into more specific outcomes which can be measured. We were provided with an Outcomes Workstream briefing dated May 2009, but nothing appears to have happened after that. The result is that there is no systematic, consistent and comparable measurement of service user / patient outcomes across the GFP.

This extract from the Programme Manager's report (August 2011) indicates why this may be the case:

The Finance Workstream had concerns that the Report Cards would not provide adequate metrics to demonstrate the savings and resource shift critical to the sustainability of the Programme. External advice was accessed to support the development of a specific Sustainability Scorecard of measures and targets that reflect impact on secondary care and care home beds....

....The greatest commitment to payback, and therefore arguably the greatest risk, lies with ABHB. It is therefore understandable that it should prefer performance formats which are familiar and which monitor impact on acute services.

In any new partnership compromises have to be made and a pragmatic approach has been adopted. However, the degree to which the Programme can claim that it has an outcomes-based performance management framework is somewhat diluted.

There is some anecdotal feedback that OBA[17] can be perceived as being 'too soft'. However, the feedback also suggests that actually seeing the impact the new approach is having on the lives of individuals is what is motivating staff and their managers through this period of change.

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[17] Outcomes Based Accountability

As the literature reviewed in section three shows, intermediate or soft outcomes are as important as financial measures, because financial benefits are likely to be seen only in the longer term. It is important to know that the programme is having an impact on users' quality of life to be able to know that the direction of travel is right and that ultimate cost benefits will follow.

Evidence of outcomes is largely anecdotal but has been supplemented by the outcomes based case studies and service user survey which form part of this evaluation. Findings from these exercises are presented in section seven. In general, the data we have collected shows that the service achieves the desired outcomes for users and is highly valued by both users and carers.

There is a wealth of information now available on measuring outcomes for users of integrated care services, following the emphasis placed on these services as a solution to the problems faced by health and social care systems. At the end of this section we make recommendations to assist the GFP to improve the measurement of service user outcomes. In the technical appendices to this report we include an example of an outcomes questionnaire developed specifically for users of integrated services.

5.2.4   Expected financial savings

The calculations prepared to support the Invest to Save (I2S) application show that the GFP originally aimed to make a total saving of £7.2m over 3 years. Once the I2S money had been paid back, the service would be sustained by savings released through a reduction in:

- Acute beds

- Community beds

- Residential care beds

- Domiciliary care packages

Figure 16 contains a breakdown of planned savings by service and locality.

Figure 16: Target activity savings from the GFP

Local authority area	Target number of extra cases (minimum)	Activity saving impact (reduction)				
		ABHB beds	Residential care beds	Nursing care beds	EMI placements	Care packages
Blaenau Gwent	1,167	11	0	0	0	0
Caerphilly	1,715	27	-10	0	-13	0

Monmouthshire	1,143	16	-1	0	-1	-15
Newport	2,868	28	-9	0	-4	-251
Torfaen	1,693	18	-10	0	-4	-50
Total	8,586	100	-30	0	-22	-316

In practice, as noted earlier in this section, realising the financial benefits of any reduction in activity means shifting resources from one part of the system to another, closing some services and moving staff and budgets from one part of the system to another. Not surprisingly, organisations wish to have robust evidence of cashable savings before making any commitment to do this. The concept of moving resources across organisational boundaries is also very challenging both for leaders and frontline staff.

In addition to the data issues identified in the introduction to this section, the GFP faces a number of challenges in being able to identify activity and cost savings:

- Community and Acute hospitals have already done their own work to identify bed savings, which are not linked to the GFP. *It will be extremely difficult to attribute savings to one initiative or another*.

- The financial assumptions for the new hospital (YYF) assume a repatriation of beds from the Royal Gwent Hospital (RGH) for Caerphilly residents and closure of beds in Caerphilly District Miners Hospital (CDMH) and Ystrad Mynach. However, the financial savings for the GFP also assume bed closures for CDMH and Ystrad Mynach.

- There is currently no firm evidence that activity levels will lead to changes in hospital admissions and lengths of stay. This is why it is important to triangulate activity data, service level indictors and individual outcomes indicators. The most reliable way to measure the link between GFP and reduction in hospital admissions, in the absence of a randomised control trial, is to track individual service use before, during and after the GFP for as many service users as possible.

Evidence of progress

5.3.1   Performance management

This section is based on the views of people who responded to our stakeholder survey. These findings sit alongside the observations we have made in this section, which are based on the information we have seen.

Stakeholders were asked about service delivery and performance management. Most stakeholders agreed that there have been some obstacles to getting GFP services up and running (84%), as shown by Figure 17. Only half of respondents agreed that the GFP has the resources it needs to deliver objectives and targets. 3 in 5 respondents disagreed that there is consistency in service delivery across the five areas.

These findings present a mixed picture of perceived progress and performance management. The key area which stakeholders agree needs to be addressed is ensuring greater consistency of service across all five localities, and this is echoed by the one-to-one interviews we carried out with a sample of key stakeholders.

Fewer than half of respondents think the GFP has appropriate systems for managing the performance of its services and, again, this is reflected in the interviews, with most people commenting that performance management systems were inadequate or not very well understood. The area which is particularly problematic is the data which managers, the Operational Co-ordinating Group and Joint Committee receive. The majority of interviewees felt that this had not helped them to manage the service or programme better, although some did acknowledge that there has recently been an improvement in the information reported.

Figure 17: Service delivery and performance management (n = 195-200)
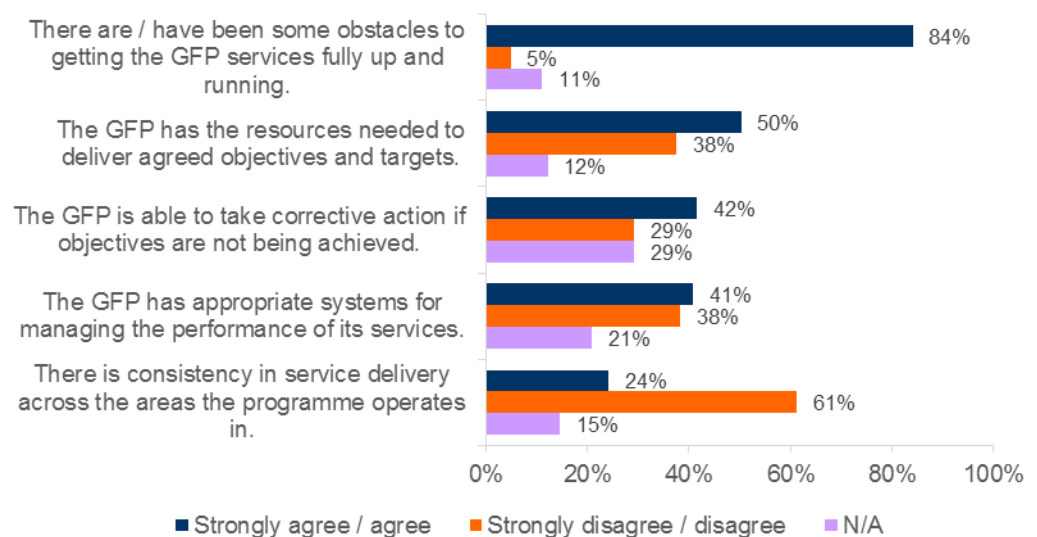
Overall, respondents from:

- Blaenau Gwent were most likely to disagree that the GFP is able to take corrective action if objectives are not being achieved and that the GFP has the resources needed to deliver agreed objectives and targets.

- Caerphilly were most likely to answer "don't know" to every question about service delivery and performance management.

- Monmouthshire were most likely to agree that the GFP has the resources needed to deliver agreed objectives and targets, and most likely to disagree that there is consistency in service delivery across the areas the programme operates in.

- Newport were most likely to agree that the GFP has appropriate systems for managing the performance of its services and that the GFP is able to take corrective action if objectives are not being achieved.

- Torfaen were most likely to agree that there are / have been some obstacles to getting the GFP services fully up and running.

- All areas were most likely to disagree that the GFP has appropriate systems for managing the performance of its services.

- The health board were much more likely to agree that the GFP is able to take corrective action if objectives are not being achieved. They were also much more likely to disagree that the GFP has the resources needed to deliver agreed objectives and targets and the GFP has appropriate systems for managing the performance of its services.

- The local authorities were most likely to answer with "don't know". Significantly more respondents from local authorities agreed that the GFP has the resources needed to deliver agreed objectives and targets.

5.3.2   Activity and spend against budget

The GFP has underspent significantly against its original budget, and has a total projected underspend for 2013/14 of £1.7m (budget report presented to the Joint Committee, p9), mostly due to delays in recruiting to posts.

The underspend has had an impact on levels of activity, which, for the most part, have been below target. Figures 18 and 19 show the number of cases accepted by locality for the years 2012/13 and 2013/14. The figures for 2011/12 cannot be broken down by locality; in total 14,350 cases were accepted, of which 6,845 received reablement and 5,722 a rapid response service. There were 1,783 falls cases.

The number of accepted referrals increased in 2012/13[18] to 16,430, with Blaenau Gwent, Monmouthshire and Newport over-providing against reablement targets, although Monmouthshire, in particular, provided significantly fewer rapid response services than expected.

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[18] Numbers taken from 2012-2014 Frailty data summary spreadsheet

Figure 18: Accepted referrals by locality and service type April 2012 to March 2013

Area	ACAT/ Rapid Response		Reablement		Falls		T
	Total cases	**% of target**	**Total cases**	**% of target**	**Total cases**	**% of target**	**Total cases**
Caerphilly	1,815	54%	1,064	35%	205	33%	3,084
Blaenau Gwent	729	53%	2,235	**165%**	180	68%	3,144
Monmouthshire	554	32%	2,879	**216%**	235	73%	3,668
Newport	1,738	63%	2,340	**123%**	187	38%	4,265
Torfaen	1,373	77%	578	36%	308	86%	2,259
Gwent Total	6,209	56%	9,096	98%	1,115	54%	16,420

In 2013/14 the number of accepted referrals appears to decrease, particularly in Blaenau Gwent, which experienced a significant period without a CRT manager. We also understand that use of the information portal has been inconsistent, which will result in gaps in data.

Figure 19: Accepted referrals by locality and service type April 2013 to March 2014

Area	ACAT/ Rapid Response		Reablement		Falls		T
	Total cases	% of target	Total cases	% of target	Total cases	% of target	Total cases
Caerphilly	1,736	52%	805	26%	380	61%	2,921
Blaenau Gwent	720	52%	555	41%	117	44%	1,392
Monmouthshire	393	23%	2,034	**153%**	307	95%	2,734
Newport	1,369	49%	1,984	**104%**	238	48%	3,591
Torfaen	1,447	81%	592	37%	250	69%	2,289
Gwent Total	5,665	51%	5,970	65%	1,292	63%	12,927

Given that activity levels are significantly below target, it is to be expected that the original target outcomes would not be achieved. Expected admissions and lengths of stay were reduced in line with actual investment.

5.3.3   Financial savings against target

According to reports presented to the JC and OCG, in 2011/12 there was a reduction in bed days for some groups. In 2012/13 and 2013/14 bed days have been above target levels. No beds have closed as a result of the GFP.

Figure 20 shows the variance in bed days under five measurement domains. The figures show that short term admissions are considerably above target levels. Figures were not available in a comparable format for 2013/14, as reports now focus on the patient journey, with one metric for bed days.

Figure 20: Hospital admissions percentage variance from target 2011/12 and 2012/13

Indicator	2011/12	2012/13
Admission avoidance < 2 days	27%	75%
Acute Ages 75+ >14 Days	6%	23%
Acute Ages <75 >10 Days	-6%	6%
Community ages 75+ > 28 days	-4%	10%
Community ages < 75 > 21 days	-13%	6%

Note: red = above target (+ve), green = below target (-ve)

We considered whether it would be possible to discern any significant variations by local authority area, but concluded that the gaps in activity and patient outcome data would mean that any attempts to draw conclusions would lack rigour.

Admissions and spells in hospital appear to have fluctuated over the life of the GFP. This is not particularly a surprise, since the context is an ageing and more dependent population, coupled with targeted efforts to reduce hospital admissions. The true effects of both will only be seen in the medium to longer term (five to fifteen years ahead).

As noted above, GFP is in effect a service which is additional to the baseline service already provided, as it has not resulted in a shift in resources from one part of the system to another. This is often what is required to implement preventative services, but the pump priming investment cannot be guaranteed in the long term and a reallocation of resources will have to be agreed if the initiative is to continue.

5.3.4   Patient journey performance dashboard

The format of performance reports was changed for the year 2013/14, and reporting now takes the form of a 'patient journey dashboard'. The report covers:

- Source of referral

- Number of referrals accepted and rejected

- Waiting time to assessment

- Service provided

- Outcome at the end of the GFP intervention

- Location at the end of GFP

The new format is informative and easy to understand. It also explains what has happened to the service user, rather than changes in indicators which may not have been influenced by the GFP at all. This is a useful basis for implementing one element of a comprehensive performance measurement system. Alongside the patient journey dashboard it would be useful to have more detailed outcome indicators, with the data collected through surveys, and to continue to monitor hospital admissions and length of stay. However, the latter should be strengthened by setting targets mapped against future demand and taking into account other initiatives. The current inconsistency in use of the portal means that the data is compromised, and drawing meaningful conclusions about avoidance of hospital admission is not secure. A key recommendation is that every case must be fully reported and quarterly reporting from the dashboard should indicate steps to 100% completion rates for each area team.

Programme achievements

This section is based on our survey of stakeholders and throws light on how well stakeholders think the GFP is performing. In general, stakeholders indicate that the GFP is achieving many of its aims, although there is some uncertainty about the programme's impact on key indicators.

5.4.1   How well the GFP is achieving its aims

Stakeholders were asked how well they believed the GFP was achieving a number of aims. As shown by Figure 21, most respondents indicated that the GFP ensures that patients and carers are treated with respect and dignity (82%) and that the GFP is ensuring that more people remain independent for longer (80%). Around three quarters of respondents indicated the GFP was achieving each of the other aims asked about, with the exception of one: less than half of respondents indicated that the GFP was achieving a reduction in the confusion and complexity for the patient receiving GFP services.

Figure 21: How well the GFP is achieving its aims (n = 194-195)
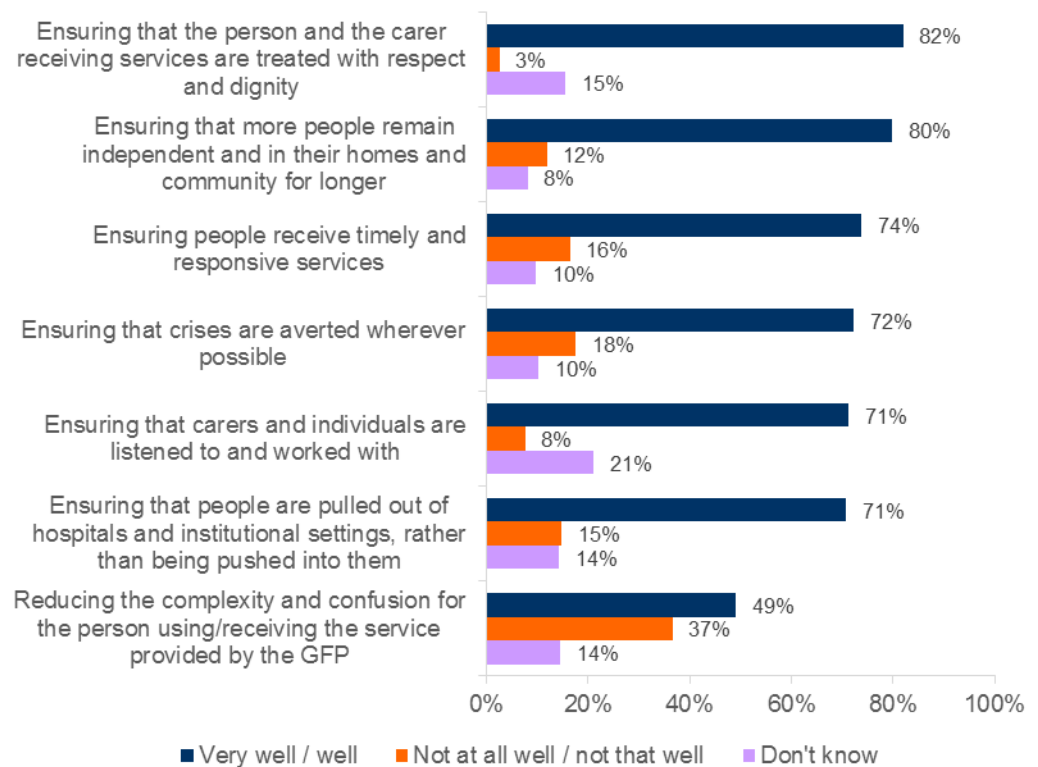
Overall, respondents from:

- Blaenau Gwent were most likely to indicate that the GFP is doing well at ensuring that the person and the carer receiving services are treated with respect and dignity. They were most likely to indicate that the GFP was not doing well in the following areas: Reducing the complexity and confusion for the person using/receiving the service provided by the GFP and ensuring that crises are averted wherever possible.

- Monmouthshire were most likely to indicate that the GFP is doing well at: reducing the complexity and confusion for the person using/receiving the service provided by the GFP, ensuring people receive timely and responsive services, and ensuring that crises are averted wherever possible. This reflects the focus of the Monmouthshire CRT on treating people in the community and 'pushing' people away from hospital rather than 'pulling' them out,

- Newport were more likely than respondents from other areas to indicate that the GFP is doing well at ensuring that people are pulled out of hospitals and institutional settings, rather than being pushed into them. This perhaps reflects the work that has gone into developing the Frail Older Person's Advice and Liaison (FOPAL) service in Newport and in the presence of members of the team on hospital wards. They were

also most likely to indicate that the GFP is doing well at ensuring that more people remain independent and in their homes and community for longer and ensuring that carers and individuals are listened to and worked with.

- Torfaen were generally comparable to other local authorities in their responses about how well the GFP is achieving its aims.

- All areas were most likely to disagree and answer "don't know" to most questions about how well the GFP is achieving its aims.

In general, respondents from:

- The health board were most likely to indicate that the GFP was doing well for all questions about how well the GFP is achieving its aims. In particular, respondents from the health board were much more likely than respondents from local authorities to say that the GFP was doing well at the following: ensuring that carers and individuals are listened to and worked with and ensuring that the person and the carer receiving services are treated with respect and dignity.

- The local authorities were most likely to answer "don't know" to all questions about how well the GFP is achieving its aims.

5.4.2   Achievements of the GFP

Respondents were asked whether they agree that the GFP is achieving a variety of objectives. Figure 22 shows that 70% or more of respondents agreed that the GFP has delivered improvements in quality of life and wellbeing of patients, improved accessibility of services, and ensured older people are more readily referred to appropriate specialist services. The only achievement that fewer than half of respondents agreed with was that the GFP has delivered a fairer geographical distribution of services than previously existed (49%).

Figure 22: Achievements accomplished by the GFP (n = 190-194)
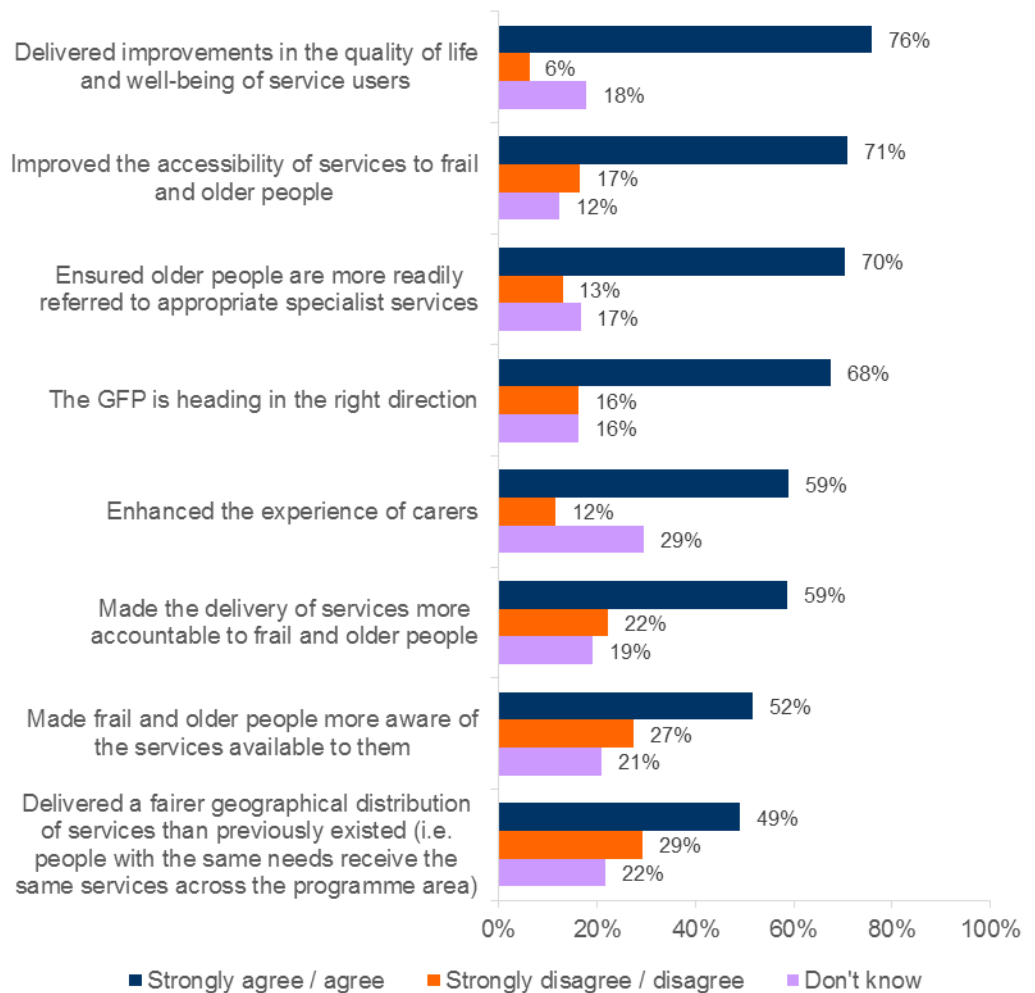
Overall, respondents from:

- Blaenau Gwent were most likely to disagree with half of the questions about achievements accomplished by the GFP. In particular, they were much more likely to disagree that the GFP has made frail and older people more aware of the services available to them and that the GFP has delivered improvements in the quality of life and well-being of service users.

- Caerphilly were most likely to answer "don't know" when asked whether the GFP has improved the accessibility of services to frail and older people.

- Monmouthshire were most likely to disagree that the GFP has made the delivery of services more accountable to frail and older people and that the GFP has ensured older people are more readily referred to appropriate specialist services.

- Newport were most likely to agree with most questions about achievements accomplished by the GFP. In particular, they were much more likely to agree that the GFP has ensured older people are more readily referred to appropriate specialist services, improved the accessibility of services to frail and older people, and that the GFP is heading in the right direction.

- Torfaen were most likely to agree that the GFP has enhanced the experience of carers and that it has delivered improvements in the quality of life and well-being of service users.

- All areas were much more likely to disagree that the GFP is heading in the right direction. They were also most likely to disagree that the GFP has delivered a fairer geographical distribution of services than previously existed.

In general, respondents from:

- The health board were most likely to agree to all questions about the achievements accomplished by the GFP. In particular, they were much more likely to agree that the GFP has: made the delivery of services more accountable to frail and older people, made frail and older people more aware of the services available to them, enhanced the experience of carers, improved the accessibility of services to frail and older people, and delivered improvements in the quality of life and well-being of service users.

- The local authorities were most likely to answer "don't know" to all questions about the achievements accomplished by the GFP. They were also more (or equally) likely to disagree with most questions.

Impact on other services

Respondents were asked if they agree the GFP has had an impact on a number of key indicators. More than half of respondents agreed that the GFP had reduced the average length of stay in hospital of frail and older people (59%) and that the GFP had led to a reduction in the take-up of acute beds (54%), as shown by Figure 23. There were a significant number of respondents answering "don't know" to questions about impact; in particular, half of respondents did not know whether the GFP had reduced the number of Welsh Ambulance Service Trust (WAST) conveyances to hospital and 47% were unsure whether the GFP had delivered savings across the Gwent health and social care economy.

The variation and apparent contradiction in responses perhaps reflects the different experiences across localities, as well as individuals' access to and ability to interpret the performance information provided. For example, in some areas, staff may know through experience that the service they have provided has stopped people from going into hospital, but this knowledge may not be reflected in higher level statistics which are influenced by other factors.

Figure 23: Impact on key indicators (n = 190-193)
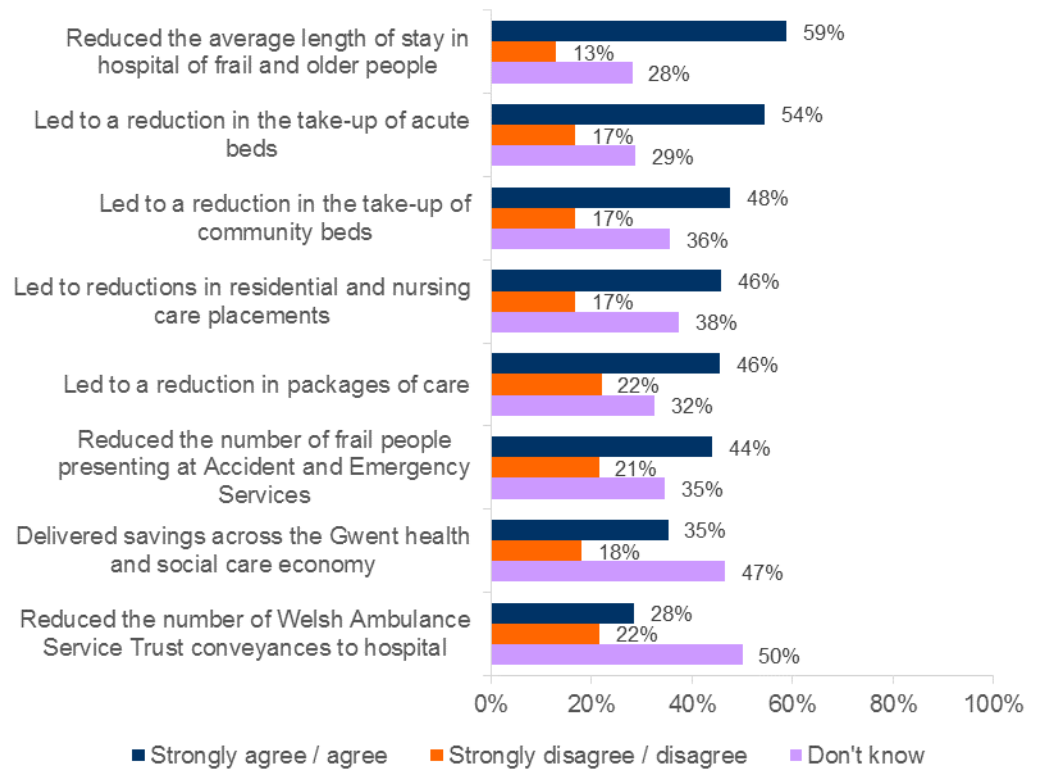
Overall, respondents from:

- Blaenau Gwent were most likely to agree that the GFP has led to a reduction in packages of care and led to a reduction in the take-up of community beds. They were also most likely to disagree that the GFP has reduced the number of Welsh Ambulance Service Trust conveyances to hospital and reduced the number of frail people presenting at A&E.

- Caerphilly were generally comparable to other local authorities in their responses about impact on key indicators.

- Monmouthshire were most likely to agree that the GFP has led to reductions in residential and nursing care placements and reduced the average length of stay in hospital of frail and older people. They were significantly more likely to disagree that the GFP has led to a reduction in packages of care.

- Newport were most likely to agree that the GFP has led to a reduction in the take-up of acute beds and has delivered savings across the Gwent health and social care economy. We understand that the Newport team has worked with mathematicians from Cardiff University to look at 300 individual patients and to measure their rates of re-admission to hospital. While on the GFP caseload 10% were admitted (which is in keeping with national standards), with an average length of stay of two weeks.

There has been a statistically significant reduction in admissions for this group. This approach could usefully be adopted in other areas and could help to quantify avoidance of admission, and early return to home settings.

- Torfaen were most likely to agree that the GFP has reduced the number of Welsh Ambulance Service Trust conveyances to hospital and reduced the number of frail people presenting at A&E. They were also most likely to disagree that the GFP has led to reductions in residential and nursing care placements.

- All areas were most likely to disagree or answer "don't know" to most questions. In particular, they were more likely to disagree that the GFP has delivered savings across the Gwent health and social care economy, led to a reduction in the take-up of community beds, or led to a reduction in the take-up of acute beds.

Respondents from:

- The health board were much more likely to agree that the GFP has reduced the number of frail people presenting at A&E, reduced the average length of stay in hospital of frail and older people, and reduced the number of Welsh Ambulance Service Trust conveyances to hospital.

- The local authorities were most likely to answer "don't know" to most questions. Although in general much less likely to agree to questions than respondents from the health board, they were slightly more likely to agree that the GFP has led to reductions in residential and nursing care placements and led to a reduction in packages of care.

Recommendations for developing performance management

5.6.1   Introduction

The GFP has been slow to develop a performance management system which meets the needs of all stakeholders. In part this reflects the challenges of operating across boundaries, and of the fact that the financial risk and impetus to track financial outcomes falls predominantly upon ABHB.

What is needed is a comprehensive suite of indicators to assist the programme to measure its performance in terms of a logic chain (see Figure 24).

Figure 24: Components of a logic chain

Dimension	Description
Inputs	All the resources necessary for supporting the service
Activities	The things the service does or offers to users
Outputs	The 'products' that result from running the service, for example number of cases seen
Outcomes	The immediate consequences and change for the participants

Dimension	Description
	that are a result of the work of the service. There are usually four key areas of change for participants: (a) knowledge, (b) skills, (c) attitudes, and (d) behaviour
Impact	The higher and usually longer-term results for a group of people and a service delivery economy, which the service may contribute towards, but which go beyond the direct and immediate change

Figure 25 illustrates the domains which ought to be included in a performance measurement and reporting system for the GFP. Choosing appropriate measures and collecting the right data to inform them will enable the GFP to evaluate its own progress by triangulating information from different sources. Figure 26 gives some examples of the measures which might be included and the data the programme could collect.

Figure 25: Suggested domains for a performance measurement system for GFP

Figure 26: Examples of performance measures and data sources

Domain	Example measure(s)	Data source(s)
CRT activity	Number of referrals accepted and rejected Services provided (the patient journey dashboard in its entirety provides suitable measures)	Referral and service user records accessible via Frailty Portal
Service user outcomes	Improved quality of life Feeling better informed about care options	Questionnaire to service users, administered consistently and regularly
Service use (for individuals using the GFP service)	Admissions to hospital Length of stay	ABHB data on individual service use, accessed with users' permission
System wide indicators (population wide)	Admissions to hospital Length of stay	ABHB aggregated data, with performance benchmarks adjusted for expected demand and impact of other initiatives
Organisational processes and behaviour	Changes in workforce composition Changes in ways of working Staff attitudes	Annual review of team composition Annual staff survey Learning events for staff

It is important that all indicators selected are SMART, that is they are **S**pecific, **M**easurable, **A**chievable, **R**ealistic and **T**imebound. All indicators should have an owner who is ultimately accountable for their delivery, and each CRT should have local indicators which feed into those of the programme overall.

5.6.2 Modelling future targets in the context of rising demand

Modelling expected demand for hospital based services and assessing GFP performance against these is a substantial technical undertaking, which is beyond the scope of this evaluation. We understand that ABHB employs a mathematical modeller who is engaged in modelling future demand for services by different cohorts and in different locations. We also understand that modelling of demand against the backdrop of an ageing

population has already been done for the Royal Gwent Hospital, although we have not specifically sought to find out whether that is also the case elsewhere.

It is important that any demand modelling happens across the whole system, otherwise there is a danger of savings being 'claimed' more than once and targets being unachievable or unattributable. Appendix three contains an example of a standard process which is used to model future demand for hospital services. Given that demand and need are set to rise through increased numbers of frail elderly, it is essential to develop new cost-models for the medium and longer-term and re-model the GFP to align with projected increase in demand for services.

5.6.3 Measuring outcomes for service users in a consistent way

We would strongly recommend the use of outcome indicators which have been tested and validated and which are used by other integrated care projects. The closest that we currently have to this is a set of draft indicators included in the report *Developing measures of people's self-reported experiences of integrated care* (January 2014), commissioned by the English Department of Health from the Picker Institute and Oxford University[19]. The study provides 18 questions that were derived from the National Voices integrated care 'I statements'[20] and tested with patients, social care service users and carers. Following advice from stakeholders some of the questions are being taken forward for survey-specific testing and to inform further work to develop surveys aimed at a range of groups.

Whilst work continues on developing a final set of survey questions, the 18 questions that have been developed may be of use to the GFP in developing its local experience measures. Examples of some of the questions are included in Appendix four. The numbering of the questions is as used in the Picker/Oxford report.

5.6.4 Activity and budget reports

The patient journey performance dashboard is a good starting point for agreeing standard measures of activity. We recommend that a small task and finish group should agree on the measures to be included in the dashboard and the format be formally agreed by the JC and implemented. Key statistics that the dashboard should generate include: a) avoidance of hospitalisation; b) speedy integrated discharge planning; c) avoidance of transport and other costs; d) any real savings or cost reductions.

The budget reports presented to the JC and OCG are clear and the commentary is useful. Spending appears to be well controlled, although this has sometimes resulted in centralised and over-bureaucratic processes which have held up implementation. It may be worth reviewing the level at which decisions can be made to ensure that the programme remains flexible.

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[19] Picker Institute and Oxford University (2014). *Developing measures of people's self-reported experiences of integrated care*

[20] Person centred co-ordinated care was developed in the National Voices and Think Local Act Personal (TLAP) narrative. (http://www.england.nhs.uk/wp-content/uploads/2013/05/nvnarrative-cc.pdf)

The JC has not taken strategic action as a result of the underspends against budget, and the main task for the programme is to decide how far it wishes to continue with the original spending plans or amend them to reflect new circumstances.

5.6.5   Measuring organisational system change

It is important to measure changes in attitudes, behaviour and organisational processes, to make sure that integrated working is becoming embedded in the whole system and is not perpetuating the problems of silo-working.

We recommend that the GFP consider conducting an annual workforce survey, covering understanding of integration; satisfaction with work; perceived outcomes for patients; personal learning and awareness of the wider system. We also suggest that GFP maps the CRT workforce and its relationship to other community services, with a view to considering further integration.

A workforce survey should also focus on elements of both organisational and team development and these can be fed into OD, workforce and training plans as shown below

5.6.6   OCG and JC response to the recommendations

The recommendation to *'set revised **savings targets** for the GFP which equate to reductions in LoS, DToC and spells for the identified cohorts, but do not assume closure of hospital beds, which are outside the control of the programme'* was **agreed** with a slight modification:

- The word 'savings' should be replaced with 'cost avoidance'

The following points were made in discussions:

- We do know that there has been a substantial reduction in bed stays.

- New measures are needed to show what we're trying to achieve. These must be measures for which we can be held to account and which relate to the individual's journey through integrated services.

- Members of the group feel more confident now about challenging the original measures which went in.

- As regards I2S, the partnership will now need to initiate an open conversation with WG about payback.

It was **agreed** that:

a) ABHB's statistician would be asked to do the necessary modelling to help the partnership arrive at appropriate cost avoidance targets.

b) The results would be reported to the Finance Workstream, which would make recommendations to the Frailty Board.

The remaining recommendations concerning performance measurement were accepted and will be taken forward by a sub-group of the OCG.

6 Programme governance and management

Overview

This section looks at stakeholders' views of programme governance and management. It is based on a survey of stakeholders, which achieved 248 responses, and in-depth interviews with a sample of senior stakeholders involved in the programme.

Key findings

- The areas of the GFP that stakeholders feel most positively about concern achieving its aims and in service delivery. More than 70% of stakeholders agreed or strongly agreed that the GFP is achieving the following aims:
  - Ensuring that the person and the carer receiving services are treated with respect and dignity.
  - Ensuring that more people remain independent and in their homes and community for longer.
  - Ensuring people receive timely and responsive services.
  - Ensuring that crises are averted wherever possible.
  - Ensuring that carers and individuals are listened to and worked with.
  - Ensuring that people are pulled out of hospitals and institutional settings, rather than being pushed into them.
  - Delivered improvements in the quality of life and well-being of service users.
  - Improved the accessibility of services to frail and older people.
  - Ensured older people are more readily referred to appropriate specialist services.

- More than 70% of stakeholders indicated that reablement, the community resource teams, and rapid response to health and social care needs are working effectively or very effectively, although there was some uncertainty around some of the other service offers.

- The areas of the GFP which stakeholders suggest could be improved include: governance and leadership, clarity of purpose, commitment and ownership of the GFP, learning and shared good practice, and consistency of services.
  - Regarding clarity of purpose, more than 50% of stakeholders disagreed or strongly disagreed with the following:
    - The GFP's purpose is clear to all.
    - It is clear how the GFP will be sustained into the future

o Regarding governance and leadership, more than 40% of stakeholders disagreed or strongly disagreed with the following:
  - It is easy to understand how partners in the GFP come to decisions.
  - People know what everyone else's roles and responsibilities are within the GFP.
  - The GFP has a clear way of coming to decisions.
  - It is clear who is accountable to whom in the GFP structure.
  - It is clearly written how we do things and work together (for example, there are ground rules and terms of reference).
  - The structure of the GFP is clear.

o Regarding commitment, ownership, and management, more than 40% of stakeholders disagreed or strongly disagreed with the following:
  - The programme communicates its aims, objectives and achievements effectively to the outside world in general.
  - There is effective communication within the programme.

o Regarding learning and shared good practice, more than 40% of stakeholders disagreed or strongly disagreed with the following:
  - There are regular opportunities for learning together.
  - There is a systematic approach to identifying and sharing good practice and information from external sources.
  - Everyone is made aware of training opportunities that are relevant to the GFP and its work.

o Additionally, one of the questions posed under service delivery and performance management had the highest rate of disagreement across all questions. 61% of respondents disagreed or strongly disagreed that there is consistency in service delivery across the areas the programme operates in. This indicates a key possible area for improvement.

- The top challenges for the future that respondents suggested were:

  o Funding

- o Ensuring consistency across all five areas

- o Communication (both within the programme and communicating the programme to others)

- o Integration (between health and social care and wider integration)

- o Increasing demand due to an aging population with complex needs

- The top areas for improvement that respondents suggested were:

  - o Improved integration and partnership working

  - o Improved communication outside the GFP (both selling it to and keeping in touch with partners and public)

  - o Improved referral process

  - o Improved communication and team-working within GFP teams

  - o Improved leadership, clarity, vision, and decision making

  - o More consistency across the five areas

- In general, there was a high rate of respondents answering survey questions with "don't know" across most topic areas which may indicate that clarity, communication, and ownership from some stakeholders in the GPP could be improved.

Governance and clarity of purpose

This section examines what GFP stakeholders think about the governance, leadership, clarity of purpose and strategic management of the GFP. These are each areas that stakeholders indicated have room for improvement.

6.2.1 Governance and leadership

Figure 27 shows that more respondents agreed than disagreed that people have clear roles and responsibilities in the GFP, that the structure of the GFP is clear, and that processes are clearly documented. Nonetheless, only around 50% of respondents agreed with these statements, while a third to almost half disagreed.

For all other questions about governance and leadership more respondents disagreed than agreed; particularly about how easy it is to understand how partners make decisions, which 52% disagreed with. It is also of note that, although there are numerous documents delineating how the GFP operates, almost as many respondents disagreed as agreed that it is clearly written how things ought to be done (43% vs. 46%).

Several interviewees used the phrase 'management by committee'. There is a widespread view that accountability for the programme is unclear and that decisions made at the JC and OCG are not consistently followed through. Several stakeholders also questioned whether the present model with no designated organisational or individual lead, is the right one.

Further clarity around governance and leadership appears to be a key area for improvement.

Figure 27: Governance and leadership of the GFP (n = 223-229)
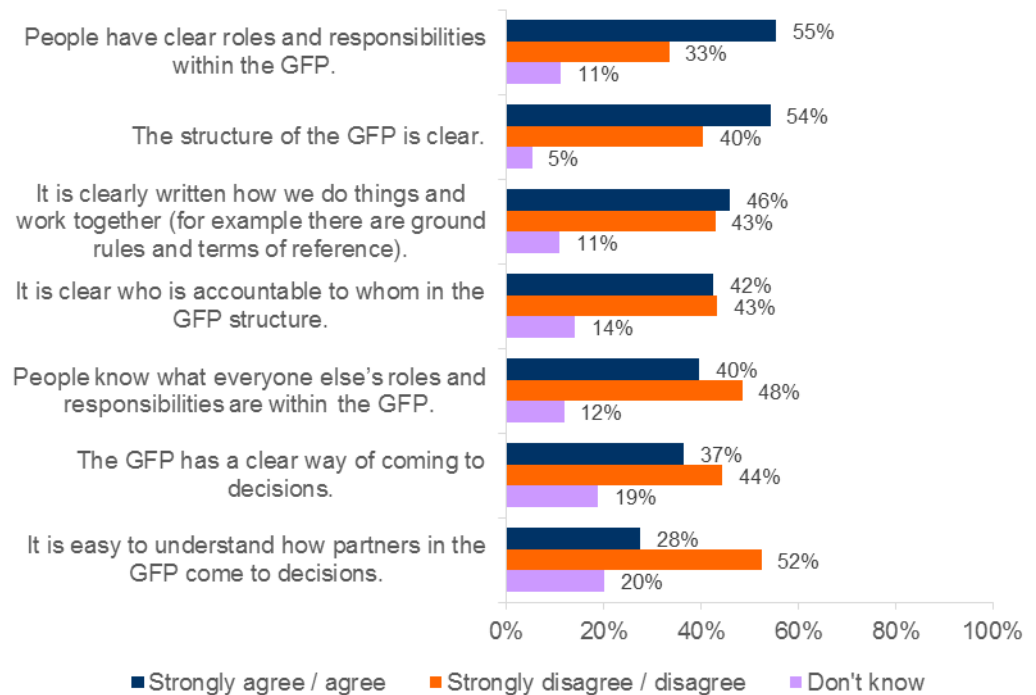
There were some key differences by area; overall, respondents from:

- Blaenau Gwent were most likely to disagree that the GFP has a clear way of coming to decisions.

- Caerphilly were most likely across all questions to answer with "don't know".

- Monmouthshire were most likely to disagree that the structure of the GFP is clear but most likely to agree that it is clearly written how things are done.

- Newport were most likely to agree that people have clear roles and responsibilities.

- Torfaen were generally comparable to other local authorities with regards to governance and leadership.

In addition:

- Respondents who work across all areas were most likely to disagree that people know everyone else's roles and responsibilities, that people have clear roles and responsibilities, and that it is clear who is accountable to whom in the GFP.

- Respondents from the health board were most likely to disagree across almost all questions, in particular that the structure of the GFP is clear.

- Respondents from local authorities were most likely to answer "don't know" across all questions.

6.2.2 Clarity of purpose

Stakeholders were asked about the clarity of the GFP's purpose. Almost three quarters of respondents agreed that the GFP knows what it wants to achieve, as shown by Figure 28. However, under half of respondents agreed with all other questions around clarity of purpose. In particular, approximately half of respondents disagreed that the GFP's purpose is clear to all or that it is clear how the GFP will be sustained into the future. Additionally, for four out of seven questions asking about clarity of purpose, approximately a third of respondents responded with "don't know", indicating confusion in this area.

In general, stakeholders think that the overarching aims of the GFP are clear, but the more detailed objectives of the programme are not. Further clarity of purpose for the GFP is indicated as a second key area for improvement.

Figure 28: Clarity of purpose (n = 210-217)
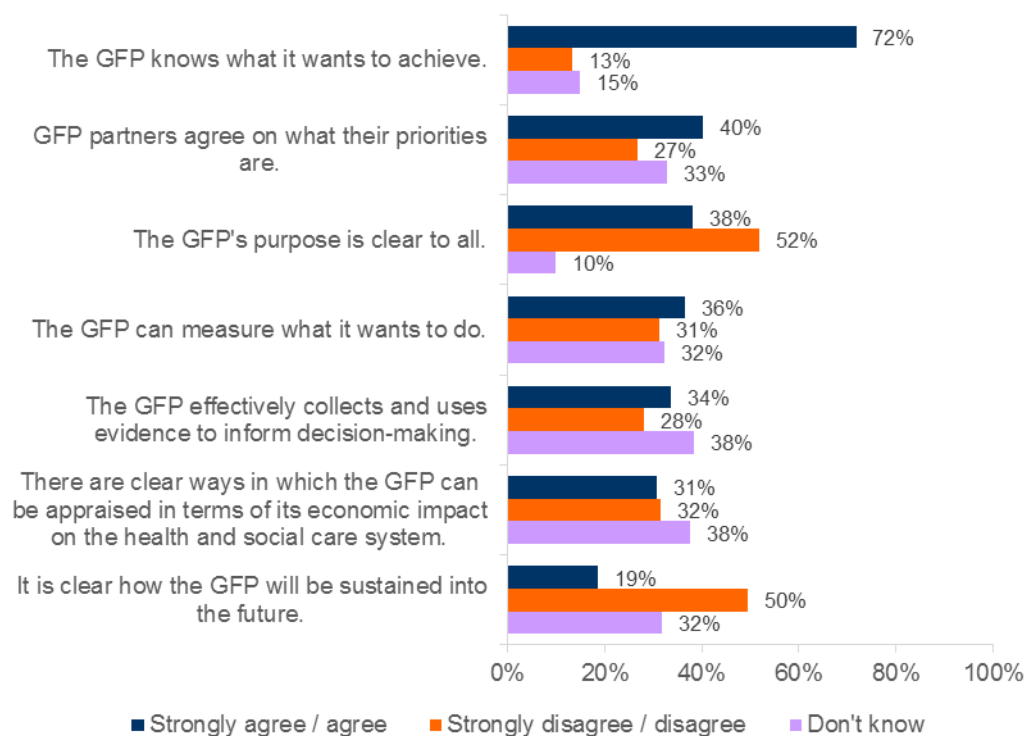
Overall, respondents from:

- Blaenau Gwent were most likely to disagree with most questions about clarity of purpose. This appears to be a key area for improvement in Blaenau Gwent.

- Caerphilly were most likely to answer questions with "don't know". They were also most likely to agree that there are clear ways in which the GFP can be appraised and that it is clear how the GFP will be sustained into the future.

- Monmouthshire were most likely to disagree that there are clear ways in which the GFP can be appraised.

- Newport were most likely to agree across most questions about clarity of purpose. In particular a further 20% more stakeholders in Newport agree that the GFP knows what it wants to achieve and GFP partners agree on what their priorities are, than the area with next highest agreement.

- Torfaen were most likely to disagree that the GFP's purpose is clear to all and it is clear how the GFP will be sustained into the future.

- All areas were most likely to disagree that GFP partners agree on what their priorities are.

- The health board were most likely to both agree and disagree with most questions about clarity of purpose, showing a stronger or more informed opinion than respondents from local authorities. In particular, respondents from the health board were much more likely to disagree that it is clear how the GFP will be sustained into the future and the GFP effectively collects and uses evidence to inform decision-making.

- The local authorities were more likely to respond to all questions with "don't know". In particular, respondents from the local authorities were much more likely to be uncertain that is clear how the GFP will be sustained into the future, that GFP partners agree on what their priorities are, and that the GFP effectively collects and uses evidence to inform decision-making.

Commitment, ownership, and management

Respondents were asked how they felt about the commitment, ownership, and management of the GFP. Figure 29 shows that half or more respondents agree that all partners are committed to achieving the goals of the GFP and there is a commitment to the GFP at a senior level in partner organisations.

Concerns were raised about communication, with around half of respondents indicating that they disagreed that the GFP communicates effectively to the outside world and that there is effective communication within the programme. There were also a significant number of "don't knows" around commitment, ownership and management, with almost a third to almost two thirds of respondents choosing this response for five out of nine questions on this topic.

Some stakeholders in the interviews reported that they felt that the programme had lost leadership and direction since the departure of the founding clinical director, Professor Khanna. As a consequence the vision of the programme is not being driven or communicated in the same way and local areas are more likely to be 'doing their own thing'. It is clear from these findings that the GFP has lost focus somewhat.

Figure 29: Commitment, ownership, and management (n = 204-208)
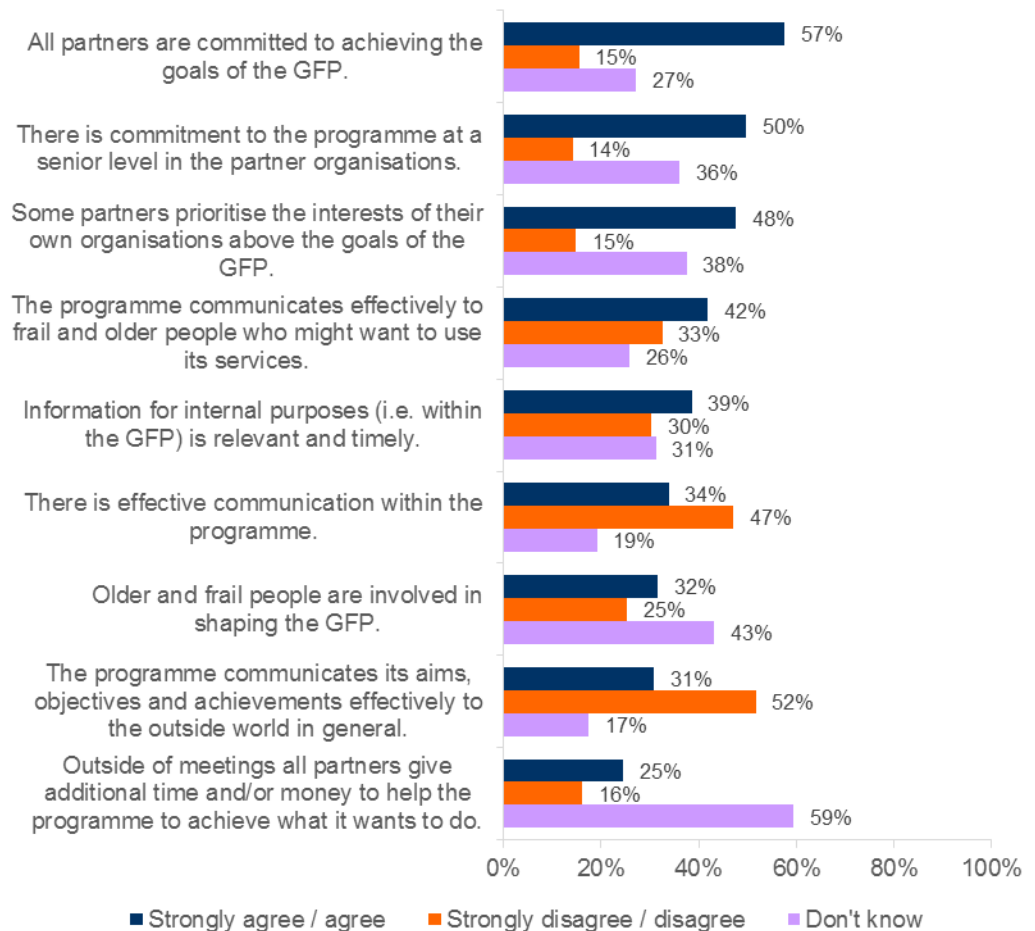
Overall, respondents from:

- Blaenau Gwent were most likely to disagree that the GFP communicates its aims, objectives and achievements effectively to the outside world and that older and frail people are involved in shaping the GFP.

- Caerphilly were again most likely to respond with "don't know" on many questions. It is unclear why there is so much uncertainty in Caerphilly, particularly on questions that should have answers available to all staff, such as whether information for internal purposes (i.e. within the GFP) is relevant and timely.

- Monmouthshire were much more likely than other areas to agree that there is effective communication within the programme, while conversely being much more likely to disagree that the programme communicates effectively to frail and older people. Respondents from Monmouthshire were also most likely to agree that there is commitment to the programme at a senior level in the partner organisations.

- Newport were more likely to agree that the GFP communicates its aims and achievements effectively to the outside world, that older and frail people are involved

in shaping the GFP, and that the programme communicates effectively to frail and older people.

- Torfaen were most likely to disagree that there is effective communication within the programme.

- All areas were most likely to disagree that outside of meetings all partners give additional time and/or money to help the programme to achieve what it wants to do.

- The health board presented stronger opinions both in agreement and disagreement. In particular, they were much more likely to agree that information for internal purposes is relevant and timely and that older and frail people are involved in shaping the GFP. They were much more likely to disagree that all partners are committed to achieving the goals of the GFP.

- The local authorities were more likely to answer questions with "don't know". In particular, they were much more likely than respondents from the health board to indicate that they did not know whether there is effective communication within the programme.

Service delivery, learning, and partnerships

This section examines what GFP stakeholders think about service delivery and performance management, learning and shared good practice, and partnership culture within the GFP. In general, stakeholders feel that core service delivery is relatively effective and partnerships appear to be stable, while learning and good practice is an area for improvement.

6.4.1   Effectiveness of service delivery

Stakeholders were asked how effectively they thought various elements of the GFP operate. As shown by Figure 30, at least 70% of respondents indicated that reablement, the community resource teams, and rapid response to health and social care needs are operating effectively.

The areas that respondents felt were not working as effectively were the single point of access (with 41% indicating it did not work effectively, while 50% felt it did work effectively), and communication and engagement with the community (with 36% each indicating it was not working effectively and indicating they "don't know").

There were a number of areas where a significant number of respondents answered with "don't know"; most notably almost three quarters of respondents indicated that they "don't know" how effectively the franchise model is working. Additionally, between 60%-70% of respondents answered "don't know" when asked how effectively the following were working: the GFP's Joint Committee, the GFP's Operational Co-ordinating Group, the Frailty Implementation Groups, and "Hot" clinics.

Overall, stakeholders seem to agree that core services are being delivered effectively, but are less certain about other areas, particularly leadership groups and committees.

Figure 30: Effectiveness of service delivery (n = 194-205)

	Very effectively / effectively	Not at all effectively / not that effectively	Don't know
Reablement	72%	18%	11%
The Community Resource Teams	70%	16%	13%
Rapid response to health and social care needs	70%	14%	17%
Falls treatment	65%	13%	22%
Emergency care at home	63%	23%	15%
Falls prevention	60%	17%	24%
Urgent (health and social care) assessment	58%	22%	21%
Single Point of Access	50%	41%	9%
Co-location of community resource teams	32%	24%	45%
Workforce development	30%	20%	49%
Communication and engagement with the community	29%	36%	36%
"Hot" clinics	26%	13%	61%
The Frailty Implementation Groups	19%	19%	62%
The GFP's Operational Co-ordinating Group	16%	18%	65%
The GFP's Joint Committee	14%	16%	69%
The "franchise" model	10%	16%	74%

Overall, respondents from:

- Blaenau Gwent were most likely to indicate that almost half of the listed programme elements were not being effectively delivered. In particular, they were much more likely to indicate that they did not believe the following are effective: falls prevention, emergency care at home, co-location of community resource teams, falls treatment, and urgent (health and social care) assessment. It raises a concern in Blaenau Gwent that so many stakeholders do not believe that these core service offers are being delivered effectively, though this may be in part due to the late establishment of certain core services in Blaenau Gwent.

- Caerphilly were generally comparable to other local authorities with regards to the effectiveness of service delivery, though they were most likely to answer "don't know" on roughly a third of the questions.

- Monmouthshire were significantly more likely than respondents from other areas to indicate that the following are effective: Frailty Implementation Groups, co-location of community resource teams, and the GFP's Operational Co-ordinating Group. They were also most likely to indicate the "franchise" model was effective, and to question the effectiveness of "hot" clinics and the single point of access.

- Newport were most likely to indicate that half of the listed programme elements are effective. In particular, they were significantly more likely than respondents from other areas to indicate that the following are effective: "hot clinics", communication and engagement with the community, urgent (health and social care) assessment, and falls prevention.

- Torfaen were generally comparable to other local authorities with regards to the effectiveness of service delivery.

- All areas were most likely to answer "don't know" or question the effectiveness of almost half (each) of the listed programme elements. In particular, they were significantly more likely than respondents from other areas to indicate that the following are not effective: the GFP's Operational Co-ordinating Group, Frailty Implementation Groups, and the "franchise" model.

- The health board were more likely to indicate that the following are effective: "hot" clinics, the single point of access, and community resource teams. Conversely, they were also more likely to indicate that "hot" clinics are not effective and that co-location of community resource teams, the "franchise" model, and the GFP's Operational Co-ordinating Group are not effective.

- The local authorities were most likely to answer "don't know" on almost every question about the effectiveness of service delivery. They were also most likely to indicate that reablement is not being delivered effectively.

The franchise model

As shown in Figure 30 above, a very small proportion of people think the 'franchise model' is working effectively. Interviewees reported that the model had been a sensible solution to the fact that different localities were starting from different places and did not have the resources to reconfigure their services significantly. It was agreed that the programme would assess which elements of the model were working well and not so well before deciding whether or not to move towards greater standardisation.

It is clear that variation across authorities has become more of a problem. The franchise model was described by more than one person as a 'fudge', which enabled the programme as a whole to delay making unpopular decisions. Some felt strongly that greater consistency was essential to get the best out of the programme; instil confidence in the public that the so-called 'postcode lottery' has been eliminated, and to sell it to secondary care clinicians and other professionals who might refer. There is a compelling case for surfacing the concerns, considering the options, and then taking decisions even when unpopular. Significant variations in approach mean that the GFP is compromised in terms of consistency, including quality of leadership and record keeping.

The areas of greatest contention are whether or not CRTs should include a consultant and/or specialty doctors; whether CRTs should be available for referrals and assessments at the same times; use of the common IT system and referrals through the Single Point of Access (SPA).

There is little hard evidence of outcomes which could be used to make an assessment of the relative merits of the models in the five areas. However, the literature reviewed in section three and experience from elsewhere does point to some possible ways forward, as do the views of stakeholders.

The literature suggests that the presence of a physician in community-based teams both encourages integration at a community level and helps programmes to avert hospital admissions. As some of those interviewed pointed out, having a consultant available enables CRTs to deal with more complex cases without referring to hospital and enables some people to be discharged from hospital more quickly. The downside is that the 'medical model' is relatively expensive and may encourage the service as a whole to look towards acute services rather than the community (although this is not a given).

On the other hand the model of complete integration of community services, as Monmouthshire has, is particularly effective in preventing people from escalating up the frailty scale and requiring higher levels of care. However, it only works well if GPs are fully on board.

On balance it would seem that the aspiration ought to be for all localities to have the best of both worlds: for Monmouthshire to employ a consultant within its team to help deal with more complex cases, and for other areas to emulate the model of community service integration in Monmouthshire.

Section 6.11 contains further recommendations for the development of the franchise model.

Performance management and information

The comments of stakeholders about the effectiveness of performance management are reflected in our observations and recommendations in the previous section. Overall, it was clear that stakeholders did not feel that performance management was particularly effective. In particular, the majority did not think the programme was using information to drive performance, although views were mixed on whether the information presented was useful and clear.

Learning and shared good practice

Respondents were asked for their opinions on learning and shared good practice within the GFP. Figure 31 shows that only 39% of respondents indicated that the GFP changes the way it does things in light of good practice and performance reviews. For the remainder of the questions about learning, more respondents disagreed than agreed that learning and shared good practice was being prioritised. This should be an area for improvement.

Figure 31: Learning and shared good practice (n = 201-202)
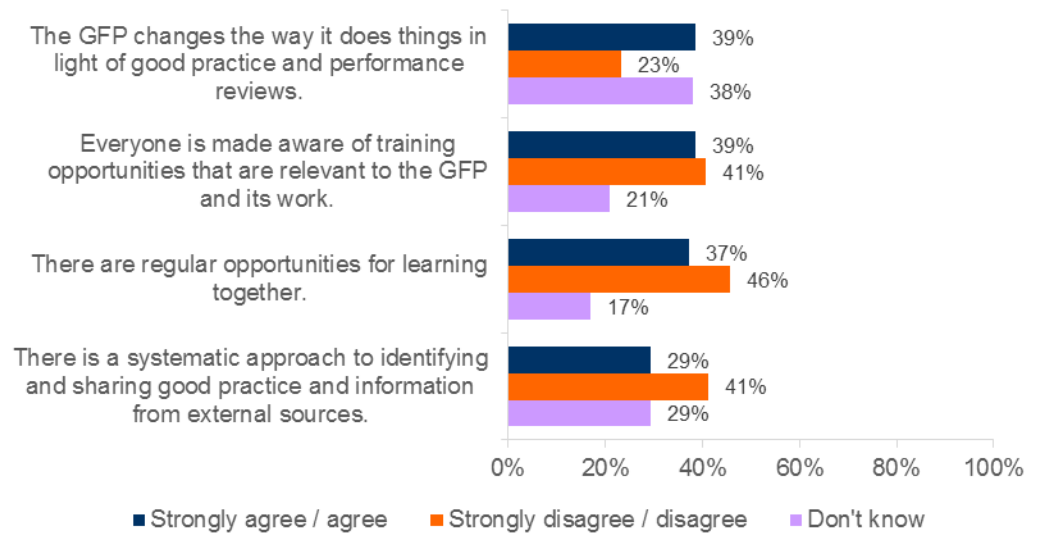
Overall, respondents from:

- Blaenau Gwent were most likely to disagree that there are regular opportunities for learning together and there is a systematic approach to identifying and sharing good practice and information from external sources.

- Caerphilly were generally comparable to other local authorities with regards to learning and shared good practice.

- Monmouthshire were much more likely than other areas to answer "don't know" when asked if everyone is made aware of training opportunities that are relevant to the GFP and its work.

- Newport were most likely to agree with all questions about learning and shared good practice. In particular, they were much more likely than other areas to agree that there is a systematic approach to identifying and sharing good practice and information from external sources.

- Torfaen were generally comparable to other local authorities with regards to learning and shared good practice.

- All areas were most likely to disagree that there is a systematic approach to identifying and sharing good practice and information from external sources.

- The health board were most likely to both agree and disagree with each question about learning and shared good practice. In particular, they were much more likely to agree that the GFP changes the way it does things in light of good practice and performance reviews and much more likely to disagree that there are regular opportunities for learning together.

- The local authorities were most likely to answer "don't know" to each question about learning and shared good practice.

Partnership culture

Stakeholders were asked several questions about partnership culture within the GFP. As shown in Figure 32 between half and two thirds of respondents agreed with the following statements: 'the GFP is focused on achieving its objectives'; 'members of the GFP have positive working relationships'; 'the original aims of the GFP are fit for purpose'; and 'different beliefs, backgrounds, and views are respected at meetings'. There was less agreement that issues are sorted out promptly and that there is too much talking and too little action within the GFP.

Figure 32: Partnership culture (n = 199-202)
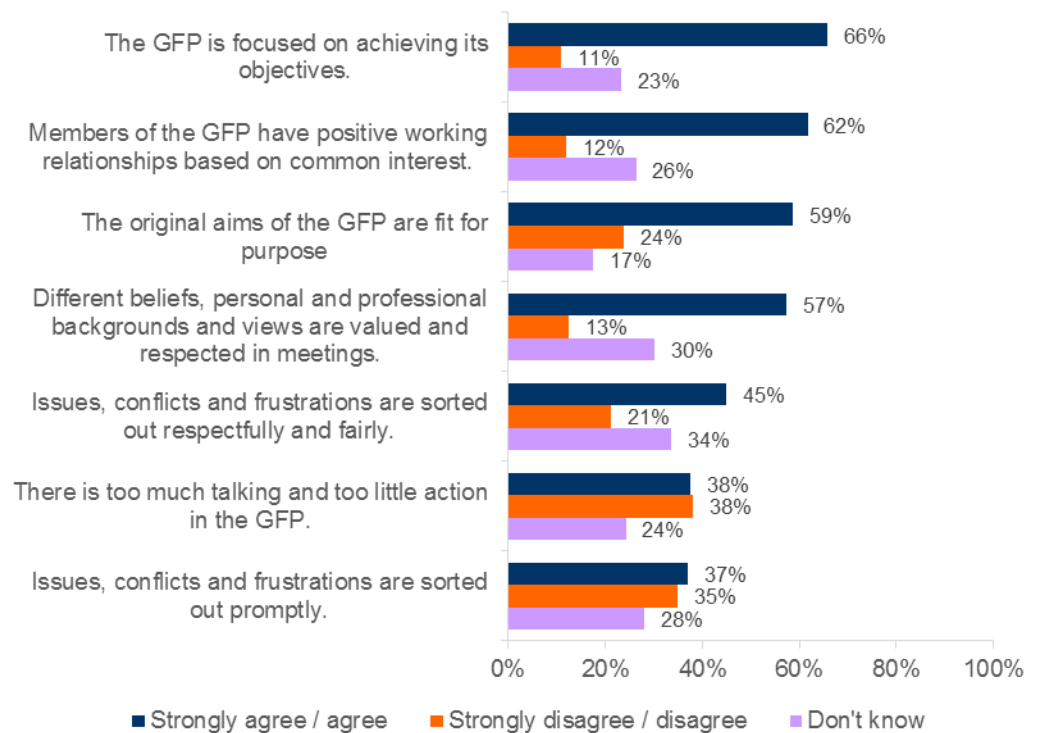
Overall, respondents from:

- Blaenau Gwent were generally comparable to other local authorities with regards to partnership culture, but most likely to disagree that members of the GFP have positive working relationships based on common interest.

- Caerphilly were most likely to respond with "don't know" for most questions.

- Monmouthshire were most likely to disagree that the original aims of the GFP are fit for purpose.

- Newport were most likely to agree with all positively worded questions about partnership culture. In particular, they were significantly more likely to agree that issues and conflicts are sorted out respectfully and fairly and different backgrounds and views are valued and respected in meetings.

- Torfaen were generally comparable to other local authorities with regards to partnership culture, but most likely to disagree that issues and conflicts are sorted out respectfully and fairly.

- All areas were most likely to disagree that the GFP is focused on achieving its objectives and that issues and conflicts are sorted out promptly. They were also most likely to agree that there is too much talking and too little action in the GFP.

- The health board were most likely to agree with all questions about partnership culture. In particular, they were significantly more likely to agree that members of the GFP have positive working relationships based on common interest, issues and conflicts are sorted out respectfully and fairly, and issues and conflicts are sorted out promptly. Respondents from the health board were also more likely to disagree that the original aims of the GFP are fit for purpose.

- The local authorities were most likely to answer "don't know" across all questions about partnership culture. In particular, more than a third indicated uncertainty about whether issues and conflicts are sorted out respectfully and fairly, different beliefs and backgrounds are valued and respected in meetings, and that members of the GFP have positive working relationships based on common interest.

Direction of travel

It is notable that the majority of people we spoke to in the course of this review believe that the direction of travel of the GFP is right. Rather than re-consider the original aims and objectives of the programme, people felt that it should continue along the same path and work towards the following medium term goals:

- Further integration of services at a community level

- Further integration of services across the Gwent area

- A comprehensive care pathway for frail people

- A single point of access and assessment

Considerable concern was expressed at the idea that the programme might be changed because it has not resulted in closure of hospital beds and cashable financial savings. It was felt that the GFP had contributed towards easing the pressure on acute beds and that, as one person put it: *'if you start from getting it right for people everything else will follow'*.

Frustrations with the GFP were mainly about the length of time it takes to get decisions made, unclear communication, problems with the IT system and the Single Point of Access. These are all process issues which can be resolved and clearly have not obscured partners' sense that the GFP is the right solution to the issues health and social care agencies have to tackle in Gwent. It was also noted that integrated services are being supported by policy makers around the world, including the Welsh Government, and that it makes sense to travel in the same direction as national policy.

Challenges and areas for improvement

Stakeholders were asked about challenges for the GFP in the future and what they would do to improve the GFP. These two questions raised many of the same issues, though the

responses about improvements were more precise and practical. **Key issues raised across both include the need for better integration, communication, and consistency across the five areas.**

6.10.1 Key challenges for the future

Respondents were asked what they believed the three biggest challenges were for the GFP in the future. As shown in Figure 33, the top five challenges put forward by 1 out of 5 or more of respondents, were the challenges of funding (31%), ensuring consistency across all five areas (25%), communication – both within the programme and communicating the programme to others (25%), integration between health and social care and wider integration (23%), and the reality that there is increasing demand for services due to an aging population with complex needs (22%).

Figure 33: Key challenges for the future (n = 142)

Challenge	Example quotes	#	%
Funding	*Sustaining the service going forward financially.* *Financial constraints* *Ensuring correct funding is maintained.*	44	31%
Consistency across all five areas	*Every borough should offer the same services and not operate a franchise model* *Achieving consensus on the future model and ensuring consistency in all services across Localities (i.e. completely eliminating the "post code lottery" in relation to Frailty services).* *We need to ensure that we have a seamless service which is reflected across Gwent. Inconsistency leads to doubt and reservations from service users be it patients, carers or our medical/social colleagues*	36	25%

Challenge	Example quotes	#	%
Communication (within and without the GFP)	*Communication- the teams seem so busy it is very rare that information is disseminated effectively within the components on each CRT- in the last 3 years we have not had a team CRT meeting to catch up on the progress of the team, and there is even less communication between the CRT teams. I am sure that the CRT managers do communicate to each other what is going on, but I do not feel this is effectively cascaded down to the staff on the ground.* *Demystifying what the GFP is to both service users and professionals* *As always it is a top-down approach with absolutely no communication between the alleged decision makers and the workers who are ultimately left to try to hold the system together with their hands tied behind their back.*	35	25%
Integration (between health and social care, and wider integration)	*Improving integration across health and social care.* *Integrating the service into core service delivery across Gwent* *Embedding Frailty into Core Services, so everyone owns it as the way we will integrate relevant health and social care services in each locality and not as a WG funded special project, which creates "tensions" with other services.*	33	23%
Increasing demand for services (aging population with complex needs)	*The impact of demographic demand (from increased aged population and increased complexity of needs) and ability of services to cope.* *Increasing numbers of frail elderly complex patients* *Increasing older population and more demand for the service.*	31	22%

Challenge	Example quotes	#	%
Working relationships (within and without the GFP)	*Acute and community staff working together instead of opposition.* *Working in collaboration* *Changing from reactive service to a proactive service working in partnership with stakeholders*	27	19%
Capacity and retention of staff	*Lack of staff to deliver the service... poor morale of staff* *Staffing levels* *Keeping staff*	24	17%
Lack of resources (in community and in acute care)	*Lack of community resources eg, respite beds/ night sitting service* *Reduction in community, secondary care beds Resources to meet the demand and complexity of patients* *To ensure that the appropriate resources are based in the community to support the reduction of hospital beds.*	22	15%

Challenge	Example quotes	#	%
Keeping people in the community and out of hospital	*To keep patients out of hospital and in the community* *Reduction in the intake of hospital beds Length stays in Hospital Keeping elderly people in their own homes* *Getting all teams focussed on admission avoidance and early discharge from hospital*	20	14%
Need for clearer leadership, direction, decision making	*Lack of commitment and understanding by senior managers in both NCC and ABHB Frictions between ABHB and NCC objectives, priorities, targets and budgets* *Clarity of vision across the Gwent area* *Agreeing clear accountabilities to reduce the decision making process*	16	11%
IT, admin, and resource issues for staff	*IT unpredictable* *Ensuring all staff in the CRT are based together and have access to essential things to work effectively (seats, desks, computers and phones).* *Computer access, difficulty using blackberry, limited access, unable to access portal on phone*	15	11%

Challenge	Example quotes	#	%
Referrals (including the single point of access)	*Adequate information on referrals from referrer to SPA. Other services still not understanding where to send appropriate referrals ie CRT or community* *Unclear about what the procedure actually is and what is going to happen once a referral has been made* *Criteria for the service e.g., Reablement*	11	8%
Timely services and consistency of opening hours, 7 days a week	*Consistency and accessibility of service at all times (7/7 24/7)* *Seeing patients in a timely manner.* *7 day cover*	11	8%
Carry on with services, or improve or expand (general)	*Sustaining a quality driven service* *Improving and expanding the service provided* *To either deliver on the original premise or adapt the premise*	11	8%
Collecting appropriate data / the right performance indicators	*Collecting data that evidences impact of our services/ measure performance.* *Agreeing the right measures of success* *Developing a strong evidence base to assess the impact of the service.*	11	8%

Challenge	Example quotes	#	%
Change management, need to respond to change	*Responding to change - being flexible enough to take on more demand and changes in organisations (from strategic - local government re-organisation, to tactical - move on of key postholders)* *Changing hospital culture and supporting hospital staff to accept changes in working practice* *Gaining confidence from inpatient service, changing old habits that they believe hospital is the best place to be.*	8	6%
Allowing for local differences	*Acknowledging local differences* *Measuring outcomes and allowing local flex in how to achieve these* *If the frailty programme keeps heading the way it is heading forcing areas to comply to a single way of working it is going to hit even more problems.*	6	4%

Challenge	Example quotes	#	%
Manage expectations (regarding initial aims)	*Managing expectations of reducing hospital admission, good community care will only defer the need for hospital admission and if a high quality of care is provided in the community, by the time patients attend hospital they will be more complex.* *Matching the expectations that the Frailty programme will help maintain independence of a growing elderly population with increasing complex needs to the reality of patchy community services/provision, inadequate housing and rise in eligibility criteria for social care direct services.* *The original business case was flawed in that it set out specific savings as a result of reducing beds in acute settings and reduced care packages. There was no consideration of reducing escalating cost pressures and as a result of this the frailty programme has failed in its primary goal, and this failure is reflected in each financial report*	6	4%
Miscellaneous challenges	*Ensuring that we are seen as the A&E of the community and that patients are given the same priority for diagnostics etc as secondary care patients i.e. Frailty patients should not be classed as non-urgent once referred as the alternative would be secondary care and then they become 'urgent'.* *Challenge - invest to save payback from acute sector. Did this give acute sector any incentive to make it work?* *Establishing an appropriate medical model for the service.*	16	11%

6.10.2 Key areas for improvements

Respondents were asked what three things they would do to improve the GFP. Figure 34 shows that the top six (two were tied for fifth place) challenges suggested by respondents were: improved integration and partnership working (40%); improved communication outside the GFP – both selling it to and keeping in touch with partners and public (30%);

improved referral process (29%); improved communication and team-working within GFP teams (22%); improved leadership, clarity, vision, and decision making; and more consistency across the five areas (both 18%).

Figure 34: Key areas for improvement (n = 146)

Areas for improvement	Example quotes	#	%
Improved integration and partnership working	*Further development of integrated team working within the GFP* *Better integration of services, service users are still passed around from one service to another, depending on whether a person meets criteria or not.* *Try to improve relationship with primary care; secondary care and community resources.*	58	40%
Improved communication outside the GFP (both selling it to and keeping in touch with partners and public)	*A strong clinically led marketing strategy to hospital and primary care doctors, to evidence the positive impact CRTs are having on people, whilst being honest about performance not yet achieved, using national evidence to demonstrate this is the right vision and strategy.* *Introduce regular communication updates to stakeholders on developments and how objectives are being met.* *Improve communication with patients and carers*	44	30%

Areas for improvement	Example quotes	#	%
Improved referral process	*Have referral pro-forma which referrer can use to ensure the information they give to SPA is relevant and accurate.* *Referral process - at present it is difficult to understand how to refer to frailty, especially Reablement, as each time a client is referred, the process appears to change. Other than contacting SPA, it is not clear if care plans, service plans etc should be completed & the service criteria is also confusing & changeable.* *Review single point of access as this is creating duplication and confusion for people referring into the service*	42	29%
Improved communication and team-working within GFP teams	*Monthly or regular Gwent Frailty Team meetings to ensure improvement in communication with GFP team members and to ensure important information is cascaded down.* *Regular meetings between HSWT, RRHDS, PATH, REABLEMENT and FALLS to feedback and discuss possible referrals between each team* *Improved communication between different elements of CRT, sometimes difficult making internal referrals, feels as if being a "nuisance" when then told "not appropriate".*	32	22%

Areas for improvement	Example quotes	#	%
Improved leadership, clarity, vision, and decision making	*Decision making - Joint Committee decisions take time and can slow the programme down. I would look to have more decisions made outside of the committee.* *A clear vision of what the program wishes to achieve and direction to be taken to achieve this that all staff are aware of with clear governance structure.* *Establish a senior role to ensure there is operational leadership and consistency across all Teams.*	27	18%
More consistency across the five areas	*Consistency in service provision across Gwent - each CRT currently operates differently, it is very confusing!* *Agreement that is the service being delivered rather than the mechanisms and services around this which are paramount, ie change of emphasis to consistency of approach and treatments rather than the same make up of teams* *1. Provide a consistent model across Gwent 2. Re launch the programme after 3 years learning 3. Single Entity for the programme*	27	18%

Areas for improvement	Example quotes	#	%
Improve IT / admin processes	*Sharing Health and social care information using one IT system. Many frustrating hours are spent entering the same information on different systems. Not all information is shared as it needs to be, or at the time it needs to be.* *One computer system.* *Continued resources to IT to ensure the digipen system improves- if all forms can move towards being on digital paperwork it will reduce time spent typing on computers and improve number of patients that can be seen.*	25	17%
Improved communication from management	*Better sharing of information between management and Community Resource Teams* *Continue communication (updates to teams, reports to management meetings, etc) so that it remains visible as to what is being done. Close off feedback loops - i.e. as issues are raised, report back on what happened (e.g. there was an issue with x, we did y and the situation is now z)* *Ensure regular structured and minuted team meetings demonstrating how the information is cascaded within the individual CRT and between the CRT teams.*	23	16%

Areas for improvement	Example quotes	#	%
More staff	*Maintain appropriate levels of staffing and finances to maintain staff morale* *Employ more staff to reduce waiting lists* *Recognition needed that in order for CRT teams to function effectively there needs to be adequate staffing (eg a CRT with one consultant as the only doctor in the team cannot effectively develop a hospital pull service when they are needed to run the hospital avoidance service in the community)*	22	15%
Service hours need to be consistent and in some cases extended, with timely service provision	*Ensure all disciplines respond out of hours, weekends and evenings to ensure continuity of care.* *Extend service hours* *Emergency Social care, for professionals to be able to access care easily over 7 days. Medical Model 7 days weekly and all providing the same amount of input across localities.*	21	14%
Teams need to be housed together, appropriately, and with necessary resources	*Ensure all members of locality teams are located together* *Allow the clinical teams to do their work with the appropriate resources. eg equipment, take the CRT out of office blocks and recognise we are clinical people.* *That we are based in one building that meets the teams needs - enough space, to ensure all staff can sit at a desk with a computer and telephone*	18	12%

Areas for improvement	Example quotes	#	%
Need to use the right performance indicators and properly evaluate the GFP	*Free the program from the initial projections of the service when set up which appear to have been unrealistic and have not taken into account our ageing population. Against these projections we are always deemed to be failing/ under performing which can affect morale.* *Need to be clearer on the outcomes we are measuring* *Clarify and develop clear, realistic performance measures. (e.g. how can you measure a reduction in ambulance conveyances if it is in fact appropriate for that person to be transferred to hospital?).*	15	10%
More responsibility and accountability	*Take more responsibility for the cases instead of passing them on to other teams to do the follow up work* *For staff within Frailty to take responsibility for work passed to them, they always seem to be "passing the buck" Clear roles and responsibilities is needed e.g. the SPA will allocate work to the CRT, then the CRT say it's not for them! This then usually gets passed to EDT who is clearly not responsible.* *Achieve clarity of accountability*	10	7%
More training and development opportunities for staff	*More integrated training opportunities* *Rolling program for learning opportunities* *To develop a career pathway and reward those who have displayed their worth within the teams*	10	7%

Areas for improvement	Example quotes	#	%
Front line workers should be involved in decision-making	*Develop stronger mechanisms to ensure citizens and front line staff help re-shape and improve the service.* *More involvement with "people on the ground" regarding changes proposed rather than discussions only being at Senior levels* *staff that are working on the ground to have input in ideas that people in higher management are putting forward, before their ideas are implemented.*	9	6%
Need to sort out funding issues	*Agree the long term funding and vision thereby removing doubts and fears about the future of the model.* *Release the funding to enable the service to fully develop.* *Ensure that all partners are valued and respected and that resources are fairly allocated. Other teams within the Newport model have seen increases in staffing and finances whilst our out of hours assessments ceased due to lack of funds. This has impacted on the service provided to older people out of hours.*	7	5%
Need flexibility	*More flexibility* *Continue to improve flexibility of support available so that we can use service to achieve individual outcomes.* *Relax about local variation.*	6	4%

Areas for improvement	Example quotes	#	%
Improve the language used in the GFP (e.g., some issues with the term "frailty")	*Name- our clients don't like being called frail* *Service users are put off by the 'Frailty' label* *Use better language to describe patients rather than for example 'pulls'*	5	3%
Miscellaneous areas for improvement (mostly areas for service development within and outside of the GFP)	*Move emphasis from hospital discharge to admission avoidance* *Change the culture in hospitals! For e.g start to Ax for outside existence pre - D/C. If you give a patient tablets four times a day in hospital, how do you know they can take themselves? We have had failed D/cs form hospital staff assuming things and not using common sense i.e. who will be doing this for the client when they get home? Need to work on hospital staff asking questions / reabling clients - not just doing for them.* *Patient should only be told that they will receive short term care which will be reviewed, not told that they will get 6 weeks free care. This makes it difficult to reduce care as patients think it is their entitlement whether they need it or not.*	21	14%

Recommendations

6.11.1 Introduction

This section contains recommendations arising from the issues raised about programme management and governance.

6.11.2 Leadership and governance

We recommend that the GFP should:

- **Appoint a senior leader (effectively a Gwent Frailty Programme Director), employed by ABHB and designate ABHB as the lead agency for the programme.** There is clearly a strong feeling that the programme lacks vision,

direction and, indeed, leadership. This is at the root of many of the issues that people have identified as problematic. We believe the Director ought to be a clinician, as this is important to enable direction to be set across the whole frailty pathway and to gain the trust and support of GPs and secondary care doctors. However, it will be critical to ensure that the person specification for the role includes a demonstrable commitment to community service provision.

- **Review the governance structure, including terms of reference and membership of the Joint Committee and OCG**. The JC and OCG are not working as well as they could at the moment; there is duplication, lack of clarity over how decisions are made and followed up and a sense that some issues are not being properly addressed. The Joint Committee is too big, and the mix of elected members and executive staff creates an environment where there is a risk of 'toeing the party line' rather than having honest discussions about problems. We suggest changing the structure of the programme to draw a clearer distinction between strategic oversight and operational management. A revised structure might look like the one illustrated in Figure 35.

Figure 35: suggested structure for the GFP
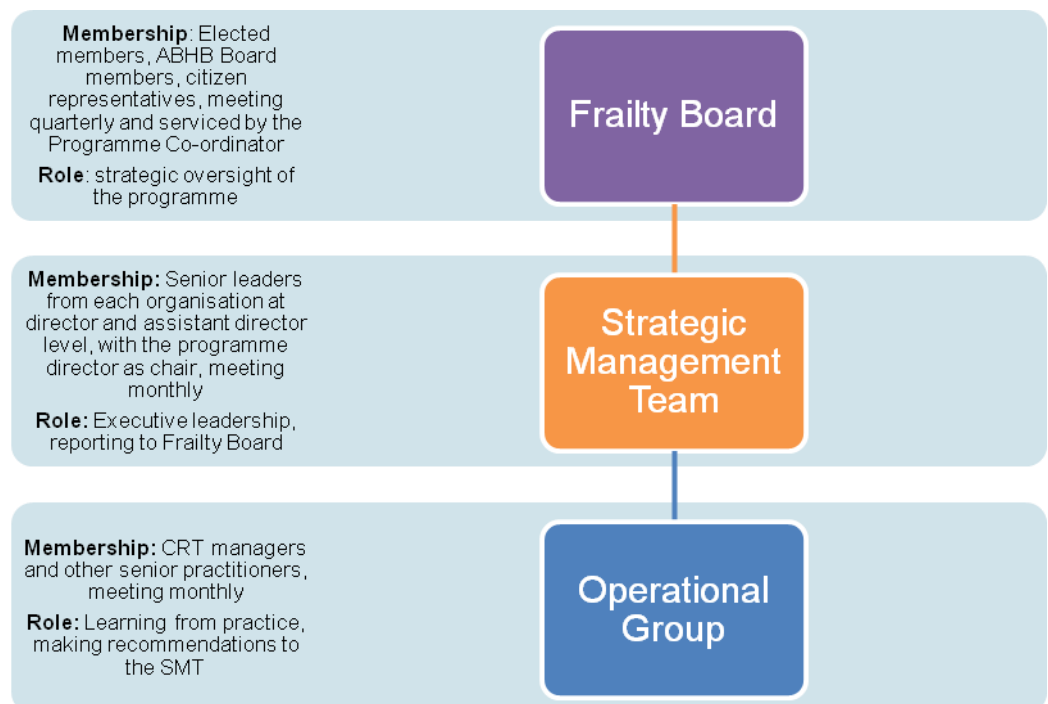
- We also recommend that all meetings adopt more structured agendas, which include some standing items. Every item on the agenda should include a summary of the purpose of the item, whether it is for information or action and what the group is being asked to do, and actions with designated responsibility.

Programme response to the recommendations

Recommendations for improving leadership and governance were agreed by OCG and proposed actions endorsed by the JC.

Concerning the appointment of a lead officer for GFP, it also agreed that:

a) It would not matter which organisation employs the post-holder; what is more important is that the right person is appointed.

b) A decision has already been made to appoint a clinical lead. To be clear, this is a different role and a general, rather than clinical, leader.

c) The post ought to focus on the wider integration of services and a pathway approach which includes Frailty but also wider wellbeing.

d) It is particularly important to make sure the person is not 'sucked into the acute sector'. This a key risk for the role.

e) Gary Hicks and Liz Majer will draft a job description and person spec.

f) The post will be advertised at Head of Service level.

g) Unspent Frailty monies could be used to fund the post.

h) Initially the post will be for two years.

i) The recruitment process will start as soon as possible, with a view to having someone in by November so that they actually have 2.5 years.

With regard to the governance structure, it was also agreed that:

a) As Sue Evans has already started a piece of work, at the request of the Welsh Government, to map local structures, she will link this piece of work in and produce draft Terms of Reference for new governance structures for Frailty.

b) This recommendation lends itself to what organisations are trying to do anyway in terms of integrated working

c) The partnership needs to make the operational group really empowered to 'get on with it' and decide what happens on the ground. There needs to be clear delegation.

d) Once the ToR are designed, Sue will work with the group to will test them out with real issues.

e) The new structure needs to be robust enough to meet WG requirements, robust enough for the S33 requirement and robust enough to allow autonomy.

f) Experts in the GFP will need to help out to manage risks.

g) The partnership also needs to review the financial framework, and agree what success looks like both in terms of finance and outcomes.

6.11.3 The service model

We recommend that the GFP should:

- Work towards implementing both the 'medical model' and fully integrated community services across all local authority areas. This will ensure consistency of service, the ability to deal with complex cases in the community and integration across organisational divides which is beneficial to the service user.

- Ensure that all areas are providing a consistent service with a similar skill mix (although the posts do not have to be identical) and available at a minimum at the times set out in the core standards (in particular until 7pm).

- Review referral criteria to ensure that they are clear and are linked to a care pathway and clinical frailty assessment tool.

- Work towards introducing triage at the point of referral (SPA) using an agreed frailty assessment tool and employing staff at the appropriate level to do this. This will ensure that best use is made of the Single Point of Access; that consistent criteria are being applied and a consistent service offered, and will encourage further integration of services across local authority areas.

Programme response to the recommendations

With respect to the medical model, the OCG and JC **modified** our recommendation. It was agreed that:

- The model should be referred to as the **clinical** model.

- The focus needs to be on the desired outcomes and equity of service rather than prescribing the precise means of achieving them. Outcomes are:
  o Rapid medical review for someone who would normally go to hospital
  o People having access to treatment in their own homes or community settings

- The partnership should explore options for sharing clinical resources across local authority boundaries, as it is expensive to have consultants based in every CRT.

It was also **agreed** that:

a) The new clinical director would be asked to convene a task and finish group to agree the details of how the clinical model would work across Gwent. The group should include GPs.

b) Broadly, the group would be asked to:
  o Decide on the desired clinical outcomes
  o Consider how they are being met, or not, now
  o Oversee a detailed analysis of caseloads (this is a substantial piece of work)
  o Consider Gwent-wide possibilities for resource sharing
  o Make recommendations for what a clinical team should look like (including doctors, nurses and consultants), what should be clinical governance arrangements and which areas the team(s) should work across

c) The partnership should be in a position to implement the group's recommendations by 1 April 2015.

d) Partnership members would agree the data to be used and be consistent in its use.

The OCG and JC **modified** the recommendation on consistency of service, as follows:

- The wording should be rephrased to say 'consistent service principles' – again emphasising that the recommendation is about outcomes for people and value for money rather than actual service delivery.

- The recommendation needs to include making clear the function of each service element as part of a continuum of services for frail people (for example, 'Discharge to assess' and step up, step down).

It was **agreed** that:

a) The new programme director will act as a critical friend to help the programme assess each of the operating models in the five areas against agreed benchmarks.

b) Once the new director is in post he/she will lead a process of revisiting and agreeing original specification for Frailty and deciding whether it is still fit for purpose.

c) Service standards should be redefined where necessary; for example there is no point in having a service open until 8pm for the sake of it if no-one is using it.

d) Once the plan is formulated, it will go to the partnership board for agreement, after which CRTs will be expected to get on with implementing what has been agreed.

The OCG and JC **rejected** the recommendation to introduce triage at the point of referral. The following points were made:

- People want to be able to have direct professional to professional conversations and the central triage gets in the way of that, e.g. a GP may want to have a discussion with a doctor who is already involved with a family.

- In general, participants did not think a central Frailty SPA would serve the programme well in the future because it doesn't fit with a fully integrated model.

- Putting professionals at the front door is where you get the best conversations happening.

- 'One place' means how you get to the *whole team* within a locality.

- If all of this means the SPA should be discontinued, then so be it. If so, the SPA could be disinvested into providing another technological solution in the 5 areas.

It was **agreed** that:

a) A smaller group needs to get together to reframe what is needed.

b) The group will look at (i) what is possible using the technology in place, for example could a caller press a button to be out through to Caerphilly? And (ii) where does the local expertise lie and where are the critical local relationships?

c) The partnership would still want to have one way of accessing an immediate response that will result in hospital avoidance.

6.11.4 Information management

- Considerable investment has been made in the IT system, and it is now beginning to work much better. The GFP should continue to embed the IT system, update it regularly as necessary, and ensure that all partners are using it consistently.

The OCG and JC **agreed** this recommendation. The following points were made in discussions:

a) To know whether the IT system works or not people have to actually use it.

b) At the moment there is no alternative for collecting the data the programme needs. The partnership needs to try harder over the next year to get some decent data.

c) Is it possible that this could turn into a single integrated system in the future?

d) Some LAs are still involved in consortia developing SWIFT systems.

e) What are the implications of the Williams review, which is looking at a new national integrated health and social care system? This could be a solution for three to five years ahead.

f) Development of the system has been agreed to set up part of it to make it suitable for district nurses (this involves turning off some fields). Other fields could be turned off to make it easier for some CRTs to use the system.

g) Frailty information being kept separately from other information is quite a serious governance risk and needs to be looked at as part of the review of governance systems and structures.

It was **agreed** that:

a) All staff should be instructed to use the portal and to log and raise any issues they experience, because there will be a review in 6 months 'time.

b) The review should look at:
   - How to use resources most efficiently
   - Investment required
   - How to overcome the current problems

c) Compliance: CRTs are responsible for their staff filling in all the mandatory fields

6.11.5 Communication

- We recommend that the GFP should introduce more consistent communication with all stakeholders, for example, regular newsletters for CRTs and other health and social care staff, and specific information aimed at GPs. In addition, the GFP website should be updated, as it creates a poor impression as the information is in some case years out of date. This recommendations was accepted.

7 Service user experience and outcomes

Introduction

This section is based on outcomes focused case studies supplied by the CRTs and a survey of GFP service users.

Outcomes focused case studies

Summary of findings

Person context

- There were four main reasons why people were referred to the GFP identified within the case studies, these were: mobility issues, recent falls, shortness of breath, and the need to access an Occupational Therapy (OT) assessment. For all local authorities, except Torfaen, the most common reason that a GFP intervention was required was because of the person's mobility issues. In Torfaen the most commonly identified reason was that the individual had recently been in hospital.
- Furthermore, a number of risk factors were recognised to suggest that the individual required extra support, the most common three risk factors were: a) that the individual lives alone, b) they live in a house with stairs, and c) they have mental health issues.

Person support

- The support offered by the GFP varied between case studies depending on the individual's circumstances. However, common types of support provided included: occupational therapy, physiotherapy, re-ablement interventions, home mobility changes, assistive technology, home care provided and home visits for medical assistance. Only one case study estimated the amount of other services' time the GFP had saved and no case study explored how much the GFP might have saved in monetary terms.

Feedback

- Most practitioners reported positive feedback from stakeholders, most commonly this was linked to the fact that the person was able to avoid an admission into hospital and could stay in their own home for treatment. Other positive comments were about the trust built up by GFP staff, developing the individual's confidence, the speed and flexibility of the service. Parents/carers were specifically positive about the way that the GFP had helped put their mind at rest and agencies were specifically pleased they could work effectively with the GFP to achieve positive outcomes.
- Reasons why people were less positive varied with each reason shared by

two stakeholders at most. Examples of the reasons offered included: (a) clients did not feel that the support they received was necessary, (b) clients did not feel that their needs were being met fully and (c) clients were unhappy they were admitted to hospital.

Impact and outcomes expected

- The three most commonly cited outcome measures were: (a) a person maintaining independence within their home, (b) preventing hospital admission, and (c) maintaining/improving mental health and emotional wellbeing.

Lessons learnt

- The three most commonly reported improvement areas referred to: a) a lack of resources available, b) better working with external agencies, and c) more night care available. The three most noted ways that the GFP was working well related to: a) positive team working, b) good outcomes and c) the ability to integrate multiple services to provide the individual with a seamless and timely response.

7.2.1 Overview

This section presents an analysis of 44 outcomes focussed case studies[21] (case studies) that were designed by Cordis Bright and completed by practitioners from the five local authority areas across which the Gwent Frailty Programme (GFP) operates.

7.2.2 Methodology

The outcomes focussed case study and instructions for how it should be completed was drafted and designed by Cordis Bright and agreed with key stakeholders from the GFP.

The Frailty Co-ordinator contacted all community resource team managers in each of the five local authority areas (Newport, Torfaen, Blaenau Gwent, Caerphilly and Monmouthshire) to collect completed case studies by practitioners. Cordis Bright received 9 case studies each from Torfaen and Newport, 10 from Caerphilly, 11 from Monmouthshire and 5 from Blaenau Gwent.

Practitioners were asked to think about three cases of individuals that they had worked with recently that fit into each of the following three categories:

- **Positive:** A case where the programme had impacted positively.

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[21] Throughout this section we will abbreviate 'outcomes focussed case studies' to 'case studies for simplicity'.

- **Mixed:** A case where the programme had a mixed impact (i.e. where things could have gone better).

- **Could be better:** A case where the programme did not work very well (i.e. outlining how things could be improved in the future).

The rationale for this was to gather a variety of views regarding the way that the GFP has worked to support individuals and avoid choosing only those instances where the GFP's involvement led to successful outcomes.

Figure 36: Number of case studies that were rated positive, mixed or could be better (n=44)

Local authority	Positive	Mixed	Could be better	Not stated	Total
Newport	3	3	3	0	9
Torfaen	3	3	3	0	9
Blaenau Gwent	2	1	1	1	5
Caerphilly	4	3	3	0	10
Monmouthshire	7	2	1	1	11
Total	**19**	**12**	**11**	**2**	**44**

7.2.3 Analysis

Analysis of the 44 case studies was undertaken using the following two steps:

Step 1: The 44 individual case studies produced in Microsoft Word were consolidated into an Excel spreadsheet to allow a matrix-based analysis and segmentation of the data.

Step 2: Each aspect of the case studies was analysed for common themes and issues as well as any differences. These themes are presented in detail in the next section.

7.2.4 Average age of case study subjects

Figure 37 shows the average age of people that were covered in the case studies sent by the five local authorities. Overall, across all five local authorities, the average age of the subjects (individuals) in the 44 case studies was 78 years old.

All case studies were about people over the age of 50, with the exception of Torfaen where one individual was 38 years old.

Figure 37: Average age of person by local authority

Local authority	Average age	Range of ages	Number
Newport	86	76-93	8
Torfaen	75	38-87	9
Blaenau Gwent	75	55-89	5
Caerphilly	74	50-85	10
Monmouthshire	75	58-99	11
For all five LA areas	78	38-99	43[22]

7.2.5 Person context

All 44 case studies gave detail of the situation that led to a GFP intervention being made. Responses to this section of the case study have been split into three main categories to describe the situation that led to a GFP intervention, these were:

- How the referral was made to the GFP

- The reasons why the individual was referred/why a GFP intervention was required

- Additional features of the individual's situation that indicated that they were in need of support.

7.2.6 How the referral was made to the GFP

Of the 44 case studies that were completed, 29 mentioned how a referral was made to the GFP. For the majority of these cases (13 out of 25) the referral was made directly by the GP. Other methods include being referred by the hospital (9 cases), a nurse (4 cases), the CRT (one case), a social worker (one case) or through a portal (one case).

In all local authorities except Caerphilly a referral by the GP was the most common source (in Monmouthshire this was as common as referral by a Nurse). In Caerphilly the most common source of referral was through a hospital.

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[22] For only one case study was an age not given, this was for Newport where the person was described as 'elderly' but a specific age was not given (therefore the total in Figure 2 is 43)

Figure 38: How the person was referred to the GFP by local authority area

How was person referred	Newport	Torfaen	Blaenau Gwent	Caerphilly	Monmouthshire	Total
Referred by GP	6	2	1	2	2	13
Referred by hospital	0	4	1	4	0	9
Referred by nurse	1	1	0	0	2	4
Referred by CRT	0	0	0	1	0	1
Referred by social worker	0	0	0	1	0	1
Referred by Portal	0	0	0	0	1	1
Total	7	7	2	8	5	29

7.2.7 The reasons why an intervention from the GFP was required

Figure 39 shows that a wide range of reasons were given to explain why the person required GFP support. Clients were often referred for multiple reasons. These reasons fell into two main categories: where a person had a specific medical condition as well as where specific types of treatment/support were required. The four most common reasons why an individual was referred were as follows:

- Mobility issues (21 cases)

- Recent falls (12 cases)

- Shortness of breath (10 cases)

- To access an Occupational Therapy (OT) assessment (10 cases)

7.2.8 Additional features of the individual's situation that indicated they were in need of support

Along with health conditions and the need for specific interventions, a number of indirect risk factors were identified which suggested that the individual was in need of support, again clients often had multiple additional risk factors. The five most cited reasons were as follows:

- The individual lives alone (9 cases)

- They live in a house with stairs (9 cases)

- They have mental health issues (7 cases)

- They lack family support (5 cases)

- They rely on family/carer for daily support (5 cases)

When broken down by local authority, the number of case studies meant that each risk factor was associated with few cases, and so whilst there are some differences in the most common risk factors across local authorities, this represents the individual circumstances most cases showed.

Figure 39: Reasons why the person was referred

Why was person referred	Newport	Torfaen	Blaenau Gwent	Caerphilly	Monmouthshire	Total
Mobility issues	6	4	3	3	5	21
Recent falls/For a referral for a falls assessment	5	0	2	2	3	12
Shortness of breath	2	3	1	1	3	10
For an OT assessment	4	2	1	1	2	10
Recent hospital admission	0	6	1	0	2	9
Rapid Medical Assessment	2	2	2	3	0	9
Unable to wash/dress independently	2	3	0	2	0	7
Pain i.e. chest pain, back pain	2	2	0	1	2	7
Access care and support	2	0	0	3	1	6
Referral to PT	2	0	0	1	2	5
Pneumonia	0	3	0	0	1	4
Fractured bone	1	1	0	1	1	4

Why was person referred	Newport	Torfaen	Blaenau Gwent	Caerphilly	Monmouthshire	Total
Referred to CRT	0	0	1	3	0	4
Referral to Social Worker	1	2	0	0	0	3
Request for Calls	0	1	1	1	0	3
Joint swelling and pain	1	0	1	0	0	2
COPD	0	0	1	0	1	2
UTI	0	1	0	0	1	2
Soft tissue damage	1	0	0	0	1	2
Fatigue	0	0	1	1	0	2
Hernia	0	1	0	1	0	2
Pulmonary Fibrosis	0	0	0	0	2	2
Gout	1	0	0	0	0	1
Multiple Sclerosis	0	0	0	0	1	1
Reablement	1	0	0	0	0	1
Cancer	0	0	1	0	0	1

Figure 40: Other risk factors that indicated that the person needs support

Other risk factors	Newport	Torfaen	Blaenau Gwent	Caerphilly	Monmouthshire	Total
Lives alone	1	4	0	1	3	9
House with stairs/ stays downstairs	2	4	1	0	2	9
Mental health issues	1	2	2	1	1	7
Lack of family support	2	1	1	0	1	5
Relies on carer/family support	1	1	2	0	1	5
Memory problems (including dementia)	1	0	1	1	1	4
Kidney impairment	1	2	0	1	0	4
Lives with ill relative	0	1	0	2	0	3
Heart conditions	0	0	2	0	1	3
Fragile skin	1	1	0	0	0	2
History of stroke	0	1	0	0	0	1
History of drug abuse	0	0	1	0	0	1
Asthma	0	0	0	0	1	1
Anaemia	0	1	0	0	0	1
Cataract	0	0	1	0	0	1
Diabetes	0	1	0	0	0	1

7.2.9 How the person was supported

As part of the case study, practitioners were asked to comment on how the person was supported both by the GFP and other services. Within their response practitioners were asked to comment on:

- Which services were delivered by the GFP and why they were delivered.

- The nature of the intervention delivered, i.e. what the GFP was seeking to address and how the service helped the person, including what may have happened had the GFP not been involved and how much other service time (in days) the GFP saved and the monetary value associated with this.

- What activities were provided and why the methods were chosen.

All but one practitioner answered this part of the case study. However, practitioners typically did not go into the level of detail requested, for instance only one practitioner commented on the estimated time saved (no monetary values were given). Also, no practitioners commented on why the methods of intervention were chosen, however in some cases the initial assessments carried out were detailed.

The specific nature of the intervention differed by the individual circumstances of each case. By analysing the responses to this question by local authority, a number of general support interventions across all local authorities were identified.

Support for an individual most typically began with an assessment. Commonly, assessments included: Multi-disciplinary assessments, CRT joint assessment, occupational therapy (OT) assessment, physiotherapy (PT) assessment, social worker assessment or an assessment by a rapid response unit/team.

After an initial assessment, the following common types of support were provided:

- Occupational Therapy (OT)

- Physiotherapy (PT)

- Reablement interventions (e.g. balance, exercise activities, confidence building and advice)

- Home mobility changes made (e.g. stair lift fitted, house rails, toilet seat and bath seat)

- Assistive technology (e.g. key safe)

- Home care provided, support with meals, washing and dressing

- Home visits for medical assistance

Alongside providing specific interventions, case studies also detailed additional referrals which were made. These were usually a referral for a falls clinic appointment, contacting

social services, referral to a district nurse or referral to a GP. These additional referrals were made alongside ongoing monitoring.

Case studies also commented on what would have happened had the GFP not been involved with the individual's case. Being admitted to hospital or being discharged at a later time were the most common potential consequences, with one practitioner stating the GFP's involvement avoided 40 days of hospital care. Practitioners also stated that the GFP intervention also reduced waiting times for assessment and reduced the duplication of assessments by different agencies.

As highlighted, most cases had features of the above support. However, in certain local authorities a few cases were identified that had slightly different features than those mentioned above. Specifically:

- In Blaenau Gwent, in three (of five) case studies there was additional mental health specialist involvement in supporting clients, and in one case study anger management support was provided and the client was referred to a dietician. The GFP support was also highlighted as preventing carer breakdown.

- In Torfaen, in one case study it was noted that without the GFP the client was likely to self-neglect.

- In Caerphilly, in one case study it was noted that without the GFP there would have been reduced information sharing.

- In Monmouthshire, in one case study additional support included twice daily calls to the client.

7.2.10 Feedback from stakeholders on the impact of the GFP

Overview

Feedback was provided in 38 case studies, and feedback was from one or more types of stakeholder (client, family/carer, or another agency[23]). The feedback was assessed to see if it was entirely positive, or if there was any negative feedback about at least one element. Most stakeholder's stated that they were pleased with all aspects of the services that they received from the GFP.

In Newport there were two case studies (out of 6 where feedback was provided) where at least one negative element was fed back. In Torfaen this was four case studies (out of 8), in Blaenau Gwent two (out of 5), Caerphilly one (out of 9) and in Monmouthshire out of the 10 case studies where feedback was received no negative feedback was provided.

In this section, the positive feedback is discussed, followed by feedback which contained at least one negative element.

Figure 41: Number of case studies that report feedback from stakeholders by local authority area

Local authority	Number of client feedback	Number of family/carer feedback	Number of other agency feedback	Total number of case studies with stakeholder feedback
Newport	6	3	1	6
Torfaen	8	5	3	8
Blaenau Gwent	4	4	3	5
Caerphilly	4	6	3	9
Monmouthshire	7	5	4	10
Total	**26**	**25**	**13**	**38**

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[23] Agencies that were specified were: GP (5), social services (social worker) (4), occupational therapist (1), nurse/district nurse (3), Hospital staff (1).

Figure 42: How different groups of stakeholders rated their experience with the GFP by local authority area

Number of clients feedback	Number of clients feedback	Number of clients feedback	Number of Family/carers feedback	Number of Other agencies and feedback
Newport	Pleased with all aspects	4	3	1
	Dissatisfied with at least one aspect	2	0	0
Torfaen	Pleased with all aspects	5	4	2
	Dissatisfied with at least one aspect	3	1	1
Blaenau Gwent	Pleased with all aspects	4	4	1
	Dissatisfied with at least one aspect	0	0	2
Caerphilly	Pleased with all aspects	4	6	2
	Dissatisfied with at least one aspect	0	0	1
Monmouthshire	Pleased with all aspects	7	4	4
	Dissatisfied with at least one aspect	0	0	0

Positive feedback from stakeholders

Clients

Apart from generic feedback stating that they were happy with the service, most of the more detailed positive feedback offered by clients was linked to the fact that they had been able to avoid a hospital admission and were able to recover/get treatment in their own home, this was considered to be a major benefit of their treatment by the GFP service. This is evidenced in the following quotes from the case studies:

> *'This lady could not thank everyone involved enough as we were able to keep her at home and treat her until she felt better. Rapid Response nurse called twice a day and also informed her GP of the course of treatment.'*

Case Study 17, Torfaen

> *'Person was happy to be at home'*

Case Study 42, Monmouthshire

> *'All parties have displayed deep gratitude due to the GFP teams intervention enabling the service user to remain at home whilst receiving the medical support, rehabilitation and social care required'*

Case study 44, Blaenau Gwent

'Both the client and his wife were very thankful for the service and appreciative of the treatment and assessment in their own homes.'

Case study 18, Torfaen

Other positive feedback was around the following areas:

- The clients felt that they were able to develop a trusting relationship with GFP staff:

'Patient has built a positive relationship with team with trust an important factor and through copd homecare she can self-refer into team but this is appropriate with short involvements. Patient no longer requires support of mental health specialist but is aware that the service is there when needed. Patient believes that the team was crucial in helping her to come to terms with her illness and not showing pre conceived ideas regarding mental health /past history.'

Case Study 22, Blaenau Gwent

'Patient would always ring me first as easy access on mobile and told me "only person I can get sense out of". Trusting relationship.'

Case Study 37, Monmouthshire

- The service had helped develop the client's confidence:

'Her confidence has improved greatly and her anxieties have been reduced. She is back to being completely independent with all aspects of her daily living and reports she is very happy'

Case Study 26, Caerphilly

'Confident and reduced pain enabling to engage in what was important to him to live a fulfilled life.'

Case Study 33, Monmouthshire

- The client was very positive about the speed and flexibility of the service:

'felt she received fast and thorough care and all her needs and worries were listened to and help provided to keep her at home'

Case Study 36, Monmouthshire

'Service user and close family members have highly praised the team and the support provided through GFP commenting upon the swift nature of intervention, flexibility to meet the service users changing needs and client centred approach to assessment and intervention.'

Case Study 44, Blaenau Gwent

Family/carers

Similarly for the family/carers of the client, there was positive feedback about the GFP including that it enabled the client to stay in their own home. Family/carers also commented on their satisfaction with the overall care package, and how this was effective in addressing the client's needs:

> *'Mrs R's sons and daughter reported that they were very happy with the service they received from the Frailty Team and that they continue to receive. They have been very happy with the care package that Mrs R has been receiving.'*

Case Study 5, Newport

> *'Wife is reassured care planning will consider her needs and ongoing needs of husband towards the end of therapy input'*

Case Study 27, Caerphilly

> *'"Made a terrific difference ", has equipment that you have has helped him walk, transport food, had hernia can't bend forward thus equipment has helped safety and independence. Rails on stairs helped…Team were really helpful. They explained about falls and what may have contributed to them. Has better walking aids which have increased his confidence. No further falls.'*

Case Study 28, Caerphilly

> *'Husband was amazed that when he arrived back from work to help with this crisis that his wife's care package had already been adjusted and increased within an hour of assessment (while he was at work) & that equipment was delivered the following day'*

Case Study 36, Monmouthshire

Family/carers also reported that the GFP had helped them was by putting their mind at rest about the client/enabling them to get some respite, for instance:

> *'Daughter-in-law very pleased and felt her mind was out at rest, enabling her to continue to work normally without the concern and worry that the client is not managing at home.'*

Case study 15, Torfaen

> *'Mrs C's family reported that they felt that the care package was necessary as it gave them piece of mind…Mrs C's family members were experiencing high levels of stress due to her inappropriate behaviour and required a period of respite in order to manage this. They were due to have a holiday and so it was agreed that we support Mrs C during this time to give them peace of mind.'*

Case Study 6, Newport

Agencies

For agencies, the reasons for providing positive feedback were linked in many instances to the fact that the client was able to stay in their home to receive care/treatment. Other agencies also commented on the ability to work alongside the GFP team to reach positive outcomes for the client:

> *'Social services feedback- positive, worked with GFP to reach a positive solution to ensure the person remained at home.'*
>
> Case Study 8, Newport

> *'Her G.P was very grateful to the DR's and nurses in the team for treating this lady at home and also for the communication which was maintained.'*
>
> Case Study 17, Torfaen

> *'Responsive, team approach – joined up and delivered at home, thus picks up environmental risk factors that weren't necessarily detected when clients were seen in outpatient departments or clinics. Team also has access to CRT Dr, diagnostics, and arranges medical assessment in the community, or at Falls Clinic or Medical Hot Clinic etc if required.*
>
> Case Study 28, Caerphilly

In Monmouthshire one of the case studies also highlighted the speed of the intervention:

> *'GP impressed with speed of intervention addressing person's need.'*
>
> Case Study 43, Monmouthshire

Less positive feedback from stakeholders

Nine instances where stakeholders were not entirely satisfied with the service provided were offered. Reasons why stakeholders were dissatisfied with at least one aspect of the service they had received from the GFP varied.

For instance, in two cases, clients did not think that the support they received from the GFP was needed:

> *'Mrs C reported that she was very happy with the care service but felt that they were not necessary as she was managing herself care within her home'*
>
> Case Study 6, Newport

> *'But also stated she can do it all herself and does not need our help.'*
>
> Case Study 14, Torfaen

One client in Torfaen was also unhappy as they felt their needs were not being effectively met:

> *'Negative feedback from client as client feels she is entitled to 6 weeks free care which was stated by the OT in hospital. Lacks confidence completing personal care tasks even though client completes these tasks independently.'*
>
> Case Study 13, Torfaen

A client in Newport was also unhappy with being admitted to hospital:

> *'Patient feedback- not happy with hospital admission but understood the restrictions to service and that safety is paramount.'*
>
> Case Study 9, Newport

In Torfaen, one agency along with one client were unhappy with the speed of the service offered:

> *'Pt on list for much longer than average 6 weeks - difficult to discharge and time/skills intensive. Did show some objective improvement but did not achieve goal.'*
>
> Case Study 10, Agency Torfaen

> *'Not all goals achieved but patient feeling more positive – improved motivation to continue rehab programme. In spite of this also felt some disappointment at slow speed of progress in other areas – attempted to reassure patient by explaining that she had been very unwell so a long period of rehab was to be expected.'*
>
> Case Study 12, Client Torfaen

One case study in Torfaen highlighted that the family felt the service had been too intrusive.

> *'Difficult for family – input felt intrusive at times.'*
>
> Case Study 12, Torfaen

In Monmouthshire one family member highlighted they would have appreciated earlier communication:

> *'Daughter concerned/lack of understanding of CHC process – earlier explanations would have helped'*
>
> Case Study 37, Monmouthshire

Agencies in two case studies also highlighted a lack of information sharing and communication between services:

> *'Psychiatrist was pleased as we had picked up on lithium toxicity but felt that mental health specialist should have at that time made more impact on the other services of the detrimental fact of this situation. '*
>
> Case Study 19, Blaenau Gwent

> *'GP when contacted had not been asked by bed management if CRT could manage and unhappy as admission was safest option'*

Case Study 24, Caerphilly

In Blaenau Gwent, in one case study a concern regarding the duplication of services was also highlighted:

> *'District nurses felt at times that there was duplication of services as sometimes tasks were done by both teams.'*

Case Study 21, Blaenau Gwent

7.2.11 Impact and outcomes expected

Each practitioner was asked to fill in a table to illustrate the impact that interventions from the GFP had on the person that the case study was about. This table asked for six pieces of information: a) the outcome measure, b) the area of impact expected, c) the target and timescale, d) How the outcome was measured, e) what the impact was and f) any further comments/referrals.

Practitioners were asked to record information for as many outcome measures as were relevant for the particular case, and often multiple outcomes were recorded. In four of the cases studies no outcome measures were recorded.

Outcome measures from the case studies fell into 12 main areas, and are detailed in Figure 43. This figure also provides examples of b) the area of impact expected for each outcome area drawn from relevant case studies.

An example case study highlighting what information was recorded for c) how the target and timescale, d) how the outcome was measured, and e) what the impact was and any further comments/referrals for each outcome measure area is also provided.

The three most commonly cited outcome measures were:

- **A person maintaining independence within their home**. This outcome measure was cited 24 times and areas of impact expected included reduced risk of falls, maintaining own standard of personal hygiene and management of own meals and medication.

- **Prevent hospital admission**. This was recorded 10 by practitioners. Areas of impact expected related to this outcome measure included the following: remaining at home to receive treatment, for the condition to improve without deterioration and to reduce the risks associated with hospital admission.

- **Maintained or improved mental health and emotional wellbeing**. This was recorded 9 times by practitioners. Areas of impact expected included: reduced

anxiety levels, medication for the mental well-being and appropriate, monitoring of their mental health, and increasing the individual's emotional wellbeing

Figure 44 shows how the outcome measures were recorded by each local authority. The final row shows for how many case studies no outcome measures were recorded. In Caerphilly for seven (out of ten) case studies no outcome measures were recorded. In Newport this was the case for three (out of nine), in Torfaen one (out of nine) and in Monmouthshire two (out of eleven).

In Newport, Torfaen, and Monmouthshire, maintain independence in own home was the most common outcome measure area. However, in Blaenau Gwent and Caerphilly, the most common outcome measure area was preventing hospital admission. Also notably, in Torfaen maintaining or improving mental health and emotional well-being, and achieving social and economic well-being were outcome measure areas used three times.

Figure 43: Summary impact and outcomes expected grid

Outcome Measure areas (Number of Outcomes)	Examples of area of impact expected	Example Target and Timescale	Example How measured	Examples Actual impact	Example Comments/Onward referrals
Maintain independence in own home (24)	Reduce risk of falls, Maintain own standard of personal hygiene safely, Promote independence in own home, To manage meals and medication	Return home with support in 2 months.	Client still at home with support	Still at home safe and secure.	Referral to day centre and ongoing attendance.
Prevent hospital admission (10)	Remaining at home to receive treatment, Condition to improve without deterioration, Reduce the risks associated with hospital admission	No additional infection at discharge date 30/04/14	Venepuncture/bloods for infection markers. Observation of patient.	No additional infections.	Referred back to GP, Practice nurse and INR clinic.
Maintained or improved mental health and emotional wellbeing (9)	Reduced anxiety levels, Patient use appropriate safe, medication for the mental well-being and appropriate, monitoring of their mental health, Ensure patient understands their illness and the limitations of this, Increase the individual's emotional wellbeing	Patient able to access mental health services though rapid response team limiting stigmatisation.	Self-referral, report from rapid response team.	Patient has been able to remain mentally and emotionally well at home without impacting on other services. Rapid response team have gained skills regards anger management.	Patient is happy with service but staff aware that if mood changes drastically then referral to GP would be needed if anxiety/mood requires other service But presently managed well in frailty.
Support family relationships/reduce	Enable respite for the carer, Reduce the risk of carer breakdown, Enable patient to take part in	Maintain cleanliness of property in 2 week	Property will be cleaned on	Person will have a reduction in skin	Cleaning agency for twice a week

Outcome Measure areas (Number of Outcomes)	Examples of area of impact expected	Example Target and Timescale	Example How measured	Examples Actual impact	Example Comments/Onward referrals
carer breakdown (8)	family activities, Enable patient to stay at home and support unwell partner		discharge and will be maintained	infections and profession contact	
Improve health conditions (4)	Reduce risk of health deterioration/Hospital admission, Reduce risk of skin breakdown and infection, Receive treatment safely and monitor response	On-going	District nurse team to monitor and manage leg dressings on a daily basis. To continue to sleep in hospital bed downstairs with pressure relief mattress.	No concerns have been reported.	Client continues to sleep downstairs and her sons are no longer transferring her on the stair lift.
Achieving social and economic well-being (4)	Ensure there is no increase in financial burden to the patient and their husband, Reduce patient fatigue and breathlessness, Provide emotional support and education about health problems	4 weeks	Feedback from client. Assessment of mood	Symptoms improved and his emotional well-being was maintained.	n/a
Protection from abuse and neglect (2)	Monitor sufficient nutrition and hydration, Maintain a healthy relationship with son	No reduction in appetite or weight loss over 2 weeks	Feedback from carers via their Documentation on nutrition intake	Nutrition and hydration maintained. Carers provided lunchtime meal as instructed, family were able to support evening meals	Mobility much improved, PATH completed planned support and the person now able to support own meal preparation during the day

Outcome Measure areas (Number of Outcomes)	Examples of area of impact expected	Example Target and Timescale	Example How measured	Examples Actual impact	Example Comments/Onward referrals
To improve mental health & emotional well-being (2)	Mood to improve with decreased feelings of isolation, Enable the patient to remain independent in their home	100% of goals achieved in 6/52	SMART goals set from initial assessment & reviewed weekly	Pt able to live in own home independently & to access outdoors for social interaction & functional activities.	Pt regained confidence which impacted positively on well-being.
Access appropriate housing (1)	Access extra care facility accommodation	No timescale – as and when a property becomes available.	Contact Extra care facility to establish waiting list place.	No impact	Due to hospital admission
Earlier discharge from inpatient setting (1)	Freeing up hospital bed	Aim for EDD set by ward.	Weekly review while inpatient & liaison between inpatient team & GFT.	D/c on original EDD	Minimised length of inpatient stay
Patient to receive a service that meets their physical needs (1)	Enable patient/carer to feel comfortable with the appropriate service	Carer stress to be reduced over a period of time through continuity. The patient to accept appropriate services in a short time	The patient has accepted care agency with no concerns. Carer is feeling less stressed through carers assessment.	Less stress for carer with continuity of care. The patient has accepted seamless care from agency. GP visits and there are less calls from carer due to continuity.	Referred to social worker for continuing healthcare assessment with appropriate services attending multi-disciplinary meeting
Improve the management of the	Enable the person to make appropriate choices and receive advice.	Reduced hospital admissions by 100%	By checking clinical work station. Visiting	Has not been admitted since, reducing risk of	Patient has more confidence in self-

Outcome Measure areas (Number of Outcomes)	Examples of area of impact expected	Example Target and Timescale	Example How measured	Examples Actual impact	Example Comments/Onward referrals
long term conditions (1)			at least monthly, more regular when unwell	hospital infection	managing his condition. Has rescue medication to use

Figure 44: Outcome Measures recorded in case studies by Local Authority

Outcome Measure areas	Newport	Torfaen	Blaenau Gwent	Caerphilly	Monmouthshire	Total
Maintain independence in own home	7	12	2	0	3	24
Prevent hospital admission	0	2	3	3	2	10
Maintained or improved mental health and emotional wellbeing	3	2	2	0	2	9
Support family relationships/reduce carer breakdown	3	3	0	0	2	8
Improve health conditions	2	0	1	0	1	4
Achieving social and economic well being	0	3	1	0	0	4
Protection from abuse and neglect	1	0	0	0	1	2
To improve mental health & emotional well being	0	2	0	0	0	2
Access appropriate housing	1	0	0	0	0	1
Earlier discharge from inpatient setting	0	1	0	0	0	1
Patient to receive a service that meets their physical needs	0	0	1	0	0	1
Improve the management of the long term conditions	0	0	0	0	1	1
No response	3	1	0	7	2	13

7.2.12 Lessons learnt

Of the 44 case studies that were returned to Cordis Bright, 18 completed a section about the lessons learnt. Figure 45 lists the number of case studies by local authority that reported a lesson learnt. In Caerphilly the lessons learnt section was not completed in any of the case studies.

Figure 46, presents information broken down by key themes that emerged in these lessons learnt. More broadly we have categorised the lessons learnt as improvement areas and positive comments. Figure 46 lists all of the lessons learnt comments.

Improvement areas

The three most commonly cited improvement areas amongst these 18 reported lessons learnt were the following:

Three case studies from two boroughs (Newport and Torfaen) suggested that there was a **lack of resources** available to the programme. However, it is worth noting that for each of these three case studies the issues with the amount of resources differs slightly. In one of the case studies from Newport,   it is mentioned that there are delays referring to other agencies due to a lack of resources, in the second case study from Newport they mention a specific lack of support available for people with behavioural issues and their families. In Torfaen, the lesson learnt specifically details a need for more community/respite beds for non-acute admissions (see Figure 46 for the exact quotes).

Three case studies from two boroughs (Newport and Torfaen) suggested that the GFP could improve by offering **better/smoother working with external agencies**. For instance, the following comment was made:

> *'Handover to Community PT[24] should have been made sooner as CRT involved for too long.'*
>
> Case Study 10, Torfaen

Two case studies raised the need for **more night care** available to clients using the GFP. Both case studies (from Newport and Torfaen) highlighted that if night care services had been available then more hospital admissions could be avoided. For instance:

> *'If there could be protected place for night sitting service within Crossroads, or if an independent service could be available for cases such as these it would prevent admissions to secondary care because of safety issues.'*
>
> Case Study 9, Newport

Other improvement areas that were suggested by only one case study, were as follows:

---

[24] Physiotherapy

- Gaps in the system during Bank holidays

- A need for better engagement with the client using the GFP services

- Avoid raised expectations that might not be met

- Quicker access to diagnostics

- Multi-team meetings

- Having same day delivery of equipment.

Positive comments

There were three key themes from the positive comments that were shared in the case studies about the GFP. These were as follows:

Five case studies (from three local authorities: Blaenau Gwent, Torfaen and Monmouthshire) reported that the **GFP integrates multiple services which consequently leads to a seamless and timely response** for the client. In two of these cases this was linked to the patient being able to return home sooner. For instance, a comment from Monmouthshire highlights this:

> *'Being able to work as an integrated service has helped to provide the correct support for the individual.'*
>
> Case Study 38, Monmouthshire

Three case studies, all from Blaenau Gwent, suggested that a strength of the GFP was its **positive team working**, for instance a practitioner from Blaenau Gwent said the following:

> *'Team cohesiveness and a holistic approach can reduce other services that may impede progress in cases that finds over involvement detrimental to their health.'*
>
> Case study 22, Blaenau Gwent

Two case studies from Blaenau Gwent and Monmouthshire reported that the GFP has been able to provide **good outcomes** that have helped to prevent serious situations occurring.

Figure 45: Number of Case studies that mentioned a lesson learnt

Local authority	Number of case studies that gave a lesson learnt
Newport	4
Torfaen	6
Blaenau Gwent	4
Caerphilly	0
Monmouthshire	4
Total	18

Figure 46: Summary of lessons learnt

Local authority	Improvement/positive area	Quote	Number
Main improvement Areas			
Newport Newport Torfaen	Lack of resources	Newport: 'delays when referring to external agencies and due to lack of resources.' Newport: 'Limited resources in Newport to access support for those with behavioural issues and support for carers of family members experiencing behavioural issues.' Torfaen: 'Need for increased resources such as community/respite beds for non-acute admissions.'	3
Newport Newport Torfaen	Better/smoother working with external agencies (including handover and referral processes)	Newport: 'There needs to be a more streamlined system between the GFP and social services in order to ensure patient care is not compromised and to remain within their own home.' Newport: 'we often experience time delays when referring to external agencies' Torfaen: 'Handover to Community PT should have been made sooner as CRT involved for too long.'	3
Newport Torfaen	Night care	Newport: 'If there could be protected place for night sitting service within Crossroads, or if an independent service could be available for cases such as these it would prevent admissions to secondary care because of safety issues.' Torfaen: 'If Community /respite bed or night care had been available, hospital admission could have been avoided.'	2
Other improvement areas			
Newport	Gap in system during Bank holidays	Newport: 'This case identified a gap in the system over the bank holiday periods.'	1
Torfaen	Better engagement with the client	Torfaen: 'Could have engaged better with patient to improve motivation & compliance.'	1
Monmouthshire	Prevent expectations being put forward that may not be met	Monmouthshire: 'Expectations of GP referral to GFP and what is promised to the person prior to our involvement can raise an expectation and make relations hard when not what the person expected.'	1
Torfaen	Quicker access to diagnostics	Torfaen: 'The need for pathways to exist for secondary care interventions that avoid unnecessary acute admission. Quicker access to diagnostics which would allow a reduced length of stay'	1

Local authority	Improvement/positive area	Quote	Number
Blaenau Gwent	Multi team meetings	Blaenau Gwent: 'Multi team meetings should be used to avoid duplication, education of each other's roles and integration. The lessons learnt that sometimes there can be too many professionals /teams involved and that can cloud the needs of that patient and result in carer stress that then can lead to criticism.'	1
Monmouthshire	Having same day delivery of equipment	Monmouthshire: 'Same day delivery of equipment would have helped and this not being limited to the next day and this would have enabled a better plan to have been put in place to hold the situation until the next day.'	1
Positive Comments			
Blaenau Gwent Torfaen Torfaen Monmouthshire Blaenau Gwent	Integration of services within the GFP team leads to a seamless and timely response from agencies at the required time. (implication that person can go home earlier)	Blaenau Gwent: 'Integration is important and essential.' Torfaen: 'Coordinated care and timely liaison enabled the client to be home earlier.' Torfaen: 'In the right condition a person can be maintained at home without having to be admitted to a more acute setting with daily visits from rapid response nurses and input from the consultants in the team.' Monmouthshire: 'Being able to work as an integrated service has helped to provide the correct support for the individual.' Blaenau Gwent: 'The professional relationships and integration of services within the GFP team lead to a seamless and timely response from agencies at the required time.'	5
Blaenau Gwent Blaenau Gwent Blaenau Gwent	Good team working	Blaenau Gwent: 'The frailty team were instrumental in preventing a grave and serious situation by good observation, communication and team working.' Blaenau Gwent: 'Integration is important and essential. Team building is important so that we do not duplicate and increase stress.' Blaenau Gwent: 'Team cohesiveness and a holistic approach can reduce other services that may impede progress in cases that finds over involvement detrimental to their health.'	3
Blaenau Gwent Monmouthshire	Provides good outcomes/instrumental in preventing a serious situation.	Blaenau Gwent: 'The frailty team were instrumental in preventing a grave and serious situation' Monmouthshire: 'Good Outcomes.'	2

Consultation with service users

7.3.1   Introduction and key findings

Patients and carers involved with the Gwent Frailty Project (GFP) were surveyed about the GFP. They were asked about what services they have received through the GFP and their opinions and experiences of the GFP.

A total of 200 surveys were completed. The analysis that follows presents overall headline findings, namely:

- Response profile

- Experience using the service

- How the service affected patients' wellbeing

Key findings

- The majority of patients and carers agreed that their experience of GFP services was good across all questions.

- **The Strongest levels of agreement were found for "I was treated with respect" and "I was treated with dignity" (for both: 99% agreement, 82% of which was strong agreement).**

- The majority of patients and carers agreed that GFP services had a positive effect on their current and future wellbeing, though there was more uncertainty about some of these questions.
  - 9 in 10 respondents agreed that the GFP had helped them to remain at home for longer, and maintain independence for longer. (56% and 47% strongly agreed, respectively).
  - A minority of respondents were uncertain whether the GFP had reduced the likelihood of them needing nursing or residential care in the future (16%), and the likelihood of hospital admission in the future (18%).

7.3.2   Response profile

Area

Figure 47 shows that over half of all patients and carers responding to the survey lived in Caerphilly (53%), followed by 20% each in Torfaen and Newport. Very few respondents were from Monmouthshire (6%) or Blaenau Gwent (2%).
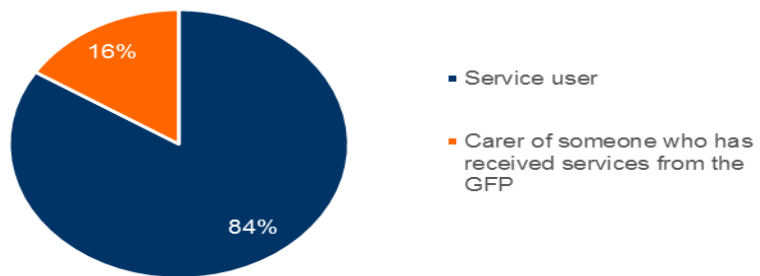
Figure 47: Where patients / carers lived (n = 199)
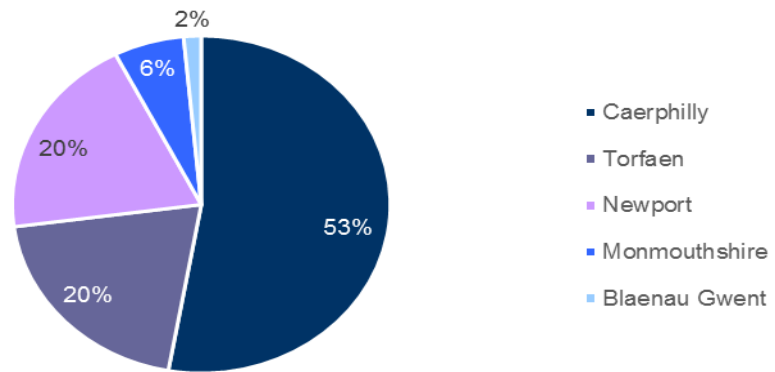
Patient or carer

Figure 48 shows that the majority of respondents were service users (84%) as opposed to carers of GFP service users (16%).
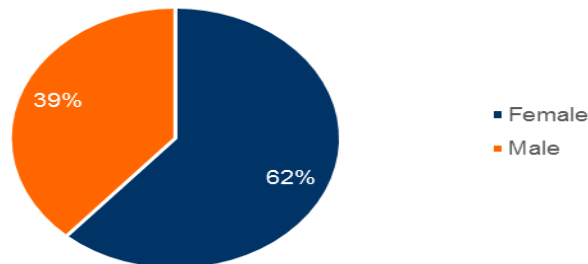
Figure 48: Whether respondents were service users or carers (n = 188)

Gender

Figure 49 shows that almost two thirds of respondents were women.

Figure 49: Gender of patients / carers (n = 169)

Ethnicity

Figure 50 shows that almost all respondents were White British. Only three respondents were of a different ethnicity; one each identified as Caribbean, Indian, and other White.

Figure 50: Ethnicity of patients / carers (n = 187)
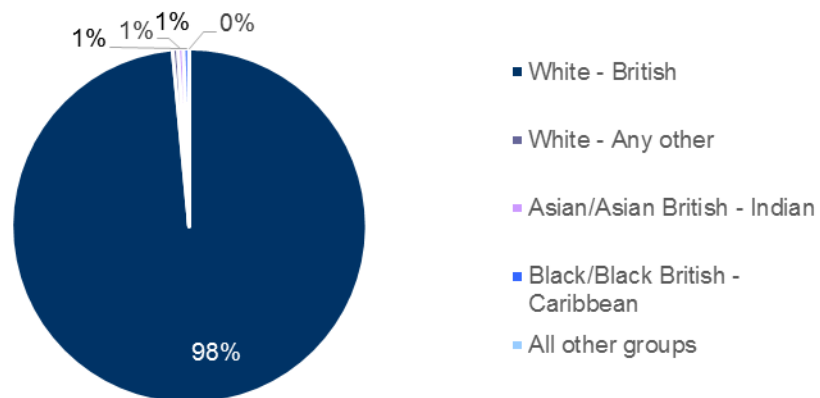
Services used

Respondents were asked which of the GFP services they or the person they cared for used. Respondents could choose more than one service, which is why percentages equal greater than 100%. Figure 51 shows that just over a third of respondents each had used Reablement and Falls services. Of the 7% who indicated they had used another service, most said Rapid – Other, followed by Emergency Care at Home.

Figure 51: GFP services used by patients / carers (n = 195)
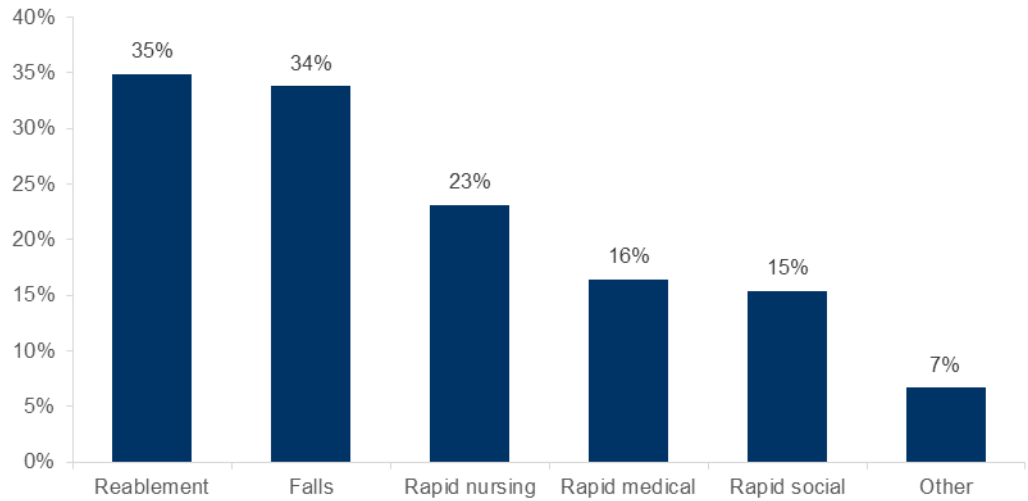
7.3.3   Experience using the service

Figure 52 shows that most patients and carers had a positive experience of the GFP services they had used. Between 97%-99% agreed or strongly agreed with all statements, which indicates a very favourable impression of the GFP. 2% disagreed that they understood what was happening at all times.

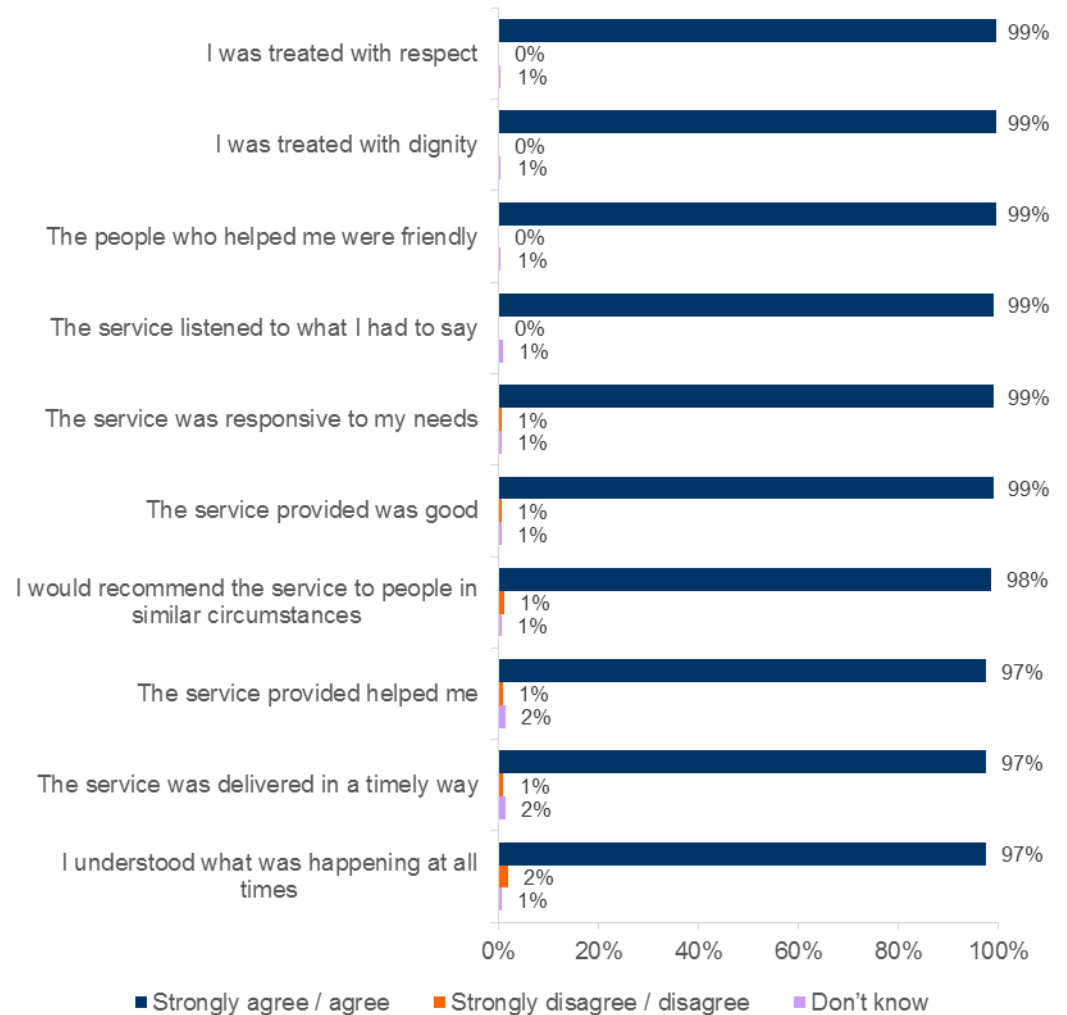*Figure 52: Experience of using GFP services (n = 197-199)*

Figure 53 shows the breakdown of patients / carers who strongly agreed versus those who agreed. "I was treated with respect" and "I was treated with dignity" were those with the highest rates of respondents who strongly agreed (each 82%), while "The service listened to what I had to say" and "I understood what was happening at all times" had the lowest rates of respondents who strongly agreed (each 64%).

Figure 53: Experience of using GFP services by agreement (n = 197-199)
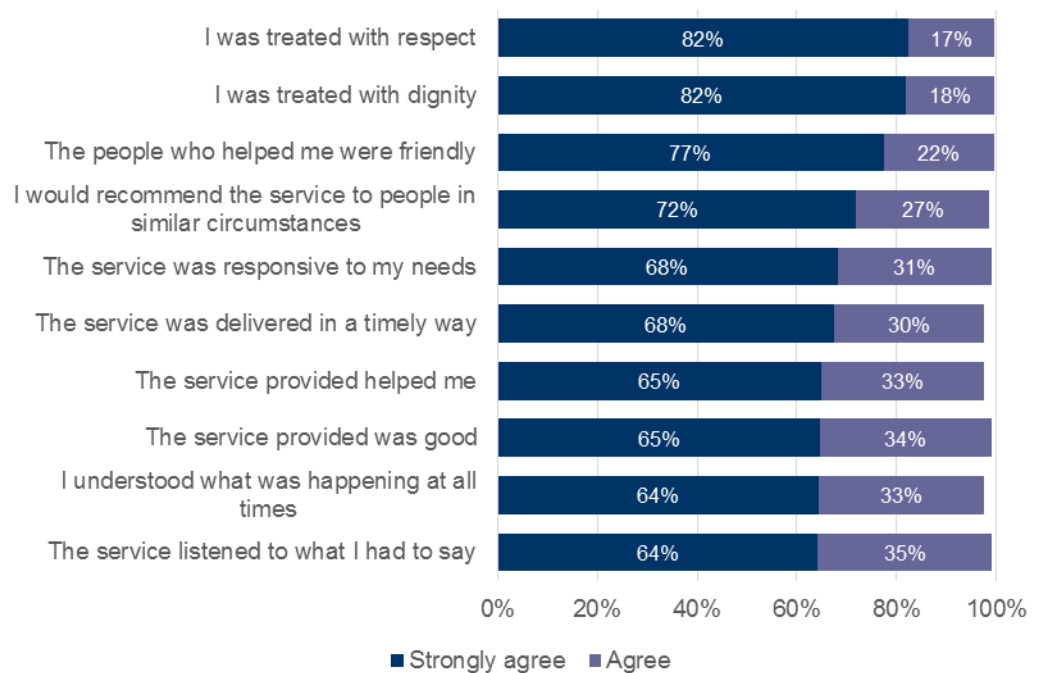
7.3.4   How the service affected patients' wellbeing

Patients and carers were asked whether the GFP had impacted on their present and future wellbeing in a number of ways. Figure 54 shows that the majority of patients and carers had a favourable view of GFP services:

9 in 10 respondents agreed that the GFP had helped them to remain at home for longer, and maintain independence for longer.

4 in 5 respondents indicated that the GFP had reduced the likelihood of them needing nursing or residential care in the future, and the likelihood of hospital admission in the future, though a greater number of respondents indicated they didn't know, or neither agreed nor disagreed with these statements (16%-18%).

2% disagreed that the GFP had reduced the likelihood of them needing nursing or residential care in the future.

Figure 54: How GFP services affected patients' wellbeing (n = 194-198)
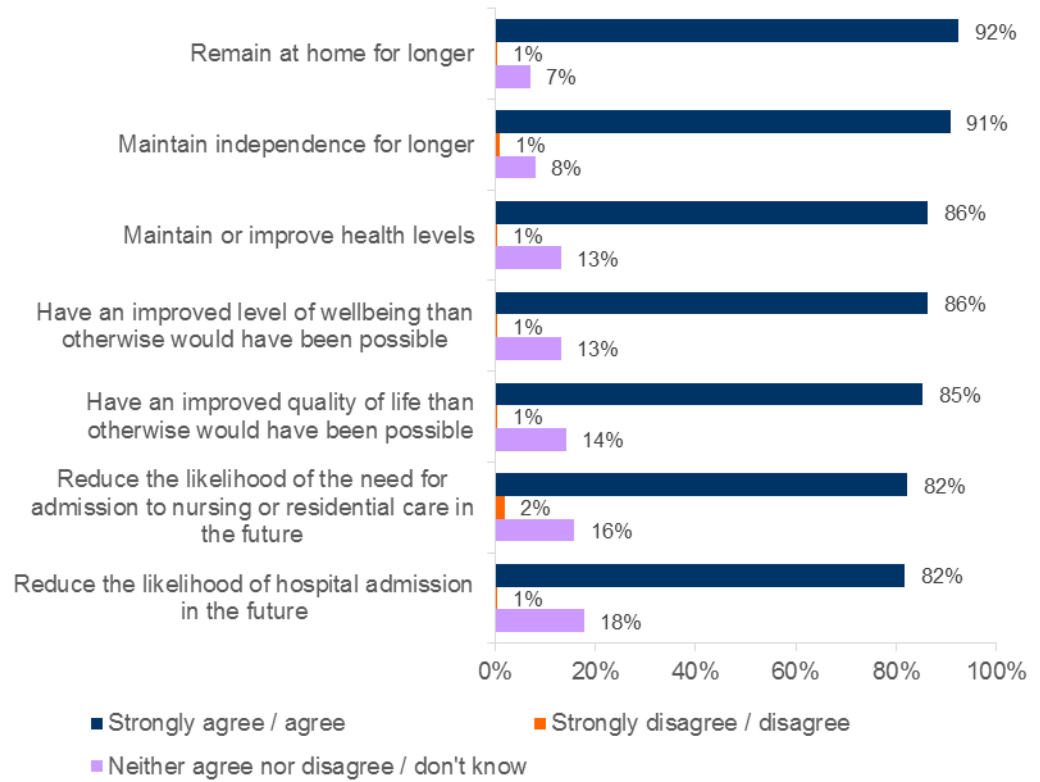

Figure 55 shows the breakdown of patients / carers who strongly agreed versus those who agreed. Respondents were most likely to strongly agree that the GFP had helped them to "Remain at home for longer" (58%), with lower rates of respondents strongly agreeing that the GFP had helped them to "Maintain or improve health levels" (38%).

Figure 55: How GFP services affected patients' wellbeing by agreement (n = 194-198)
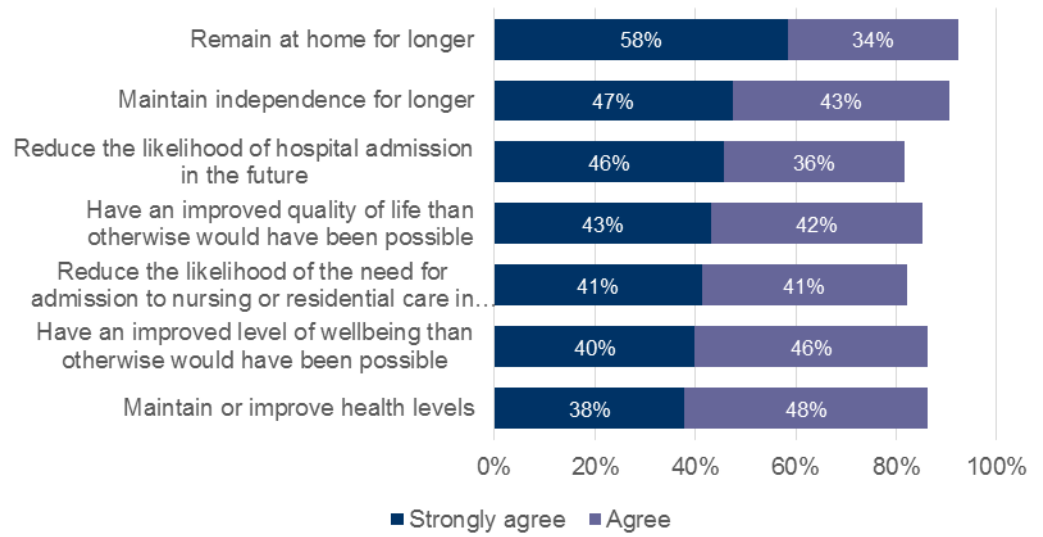
8 Conclusions

Overview of progress

The GFP is one of the first integrated care partnerships in Wales and has had to find its way without many models to follow. It is a strength that the partners have had the tenacity, vision and commitment to do this. Implementing new ways of working is not easy and takes time, and partners should not be disheartened or thrown off course by things that have not gone well. The GFP is in the forefront of policy initiatives in Wales and other parts of the UK to implement integrated care as a policy response to reducing public sector resources and increasing demand.

Many of the issues that have arisen could be addressed by clarifying leadership of the programme; ensuring a clearer delineation between strategic and operational decision making and putting in place a multi-dimensional performance management system. Ultimately, the programme is well placed to be a starting point for greater integration of community services within and across localities.

Every local authority area has examples of good practice and successful outcomes which point the way to further development for the GFP; for example:

- The integrated service model in Monmouthshire has proved to be effective in diverting people away from higher dependency settings and is valued by users, and is an example of a success factor cited in the literature.

- Newport and Caerphilly have focused on getting people out of hospital and been successful at that, with a combination of consultant and OT input. In Caerphilly reablement has been strong and the programme has been successful at helping people to regain their independence.

- Medical leadership in Torfaen and Newport is strong and helps the CRTs to build good relationships with GPs and secondary care.

- Blaenau Gwent has experienced some delays in rolling out the programme, due to having to recruit a new CRT manager, but is in the forefront of developing integrated services – for example rapid response and OT services - across the area.

Assessment of the GFP against models of good practice

Returning to the 'success factors' highlighted in section three of this report, we have used the evidence gathered through this review to make a rapid assessment of the performance of the GFP against these benchmarks of good practice. As Figure 56 below shows, the programme does demonstrate some features of a successful project, but has further to go to achieve others.

Figure 56: Rapid assessment of GFP against success factors for integrated care

Success factors	Comment
Overarching success factors:	
Starting from a focus on individuals	The GFP has a clear focus on improving people's lives and listening to what they want, as evidenced by the comprehensive consultation exercise undertaken to inform the programme and the approach of the CRTs.
Supportive legislative and policy environment	The policy environment is highly supportive of integrated care. There are no other alternatives being suggested to tackle the problems of an ageing population and rising demand.
Service factors:	
A clear care pathway for frail people	At the moment the pathway for Frailty service users is not as clear as it could be and varies from area to area.
Physician integration	This is happening more effectively in some areas than in others. There is also a need to integrate physicians who are not part of the GFP.
Case finding	This is not currently happening across the GFP.
Comprehensive assessment	The assessment taking place now is not a comprehensive geriatric assessment in all areas. We recommend that the GFP introduces this, and we have cited potential models for this.
Organisational factors:	
Clear and effective leadership	This is the key area for improvement for GFP, and clarifying leadership would go some way towards resolving many other issues. The leader should have executive authority to manage performance across the areas.
Effective communication of aims and objectives	This is another area for improvement, both within and outside the programme. The new leader should oversee the see the production of a marketing and communication strategy for GFP.
Governance structure	The current structure does not facilitate decision making, participation and accountability. We have made a recommendation for revising the structure.
Performance management	This is also an area which has been inconsistent

Success factors	Comment
	and we have made some recommendations for improvement.
Information systems and financial monitoring	IT has been extremely problematic, but is now improving. Use of the portal needs to be consistent across all teams, and monitored quarterly for dashboard reports. A renewed focus on both improved outcomes and cost shifting, control and potential/actual savings is essential.
A culture of collaboration	This is present to some extent, although there is still a tendency for local authorities to 'do their own thing' and to regard what others are doing with some suspicion. However, there is a genuine and widespread willingness to make integration work.
A culture of learning	Again, this is an area for improvement. CRT managers and staff would like more opportunities for sharing learning to improve practice and the whole programme needs to be able to use information better to drive improvement.

Further recommendations for taking forward the Frailty model

Following on from this review, we recommend that the GFP should:

- Develop revised **workforce plans** across localities and recruit to vacant posts in the newly agreed structure. In planning resources and activity, the programme should be ambitious and not retrench form its original intentions, as continuing to do things in the same way is simply not an option. This recommendations was accepted.

- Adopt a common **frailty assessment tool** for use across all localities and by the triage nurses based in the SPA. It would make sense to use the Dalhousie University toll, as Newport has already been using this. This recommendation may be explored further once the new director and clinical director are in post.

- Work towards adopt a **case finding** approach and tools to find people at greatest risk of hospital admission and work with them as early in the pathway as possible to help them remain in the community for longer. Similarly, this recommendation concerns operational detail, which will be address once a new governance and leadership structure is in place.

- Be clear within the GFP and with other partners about the **'frailty care pathway'** and the role of the GFP within it. A model pathway is set out in section three, and further details of the interventions which might be included at each stage of the pathway are included in the appendices to this report. This was accepted.

- Develop a revised **marketing and communication strategy** aimed at hospital doctors and GPs and, in due course, the wider public. This might involve re-launching Frailty and highlighting new aspects of the service. As part of the marketing strategy consider re-badging the programme as 'Community Services', since, as several people pointed out, the word 'frailty' has pejorative connotations and is not widely recognised outside of health and social care as a clinical state. This was accepted and will be taken forward once the new programme director and clinical director are in post.

- Introduce a structured programme of **staff training and learning and team development** opportunities for all staff in the programme. Examples of how this might be done and tools to help the GFP are included in the appendices to this report. This was accepted and will be taken forward once the new programme director and clinical director are in post.

- Work towards the **physical co-location** of all staff in each CRT, where this is feasible and practical, since evidence suggests that this is more likely to lead to successful integration. The recommendation was agreed. It was noted in discussions that this is happening anyway and, in some areas, is part of a move towards further integration beyond Frailty. The main barrier to co-location is the availability and suitability of buildings. It was also noted that integration needs to be multi-faceted, and not only about physical co-location.

- Use the GFP as a starting point to work towards the **further integration** of primary healthcare and social care in all five local authority areas. The overall aim should be try to make the programme more of a Gwent wide service, rather than a composite of activity in different local authorities.

The final recommendation was **agreed**. The following points were made:

- Again, there was a need to focus on outcomes for people, rather than mechanisms for organisations.

- The programme has moved beyond 'Frailty' even since the evaluation began.

- Integration also needs to consider mental health services and the interface between hospital and community services, to avoid ending up with a new and different kind of silo.

- There needs to be more flow of staff between hospital and community settings, particularly in relation to care of the elderly; for example, could staff follow people into hospital and 'pull them out'? Could some of the current hospital care be replaced by community-based care?

- The service should always work on the '80:20' principle, that is that all staff should be able to provide 80% of the care and support a person is likely to need, with 20% being provided by specialists.

Overall, the GFP is moving in the right direction but has been hampered by uncertainty, indecision and fear of taking action without assurances of financial savings. This report has set out a road map to an improved service. Doing nothing will not solve any of the problems that the health and social care system faces. Taking action by putting service users' independence at the heart of decision making will yield results, including financial benefit, in the longer term, but integration is not a 'quick fix'. The GFP has the advantage of being further along the road than most other localities in the UK.

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