My name is Tom Barton. I'm the Lead Advanced Practitioner working within the Community Resource Team in Bridgend. Specifically, I lead the Acute Clinical Team, which is one of the several intermediate care services working within the Community Resource Teams that were set up in 2001.

Development of the service

Over the last 22 years, intermediate care services have grown from modest small teams into the large set of services that now exist in Bridgend. They were funded initially by Welsh Government under the integrated care fund and that money has helped grow these services into what they are today.

Crucially, they are integrated services (Bridgend County Borough Council and Cwm Taf Morgannwg University Health Board) working together to generate these services by pooling expertise and resources together to make a better service.

The Community Resource Team is comprised of several different teams; At the front end of the service, we have an early intervention and prevention hub. This is a team of social care professionals who primarily take all the referrals and enquiries coming into the service and they signpost those service users, people, the public, healthcare professionals to the right place within the team. Where appropriate, they go out and meet people in their own homes to gather more information and enact some early interventions and actions to try and keep people safe within their own home.

There are then several larger teams; One is the acute clinical team. This is the team I lead. It is an early response team of multiple professions, advanced practitioners, doctors, nurses, physios, and occupational therapists. We can get out to people within about four hours if we have a concern that someone is having a crisis in their own home. For example, someone could be stuck in their chair, they could have fallen and be stuck on the floor. They may be uninjured and therefore don't need an acute hospital admission but the general story of this kind of referral will be that if we don't intervene rapidly, there'll be no other choice but to take that person to hospital. And like I said, there may be no acute medical reason for that person to go to hospital. They may have a minor complaint that's having a disproportionate effect on them and what they need is timely care and a multi-disciplinary team assessment as well as some timely delivery of care to keep them at home.

One of the other teams we have is the reablement team, led by physiotherapists and occupational therapists. This is very much a service designed in mind with keeping people more independent and keeping people in their own home. For example, someone may have had a fractured hip, been in hospital and had a replacement. They were independent before their injury, but now they are dependent on other people. Ideally we would want for that person to go back to being independent once again on their return home. The idea of this service is for therapists and care staff there for them are designed with those goals - to get that person independent again.

The Bridge Start team is similar to the reablement team but deals with people who have established health needs. They may be frail in the long term, and they may have been in hospital and for some reason are beginning to struggle at home, but it’s not necessarily an emergency or urgent situation. We know that these people, if we can get our occupational therapists to undertake a full assessment with them, look at what we can do to enable them through delivery of equipment, help them work through different processes so that they can live their lives slightly differently. They'd have less need for care in their own homes and they can live a more independent and quality life at the home The whole service is then supported by a series of other services.

We have a team of community Occupational Therapists who will deal with quite specific requests for assistance. So this might include delivery of equipment. It could involve making assessments for showers or stairlifts or a range of other means that someone might have that falls into the category of maybe non-urgent and Occupational Therapist specific kind of request

We also have Speech & Language Therapist and dietetics support. So these are specialists in nutrition and swallowing and speech for people who might have those kinds of needs. So we have a full multi-disciplinary approach from the wider service when we need.

Similarly, we have a pharmacy team who can help all of the teams with people who have difficulty taking their medicines. As we know, if someone's not taking their medicines properly, then of course they're going to have problems with their diseases not being managed appropriately and they could become unwell in future.

Our Community Resource Team will help those people with various interventions such as clever medicines dispensing systems or simply having the right reminders in place for them to help them manage their medicines more effectively. We also have a large pool of carers who support all of our services, and these are the backbone of our service and they're really vital to everything that we do. But we have a specialist subgroup of people who we call the mobile response team. For those people who use telecare services in Bridgend, so these are the pendants that people can press when they fall or are stuck and have an emergency, we have this team who can go and respond to them instead of family members who may be unavailable or indeed an ambulance again when that person isn’t injured, and they'll work 24-7 and they’ll respond to calls and help recover those people from where they're stuck. And because they are care staff, if that person has soiled themselves, they’ll get them clean again. If they need a cup of tea and a bit of food, just to settle them back down. And they ‘retrained to the extent that if they look unwell, they can summon medical support from GPs or if it does look as though they're injured when they attend, they can summon 999 support and get that ambulance safely to that person and then they’re there with the person to keep them safe until they've had a response.

We’re also supported by a couple of mental health professionals who help support people who have memory problems and mental health issues that are affecting their care here in the community or when being looked after by other teams.

And finally we have a sensory team who can help assess people who have single or dual sensory loss, so specifically hearing and sight problems, and they can undertake range of different interventions from assessments such as lighting assessments to help make people safer in their own home, to making sure that people are on all the right benefits and support that they're entitled to so that they can live a more independent life. And finally we have a falls coordinator who is a professional, helps coordinate all the different falls services that go on within the Community Resource Team and course the wider community of things going on in the third sector, primary care and with the hospitals.

How the services were developed

The Community Resource Team services have been developed for many years under the auspices of what we call the Western Bay Project when we were formerly part of the former ABMU Health Board. This was an oversight group that came up with an optimal model if you like of what service should look like across the Swansea Bay region. Due to some changes in how the Health Boards have been arranged we're now part of the Cwm Taf Health Board and the Health Board at the moment is working hard to develop a new vision for how it wants its own intermediate care services to look going forward. And there’s workshops happening as we speak and as I make this video on what that should look like so that the services here in Bridgend look similar to what you would get in Rhondda Cynon Taf and Ely and Merthyr so that we don't have discrepancies between what people get between different parts of our organisations.

Naturally that's a big change project and it’s going to take some time to get it all in line but thankfully because of the really good integrated working we've been doing here in Bridgend we hope we can show our colleagues across the region a good model of care that we have here in Bridgend and share what we've learned. For the most part, service users, patients, clients can access the service through that early intervention and prevention hub so it's kind of like a single point of access for everyone accessing these services. Those referrals can come from the hospitals, from GPs and primary care, from the Welsh ambulance service or indeed from the general public themselves referring themselves in. More often than not when they have the number they think that they're coming through to social services which is technically correct but few of them really realise the scope of the services that they could be accessing depending on their needs. And that early contact point they can direct simple enquiries to the answers very simply co-producing with members of the public so if all someone wants is some information about Meals on Wheels services that can be given to them instantly. If it's a much more complicated request or ask or problem then obviously that gets assessed and would get directed through to the right services which could be one of the Community Resource Team services if appropriate it could go back to our primary care networks or to third sector services depending on what the problem is.

Urgent Care

There is one exception to the rule which is the acute clinical team. The very acute and clinical nature of this service where we're dealing with acutely unwell patients and people who might have active acute medical problems we do allow healthcare professionals to refer directly to us and we have a hot phone which is a mobile held by one of our practitioners leading the team every day and then you have a clinician to clinician phone call so that the correct course of action and the most safe option is chosen for that person and that's all about keeping people safe as well trying to avoid admissions to hospital.

Care closer to home

So one of the main challenges for our region our society in general is that everyone's getting older and as people get older they are more likely to have problems with their health and more likely to have problems with frailty so this could vary from finding it more difficult to do things day to day that people could do before or more complicated problems like falling over and we know that the number of older people in Wales and certainly the country as a whole is growing all the time. Our challenge is preparing for a future where people live to be older, and we want people to live at home independently for as long as we can so that when they become older as much of that time that they have left of their lives is good quality and not spent struggling with the burden of their various chronic diseases.

We also have other challenges our society such as the fact that we find it difficult to recruit care staff into the Community Resource Team, but also to the wider third sector services and one of the main goals for our organisations is we can reduce that burden if people don’t need the care as much so one of the big goals of the Community Resource Team services is if we can keep people independent there's less demand on these services but primarily it's for people's own well-being. We are aware when we look at the extreme age or the extreme end of frailty people may go and spend time in care homes and what the Community Resource Team has managed to show over the years is that the age at which people in Bridgend go into care homes has become older and the time at which people live in that home has become shorter so what that tells us is that people lived at home for longer until they were later in their disease processes before they finally needed that high level of care provided by a care home and that's one of the various outcomes measures we can use to show that the service is successful in doing what it intends.

Positive benefits

The benefits of the service are primarily for that person. I think if we asked 100 people,100 people would say they want to live independently, they want to live their fullest life, they want to have a high quality of life. We know that if we looked at our very oldest populations the 85 years old plus that maybe 25 to 50 percent of people may have frailty, but we've got to think of that carefully and think that if you flip that around that means 50 to 75 percent of people are not and they're busy having grandchildren, living their lives, going on holidays and ideally we want to keep people doing that for as long as possible and that is the primary outcome. The convenient side effect of ensuring that people stay that way is they have less need of care services. There's less need for care, there's less need for health care and that reduces the demand on our other services so as far as we’re concerned intermediate care plays really vital role in our modern health care service working between secondary care where people have high and acute levels of care and primary care who are dealing with chronic disease and managing people's ongoing health throughout the year we sit in the middle of those two services offering a bit more than what primary care can provide but obviously stopping short of what hospital would provide.

Lessons learned

I think the key lessons from Community Resource Team Bridgend, has been the effectiveness of integrated working, bringing all the people that you need around the same table bringing all the people that to intervene for that person so if someone's got a crisis at home we need an array of people to look after them, we need those health care professionals, they need that medical person who's going to come and work up what they need, they need those nurses to meet their nursing needs, we need those therapists to meet all of those goals they want to achieve going forward, we need to have those social workers who are going to provide that support and crucially those health and social care carers and professionals who are going to help keep everything going for that person as we go forward through time. We know that undertaking a comprehensive geriatric assessment which is essentially a joined-up multi-disciplinary team assessment results in better outcomes and the King’s Fund has done some really excellent working proving that works, so having all the right people around the table, having effective multi-disciplinary team, multi-agency team that’s seamless at the point of delivery is really important and having those relationship between the two organisations where we don't have siloing of resources and we don't have barriers between our different services and what that service user has is what they feel is a single team coming to respond to their need is really vital.

People don't like telling their story over and over and this is what we try to achieve in the Community Resource Team is that joined-up single team approach despite there from a professional point of view being lots of elements and complexity to how the service is delivered. So one of the challenges we have in Wales is there isn't a set framework, per se, for how services should look from one region to the next so our former model from the Swansea Bay area is different from what it’s going to be here in Cwm Taf and certainly because we've come to the Cwm Taf region what happens in the former Cwm Taf areas is slightly different to what we do here but we've got some working groups together now to work out what’s going to be best for our population.

We operate over an array of valleys and ex-mining communities as well as having a couple of large market towns and other towns and rural areas so it's quite a challenging patch for us to deliver services to and what we hope to do as we go forward now is take all the best bits from the different services that have been developed between the two or the several regions and come up with an even better newer model fit for us going forward.

One of the challenges we have as a Community Resource Team the service outside of our immediate healthcare professionals is not well understood and I think there needs to be more awareness of these types of services and crucially the importance they play in delivering healthcare in Wales but across the country. I think going forward we need to do more to engage with the general public make them aware that these services exist and to come forward to ask for help in a timely manner if they think they or a loved one is beginning to struggle and would benefit from having a more enhanced specific assessment to help them live their life more independently. Many people will often go to their primary care provider their GPs in the first instance and the GPs will more often they’re not referring on to us appropriately but there’s nothing to stop people from self-referring to that service and I think what would be nice going forward is seeing more and more from our Welsh Government and policy across Wales to really further invest and further develop these services and to create more consistency and frameworks around how the services and the Community Resource Teams across Wales are delivered. Accounting for the fact that the different regions of Wales have different needs and there'll always naturally be a little bit of difference between them all.