

## Appendix 6

### Performance Review Provider Services

In Swindon, Health and Social Care services are integrated, with the Council working in close partnership with the NHS and its providers SEQOL and the Avon and Wiltshire Mental Health Trust (AWP). The joint working supports us in delivering better targeted support and care pathways which focus on the need of the needs of individuals.

Performance information is considered at Joint Commissioning Group and at Adults Health, Social Care and Housing Scrutiny Committee.

#### 1 Avon and Wiltshire Mental Health Partnership (AWP) Performance

Avon and Wiltshire Mental Health continue to develop services in line with Commissioning Intentions and National Best Practice. All services are continually reviewed in line with developments in National Services and as a response to reviews undertaken by regulatory authorities.

The services undergoing further review include:

- 1.1 **All age Primary Care Liaison Service:** The PCLS service was introduced in Swindon in 2012/13. This service is often the first point of contact for people experiencing mental health problems. It is, therefore, a local front door and supports primary care professionals who are concerned about the mental wellbeing of any of their patients, with the overall aim of people getting access to the right care at the right time in a way which suits them.

During 2014/15 the service has received an increase in the number of referrals with a decrease in the number of service users screened or assessed and discharged. However, the number of service users who received brief intervention by the team has increased slightly. Only 5% of service users referred required substantial intervention from the secondary services.

	2012/13	2013/14	2014/15
Referrals	2007 (21% increase on previous year)	2312	2569 (..% increase on previous year)
Screened or assessed and discharged	59%	76%	67%
Received brief intervention	27%	24%	26%

#### 1.2 Acute Hospital Liaison Service

The Acute Hospital Liaison team based at GWH continues to provide advice and support for clinical colleagues within the acute hospital setting and all age assessment and referral services in the Emergency Department. The team also provides a treatment service for people on acute wards to manage mental health difficulties and reduce potential

delayed transfers of care. The team received 1643 referrals in 2014/15 which is significantly higher than 2013/14. Of those referred, 1198 (73%) were either screened or assessed and discharged, 373 (23%) had brief intervention with 72 (4%) going on to receive further treatment from AWP.

### 1.3 **Intensive service**

The Swindon Intensive service has undergone a review of its service as it was identified that the team was not always able to completely meet the demands on the service, as it was initially configured. The review included a review of the leadership, skill mix and care pathways. This review is now complete and the service is now able to provide a more timely and effective service to people experiencing a mental health crisis and those requiring intensive treatment.

The two nationally mandated standards for the team are:

- Assessment within 4 hours of an emergency referral to the team. This standard is measured and reported on a monthly basis. The Intensive team had not achieved this target on a regular basis during 2013/14 but with the changes made to the team, as a result of the review, the team has achieved this target in the last quarter of 2014/15 and is currently reporting 100% for the first two months of 2015/16.
- Gatekeeping Acute Admissions. In order to ensure all admissions to the inpatient unit are appropriate the Intensive team are required to complete an assessment before the decision is taken for admission. The target for this indicator is 95% which the team have successfully exceeded for the last six months.

### 1.4 **Recovery service**

The Recovery service continues to work with people with serious mental health to improve their quality of life. Helping people make the most of opportunities to improve their mental health and wellbeing, lead meaningful lives and participate in the wider community are key objectives of the team.

In line with this holistic approach the National Indicators for the Recovery Team look at the numbers of service users in settled accommodation as well as Employment. The Recovery team are reporting a stable number of service users in employment but there has been a drop in the number of service users in settled accommodation. The reported performance against this indicator is currently under review to ensure that the data has been accurately captured.

At the end of 2014/15 98% of service users of the Recovery team have received a Care Programme Approach (CPA) review in line with cluster review timings which is well above the standard of 95% and very slightly higher than last reported.

Referrals to the Recovery team have remained lower than in the years before the introduction of PCLS in 2012. The decrease in caseload for the Recovery team, which reduced from around 700 in December 2012 has been maintained, reported at 588 at the end of March 2014 and 556 at the end of March 2015. This reduction was managed as the result of an intense review of all caseloads and was a positive result in the management of service to the Swindon community, ensuring that service users received the right services from the right team.

#### **1.5 Complex Intervention and Treatment Teams (CITT)**

The Complex Intervention & Treatment Teams (CITT) offer a range of multidisciplinary services to patients with complex mental health needs. They are not dementia specific but aimed towards meeting the changing psychosocial and environmental needs of an ageing population and promoting successful ageing. The CIT team currently has a caseload of 365 service users who receive support in the community.

The indicator measuring the percentage of service users on CPA who have had a review is reporting above standard at 97%, which is in line with previous reports.

#### **1.6 Memory Service**

In order to promote early access to dementia services, and in keeping with the National Dementia Strategy objectives, the memory service is intended to be a wide-ranging and inclusive service. The Team leaders triage all referrals and advise GP's if a referral is considered to be inappropriate giving reasons for this decision. This however is proving to be an ongoing difficulty for the service in Swindon. The memory service received 449 referrals in 2013/14 and over 800 referrals in 2014/15. AWP is continuing to work with the Swindon CCG and SBC to implement the Dementia Strategy which will allow the team to work in partnership with GPs in order to address this demand for services.

#### **1.7 Inpatient Services**

In addition to the Community Services, AWP also provide the following Inpatient Services.

- 18 acute mental health beds (Applewood House)
- 1.6 Psychiatric Intensive Care Unit beds (PICU) based in our specialist units in Bristol
- 14 Rehab beds (Windswept House)
- 26 older people beds (Victoria Centre)

#### **1.8 Adult Acute Inpatient service**

The Adult Acute inpatient service provides care for Adults in an In-Patient setting, 24 hours, 7 days a week, for people with mental health problems experiencing an acute psychiatric crisis.

There has been significant work undertaken throughout 2014/15 to improve the Acute Care Pathway. This includes the admission,

discharge, length of stay and delayed transfer of care of service users to the Adult Acute inpatient unit – Applewood Ward.

In March 2014 Applewood Ward was reported to have 100.6% occupancy (this includes leave days) while in March 2015 the occupancy rate had fallen to 86.7%. The median length of stay for an inpatient in March 2014 was reported as 39 days and in March 2015 it was reported at 33 days. In March 2014 Swindon service users who required an inpatient admission were placed in inpatient units outside of Swindon for 74 days, in March 2015 there were no Swindon service users in beds other than in Swindon.

The national indicators for Acute Inpatient services are reflecting the good practice that has been developed within the inpatient ward. Currently the indicator for follow-up within 7 days of discharge is reporting 100% and the Delayed Transfer of Care (DTOC) for Applewood Ward is reporting 0.76%.

#### **1.9 Victoria Centre**

AWP have two wards at the Victoria Centre which provide in-patient care 24 hour, 7 days a week for Older People.

Hodson ward provides acute assessment. This is an ageless service to people who are presenting with a severe functional mental illness such as any psychotic illness, moderate to severe depression, suicidal ideas and anxiety.

Liddington Ward also an acute assessment unit providing care and treatment to service users with a moderate to severe organic illness, dealing with all aspects of dementia, including those diagnosed with Alzheimer's, Lewy Body, Frontal Lobe and Vascular dementia.

These two wards are also subject to the national indicators for follow-up within 7 days of discharge and DTOC. Both wards have consistently achieved 100% for follow-up but have had increasing difficulty in achieving the DTOC target of less than 7.5%. There has been significant focus on DTOC within 2014/15 and the target has been achieved and is currently reporting 4.7%. This improvement is due to the joint work between AWP, the Commissioners and SBC.

#### **1.10 Windswept House**

The Windswept Unit which provides mental health rehabilitation services in Swindon was relocated to a newly refurbished building on the Sandalwood Court site on 22<sup>nd</sup> November 2013. The unit offers an additional four rehab beds, available to other AWP localities or to other Trusts, along with dedicated rooms for therapeutic activity and reflection. A self-contained flat is also available for users in the last stage of rehabilitation to prepare them for living independently.

Being integrated within the Sandalwood site has provided excellent access to acute ward staff, intensive team, medical staff and the Active Life team. This enables service users with more complex mental health problems to be accommodated on the unit and provides better support in times of emergency.

## **2. SEQOL Performance**

In Swindon, integrated health and social care services are provided by the social enterprise, SEQOL. Swindon Borough Council and NHS Swindon as the commissioners, and SEQOL as the provider, work to an agreed contract which lays out how we work together, what performance indicators, including quality indicators, that SEQOL is performance managed on. The social care value of the SEQOL's contract is £9 million LA and £15m CCG.

Swindon Borough Council and NHS Swindon hold SEQOL to account through monthly contract performance reviews. Additionally the Director of Adult Services (DASS, also Board Director Commissioning and Director Children's Services) meets with the Chief Executive of SEQOL every three weeks and Swindon Borough Council officers meet with the Chief Executive and Director of Finance fortnightly. The Cabinet Member for Health and Adult Social Care also meets regularly with the Chair and Chief Executive of SEQOL.

Commissioners established SEQOL to deliver a business plan which drives modernisation, efficiency and change and secures revised models of care which supports the promotion of independence and the reduction of demand for specific services. Since its inception in October 2011, SEQOL has delivered significant change programmes and substantially improved the choice and experience offered to people in Swindon. Key areas of change are outlined below.

### **2.1 Redesigned day services**

Day Services are provided for older people and people with physical disabilities and learning disabilities through Day Centres and through Leisure Services and through the voluntary and community sector.

271 people are registered with SEQOL's day opportunities, compared to 212 in 2013/14 and, of those, 146 are aged 65+, compared to 83 last year and 125 are registered with OK4U, compared to 129 last year.

Since it was established SEQOL has worked with service users and their carers to provide a modernised service which supports people to use mainstream services in the community and reduce dependency on day centres. A tailored menu of activities is available to each client and they can develop their own personalised programme. This includes improving life skills with cooking, budgeting and learning to use a computer and staying active activities such as the always popular jabadao which uses parachutes and other equipment to give people of

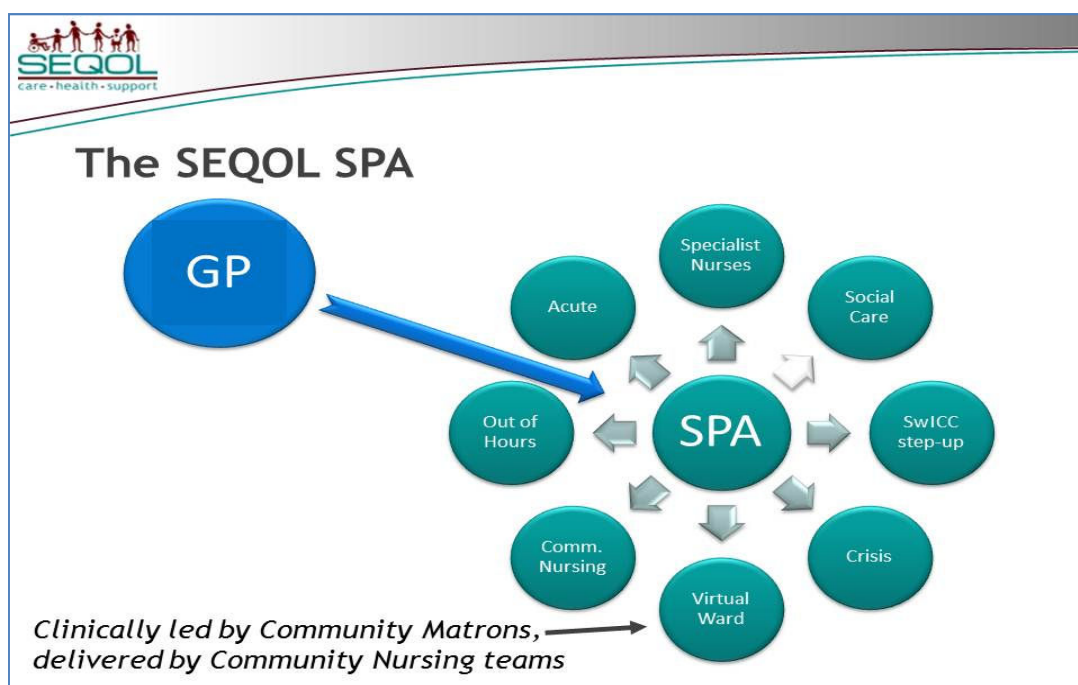
all ages and abilities opportunities to dance and play. Underpinned by research, it helps develop movement, balance and team work, and also swimming and rock climbing. Through this SEQOL is supporting the increased uptake of direct payments and personalised budgets.

## 2.2 Increased Personalisation

SEQOL has a determined focus on the improvement on the Personalisation agenda and sees this as a cultural change which supports independence. SEQOL continue to work with clients and the Council to ensure as many eligible clients have the opportunity to design their own care programmes. In 2014/15 the way the target was measured changed, with much clearer guidance on who is and is not eligible for a personal budget. Through 2014/15 the percentage of people on a personal budget and/or direct payment increased to 79.9% from 47.4% in 2013/14

## 2.3 Provided alternative pathways which support independence in the community

The key to the flow of people in SEQOL is the Single Point of Access (SPA). This co-ordinates care pathways, ensuring people access the right service first time and can be accessed by professionals and people on 01793 646466. This number is used mainly by people accessing 24/7 primary care services and by people with long term conditions accessing SEQOL services.



Through 2014/15, SPA received 41,750 calls of which

- 22,369 related to community nursing and virtual wards compared to 24,782 for the same period last year. This decrease is due to the

introduction of the virtual ward clerks that people on the case loads and GP Practices have direct access to.

- 1,176 related to community ambulatory care pathways compared to 1,155 in the same period last year.
- 2,129 related to the rapid response service, compared to 3,106 in the same period last year.

The remaining 25,674 calls were mainly calls from people with long term conditions asking for advice and support.

The figures above exclude calls specifically for primary care out of hours which has seen the following increases:

- The GPs and Nurses triaged 17,294 telephone calls in 2014/15, compared to 15,145 in the same period last year.
- The GPs carried out 5,738 home visits, compared to 4,236 in the same period last year.
- 12,447 were given an appointment at the Urgent Care Centre, compared to 7,904 in the same period last year.

#### **2.4 Urgent Care Centre**

To improve access to primary care services, 24/7, the urgent care centre (on the GWH campus) opened for people to walk-in directly, without the need to go to the hospitals A&E department first. This has been popular with the people of Swindon, with 20,011 people using the service in 2014/15 compared to 15,000 in the same period last year.

#### **2.5 Care at the Scene**

The CCG have commissioned a GP to work with the ambulance service for 72 hours at weekends (Friday afternoon to Monday lunchtime). The purpose is to provide senior clinical support to ambulance crews, reducing the need for people to attend the emergency department. April to November 2014, the GPs avoided 912 admissions and 165 attendances to the emergency department through assessing and treating people in their own home.

#### **2.6 Long Term Conditions**

There are a number of services supporting people with Long Term Conditions to manage their conditions and make the most of their lives.

**Virtual Wards** prevent hospital admissions by providing intensive nursing and care to people with an exacerbation of their condition, in their own homes. The virtual wards managed 6,140 episodes of care in 2014/15 compared to 4,140 in 2013/14.

**Community Intermediate Care** provides rehabilitation to people following injury or surgery, provides the balance clinics that help people to stop falling over. Through 2013/14 the team saw 16,301 people either at home or in clinics compared to 12,960 the previous year. The team also provides pulmonary rehabilitation for people with respiratory disease, jointly with the Council leisure services.

### **Community Nurses**

Through 2014/15, the nurses saw 90,590 people, an increase from 88,275 in 2013/14. In addition, the community matrons had 8,207 contacts compared to 3,881 in the same period last year.

Community Nursing work is split across caring for people on the virtual ward and their generic work load (assessments, reviews, injections, dressings, nursing care etc). The community nurses are attached to GP Practices with GPs guiding their work flows.

The community matrons continue to engage with the GP risk stratification programme, working with GPs and the people identified at risk to develop detailed health and social care plans (life plans), which include clinical management plans.

### **2.7 Specialist Teams support Primary Care, all SEQOL services and care homes**

- Tissue Viability Nurse assesses, diagnose and treat conditions such as leg ulcers and pressure ulcers. The nurse visited 347 people 2014/15 providing assessments, treatment plans and advice.
- The Chronic Obstructive Pulmonary Disease (COPD) and Oxygen Therapy Nurses help people with respiratory disease to optimise their condition by making sure they understand the options available to them. The nurses had 3,232 contacts with people through home visits, clinics and telephone advice.
- The Stroke team comprises of Physiotherapists, Occupational Therapists, Speech and Language Therapy and Nurses to provide therapy for people who have had a stroke across their whole rehabilitation journey – from their time in an acute stroke ward through to SwICC to home. Through 2014/15 the team had 4,531 contacts with people through home visits, clinics and telephone advice. This reflects the improvements in outcomes for people following stroke as it compares to 4,163 in the same period last year.
- The Continence Nursing Service offers advice and treatment options for bladder and bowel problems, ranging from exercises and bladder training to the provision of continence pads or other devices as a last resort and can loan specialist equipment. An effective continence service can contribute to the number of domiciliary care calls delivered to an individual and works to promote dignity and respect in personal care of service users. The team has supported 957 people through 2014/15 compared to 916 in 2013/14. In addition they have carried out a procurement exercise to ensure continence products are purchased at best value. They have also audited use of products in care homes and



carried out spot visits to ensure homes are compliant with continence care plans.

## 2.8 **Discharge services**

### **Integrated Discharge Team**

The integrated discharge team and the Discharge Assessment and Referral Team (DART), with the wards in Great Western Hospital support the discharge of people with complex needs who need ongoing support at home. For example, they work with people and their families to assess social and health care needs, they carry out best interest assessments, they liaise with the continuing health care team and the integrated equipment stores, they carry out home visits and they fast track people at the end of their life back home to the care of their GP and the community nursing team. Through 2014/15 they facilitated the discharge of 5,097 people. They also manage safeguarding alerts raised by the hospital.

## 2.10 **Cost Reduction**

### **Learning Disabilities**

Through 2014/15 SEQOL worked with the Council to deliver the savings plan for Learning Disability Services. For the first time, the target to review 71% of people with a learning disability, ensuring they had personalised support plans in place was achieved. In addition, a focussed project to ensure the young people who will transition to adulthood over the next five years with assessment and reviews planned, was also achieved. This reduced spend on the Learning Disability budget in excess of £1m.

## 2.11 **Efficiency and productivity**

Since SEQOL went live on 1<sup>st</sup> October 2011, SEQOL have continually worked with Health & Social Care professionals to deliver cashable savings and non-cashable productivity gains.

SEQOL has remained financial viable by delivering a post-tax profit in each of the 3 financial years (2014/15 is a forecast post-tax profit)

	<b>Actual 2012/13 £'000</b>	<b>Actual 2013/14 £'000</b>	<b>Actual 2014/15 £,000 0</b>
SEQOL Post tax Profit	109	102	109

## 2.12 Social Care

SEQOL gathers information from service users for the assessment and review process for adults in receipt of Social Care Services, and their carers.

### Reviews

The first step in the process, and in order to understand the needs and eligibility of an adult, an assessment of need is completed. Through 2014/15, SEQOL carried out 3,159 reviews adult reviews, of which 462 were of people with Learning Disabilities. For the first time the Learning Disability target of 71% reviews was achieved.

## 2.13 Reablement

The reablement service was set up in 2010-11 based on the CSED (Care Services Efficiency Delivery) model. The service was subsequently commissioned by SBC to continue delivering the model. The CSED indicative outcomes have been used to categorise the outcomes achieved for individual service users supported by the SEQOL reablement service for the last 2 years. The table below shows Swindon performance against the Department of Health targets.

Description	DoH ServiceTarget	2014/15		2013/14 (8 Mths)	
		Actual %	% VarianceAgainst Target	Actual %	%Variance AgainstTarget
No ongoing support	50%	61.4%	+23%	61.6%	+23%
Reduced homecare package	16%	14.8%	(8%)	14.2%	(11%)
Continuing on same package	16%	5.1%	(68%)	3.8%	(76%)
Increased package	8%	1.0%	+88%	0.5%	+94%
Exiting service without completing	10%	17.7%	(77%)	19.9%	(99%)

This shows that the reablement service offered is delivering outcomes and activity above that set out in national guidance in three key areas, with the table above demonstrating the differences.

Although nationally 50% of clients would be expected to receive no ongoing support, SEQOL achieved 61.4% in 2014/15, which is consistent with the rate of 61.6% in 2013/14. This will result in greater savings for commissioners which could be audited through individual case reviews if necessary. The figure for service users not completing, is higher than average and this is linked to the use of this service in escalation along with re-admissions during the winter months rising in for both years.