DETAILED FINDINGS FROM THE EMBRACE CARE DIAGNOSTIC REVIEW

FRIDAY 16 AUGUST 2019

NEWTON

Over the past few weeks, over 200 colleagues from across the health and care system have come together at a series of meetings, a Summit and two Conferences to hear about and discuss the findings from the Embrace Care Diagnostic Review. Since then lots of people have expressed an interest in receiving the Detailed Presentation Pack and so here it is, as presented at the final Embrace Care Conference on Tuesday 6 August.

Embrace Care is about improving the way we care for and support older people. We will work together to support older people to live independently at home and to avoid unnecessary hospital admission. When people do need to go to hospital, we will also work hard to make sure they get home easily and safely.

When looking at some of the slides, some of the messages that they contain are stark and they focus on particular services and experiences. What is presented is a selection of analysis and case studies to present a picture and a case for change, not to allocate blame or to single out particular services. Above all, the Embrace Care Project is about looking forward and identifying areas for improvement and opportunities to work together better. What will follow next is a comprehensive plan for taking forward the key conclusions. Key to this plan will be further engagement and the involvement of residents, patients and staff and our politicians and board members before fundamental changes are made to our services.

Work on developing the plan has now started and over the next few weeks, colleagues from across the system will be asked to help and contribute. At the end of September, the plan will be shared. At that time there will be a further opportunity to comment and contribute. From October, the hard work on delivering the change and the improvements that we all want will begin.

In the meantime, please do spend some time to look at and consider the analysis presented in this pack and if you would like to get involved in the Embrace Care Project, have comments to make, or questions to ask, please email us at embracecare@cornwall.gov.uk

Thanks for reading

Helen Childs
Chief Operating Officer and Senior Responsible Officer for Embrace Care
NHS Kernow

SCOPE

The diagnostic will establish an evidence base to show where the challenges are. This will allow us to work out exactly what to change, and how best to change to improve things for the people we care for, and our staff.

5 PATIENT PATHWAY WORKSHOPS WITH >130 STAFF

265 CASES REVIEWED

943 BEDS REVIEWED ACROSS CORNWALL

320 PEOPLE ENGAGED

1,000,000 ROWS OF DATA ANALYSED

Cornwall Council

Council of the Isles of Scilly

NHS Cornwall Partnership NHS Foundation Trust

NHS Kernow Clinical Commissioning Group

NHS Royal Cornwall Hospitals NHS Trust

NHS University Hospitals Plymouth NHS Trust

NHS South Western Ambulance Service NHS Foundation Trust

Kernow Health

Volunteer Cornwall

THE CONTEXT
WHAT IS THE SYSTEM AIMING FOR?

The system has committed to this vision:

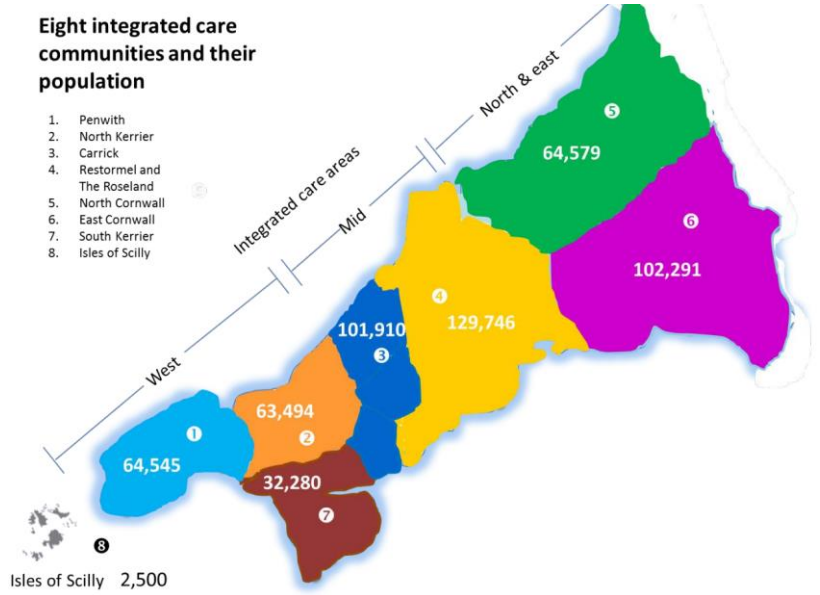
We will work together to ensure the people of Cornwall and the Isles of Scilly stay as healthy as possible for as long as possible

We will support people to help themselves and each other so they stay independent and well in their community

We will provide services that everyone can be proud of and that reduce the cost overall.

With the current system priorities being:

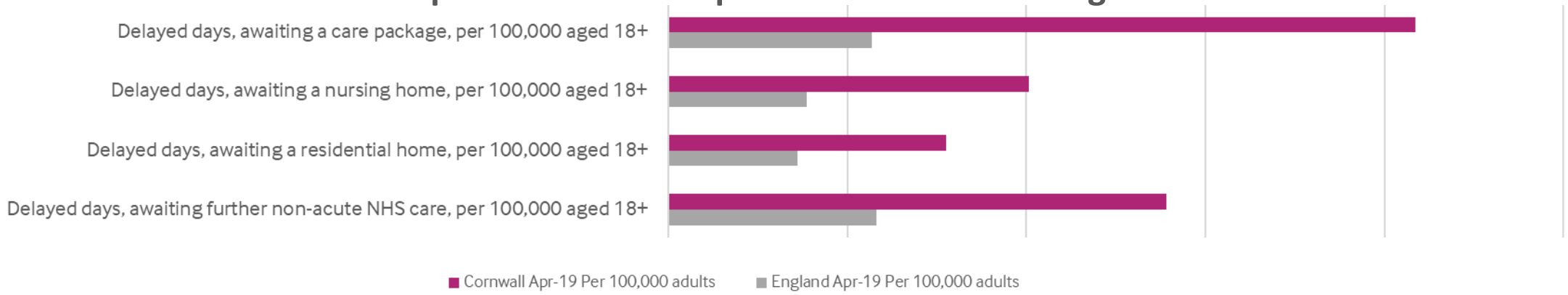
- Improve performance and quality of the system jointly
- Delivery of an affordable health and care system
- Develop an integrated health and care system; testing, reviewing and refining the approach during 2018/19
- Transformation of our place based model of care
- Secure devolution of health and social care as a strategic enabler



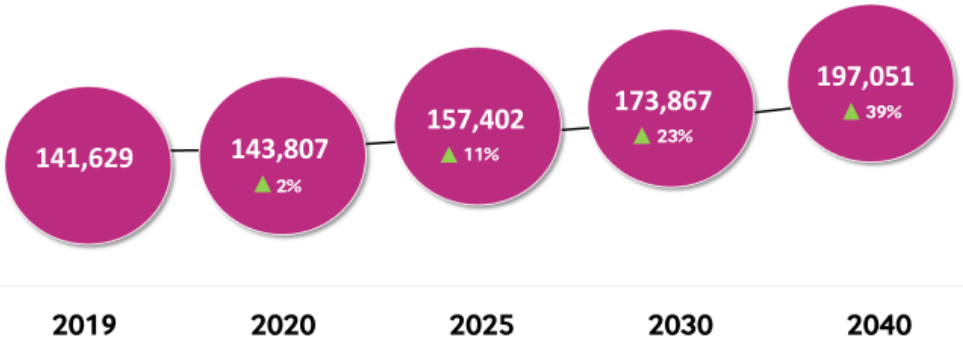
Within the context of the move to integrated care communities, the Embrace project is focusing on the integrated health and care system

THE CONTEXT
WHAT ARE THE CHALLENGES?

Poor performance compared to national averages



An increasing challenge, with a rapidly growing population of adults over 65



But a team who are ready for change

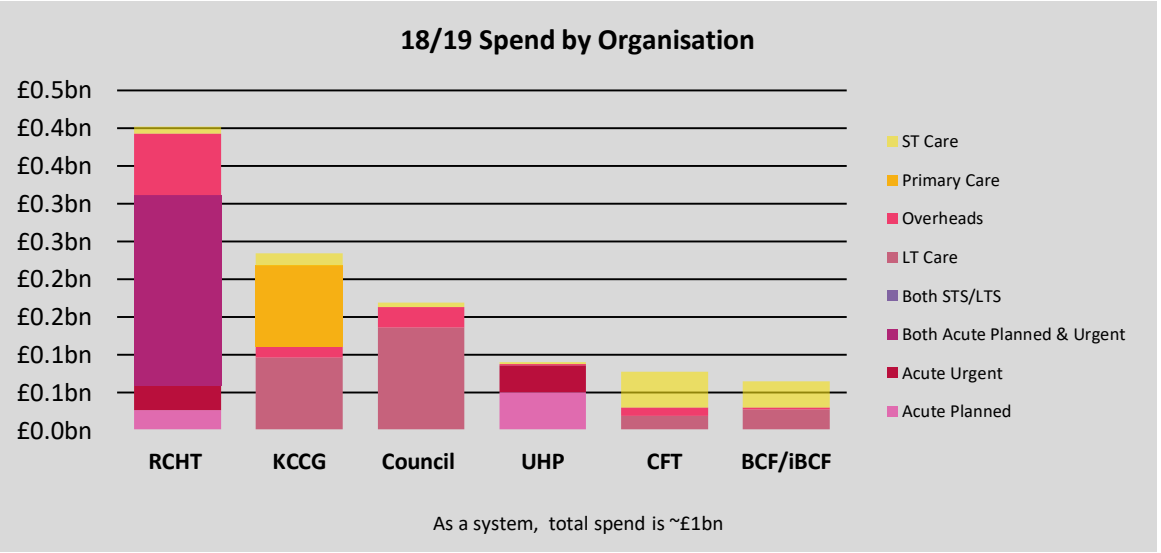
"I know it's hard but **we have to be more proactive** in our discharge planning" – *Discharge Coordinator*

"An acute hospital shouldn't be seen as a place of safety… protracted length of stays can do **significant harm to a patient** *– Consultant Geriatrician*

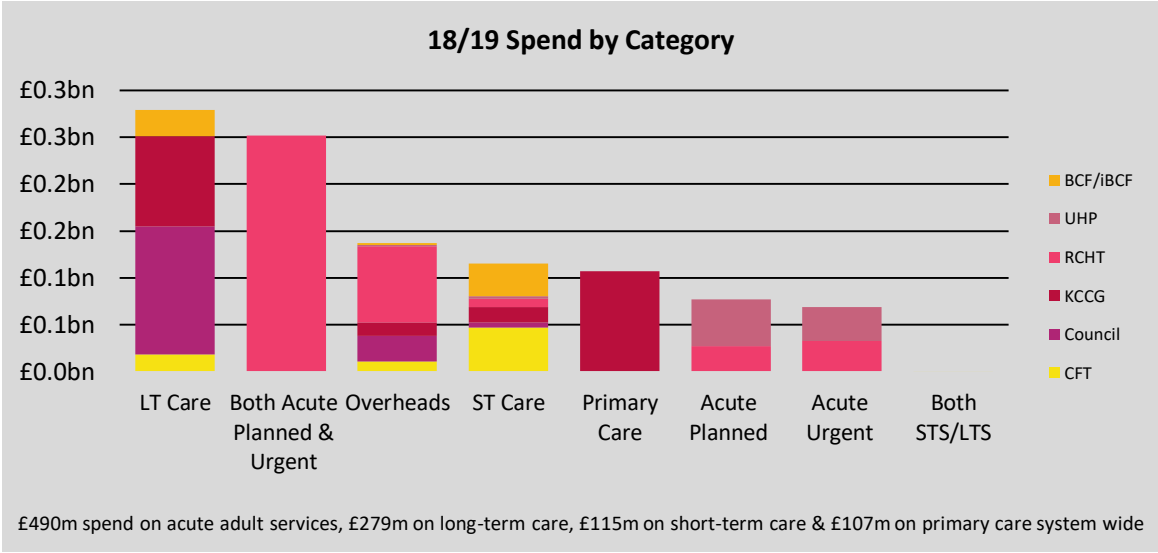
Can we not deal with that in the community? Why do they need an acute bed? **What are we waiting for?** *– Discharge Coordinator*

FINANCIAL CONTEXT

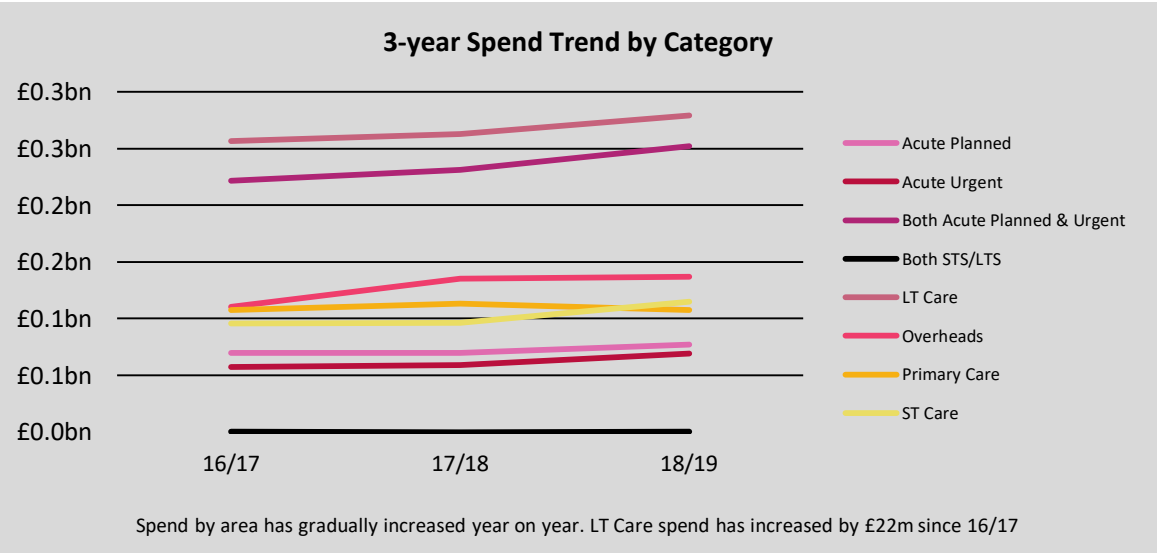
The four graphs below show the system's current financial picture. The numbers used are for adult services spend and do not include children's spend



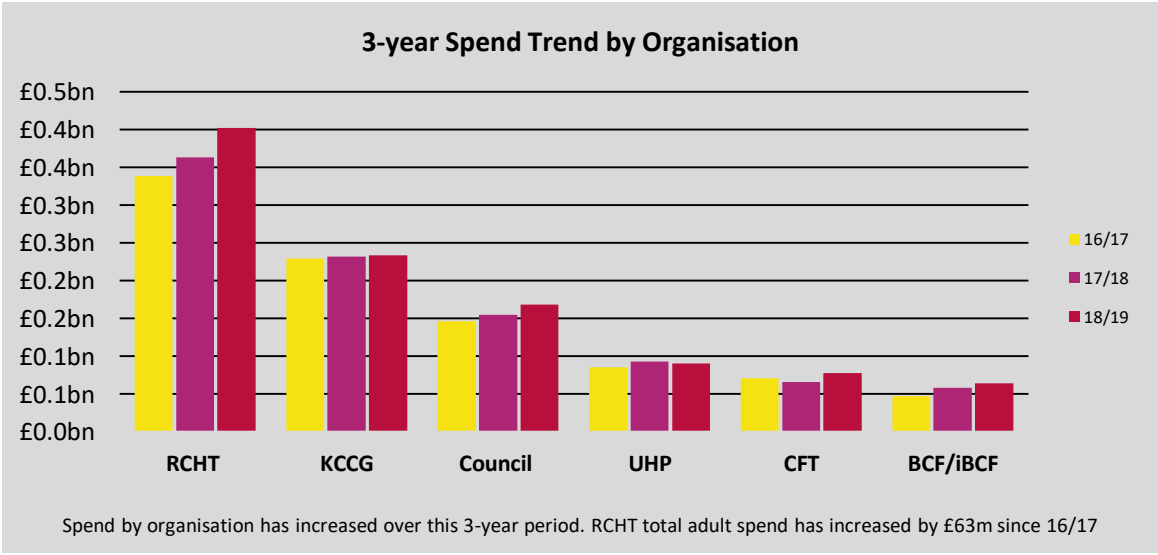
As a system, total spend is ~£1bn



£490m spend on acute adult services, £279m on long-term care, £115m on short-term care & £107m on primary care system wide



Spend by area has gradually increased year on year. LT Care spend has increased by £22m since 16/17



Spend by organisation has increased over this 3-year period. RCHT total adult spend has increased by £63m since 16/17

THE DIAGNOSTIC APPROACH

We've looked to understand how the system could better support older people to remain independent, enabling people to get the care they need in the best place for them, at home where possible.

We've spent time with frontline teams, run case review workshops, shadowed practitioners, analysed data, run surveys and met the leadership teams. We started by trying to understand whether or not the system was able to deliver ideal outcomes for older people.

In case review workshops, we asked 131 practitioners to define what we mean by an ideal outcomes. They said:

"The right service, at the right time, with the right person"

Person centred	Consistent	Maximise independence	Collaborative	Supports people in the community	Builds strong relationships & trust
people feeling empowered and supported to make their own choice (even if it's "risky")	parity of service across locations and no 'gaps' in the service	providing the care that will be the least restrictive and prioritising prevention over treatment	good communication between services and access to the same information across IT systems	maximising the use of voluntary sector and informal support	ensure the person has the best experience throughout their journey

So this is what we looked for.

WE ALREADY SEE EXAMPLES OF IDEAL OUTCOMES BEING ACHIEVED

John was a double amputee living at home with his wife. He was being reviewed as his care needs were increasing. John already had a ceiling track hoist that aided his wife in helping him be cared for.

After discussion with the community independence teams, it seemed that by combining his hoist with specialist satin sheets, John could use the remote to move himself around the bed unaided. John could roll himself, by attaching the hoist to one side of the sheet and move himself up and down the bed. After this, it was deemed that John no longer needed a POC to support him and his wife, and they could now live independently in their own home.

After consultation with the satin sheet manufacturers, they believed this was the first instance of someone using the sheets and hoist to move themselves around.

BUT WE DON'T ALWAYS GET IT RIGHT

Jean, a 90-Year-old woman, with a history of falls, was admitted to a community hospital. During her early stay, she is using a commode, washing herself (some support to clean her feet), cleaning her teeth, brushing her hair, and moving around regularly through the day. A search begins for a package of care to support her at home. Jean expresses her wish to return home.

Two months later, she is told that a POC cannot be sourced and that she is going to be moved into an intermediate care setting whilst this is sorted. She spent the following two days in bed when she was previously active every day. After a further two days, full washing support is recorded.

14 days pass before a POC is sourced. However, the physio now suggests that Jean's level of need cannot be met with the package and it is turned down. Four days later, a CHC checklist is completed, where she expressed her desire to return home.

Three months after her admission, Jean is moved into a temporary bed within a care home. Three months later, in the same care home, Jean passed away.

ARE PEOPLE GETTING AN IDEAL OUTCOME FROM OUR SYSTEM?

“The right service, at the right time, with the right person”

ARE PEOPLE GETTING AN IDEAL OUTCOME FROM OUR SYSTEM?

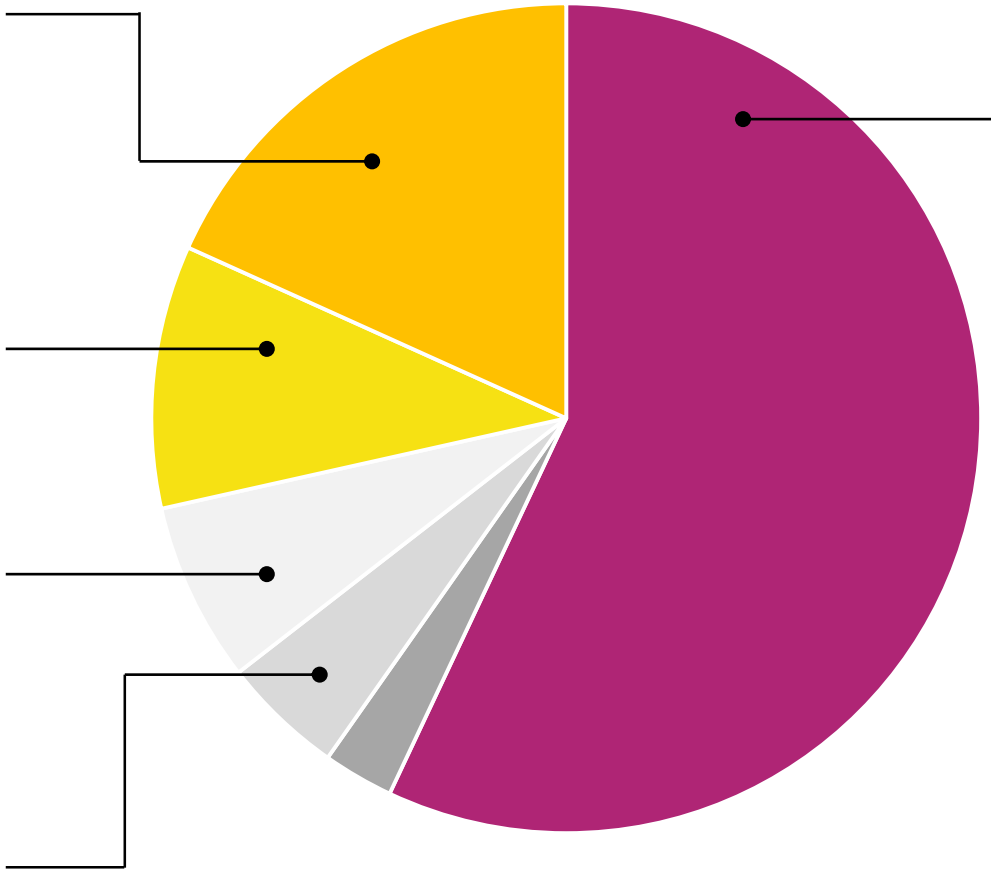
We reviewed 265 cases across 5 workshops with 131 practitioners from across Cornwall. Practitioners were asked whether they felt the person's outcome was ideal or not, and if not, why not

18%
of the cases were not ideal due to not being able to access the right services; either through lack of capacity or the right service not existing

11%
of the cases were due to decision making and behaviours, primarily through risk aversion or lack of clarity on what services are available

7%
of the cases were due to the patient, family or carer's choice to take an alternative pathway

5%
of the cases were due to the lack of collaborative working and a multidisciplinary team approach



57%
of the cases reviewed were felt to be ideal, whether that was an admission, a discharge decision or community provision

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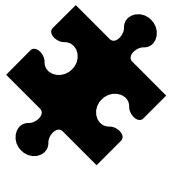
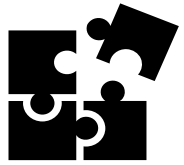


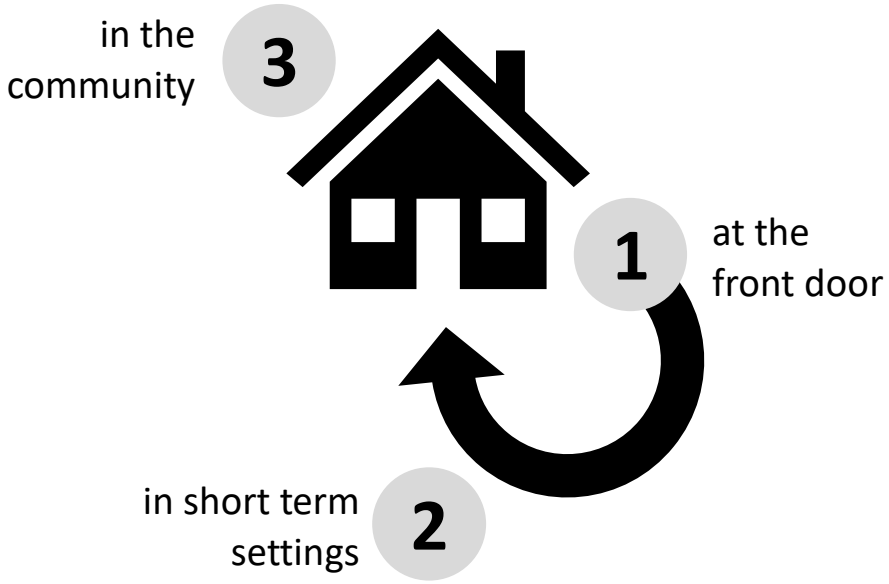
Do we have the right model of care?
Do we have enough of the right services, with the right staff, in the right place?



Are we using services effectively?
Do we work and make decisions in the best way to ensure people access the right services for them?

What impact does this have on outcomes?
The right service?
The right time?
The right professional?

WE'VE LOOKED TO UNDERSTAND THESE QUESTIONS ACROSS THE SYSTEM



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in the community 3

at the front door

in short term settings 2

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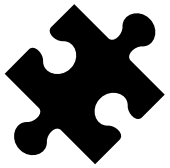
AT THE FRONT DOOR
DO WE HAVE THE RIGHT MODEL OF CARE?



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DO WE HAVE THE RIGHT MODEL OF CARE?
ENOUGH CAPACITY FOR GOOD QUALITY CARE

If we had the right model of care, every older person would be achieving their ideal outcome

So, is this the case?

If it is, we should have capacity to admit you if that's what you need, wherever you live and whenever you arrive.

But our bed occupancy is now higher than national recommendations

Avg, Jan-Mar 2019

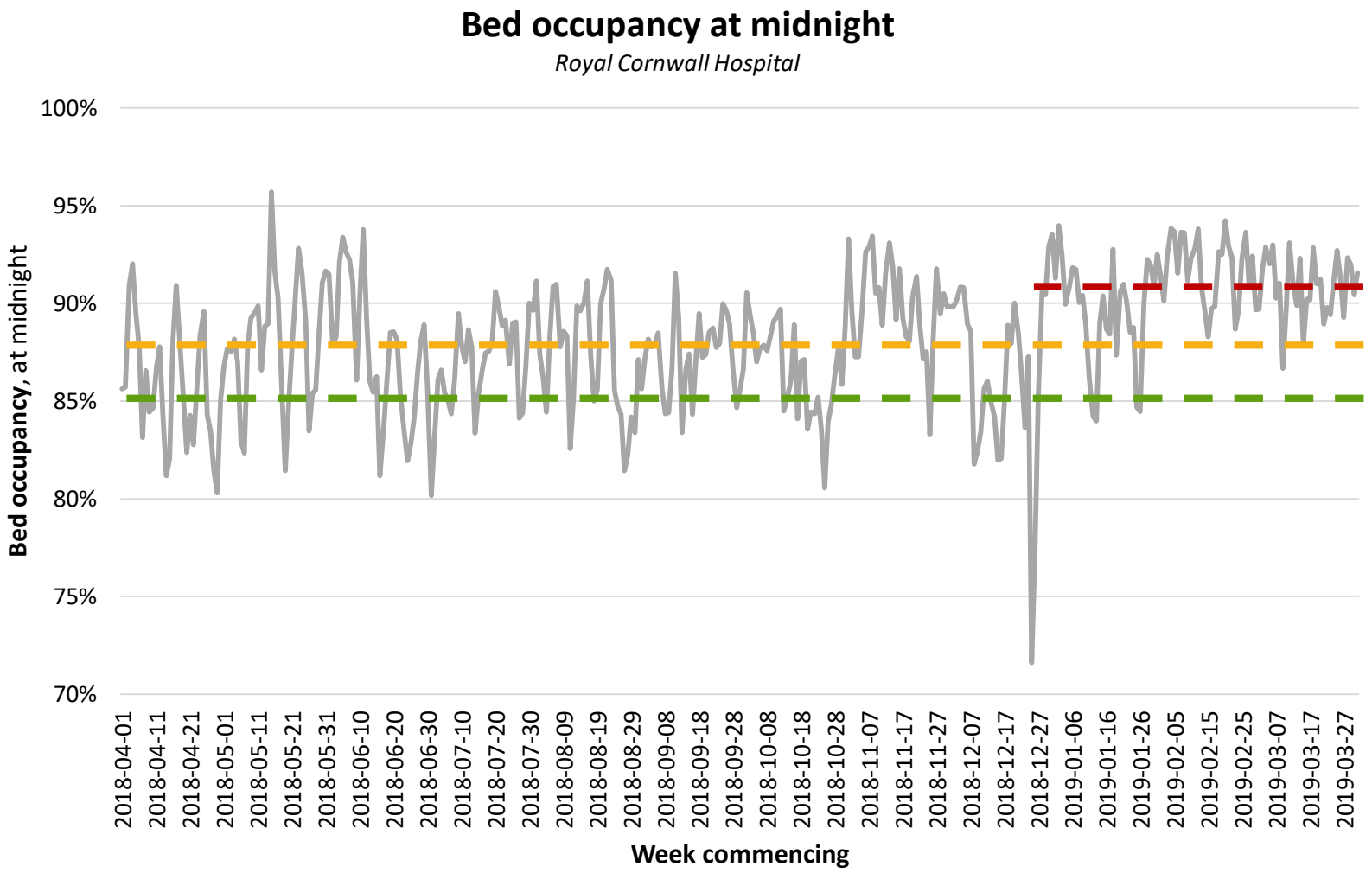
91%

Avg, FY 2018/19

88%

National standard

85%

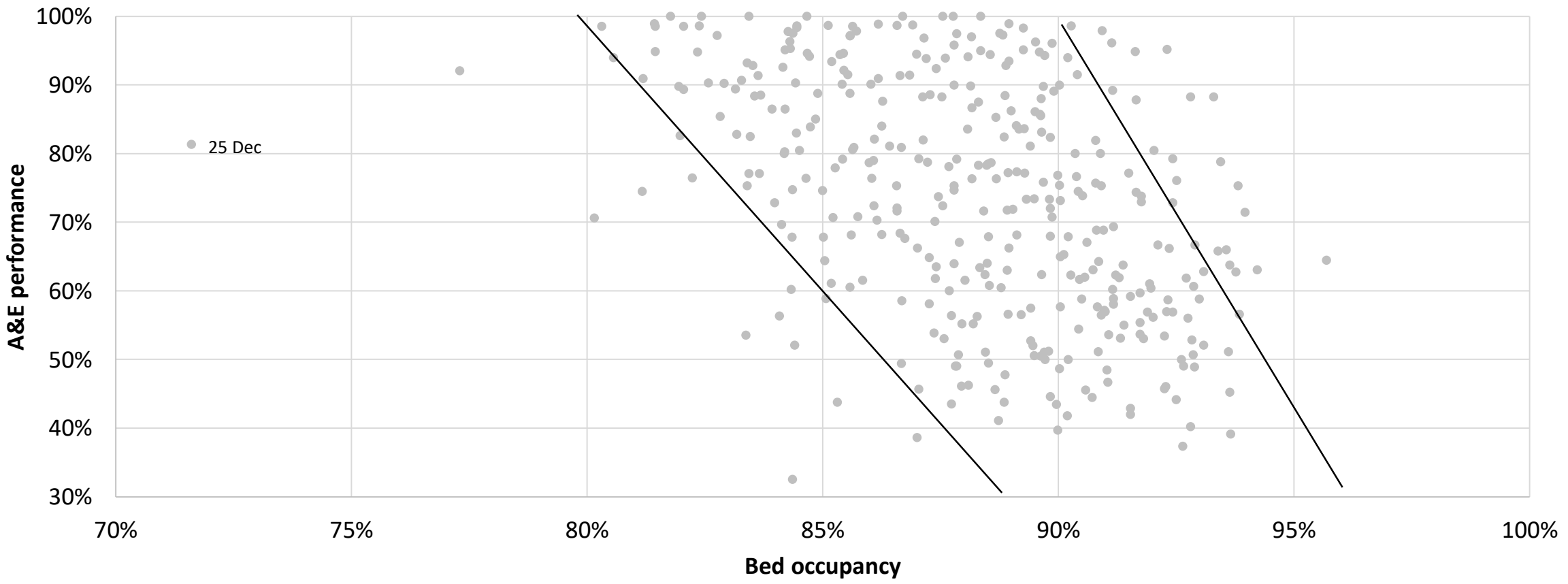


DO WE HAVE THE RIGHT MODEL OF CARE?
ENOUGH CAPACITY FOR GOOD QUALITY CARE

And if we look at the correlation between A&E performance and Bed Occupancy, we know that we perform worse when the hospital is full

A&E performance vs Bed occupancy

For all 65+ admissions; comparing average daily A&E wait time performance against bed utilisation at midnight



DO WE HAVE THE RIGHT MODEL OF CARE?
ACCESSING THE RIGHT SERVICES

Case review workshop of 54 patients admitted to RCHT, UHP and CFT. 36 workshop attendees from acute ED, inpatient wards and health onward care team, adult social care, therapy, home-based reablement and GPs.

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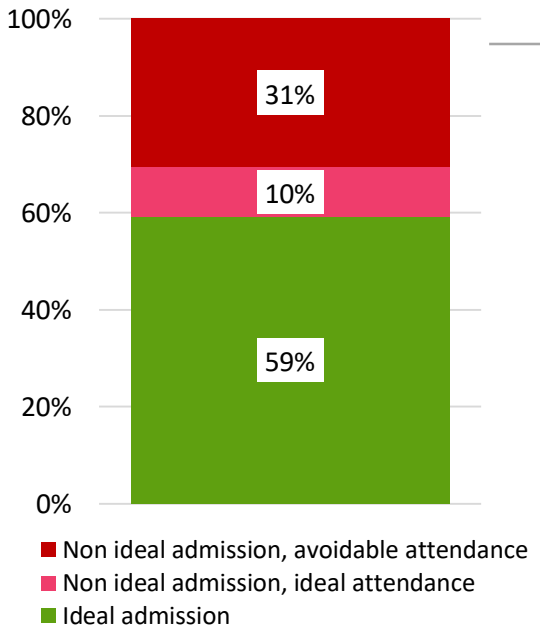
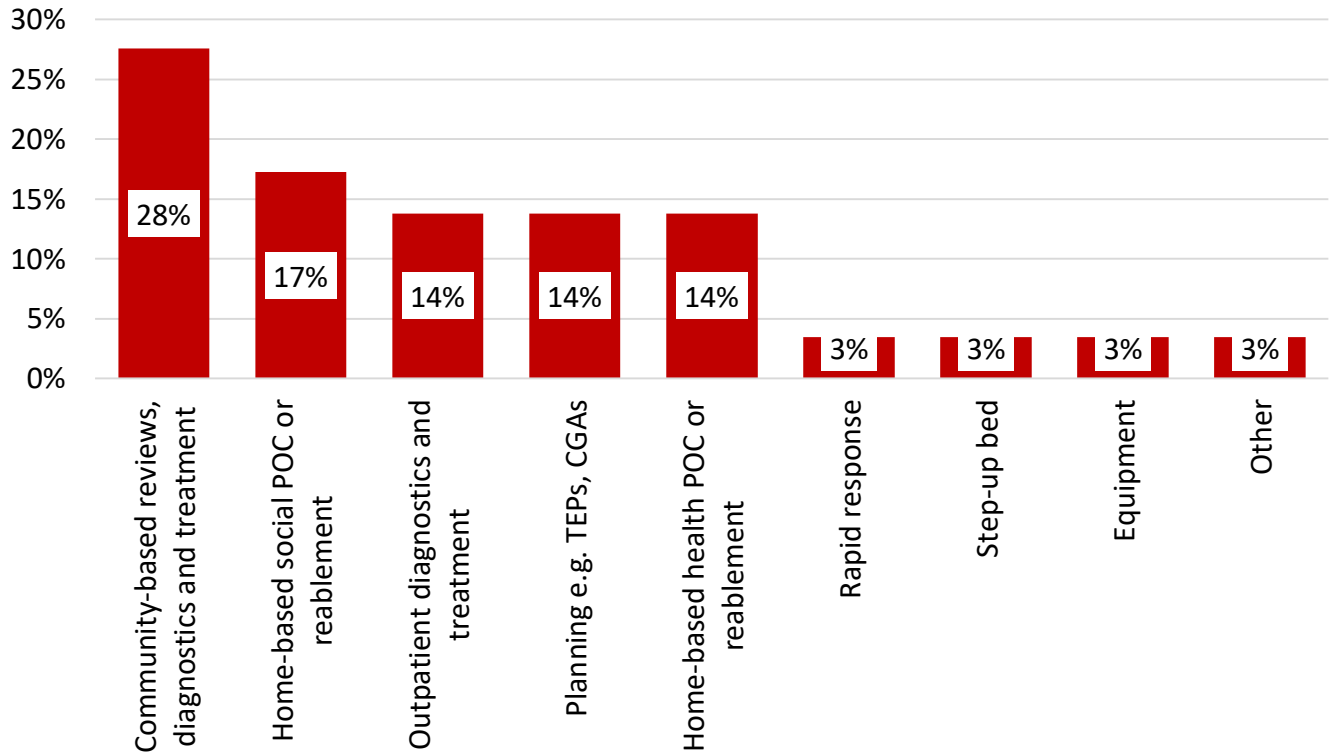
Are we managing the demand coming in at the front door effectively?

We asked for adults over 65 "should the person have been admitted?"



How could we have avoided inappropriate attendances?

Support or services which attendees felt would have avoided attendance, either at point of attendance or in the time period leading up to hospital attendance



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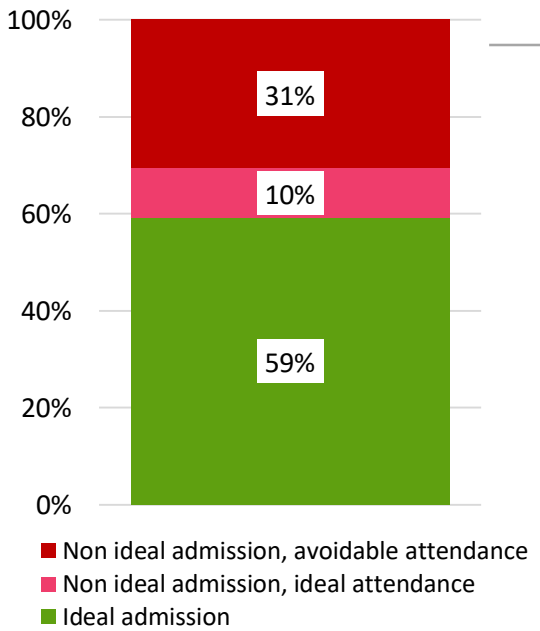

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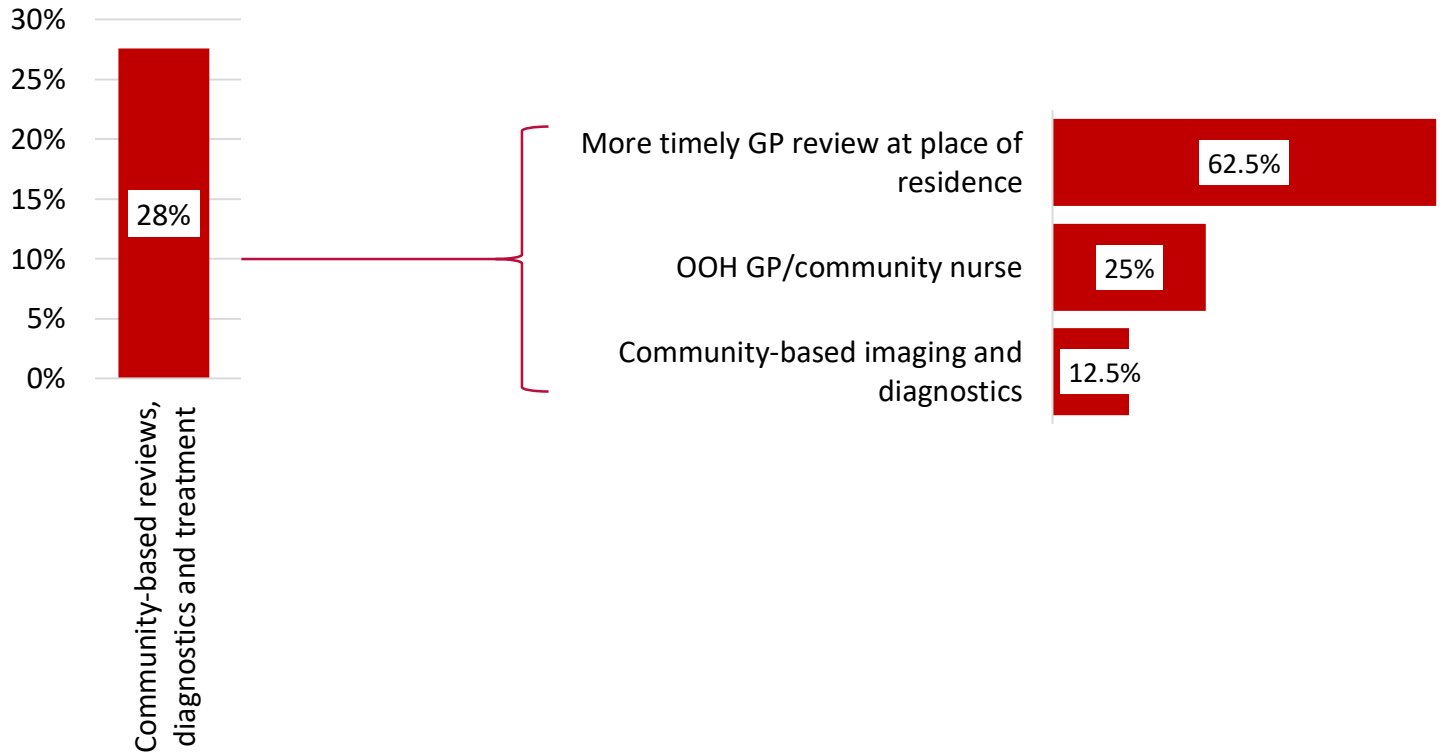
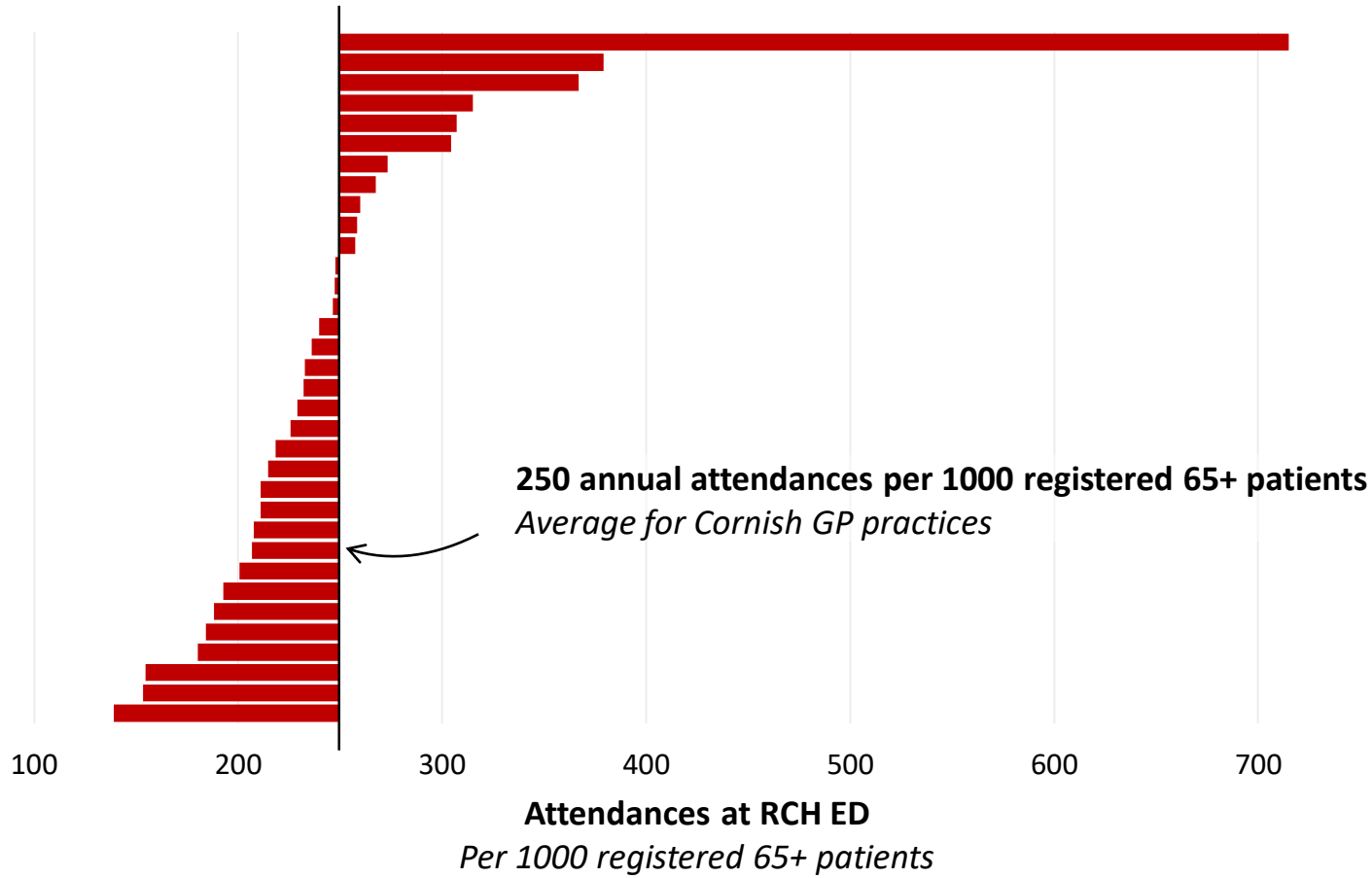


DO WE HAVE THE RIGHT MODEL OF CARE?
ACCESSING THE RIGHT SERVICES

Attendances at RCH ED by 65+ patients in FY 2018/19 split by patient's GP practice.

When we look at the attendances per 1,000 over 65 population, we could focus on some key areas to influence the demand at the front door



"We tend to get a lot of social admissions from the Camborne area, where there is no obvious clinical need"
– Nurse, Onward Care Team

"Why is it that in some areas we are good at treating the patient in the community, and in others we don't seem to be as good?"
– Ward staff

"There is so much variation in community provision between areas – of course we'll see a variation at ED"
– Occupational therapist

AT THE FRONT DOOR
DO WE HAVE THE RIGHT MODEL OF CARE?

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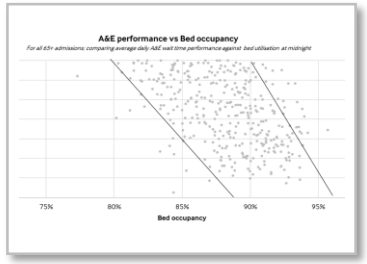
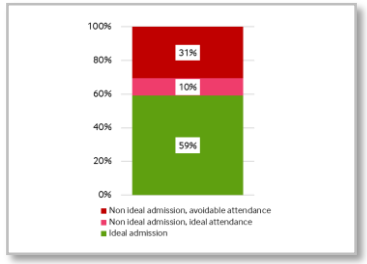
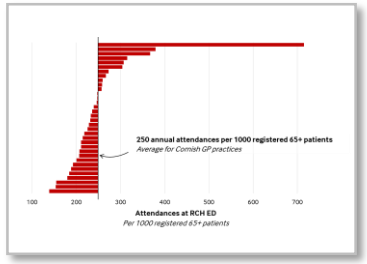


We know that as the system is under pressure, there is a strong correlation between more pressure and lower performance

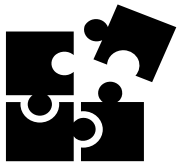


In workshops, admission to an acute bed was only the ideal outcome for 59% of the cases reviewed who were admitted



There are geographical and demographic factors which are influencing the flow of people through the system, and links to who is able to access the right services for them

AT THE FRONT DOOR
ARE WE USING SERVICES EFFECTIVELY?



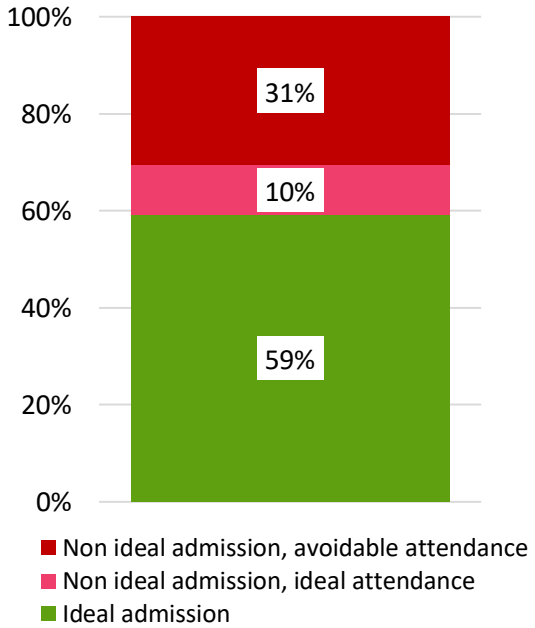
Are we using services effectively?
Do we work and make decisions in the best way to ensure people access the right services for them?

ARE WE USING SERVICES EFFECTIVELY?
ARE WE MAKING THE BEST DECISIONS?

Case review workshop of 54 cases admitted to RCHT, UHP and CFT. 36 workshop attendees from acute ED, inpatient wards and health onward care team, adult social care, therapy, home-based reablement and GPs.

If we were using services effectively, then the outcomes that people achieve should be consistent no matter when they arrive or who they see. Are they?

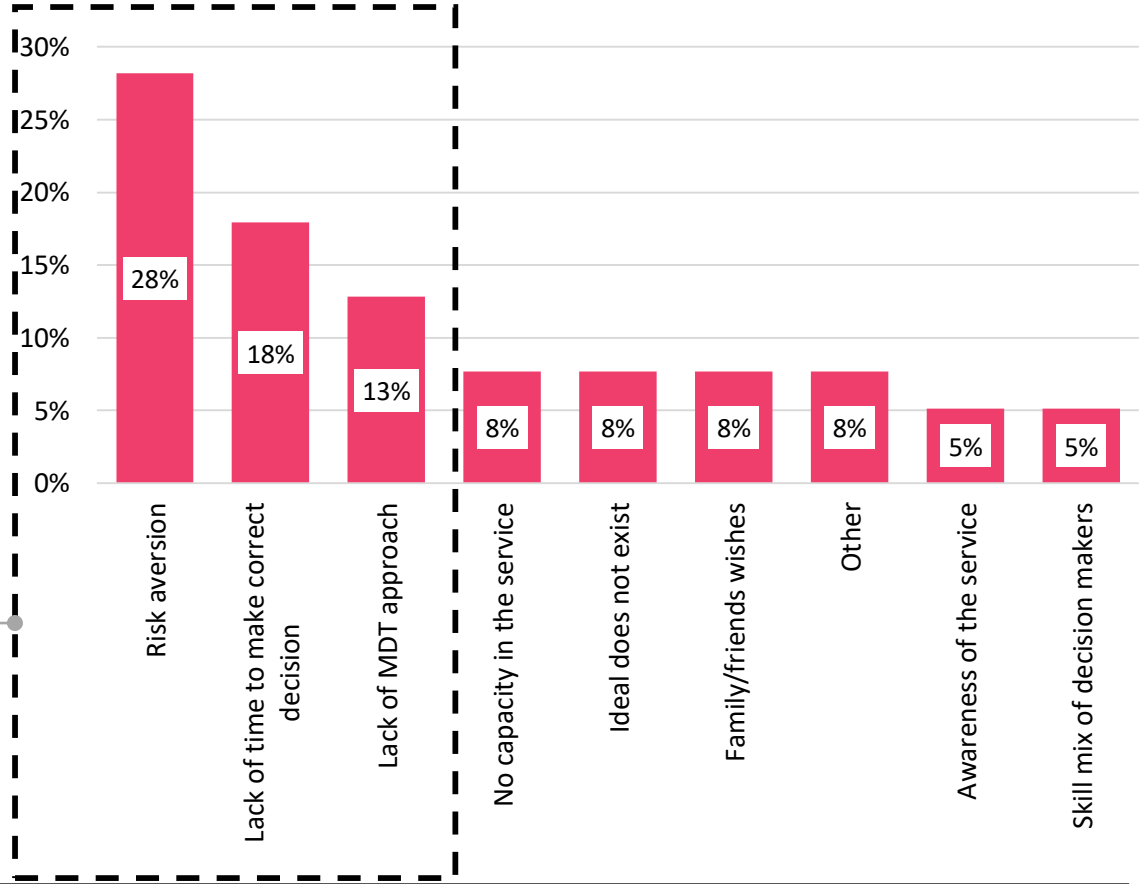
We asked "should the patient have been admitted?"



Behaviour drives the top 3 reasons for non-ideal decisions

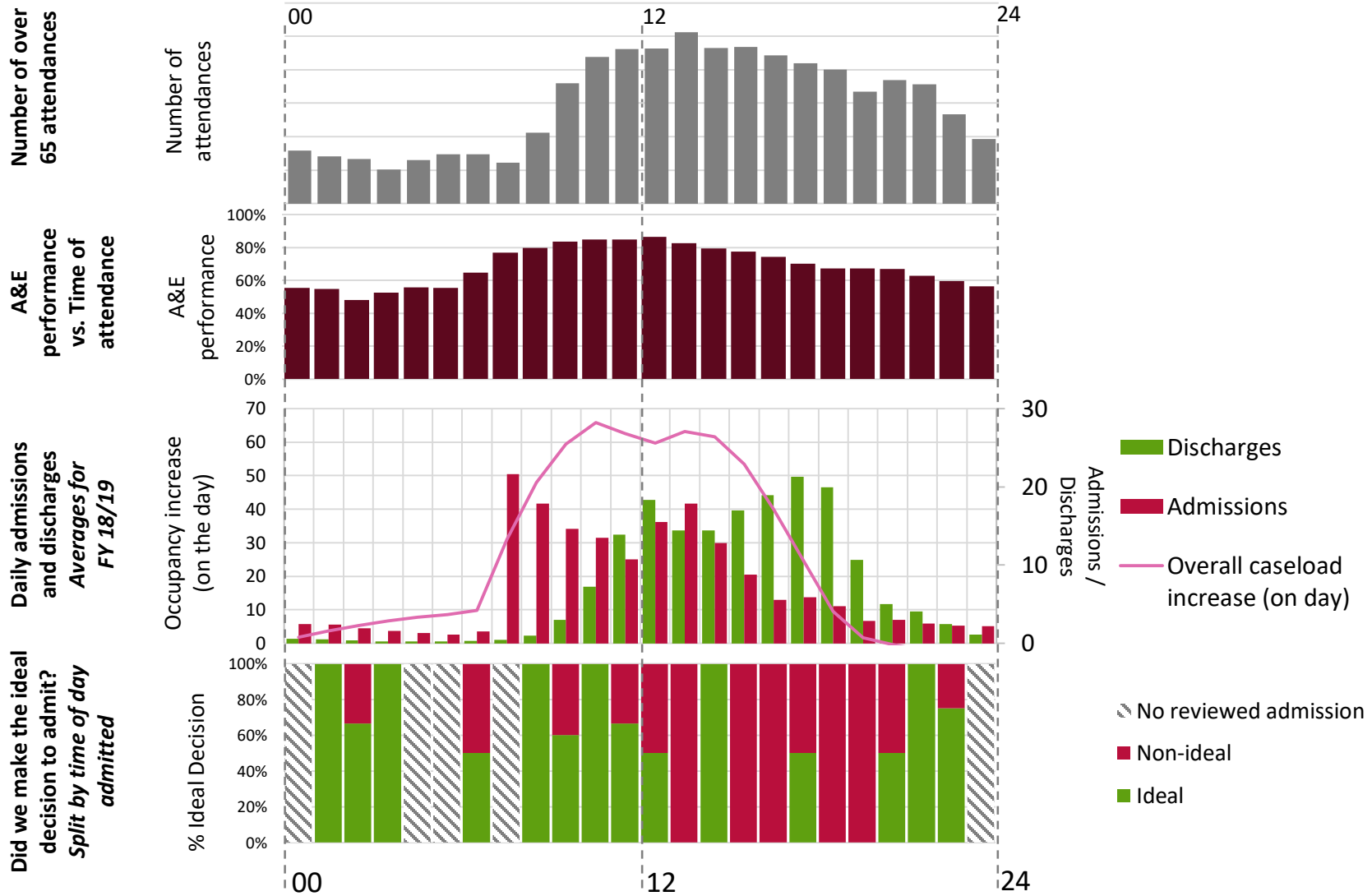
Why do we make non-ideal decisions to admit?

Factors leading to non-ideal decision making at point of admission



ARE WE USING SERVICES EFFECTIVELY?
ARE WE MAKING THE BEST DECISIONS?

* Please note, the A&E performance graph does not take account of volume, so the average overall performance cannot be seen on this graph



Our front door attendances for over 65s starts to rise from mid morning and peaks after lunch

Our A&E performance varies through the day. As attendances continue, our performance starts to drop around midday, and continues to be poor as we build up a backlog into the night

Our discharge profile lags behind our admissions profile, so during the day, we have a peak in overall caseload increase at the same time as the 8am ED attendance spike hits the 4 hour mark and as our elective cases start to finish in theatre

As we are at the peak of pressure on beds in the daily cycle, we see performance start to drop in A&E and also in the % of admissions which are ideal

ARE WE USING SERVICES EFFECTIVELY?
ARE WE MAKING THE BEST DECISIONS?

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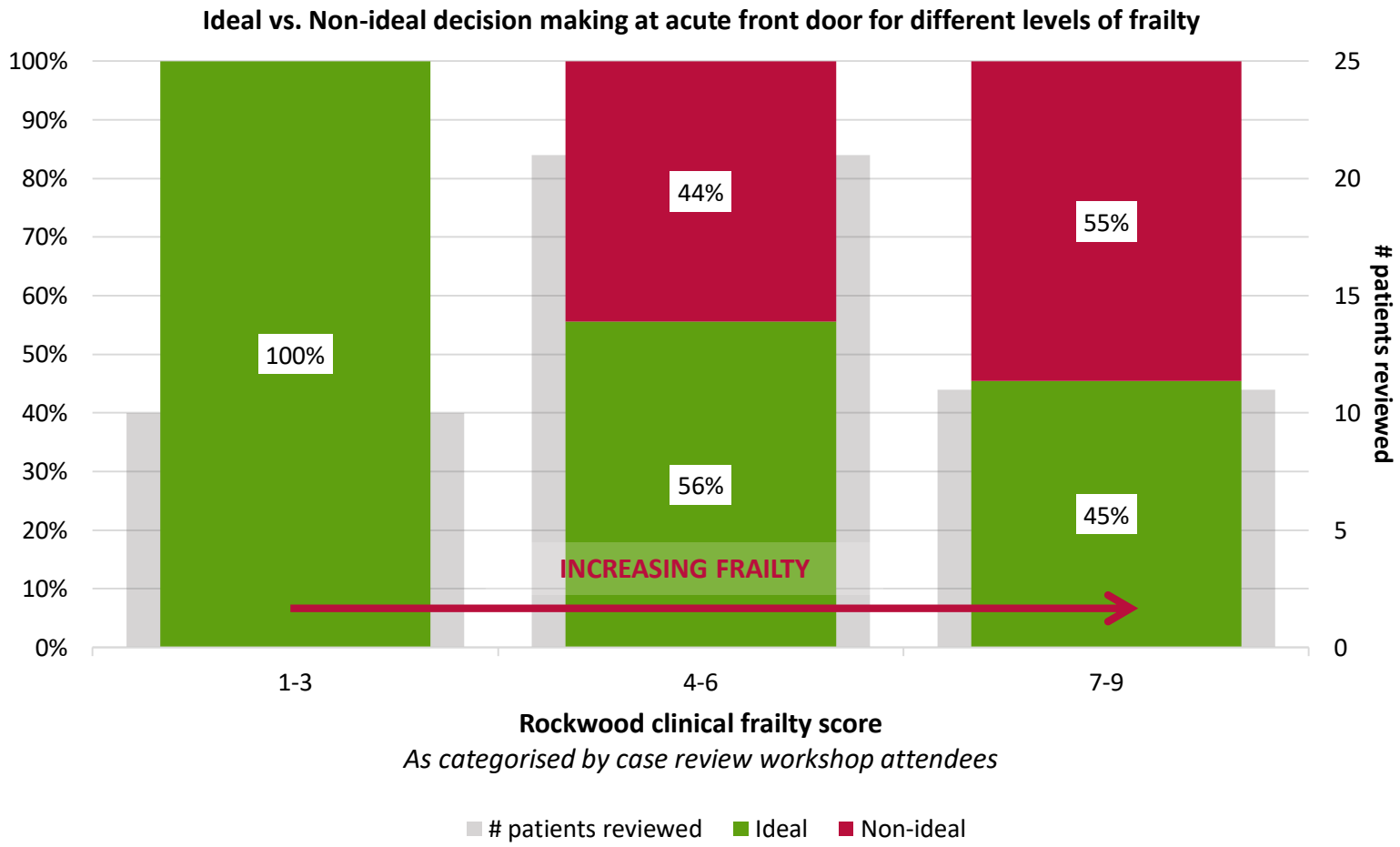


"Inexperienced clinicians at the front door at OOH times, of course decision making is going to be affected!" – *Geriatric consultant*

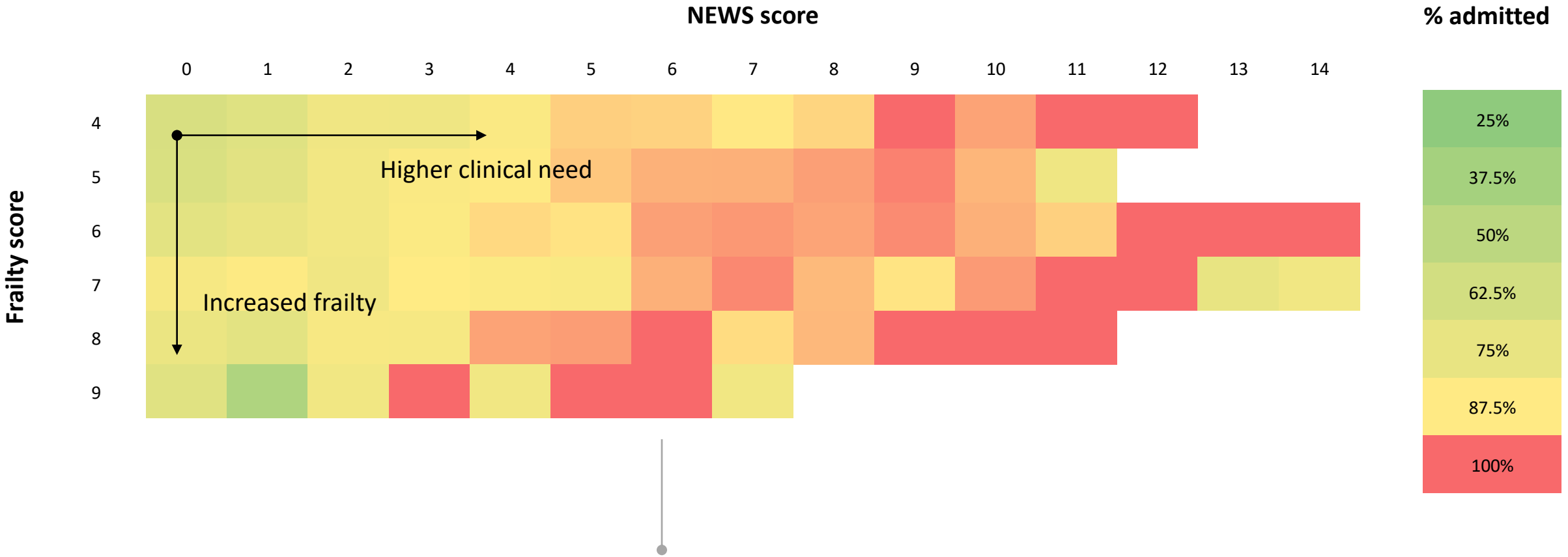
"It's much harder to discharge someone from ED into community services later in the day… admitting them is the easiest option" – *Discharge coordinator*

Does this apply equally to different service user groups?

As we are at the peak of pressure on beds in the daily cycle, we see performance start to drop in A&E and also in the % of admissions which are ideal

ARE WE USING SERVICES EFFECTIVELY?
ARE WE MAKING THE BEST DECISIONS?

Data supplied by RCH information team. Attendances at ED FY 2018/19.



There is opportunity to ensure that we have the right model of care so that we avoid admitting frail patients when it is not the ideal outcome for them

AT THE FRONT DOOR
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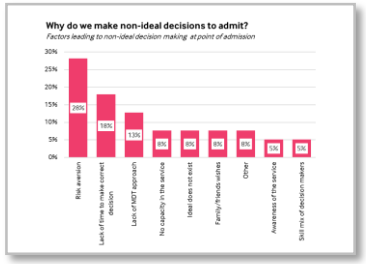
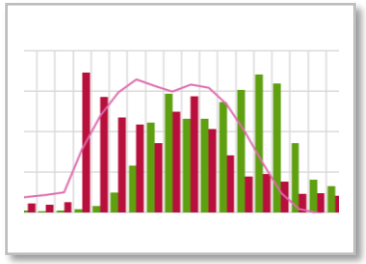
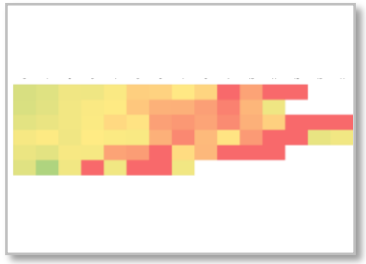
Do we work and make decisions in the best way to ensure people access the right services for them?



Behaviour drives the top reasons for people being admitted to hospital when that's not the ideal outcome for them



Our performance **varies through the day**, and this is linked to the pressure that is felt by our teams across the system



We aren't always able to **support frail patients** in the same way as non frail patients, with 100% of non frail patients getting ideal outcomes compared to 45% of frail patients

in the community 3

1 at the front door

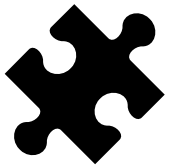
in short term settings 2

Do we have the right model of care?
Do we have enough of the right services, with the right staff, in the right place?

Are we using services effectively?
Do we work and make decisions in the best way to ensure people access the right services for them?

What impact does this have on outcomes?
The right service?
The right time?
The right professional?

IN SHORT TERM SETTINGS
DO WE HAVE THE RIGHT MODEL OF CARE?

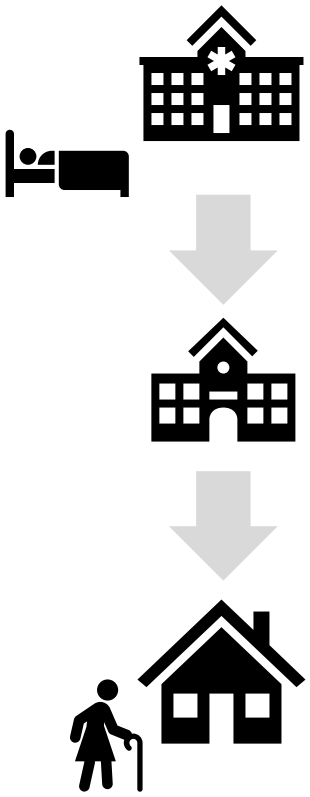


Do we have the right model of care?
Do we have enough of the right services, with the right staff, in the right place?

DO WE HAVE THE RIGHT MODEL OF CARE?
THE IMPACT OF PATHWAYS

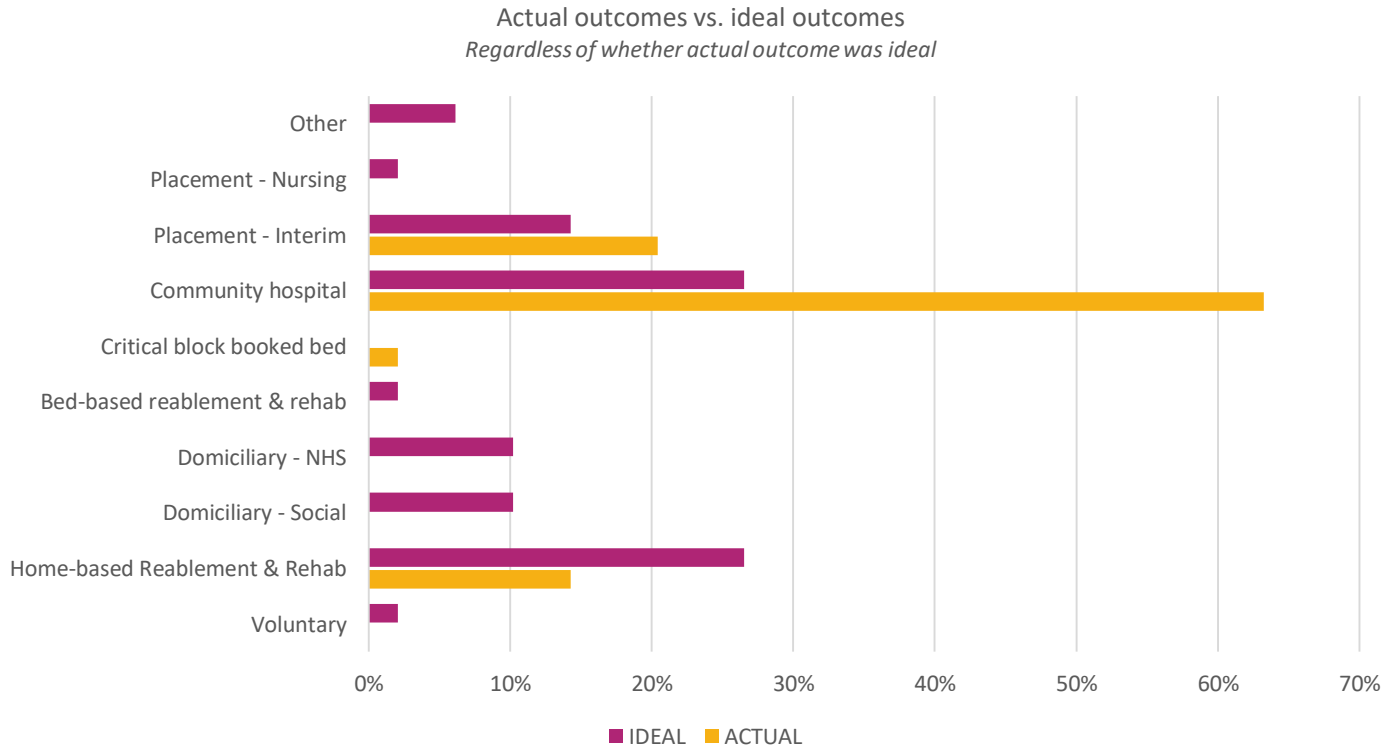
From workshops with practitioners from across the system, including nurses, GPs, geriatricians, OTs, Physios and Social Workers

Are we achieving the best outcome for every older person?



The reality is that this step is only ideal for almost **half** of the people that this currently happens for

In **47%** of cases, there was the opportunity to improve the outcome for the person when moving from one short term setting to another

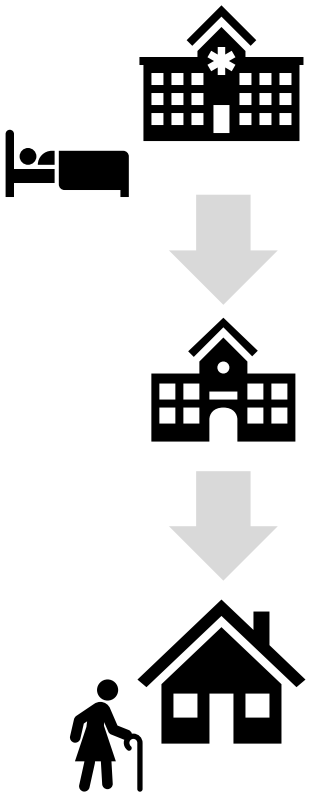


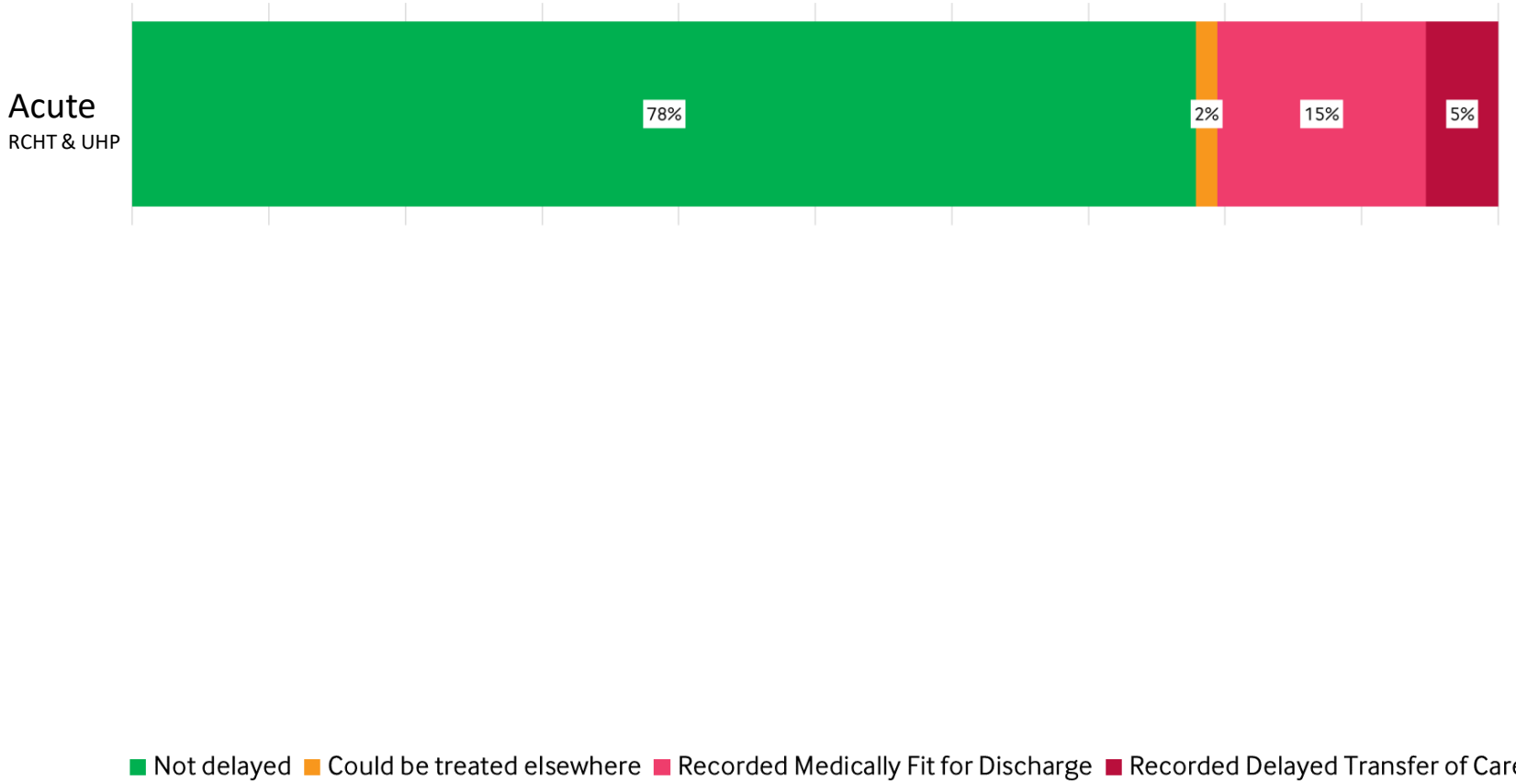
DO WE HAVE THE RIGHT MODEL OF CARE?
THE IMPACT OF PATHWAYS

Review of 943 beds across acute and community hospitals, asking what the next step is for the patient

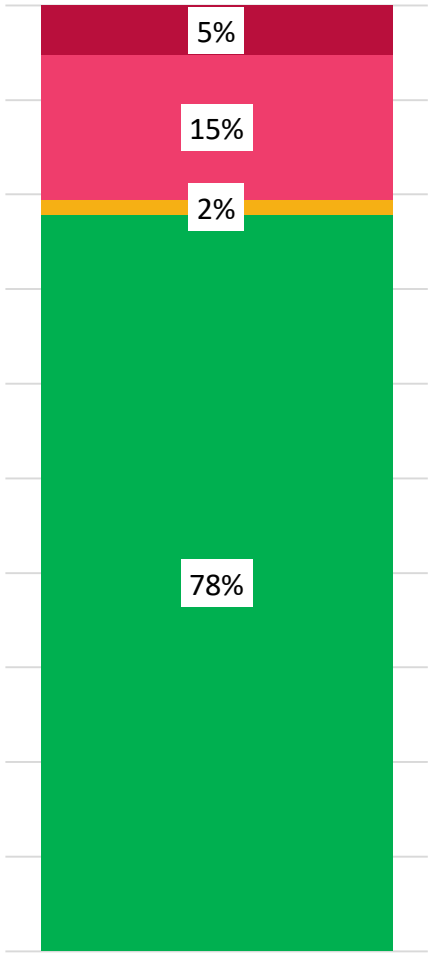
Are we achieving the best outcome for every older person?

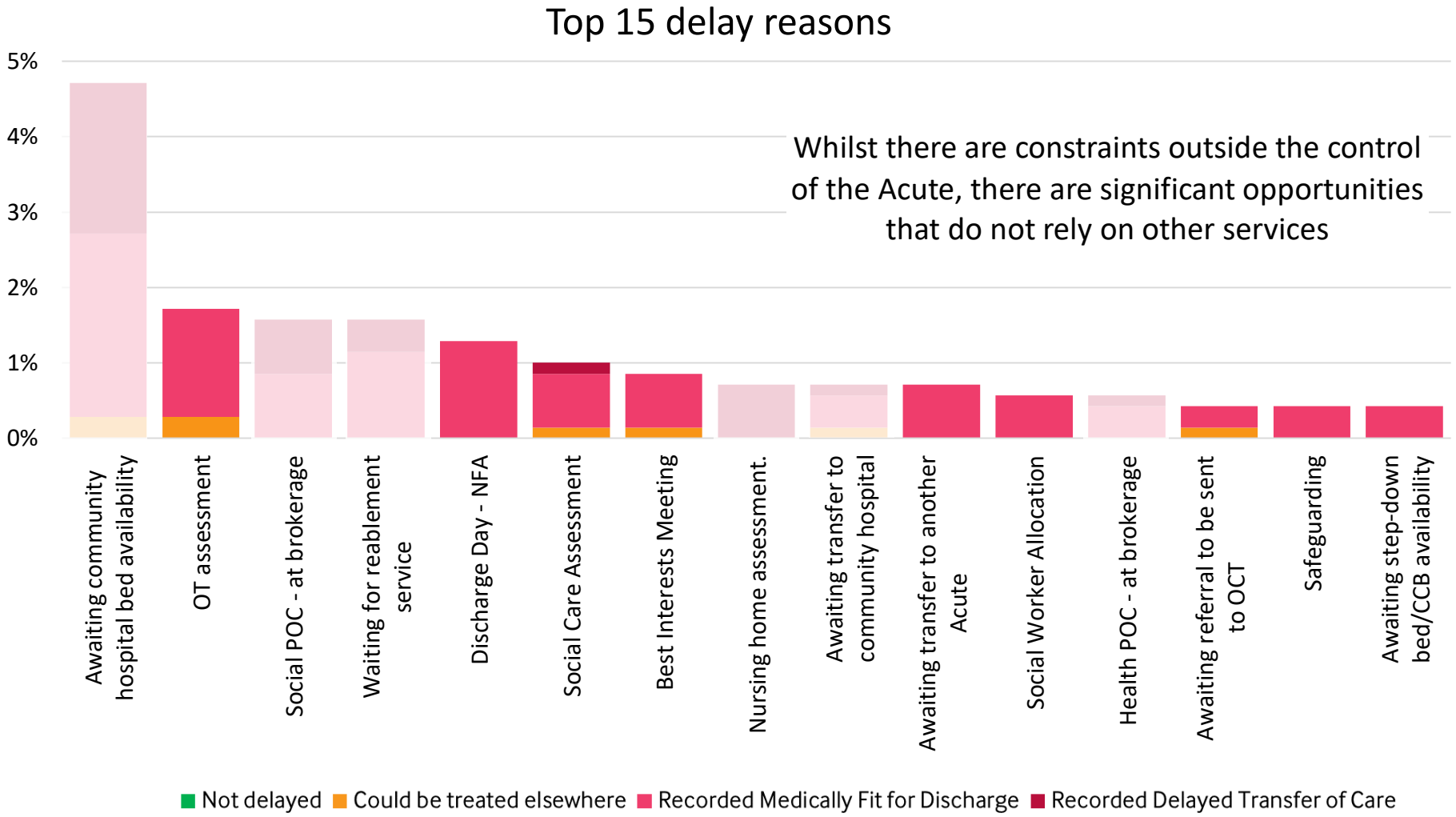
When we look at the next steps for patients in our Acute and Community beds, we see that a significant proportion of our beds are filled with patients who ideally would not be there



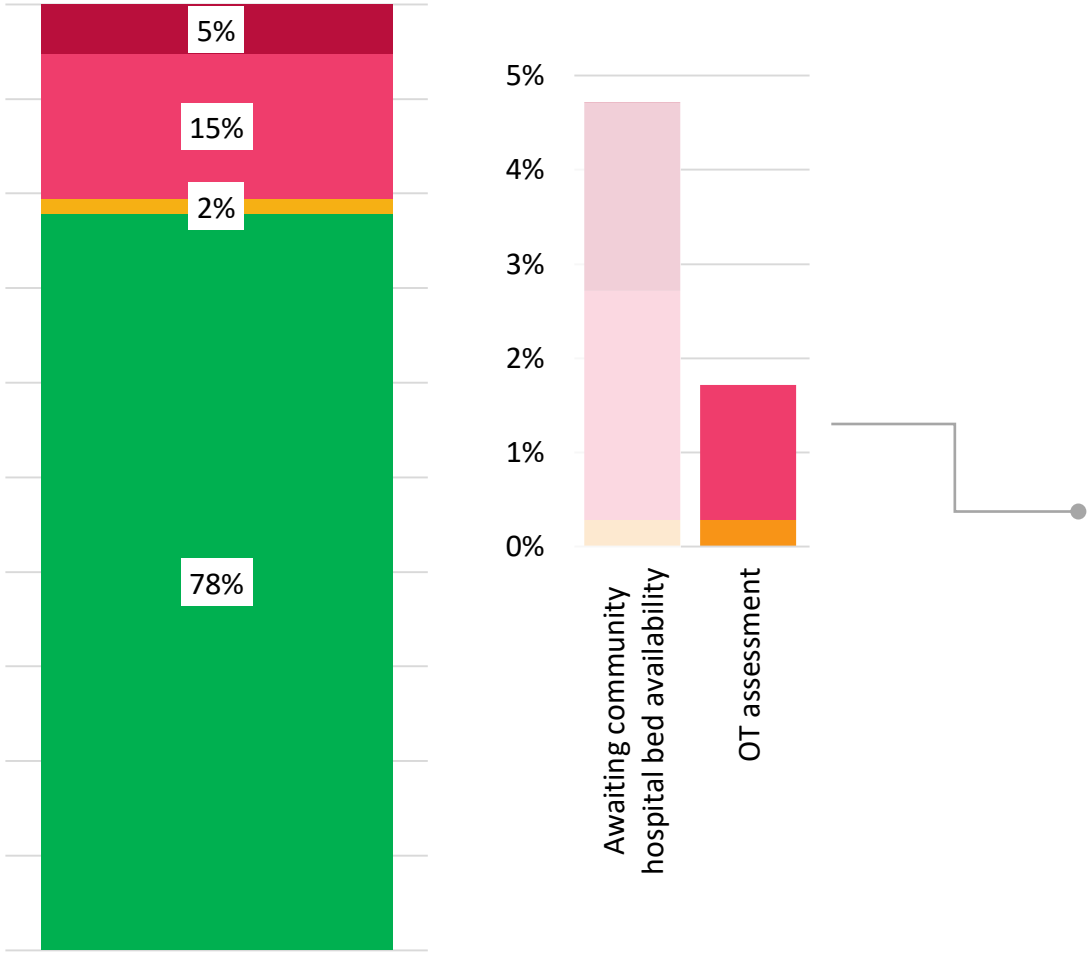


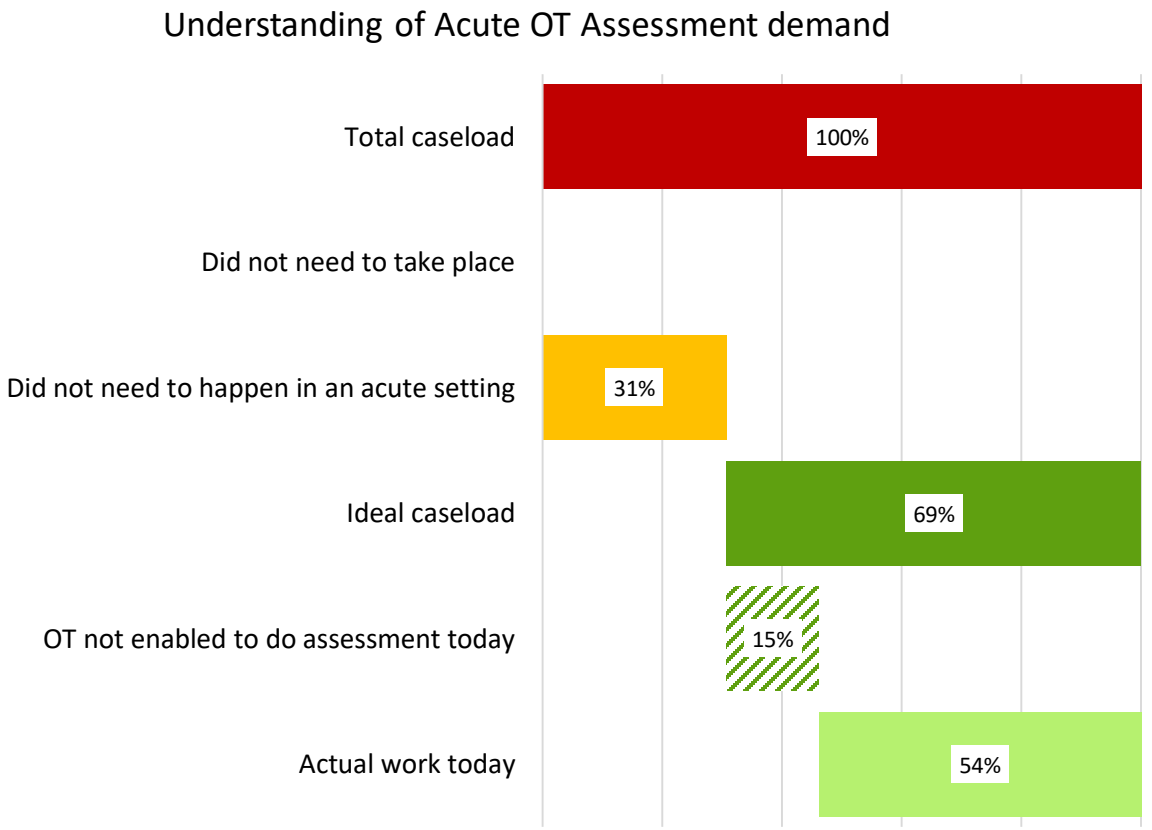
DO WE HAVE THE RIGHT MODEL OF CARE?
THE IMPACT OF PATHWAYS





DO WE HAVE THE RIGHT MODEL OF CARE?
THE IMPACT OF PATHWAYS



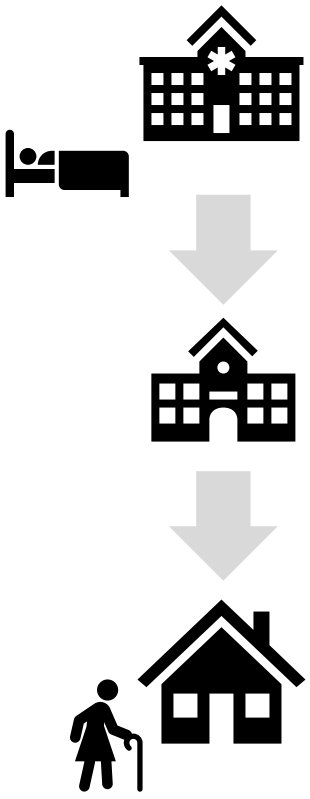


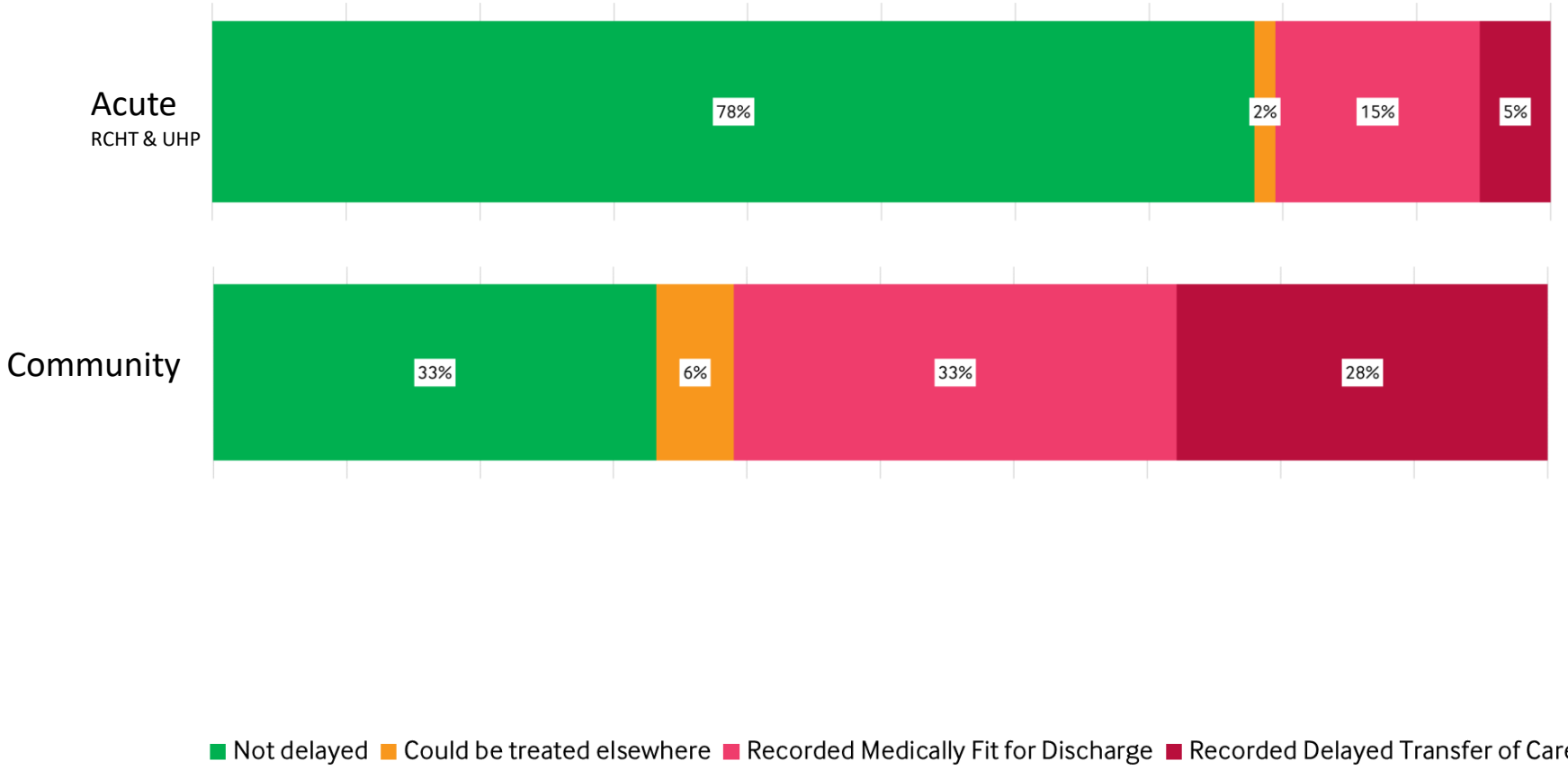
DO WE HAVE THE RIGHT MODEL OF CARE?
THE IMPACTS OF CAPACITY CHALLENGES

Review of 943 beds across acute and community hospitals, asking what the next step is for the patient

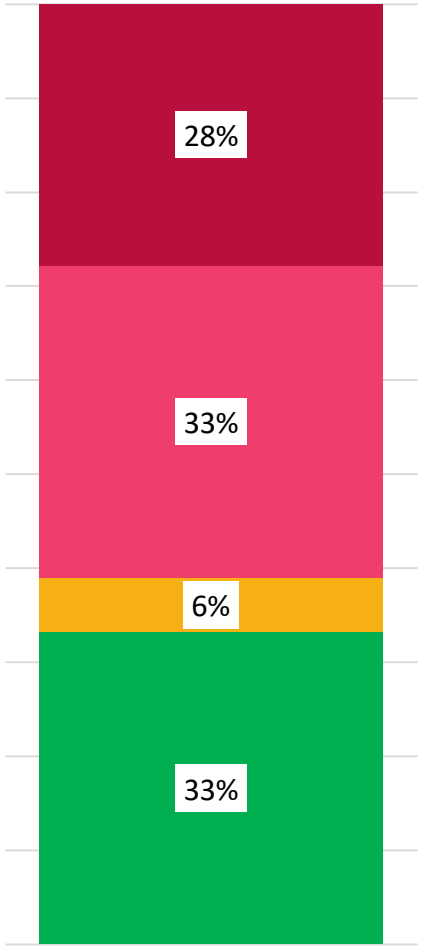
Are we achieving the best outcome for every older person?

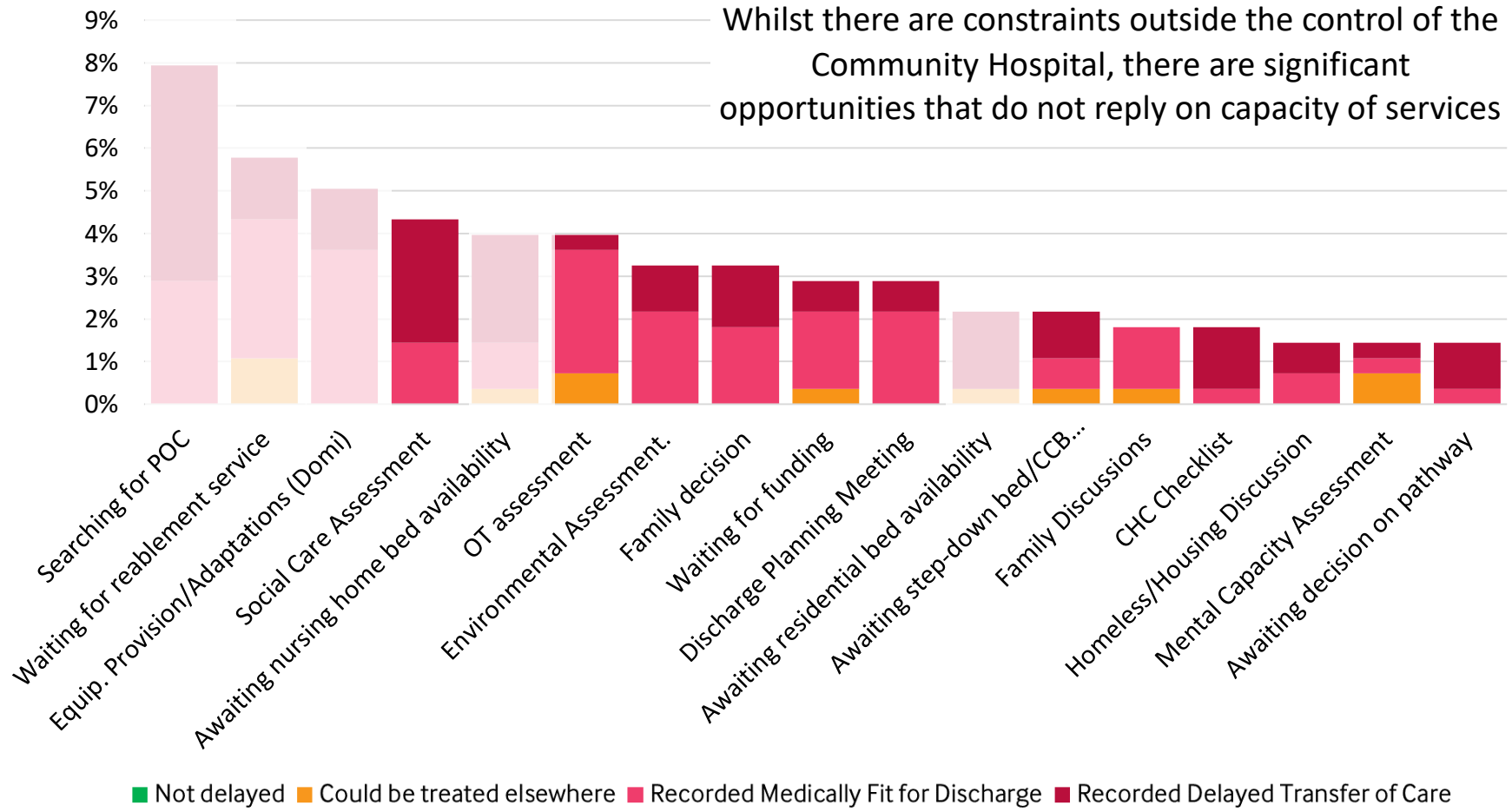
When we look at the next steps for patients in our Acute and Community beds, we see that a significant proportion of our beds are filled with patients who ideally would not be there





DO WE HAVE THE RIGHT MODEL OF CARE?
THE IMPACTS OF CAPACITY CHALLENGES

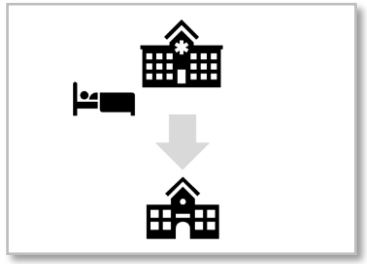




Whilst there are constraints outside the control of the Community Hospital, there are significant opportunities that do not reply on capacity of services

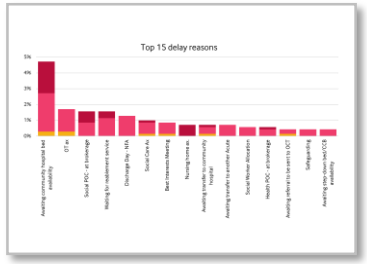
IN SHORT TERM SETTINGS
DO WE HAVE THE RIGHT MODEL OF CARE?

Do we have the right model of care?
Do we have enough of the right services, with the right staff, in the right place?



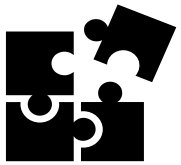
When we discharge from the acute into another short term setting, that is only the **ideal outcome for half** of the people who we follow this pathway

22% of our acute beds and 67% of our community beds are filled with patients who would be better suited elsewhere



When we look at the reasons for why we are delayed, the delays are split between those due to **capacity** further down the pathway, and delays due to **behaviours and processes**

IN SHORT TERM SETTINGS
ARE WE USING SERVICES EFFECTIVELY?

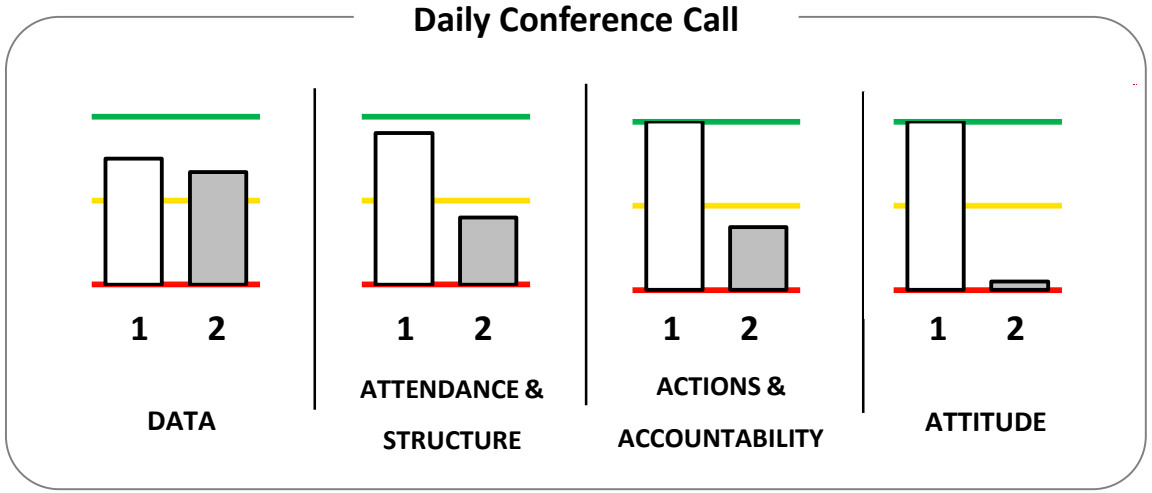


Are we using services effectively?
Do we work and make decisions in the best way to ensure people access the right services for them?

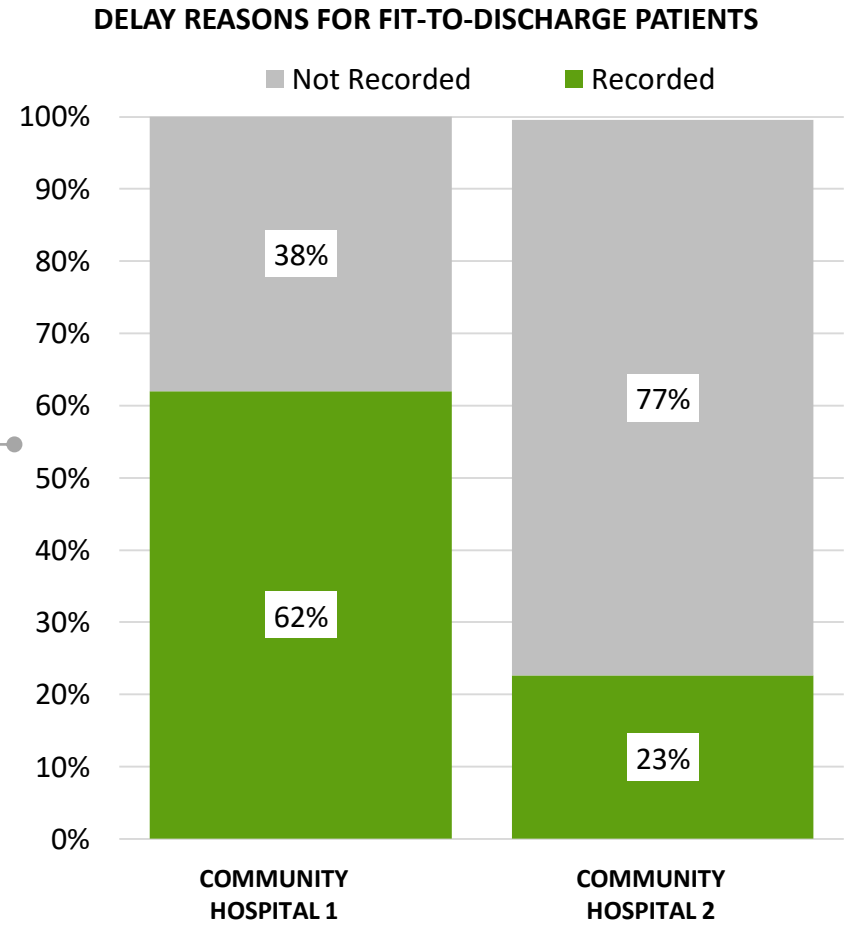
ARE WE USING SERVICES EFFECTIVELY?
WHAT WORKING ENVIRONMENT ARE WE CREATING?

ARE WE USING SERVICES EFFECTIVELY?
HOW ARE WE USING INFORMATION?

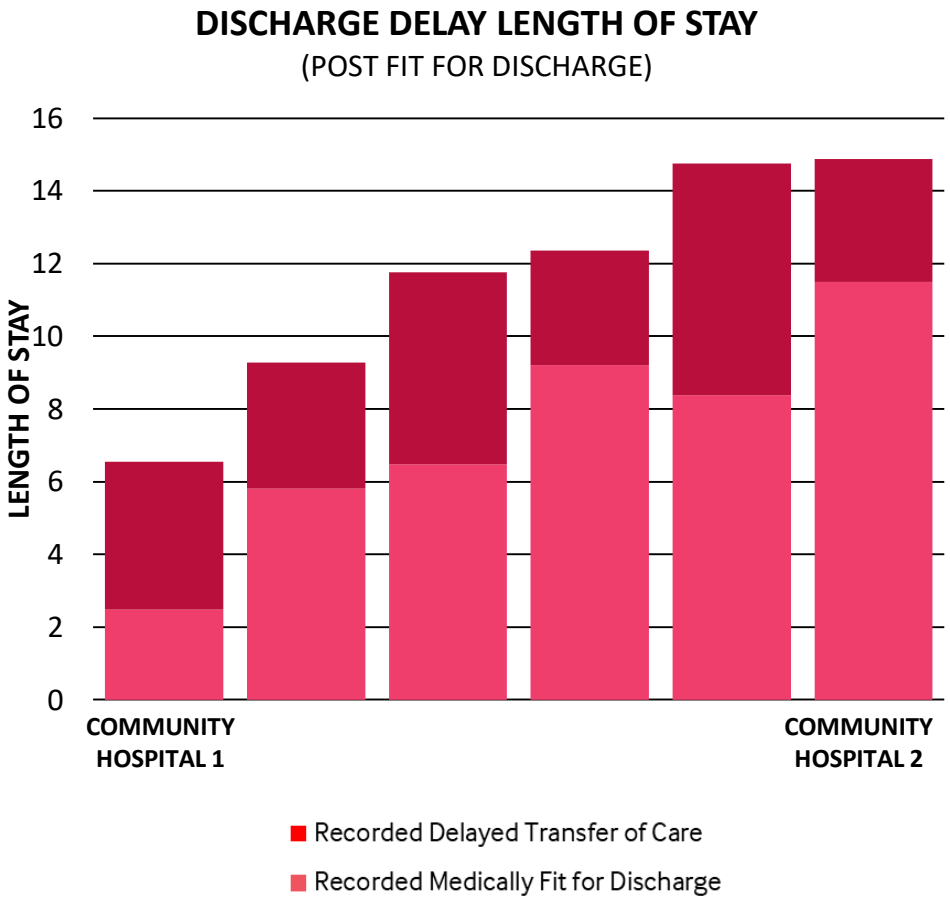
Two Community Hospital daily delay conference calls were reviewed using our improvement cycle analysis framework, staff attitudes, and actions and accountability from those meetings dramatically differ



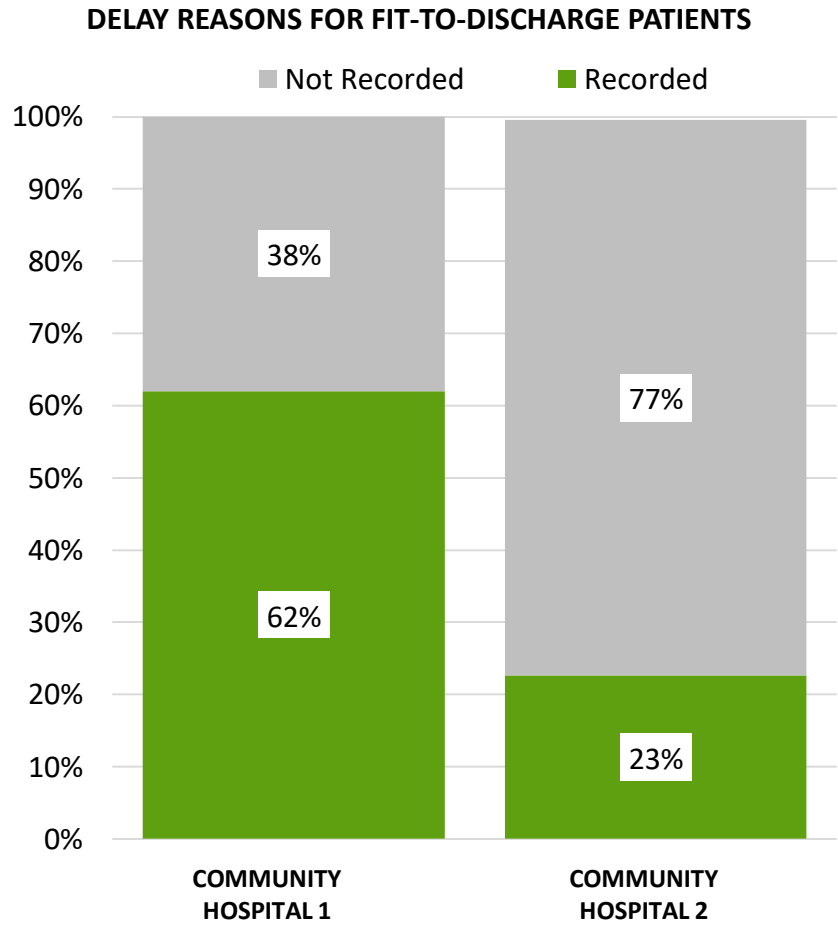
Effective meeting and review enables Community Hospital 1 to have a much higher visibility of delays during discussion, allowing for more effective planning and focused problem solving



ARE WE USING SERVICES EFFECTIVELY?
HOW DOES THIS IMPACT PEOPLE?



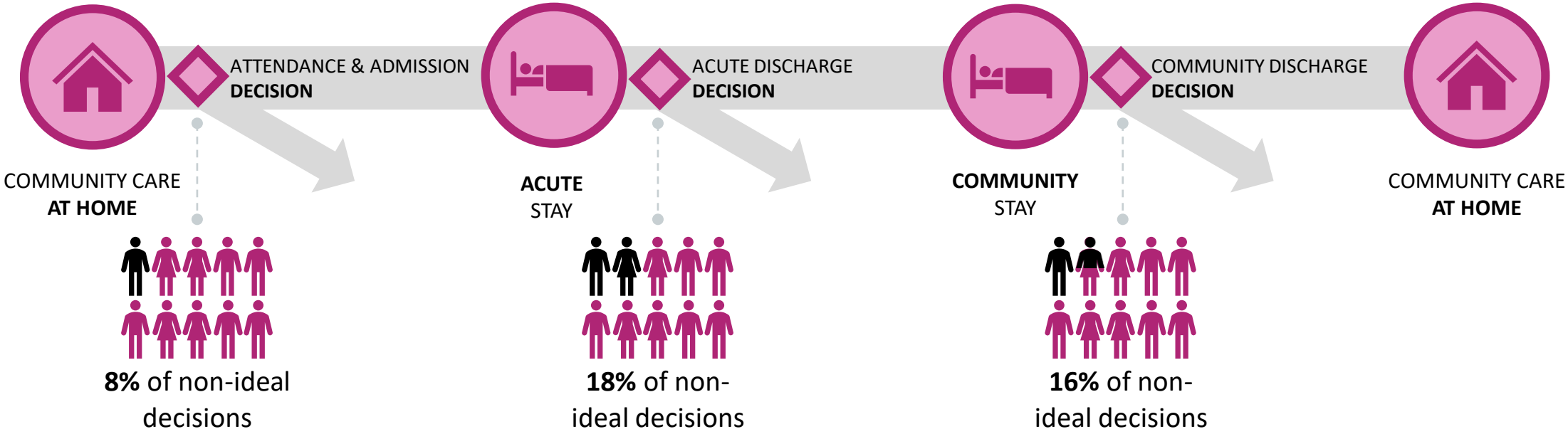
The hospital with better visibility of delay reasons has a much shorter length of stay than the other



ARE WE USING SERVICES EFFECTIVELY?
ARE WE HELPING TO SET THE RIGHT EXPECTATIONS?

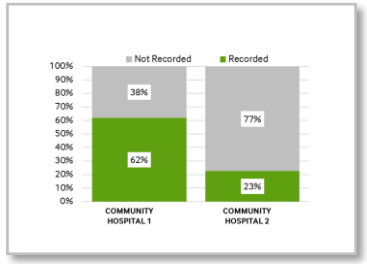
We need to use the community around us to help with improving outcomes, especially the person's family and/or carers

When we look at non ideal outcomes, these are driven by family choice at every stage

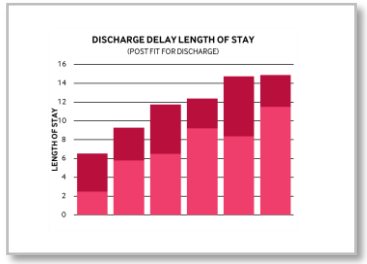


IN SHORT TERM SETTINGS
ARE WE USING SERVICES EFFECTIVELY?

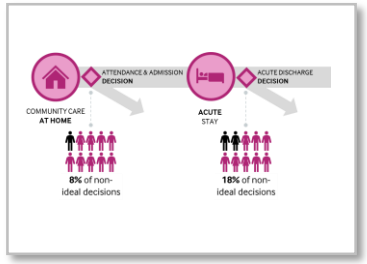
Are we using services effectively?
Do we work and make decisions in the best way to ensure people access the right services for them?



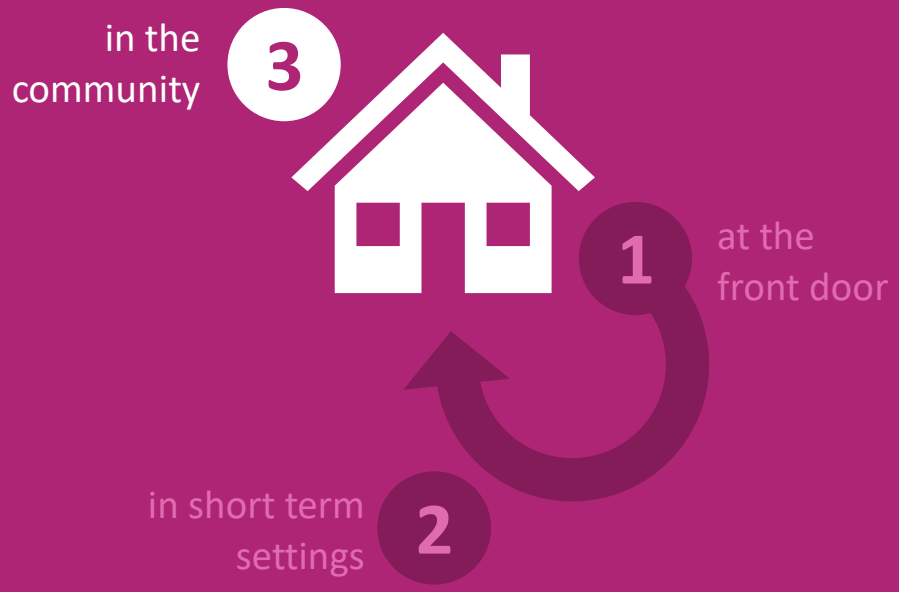
Having the **right visibility of the reasons why** people are prevented from returning home varies significantly, and this different way of working impacts the outcomes we can achieve



Our **length of stay in short term settings varies**, and even within similar types of beds there is variation. Getting clarity on what the delay reasons are, and clarity on the difference in offering between bed types will drive performance up



It's not just colleagues in the system who can affect outcomes, with **family choice** being a significant driver for non-ideal outcomes at every stage of the pathway

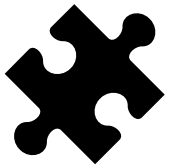


Do we have the right model of care?
Do we have enough of the right services, with the right staff, in the right place?

Are we using services effectively?
Do we work and make decisions in the best way to ensure people access the right services for them?

What impact does this have for people?
Does this affect flow through the system, and pace of delivering quality outcomes?

IN THE COMMUNITY
DO WE HAVE THE RIGHT MODEL OF CARE?



Do we have the right model of care?
Do we have enough of the right services, with the right staff, in the right place?

DO WE HAVE THE RIGHT MODEL OF CARE?
THE RIGHT SERVICES

81 cases reviewed in Community Provision workshops on 4th and 5th June 2019

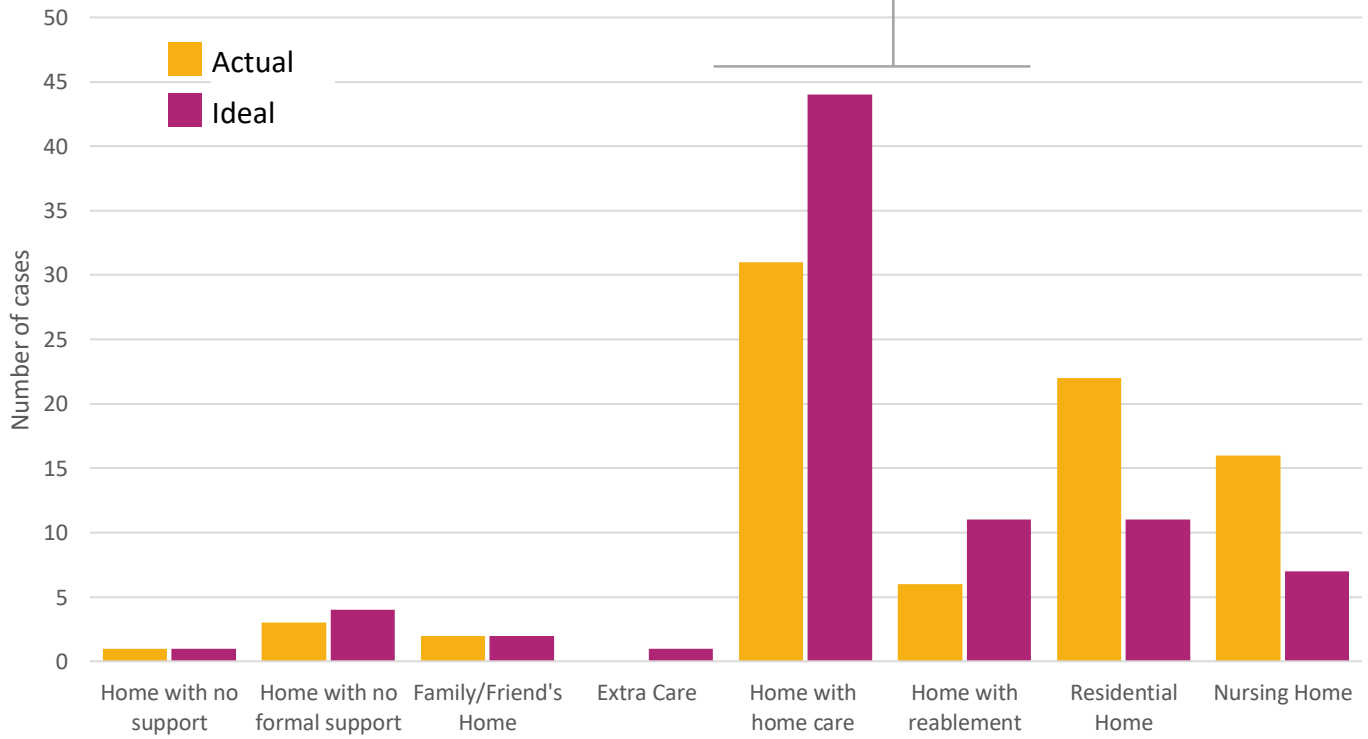
If we had the right model of care, every older person would be achieving their ideal outcome

So, is this the case?

In workshops, multidisciplinary teams of practitioners reviewed real cases to examine whether or not the person's outcomes were ideal.

When looking at the provision of care in the community, **only 43% of the cases reviewed were achieving the ideal outcome**, with some people not being supported in the best setting for them.

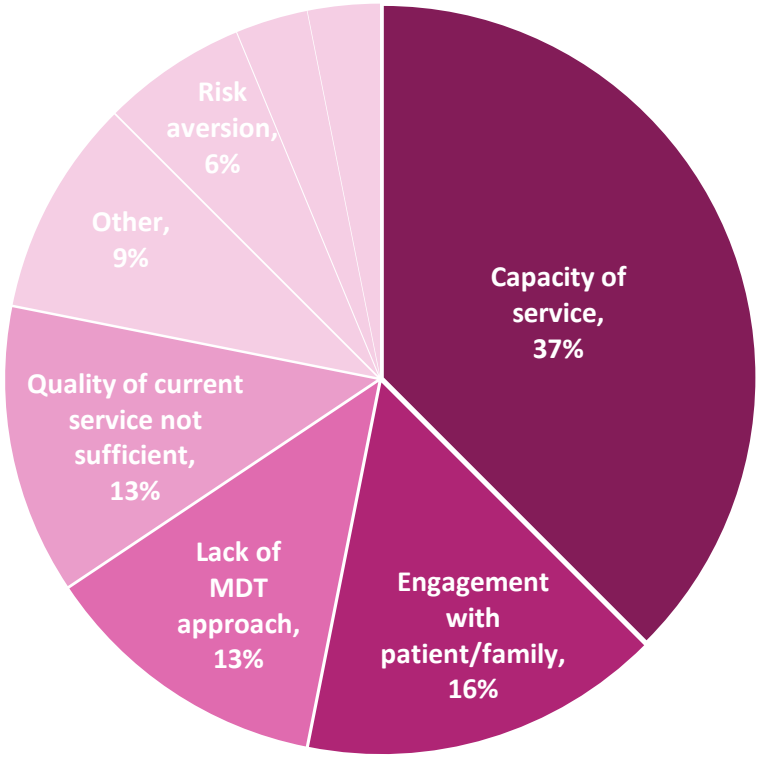
Why weren't we able to support people in their own home?

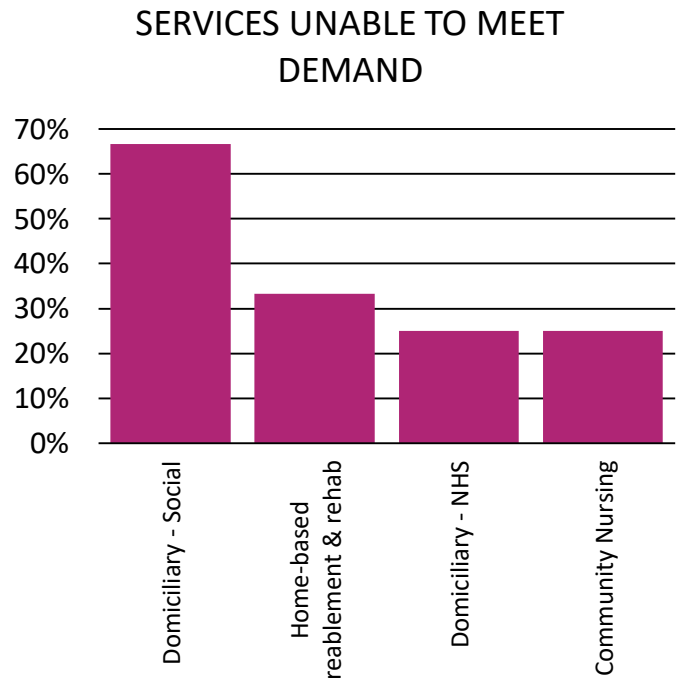


DO WE HAVE THE RIGHT MODEL OF CARE?
THE RIGHT SERVICES

Only **59%** of outcomes were ideal on discharge out of short term settings

Why weren't we able to support people in their own home?

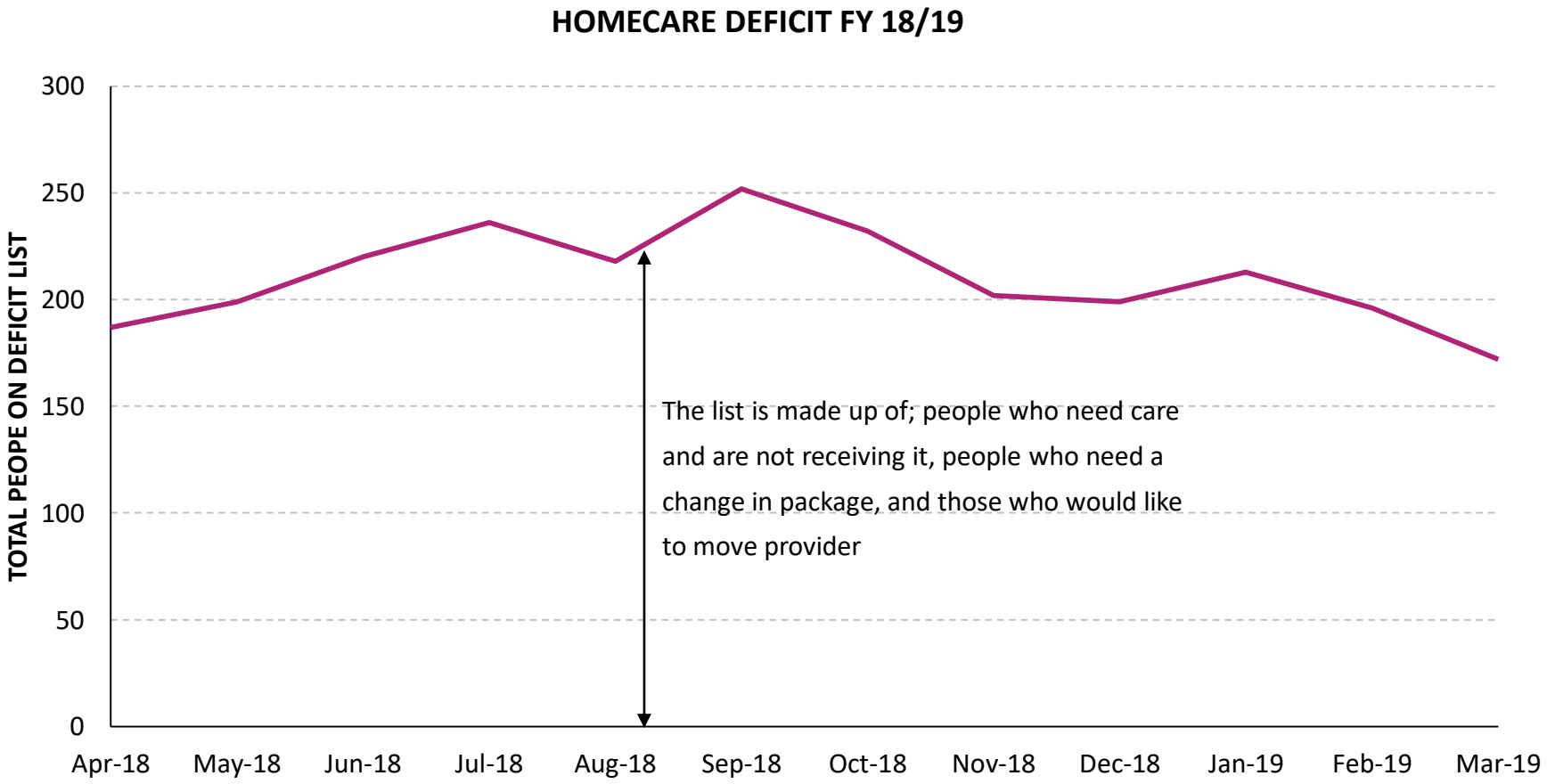




Is this capacity challenge real or perceived?

DO WE HAVE THE RIGHT MODEL OF CARE?
SUPPORTING PEOPLE IN THEIR OWN HOME

Trend in overall numbers of people on the unmet demand for the financial year 2018-19, across the whole of Cornwall.



We have a steady number of people awaiting home care packages who we aren't able to place

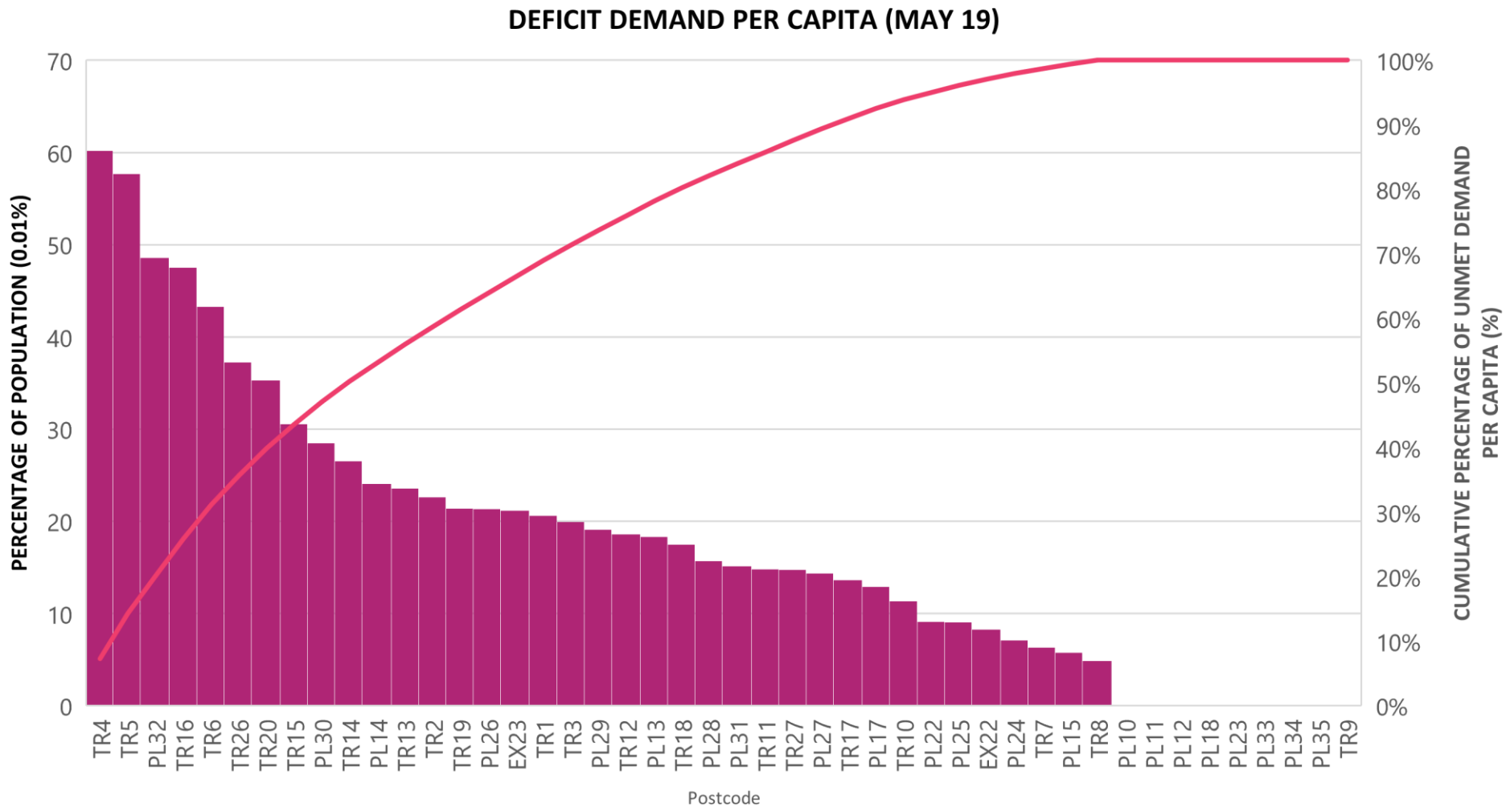
How can we prioritise where to start looking at capacity?

DO WE HAVE THE RIGHT MODEL OF CARE?
SUPPORTING PEOPLE IN THEIR OWN HOME

A snapshot of the volume of people on the unmet demand list from May 2019 across Cornwall, normalised against the over 65 population in each area (data from the ONS).

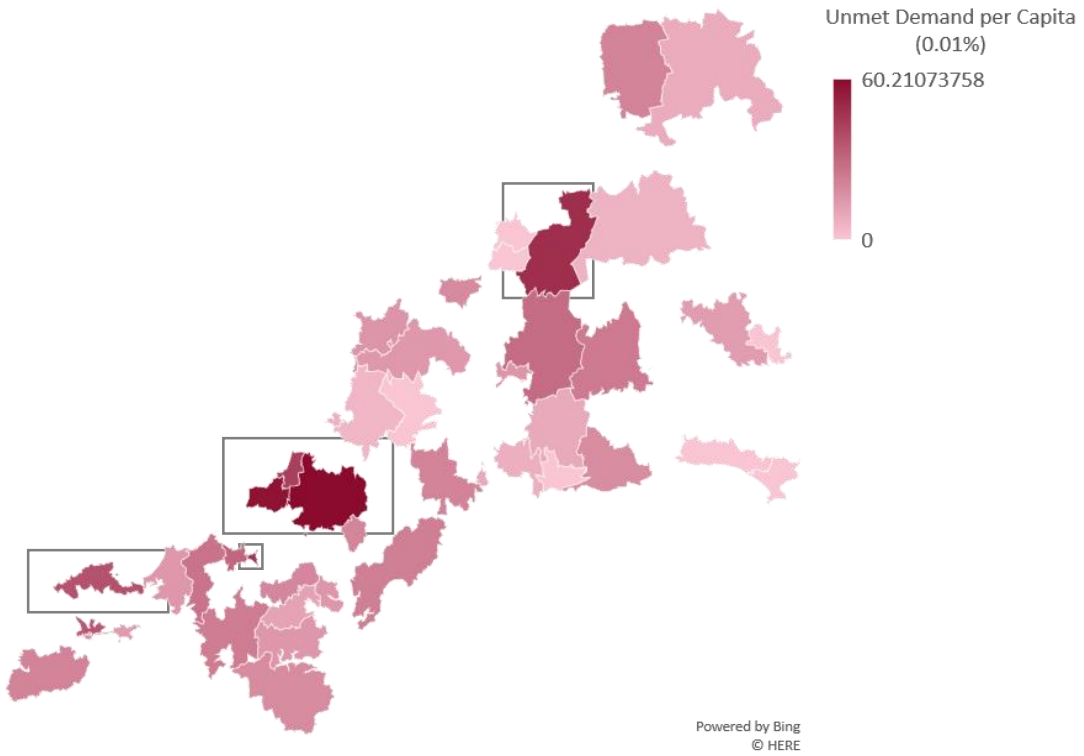
People accessing our services are impacted by where they live.

The top 8 postcodes account for 50% of the unmet demand per capita.



DO WE HAVE THE RIGHT MODEL OF CARE?
SUPPORTING PEOPLE IN THEIR OWN HOME

Deficit Demand per Capita (May 19)



For the areas with the highest deficit demand per capita, we looked at the number of providers currently delivering home care in these areas.

Postcode	Home care packages currently delivered in that area	Number of providers working across that area	Packages delivered per provider
TR4	37	12	3.08
TR5	11	6	1.83
PL32	23	5	4.60
TR16	43	13	3.31
TR6	12	5	2.40

So we do provide homecare in those areas; so why can't we get enough?

DO WE HAVE THE RIGHT MODEL OF CARE?
SUPPORTING PEOPLE IN THEIR OWN HOME

Telephone conversation on 17/06 with the Operations Manager from a DPS registered home care provider covering Mid and West Cornwall.

We spoke to a home care provider about the geographical challenges of providing care for people in Cornwall. The council Home Care Provider list states that this provider is able to cover 27 of the 48 postcode areas.

EX20	EX21	EX22	EX23	PL10	PL11	PL12	PL13	PL14	PL15	PL17	PL18	PL22	PL23	PL24	PL25	PL26	PL27	PL28	PL29	PL30	PL31	PL32	PL33	PL34	PL35	TR1	TR2	TR3	TR4	TR5	TR6	TR7	TR8	TR9	TR10	TR11	TR12	TR13	TR14	TR15	TR16	TR17	TR18	TR19	TR20	TR26	TR27
												X	X	X	X	X										X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X

This provider does not currently work in several areas including areas such as St Ives, Penzance and Camborne as they are **“not viable from a staffing point of view”**

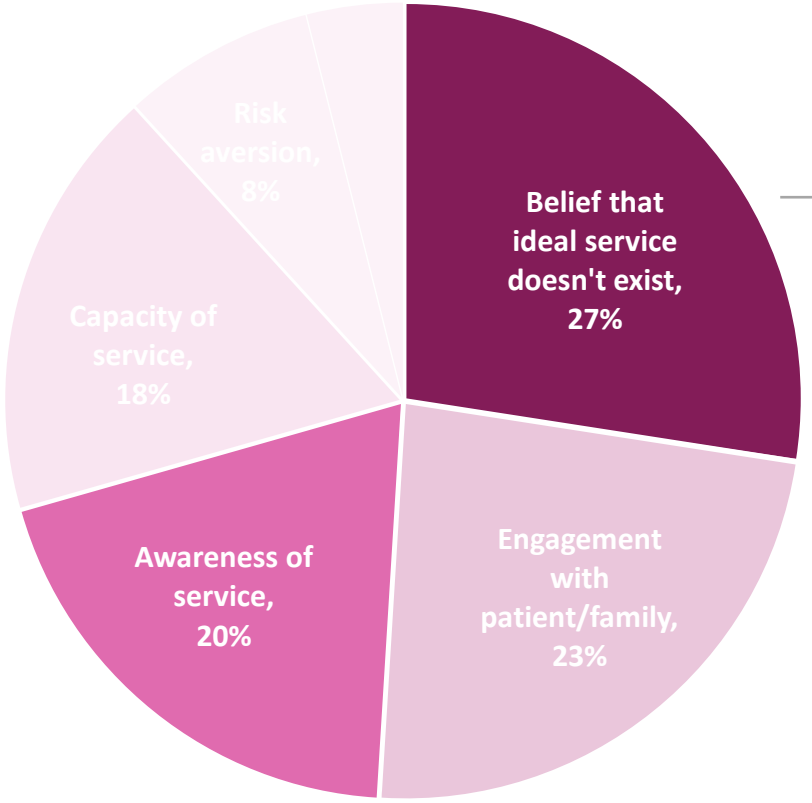
This care provider suggested:

Care providers working together: care providers working together to cover certain areas to make it worth while

Change the way we commission care: commissioning care in shifts rather than per visit, allowing a carer to be based in a certain place all day, preventing additional travel to and from the area

DO WE HAVE THE RIGHT MODEL OF CARE?
AVAILABILITY OF THE RIGHT SERVICES

There's some work to do to make sure we have the right capacity, but we also need to be aware of that capacity. Is that the case now?



27% of cases didn't get an ideal outcome because it was felt that no suitable services exists

50% of these patients needed a night-sitting service for their ideal outcome

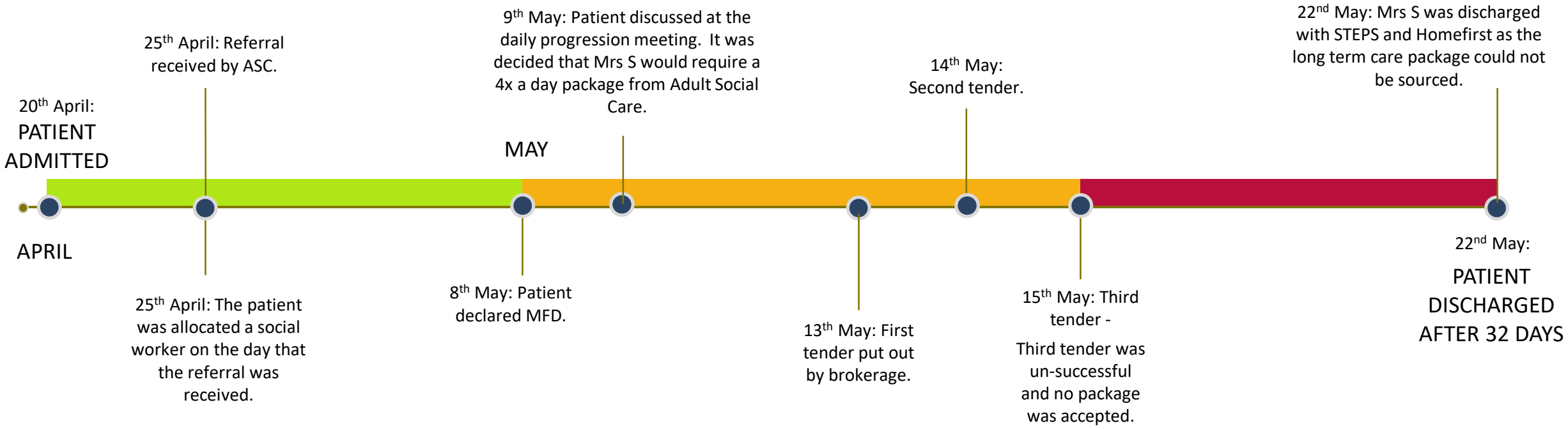
This service does exist, and can be built into care plans by social workers

In an interview, a social worker told us that there is an 'unspoken rule' that they shouldn't request night sitting. Staff do not understand how to ask for it and assume they cannot get it. A patient's chances of getting access to night sitting **"depends on how well your social worker understands the legislation, and whether they're willing to speak up at panel"**

DO WE HAVE THE RIGHT MODEL OF CARE?
USING THE RIGHT SERVICES

An example of a patient journey through WCH – this person was awaiting to be discharged home with a QDS package of care.

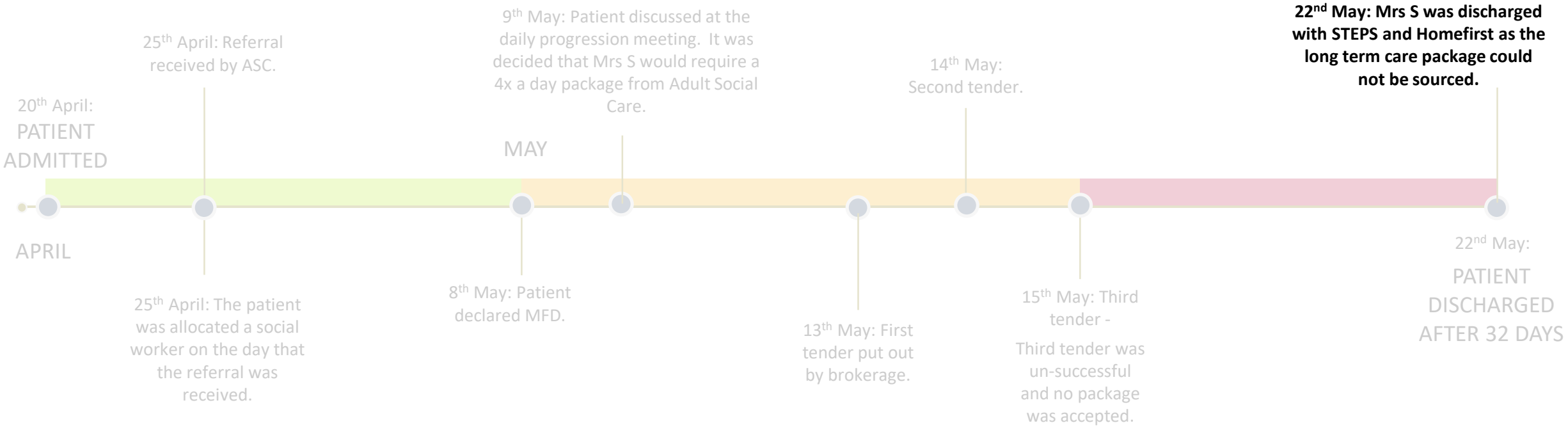
Mrs S is an 86 year old female who was admitted to WCH on the 20th of April following a fall. When a 4 x daily package of care could not be sourced, she was sent home with Homefirst and STEPS to cover her 4 visits a day.



DO WE HAVE THE RIGHT MODEL OF CARE?
USING THE RIGHT SERVICES

An example of a patient journey through WCH – this person was awaiting to be discharged home with a QDS package of care.

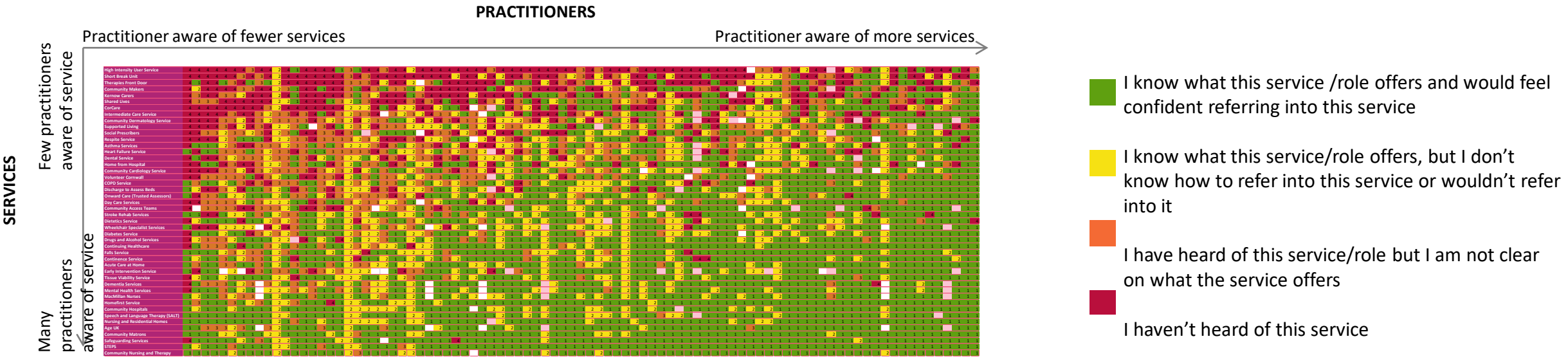
STEPS and Homefirst have been able to support Mrs S to become independent in her lunch, PM and tea time calls. Mrs S now requires an AM call, a request which is sitting with brokerage. Homefirst continue to cover the AM care call until the package can be sourced.



DO WE HAVE THE RIGHT MODEL OF CARE?
USING THE RIGHT SERVICES

How easy is it for both colleagues and older people to access the right services?

We asked 89 professionals (including GP's, social workers, therapists, community and acute nurses, support workers and community makers) about their knowledge and confidence of a range of health, social and voluntary services.

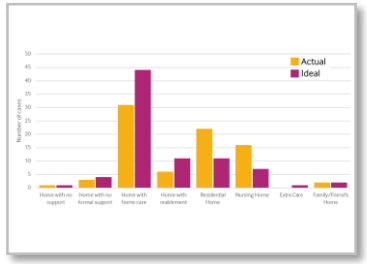


"Clearly there are too many – hence the fundamental problem for hospital staff to support discharge planning. There needs to be one single point of access to support discharge planning navigation"

- Consultant Geriatrician

IN THE COMMUNITY
DO WE HAVE THE RIGHT MODEL OF CARE?

Do we have the right model of care?
Do we have enough of the right services, with the right staff, in the right place?



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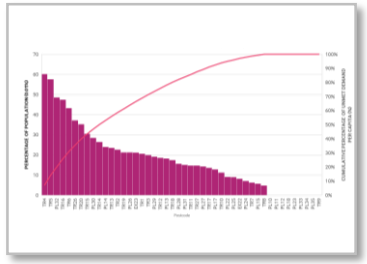

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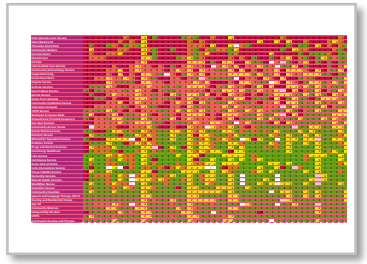
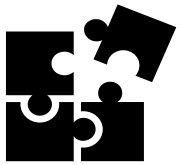


The number and **range of services available is confusing** for colleagues, and will lead to some people missing out on accessing services that would be ideal for their needs

IN THE COMMUNITY
ARE WE USING SERVICES EFFECTIVELY?



Are we using services effectively?
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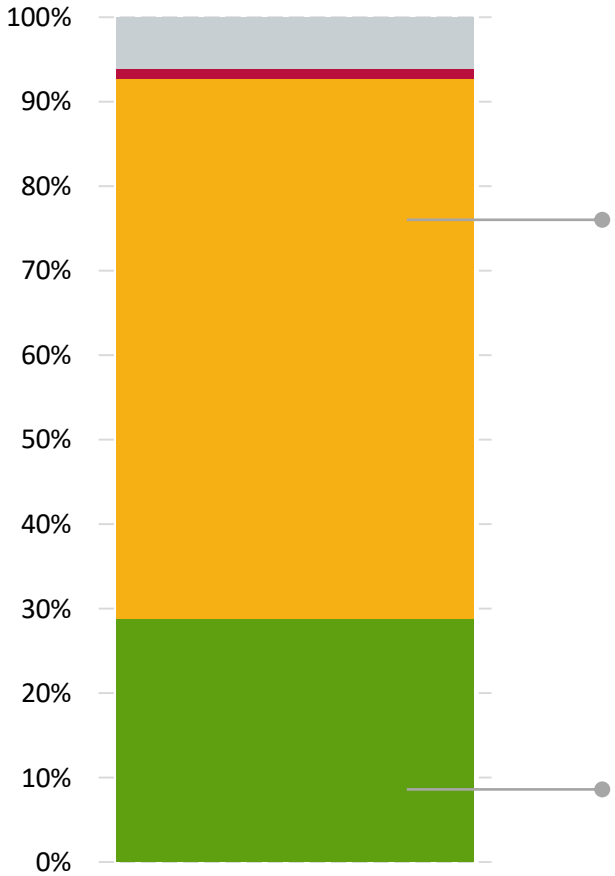
ARE WE USING SERVICES EFFECTIVELY?
HOW ARE WE USING THE CAPACITY WE HAVE?

DAILY THERAPIST TIME BREAKDOWN



64% of therapist time is spent on essential tasks, but those which are not delivering therapy

- **30%** of therapist time is spent on paperwork
- **20%** of therapist time is spent on travelling between visits and meetings

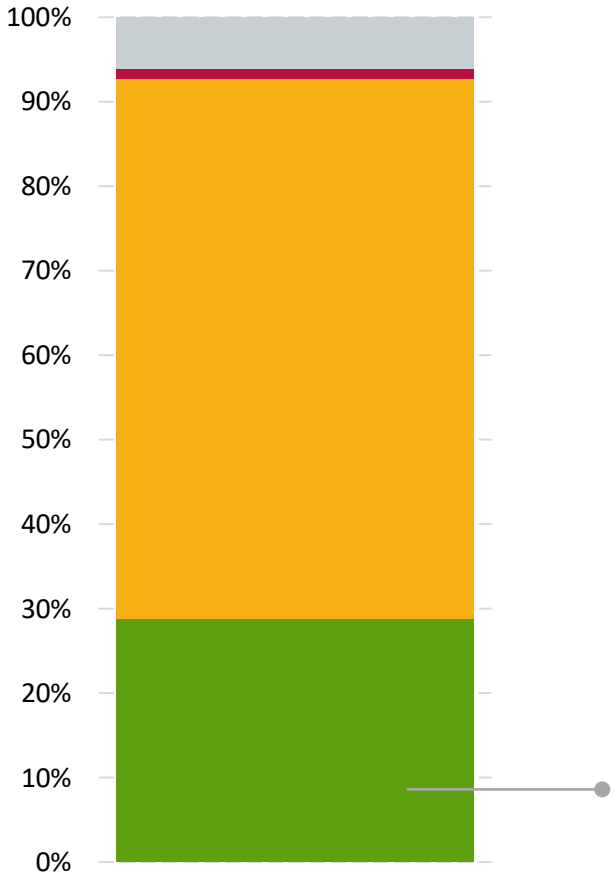
29% of therapist time is spent directly in contact with people, carers or families,

- Time spent with people or their carers/families (e.g. individual assessments or reviews).
- Time spent doing essential tasks, but those which are not directly in contact with a person, carer or family (e.g. writing case notes).
- Non-essential time spent outside of contacts (e.g. travelling to a DNA)

ARE WE USING SERVICES EFFECTIVELY?
HOW ARE WE USING THE CAPACITY WE HAVE?

We reviewed 106 therapy visits with band 6 and 7 therapists to understand how patient-facing time was being spent.

DAILY THERAPIST TIME BREAKDOWN



We reviewed 106 therapy visits with band 6 and 7 therapists to understand how patient-facing time was being spent.

But is all this time spent effectively?

29% of therapist time is spent directly in contact with people, carers or families,

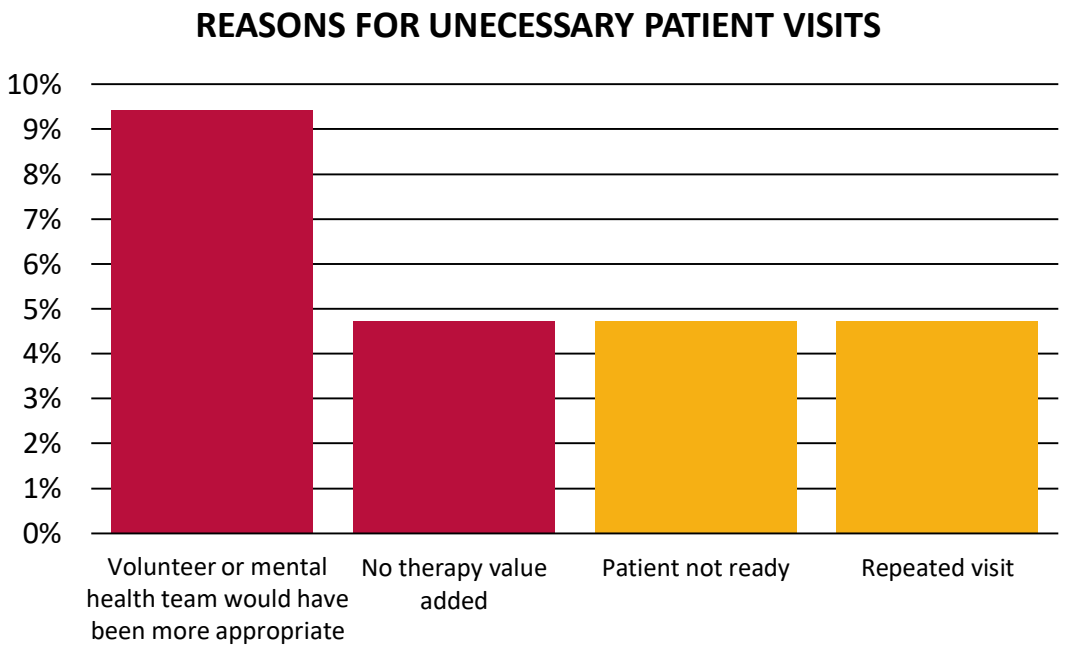
13% of the visits were non therapy visits

The majority of visits were effective for the people receiving therapy

10% did not get value from the therapy visit

ARE WE USING SERVICES EFFECTIVELY?
ARE WE WORKING IN THE BEST WAY?

We reviewed 106 therapy visits with band 6 and 7 therapists to understand how patient-facing time was being spent.



Nearly one quarter of the visits were not using therapist time effectively. Most of these unnecessary visits were covering for patients with mental health needs, not therapy needs. This takes up **370 visits each month.**

ARE WE USING SERVICES EFFECTIVELY?
ARE WE WORKING IN THE BEST WAY?

We see that community therapy teams are struggling to meet patient needs due to job dissatisfaction and limited resource.

For example, North Kerrier has been struggling with dissatisfaction in their teams, leading to staff shortages and patient care delays. One band 6 OT has to spend 40% of her time conducting personal care visits, which are usually done by band 3 support workers.

“It has been a big problem for the last 3 months. I have to cover personal care visits instead of assessing new patients.”

According to the North Kerrier Integrated Care Team, support workers are experiencing poor job satisfaction, causing vacancies and leaves of absence due to mental health reasons. Support workers don’t feel that their visits give them the reablement experience that they expected from the role, and with skilled Band 6 assessors having to cover personal care visits to fill the gap, we miss the opportunity to use their assessment skills.

ARE WE USING SERVICES EFFECTIVELY?
ARE WE WORKING IN THE BEST WAY?

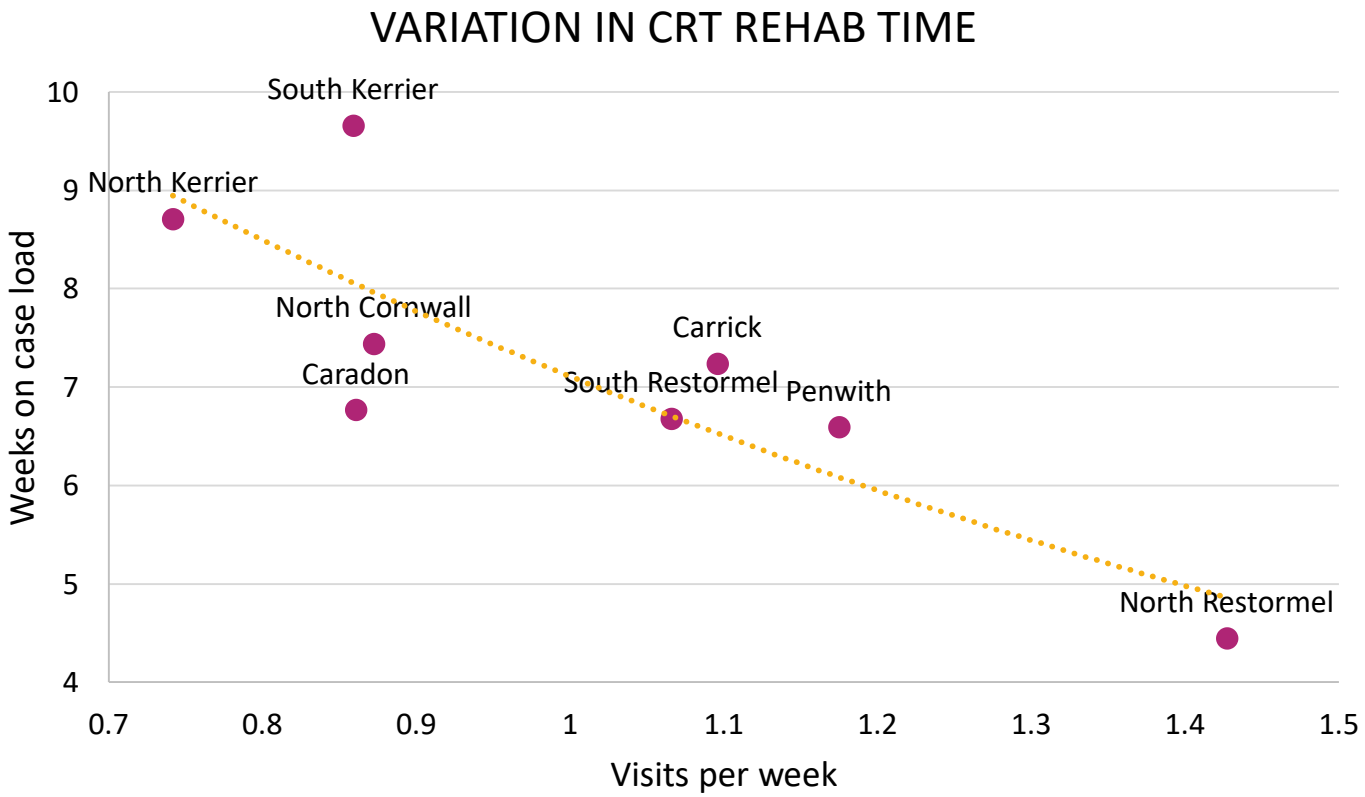
We reviewed 106 therapy visits with band 6 and 7 therapists to understand how patient-facing time was being spent.

29% of therapy visits could have been done by a lower band worker. If we had an extra 10 General Support Workers, Band 6+ therapists would be able to increase their provision of higher-need assessments and care, creating capacity for **460 extra high-need visits each month**

ARE WE USING SERVICES EFFECTIVELY?
ARE WE WORKING IN THE BEST WAY?

We analysed a year's worth of at-home therapy with CRT, and found that the time patients spend in rehab with more frequent therapy could be halved

The impact of pressures on teams quickly begin to impact older people and the support we are providing



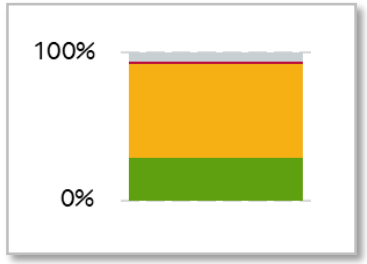
Older people in need of rehab don't only have to contend with wait times for short-term therapy.

The care that they receive once their treatment begins also varies significantly between teams. In North Kerrier, patients receive one visit every 10 days and take **twice as long to rehabilitate** as patients in North Restormel, where patients are visited every 5 days.

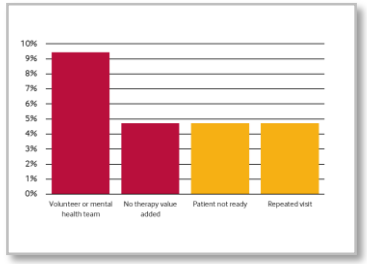
This has an impact on other services supporting individuals as in some cases it takes longer for them to reach independence.

IN THE COMMUNITY
ARE WE USING SERVICES EFFECTIVELY?

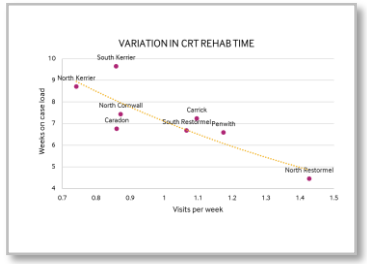
Are we using services effectively?
Do we work and make decisions in the best way to ensure people access the right services for them?



Colleagues are only able to spend **29% of their time directly in contact with older people**



Not every contact that we have with a person is **making the best use of the professional's skills**, with 23% of therapy visits not adding value to the person



The difference in time available and ways of working mean we are delivering different services to people depending on where they live, with some people **waiting twice as long** before reaching their most independent state

THE REALITY OF MAKING CHANGE HAPPEN

WHAT CHALLENGES DO WE NEED TO OVERCOME?
RELATIONSHIPS ACROSS THE SYSTEM

"Its about decision making and risk averseness throughout pathway to admission – not just outside hospital. GPs, Nursing Homes, SWASFT, Doctors"

- Service Manger, Acute

"Contractual and organisational architecture has got in the way in the past"

– Senior Manager, NHS Kernow

"There is a lack of recognition that frailty is a real thing."

- CFT, Frailty Team

55%

of colleagues believe that their role and team's role is not understood across the system

50%

of colleagues don't think teams collaborate with each other across providers, areas and systems

WHAT CHALLENGES DO WE NEED TO OVERCOME?
EFFECTIVE CHANGE MANAGEMENT

"The ability to support transformational change on top of the day job is a significant capacity challenge with operational priorities normally taking priority"

Only 13%

of colleagues answered yes when asked if the system has a successful track record of landing change

17%

of colleagues felt that the system sees major change initiatives through to completion before starting the next one

WHAT STRENGTHS DO WE NEED TO USE?

We see the need for change across the system, with

76% of colleagues believing that the leadership of the STP organisations recognise a need for change.

And day to day, there are positives

72% of colleagues believe they receive appropriate training to equip them with the skills required to successfully carry out their work

81% of colleagues receive regular feedback from their manager on how they are performing, with 75% of colleagues agreeing that the feedback they receive is constructive

What are colleagues saying about their work and support?

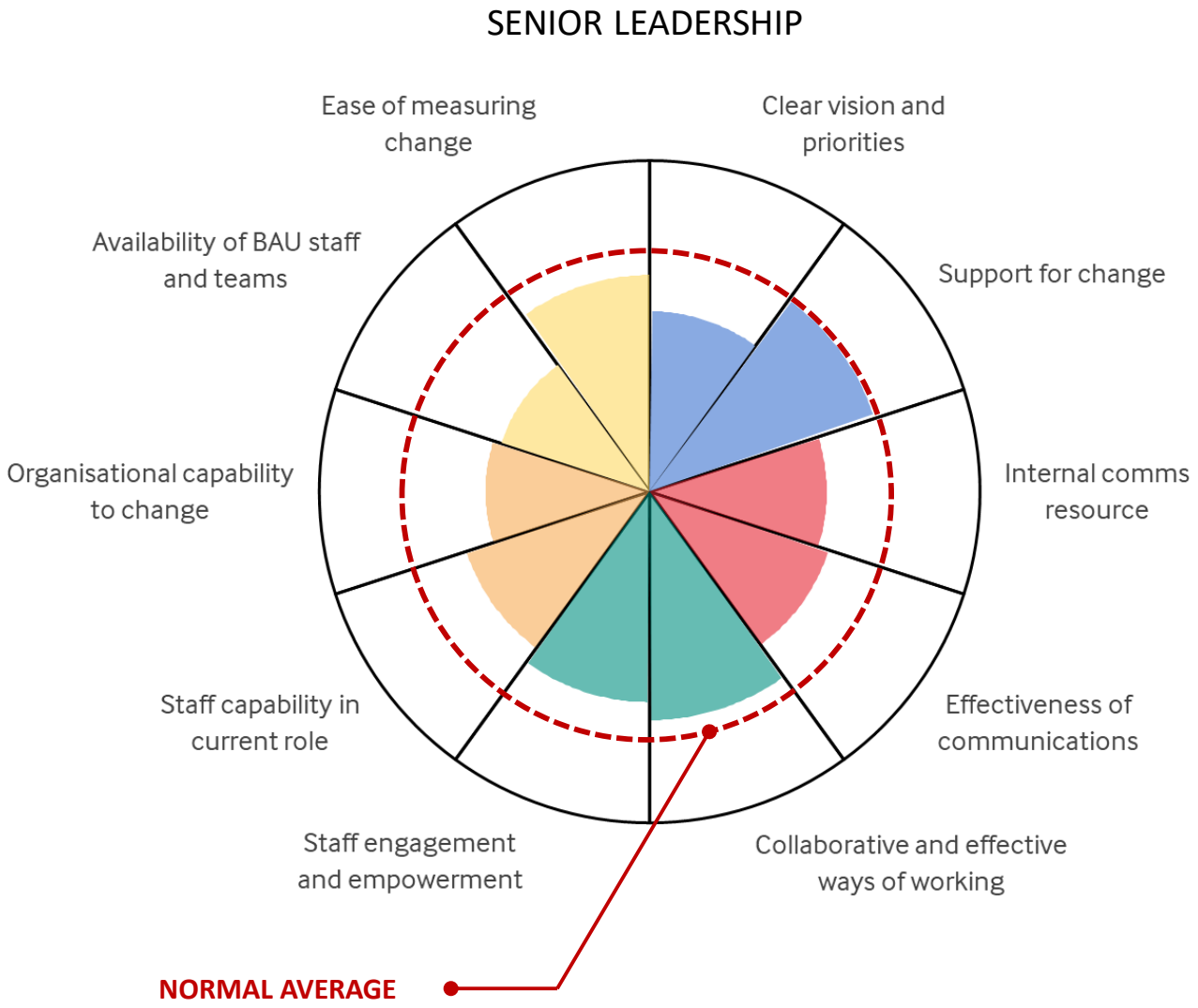
THE ENVIRONMENT FOR CHANGE

119 surveys from staff across the system partners

We asked 119 people across the system to answer questions about how ready the system is for change.

We look at the 10 key categories which our experience shows are essential for large scale change to be successful and sustainable.

We see strengths in the capability of staff and their engagement, but weaknesses in the capability for change and communications.



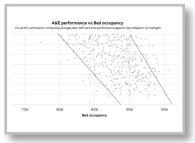
NEXT STEPS

SUMMARY OF OPPORTUNITIES

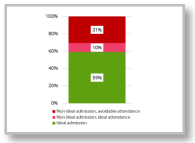
MODEL OF CARE

USING THE RIGHT SERVICES

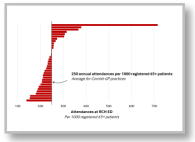
FRONT DOOR



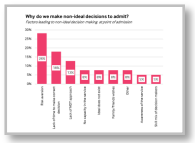
We know that as the system is under pressure, there is a strong correlation between more pressure and lower performance



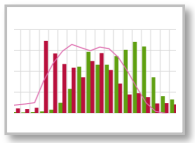
In workshops, admission to an acute bed was only the **ideal outcome for 59%** of the cases reviewed who were admitted



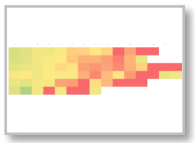
There are **geographical and demographic** factors which are influencing the flow of people through the system, and links to who is able to access the right services for them



Behaviour drives the top reasons for people being admitted to hospital when that's not the ideal outcome for them

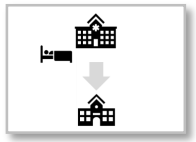


Our **performance varies through the day**, and this is linked to the pressure that is felt by our teams across the system

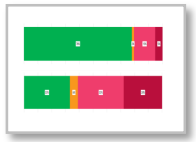


We aren't always able to **support frail patients** in the same way as non frail patients, with 100% of non frail patients getting ideal outcomes compared to 45% of frail patients

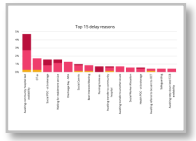
SHORT TERM SETTINGS



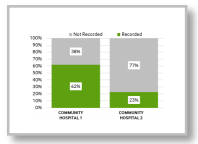
When we discharge from the acute into another short term setting, that is only the **ideal outcome for half** of the people who we follow this pathway



22% of our acute beds and 67% of our community beds are filled with patients who would be better suited elsewhere

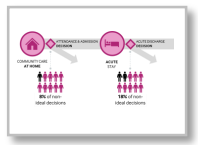


When we look at the reasons for why we are delayed, the delays are split between those due to **capacity** further down the pathway, and delays due to **behaviours and processes**



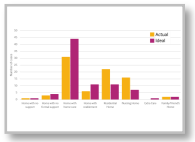
Having the **right visibility of the reasons why** people are prevented from returning home varies significantly, and this different way of working impacts the outcomes we can achieve

Our **length of stay in short term settings varies**, and even within similar types of beds there is variation. Getting clarity on what the delay reasons are, and clarity on the difference in offering between bed types will drive performance up



It's not just colleagues in the system who can affect outcomes, with **family choice** being a significant driver for non-ideal outcomes at every stage of the pathway

COMMUNITY



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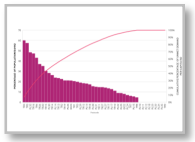

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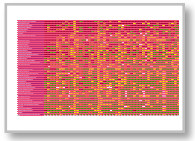

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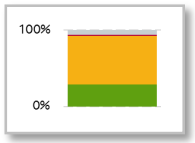

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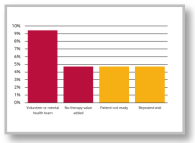

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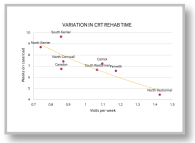

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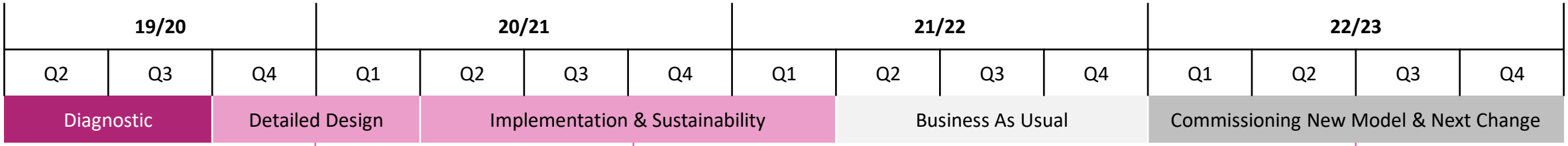
IMPLEMENTATION JOURNEY & NEXT STEPS



Setting this up correctly is our focus for August. The programme is going to deliver significant financial performance and deliver system stability, so setting it up right is vital

As we start to roll out the new model across Cornwall, this is when we make localities the centre of our model. We will start to see the impact of using our community services more effectively

After the operational changes are embedded and stable, any alliance contracting that is required can be completed and we can embed our ICS

THANK YOU
TO EVERYONE WHO HAS GIVEN UP THEIR TIME TO HELP THIS WORK

131 PEOPLE WHO ATTENDED WORKSHOPS

320 PEOPLE WHO MET WITH US

119 PEOPLE WHO COMPLETED THE SURVEY