Cornwall and the Isles of Scilly Health and Care Partnership

South West Clinical Senate Council Meeting

Builders as enablers of care and services

19 September, 2019

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Introducing the projects and our context

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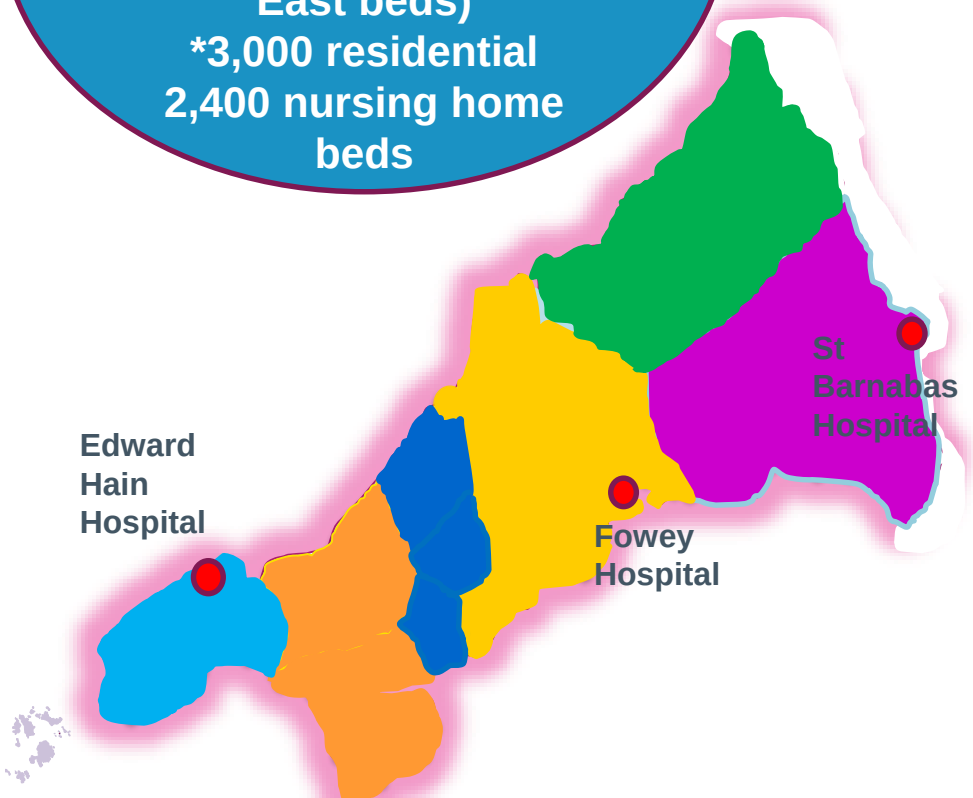
High level summary:

- Development of the integrated community model of care
- Engagement process
- Co-development of case for change
- Co-development of options and evaluation criteria
- Three separate, but aligned projects
- Same process, but pace may vary
- NHS E Stage one review completed Jan-19

***550,000 total population**
***283 community hospital beds**
***698 general and acute hospital beds (plus East beds)**
***3,000 residential**
2,400 nursing home beds



Our System Plan: Integrated place based community services

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Place based Integrated Community Model of Care aims to:

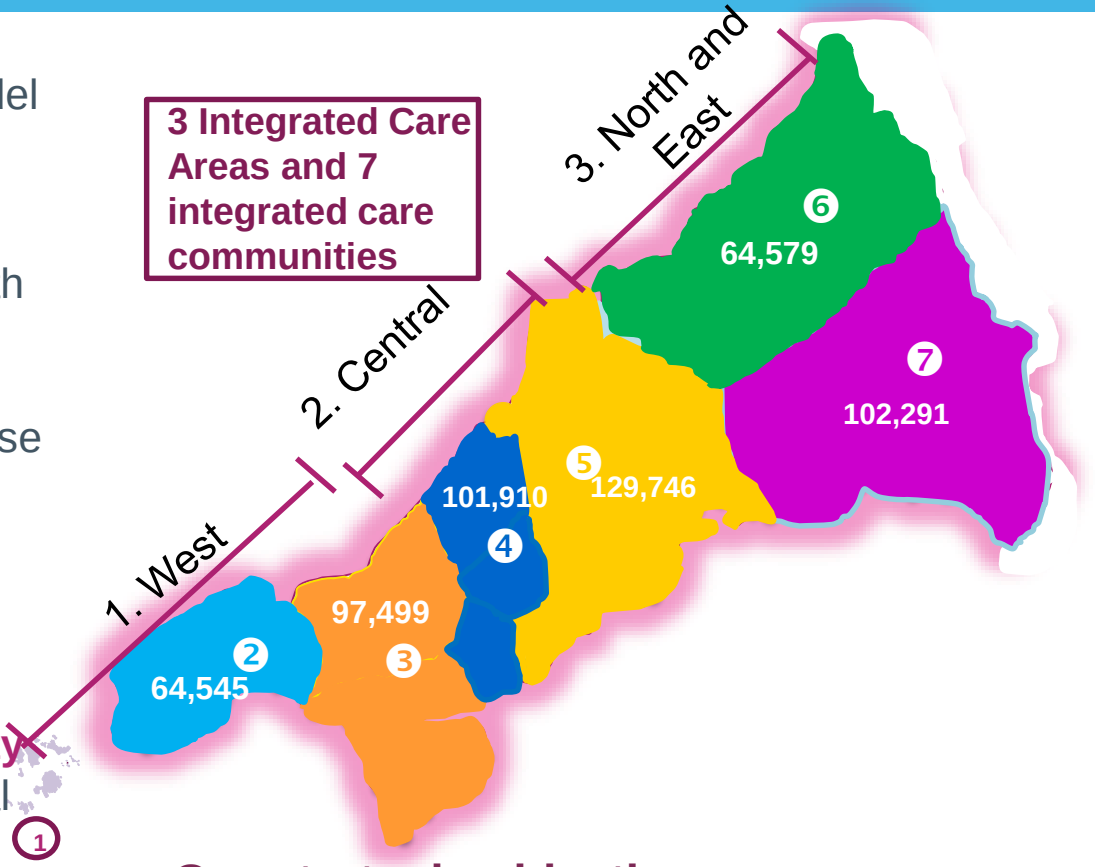
i) Proactively empower people to take control of their own lives and interact with relevant key workers as required

ii) Provide person-centred care as close to home as possible

iii) Operate without barriers across different teams and organisations

iv) Include members of the community working in partnership with health, social care and voluntary sector colleagues.

The development of the integrated community services will play a significant part in how our community assets are utilised in the future.



Our strategic objectives

1.Improve health and wellbeing.
2.Improve people's experience of care.
3.Reduce the cost of care per capita
4.Improve people's experience at work.

1. Penwith area/Edward Hain hospital key facts:

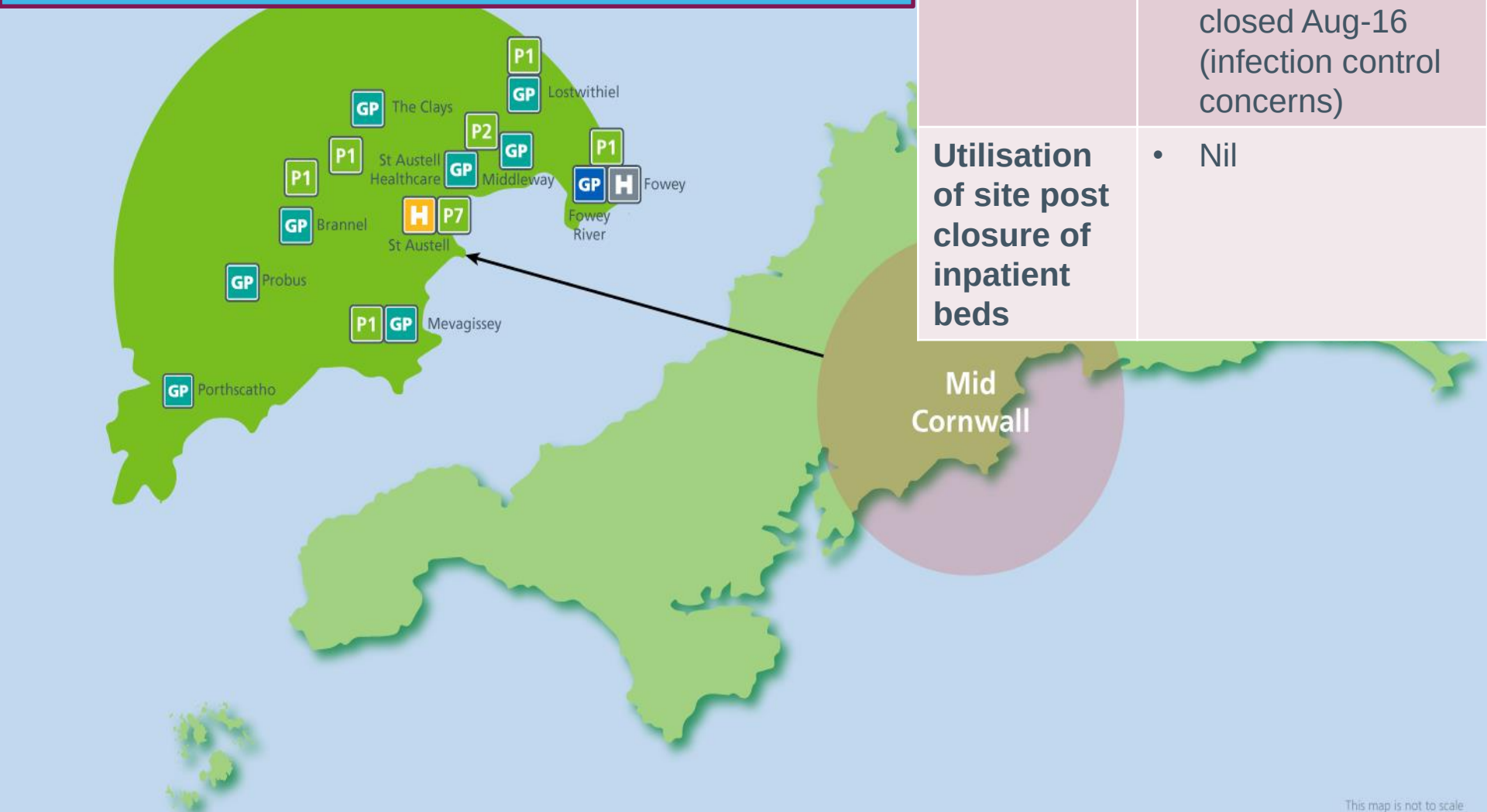
8 GP practices
65,170 population
183 hospital IP spells (174 people)
Urgent Treatment Centre-9 miles/25 mins
Community hospital-16 miles/30mins

1. Edward Hain Hospital-12 beds	
Services pre closure	• 12 beds, closed Feb-16 (fire safety concerns), including 1 alcohol detox bed. • Podiatry clinics, therapy, ad hoc community clinic appointments
Utilisation of site post closure of inpatient beds	• 3 x weekly podiatry clinics, ad hoc community clinic appointments • Reablement pilot (Jan-Sept) voluntary sector-led reablement/ wellbeing day service

This map is not to scale

2. Mid/central area/Fowey hospital key facts:

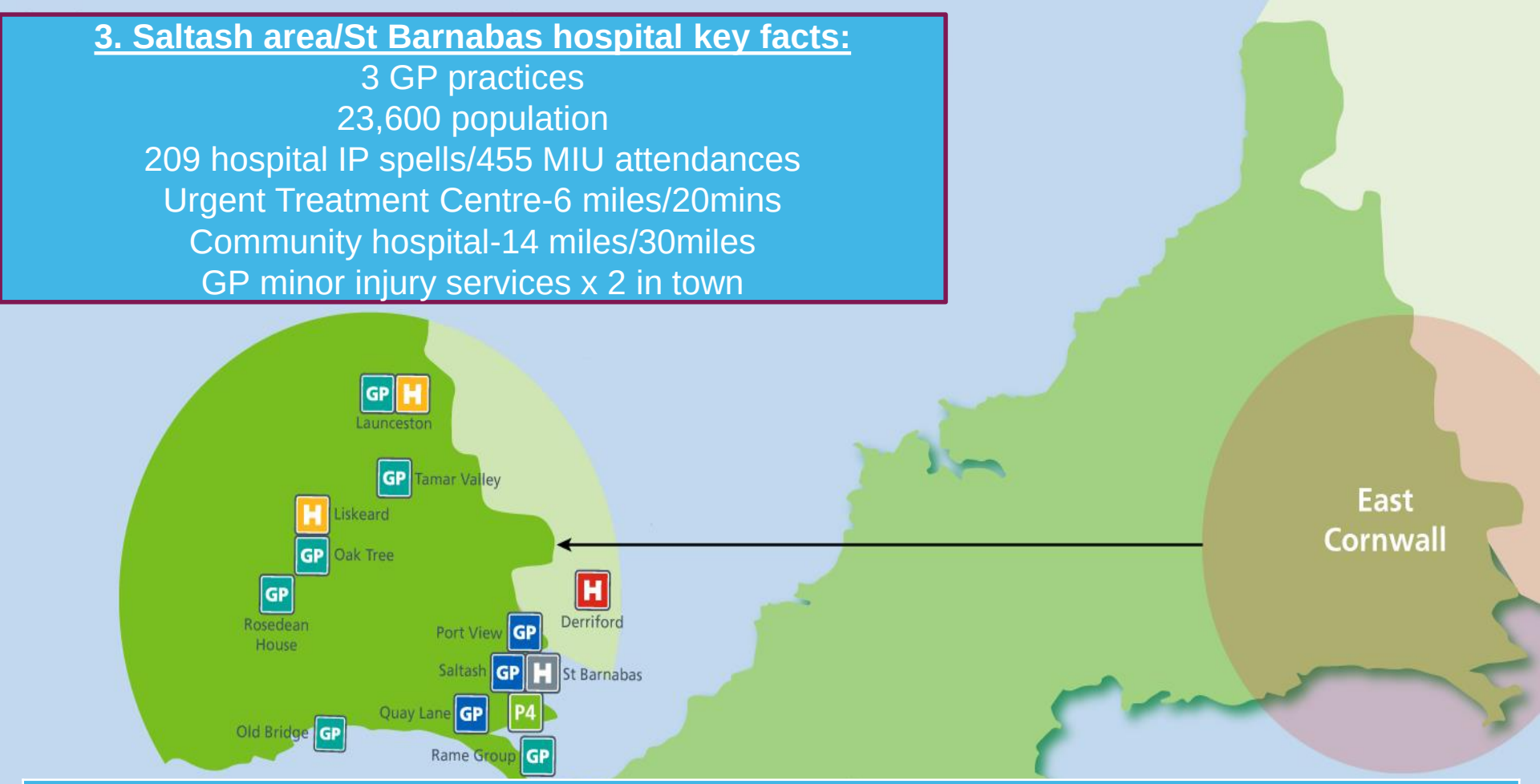
3 GP practices
19,470 population (8,000 in Fowey)
144 hospital IP spells (130 people)/ 59 MIU attendances
Urgent Treatment Centre-25 miles/1 hr 10mins
Community hospital/MIU-8 miles/25mins
GP minor injury service in town



2. Fowey Hospital-10 beds	
Services pre closure	• MIU (closed 2015 due to low use) • Beds reduced from 10 to 6 Mar-16. Rest of beds closed Aug-16 (infection control concerns)
Utilisation of site post closure of inpatient beds	• Nil

3. Saltash area/St Barnabas hospital key facts:

3 GP practices
23,600 population
209 hospital IP spells/455 MIU attendances
Urgent Treatment Centre-6 miles/20mins
Community hospital-14 miles/30miles
GP minor injury services x 2 in town



3.Saltash area and St Barnabas-9 beds	
Services pre closure	• MIU (closed Dec-16 due to staffing issues) • 9 beds (closed Feb-17 to support safe staffing at Liskeard) • Community clinics: continence, falls, orthotics, physio
Utilisation of site post closure of inpatient beds	• Community clinics: continence, falls, orthotics, physio • 5 consultant clinics. Approx 2,200 clinic attendances/ yr • Base for 70+ staff

The process: place based vs system

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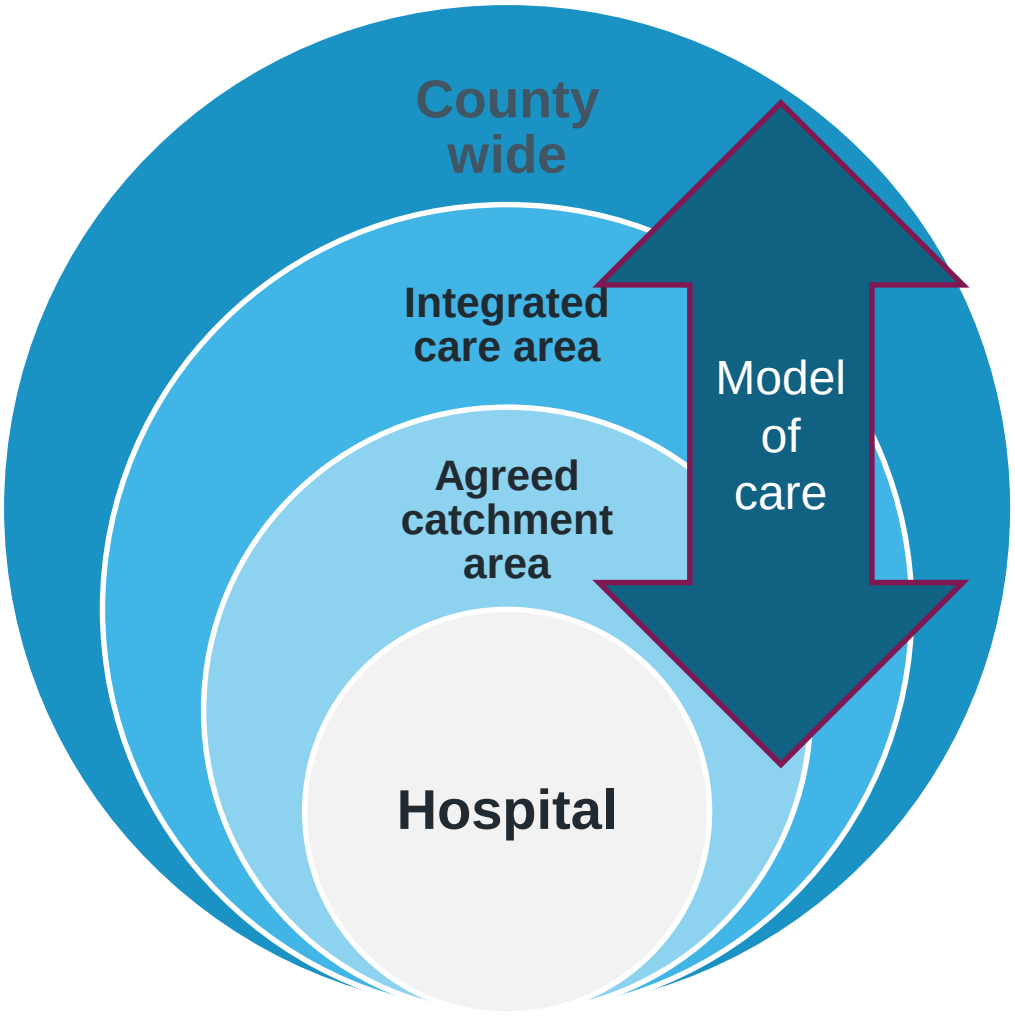

Place focus

- Co-development of case for change
- Defining principles
- Co-development of options
- Co-evaluation

System context

- Strategy
- Agreeing single set of evaluation criteria
- Endorsement of process
- Co-evaluation

Co-development of options

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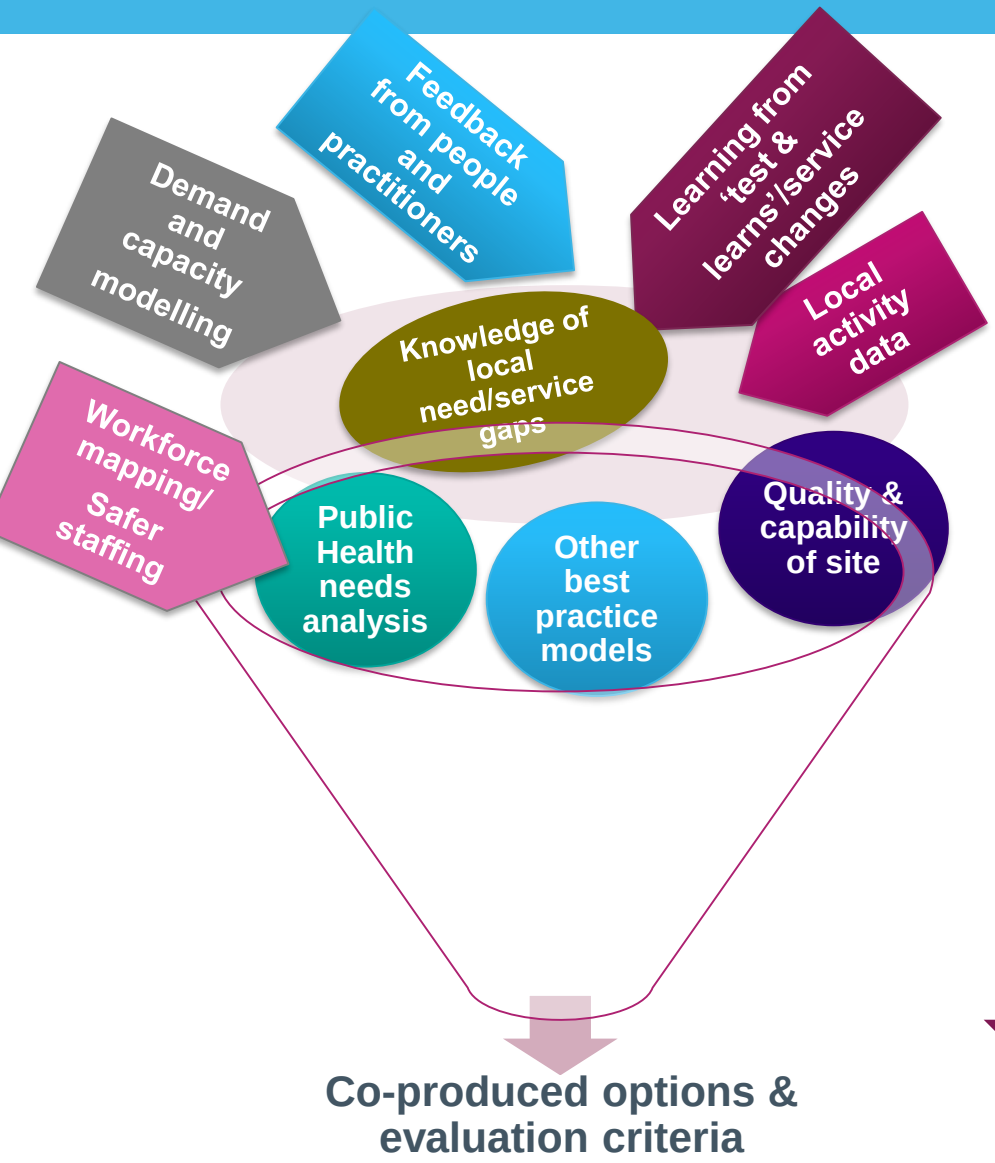

Developing relationships & trust

- Building on previous engagement
- 3 multi-agency project groups
- 3 face to face and virtual stakeholder groups
- Community workshops
- Public drop ins
- Feasibility studies/options appraisal
- Options and evaluation criteria co-developed with local communities.

1. What is the need?
2. What is the service delivery to respond to the need?
3. What does that mean for the future role of the hospitals?

A simple community model

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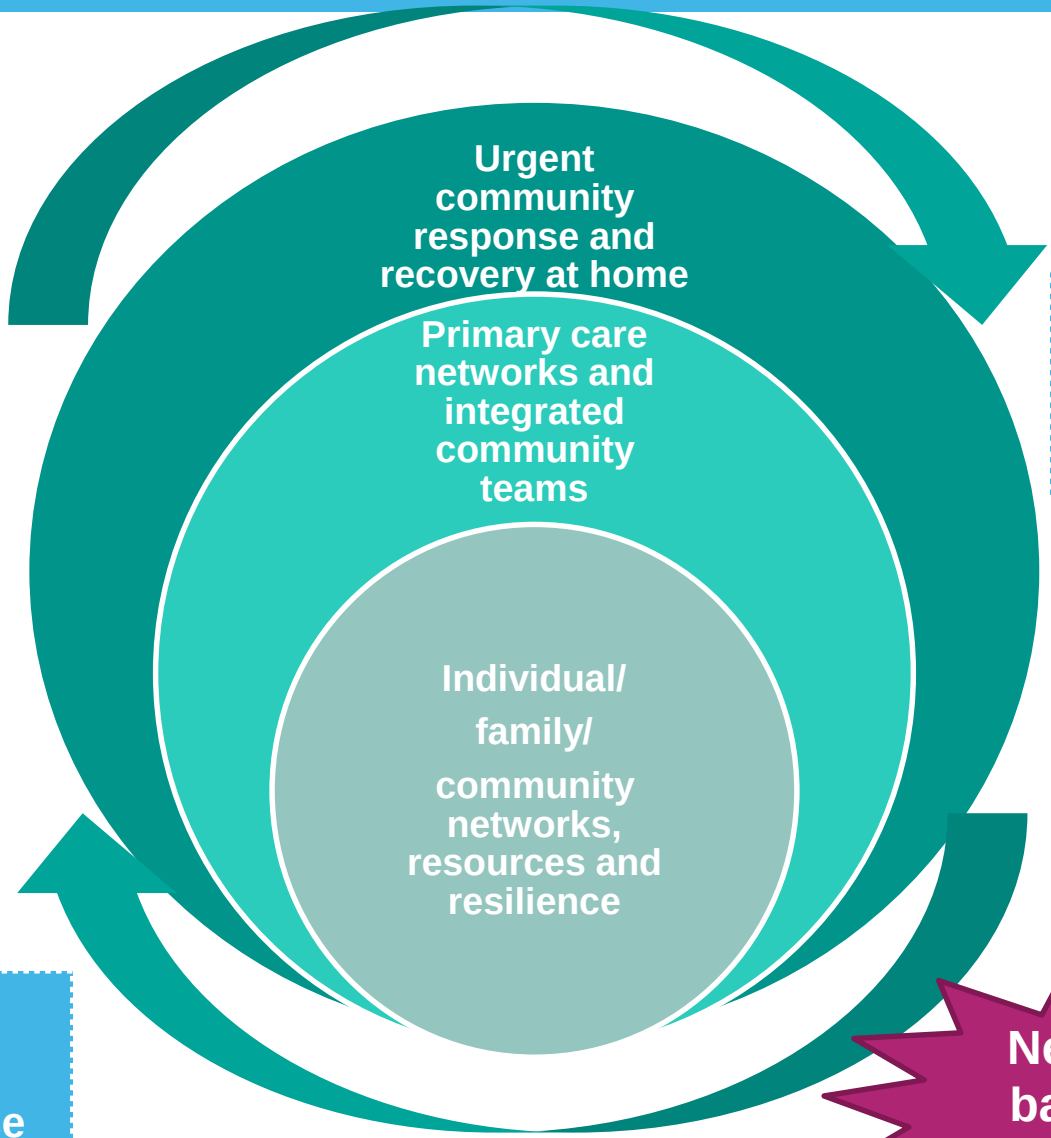
Locally agreed principles
Person first
Close to/at home
Community based
Prevention focussed
Community connectedness
Local ownership
Shared resources
Enhance primary/community care capacity



Community proactive care and support

Community reactive and rapid response

Needs based

Achieving the best outcomes for people: Embrace care project

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What is the Embrace Care Project? The project is about:

- Improving the way we care for and support older people.
- A whole system approach.
- Improving outcomes for adults older than 65 years.
- Identifying need and evidence to pinpoint changes required
- Shaping our future model of care-an integrated health and care system

- Review and analysis to find out:
  - "Could we have supported individuals to stay at home if their needs can be met there?"
  - "What can we do to support people to get back home as soon as they are well enough?"
- What has this involved?
  - Reviewed the next steps for people in 943 acute and community beds.
  - 265 individual cases were reviewed in workshops by 131 practitioners.
  - Spoken to over 320 people working in the system and receiving care and support.
  - Reviewed 100 responses to a culture survey to build a picture of some of the key challenges facing the system

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%

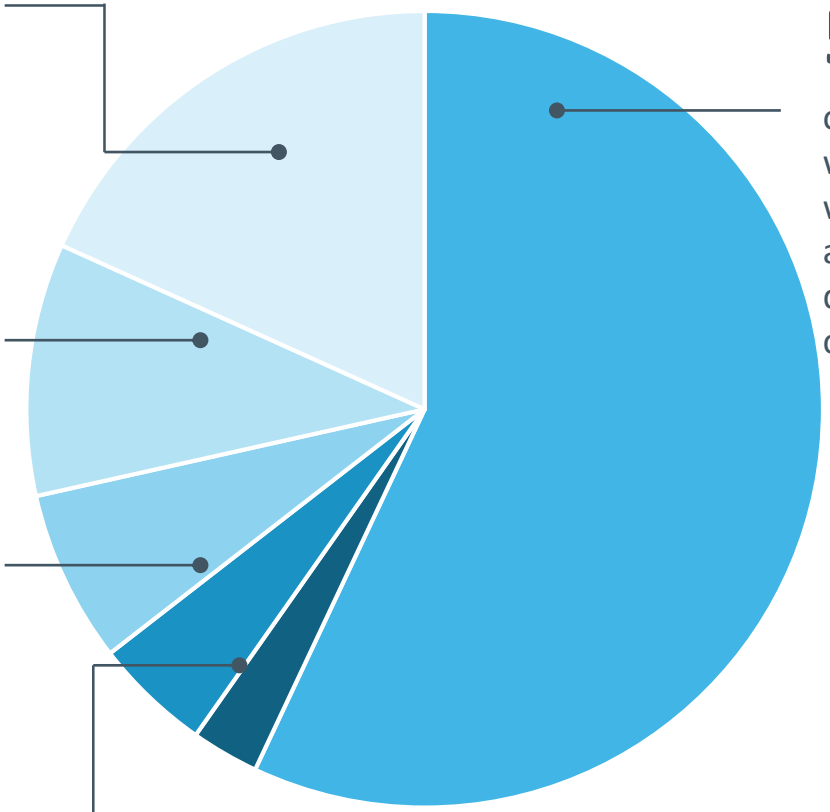
of the cases were due to decision making and behaviours, primarily through risk aversion or lack of clarity on what services are available

7%

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

5%

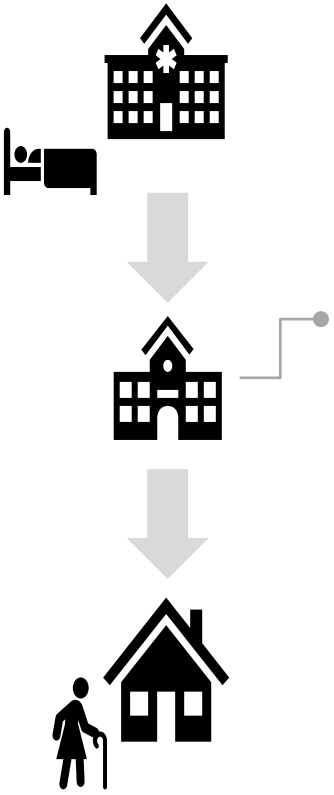
of the cases were due to a lack of collaborative working and a multidisciplinary team approach



57%

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

Do we have the right model of care?
The impact of pathways



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

- 31% of 65+ attendances reviewed don't need to happen
- 41% of 65+ admissions reviewed are avoidable
- In workshops, the number of people in residential or nursing placements where that was the **ideal outcome was only 56%**
- When we discharge from the acute into another short term setting, that is only the **ideal outcome for half** of the people
- **22% of our acute beds and 67% of our community beds** are filled with people who would be better suited elsewhere
- *We aren't always achieving the best outcome for older people*

Quantifying need….

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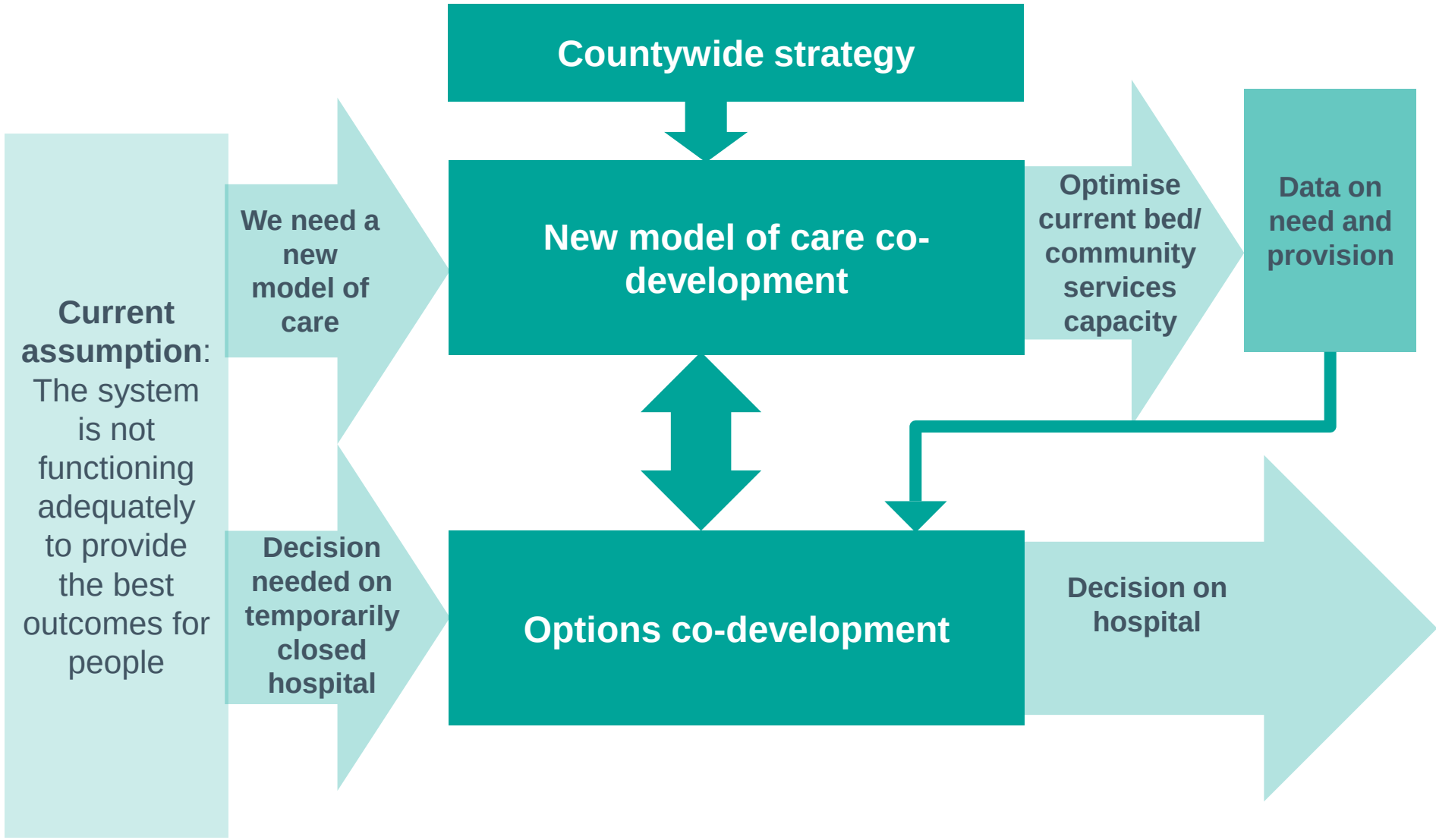

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Points to consider

1. Current system activity is likely not to reflect need-how can regional recommendations support this?

2. Will there/could there be any regional recommendations/ principles produced to outline the most efficient and effective number of beds in a community healthcare facility?

3. Will there/could there be a regional approach to defining the levels/functions of care that could be provided in a community healthcare facility and if so, could we have a regional approach to supporting the public to understand the changing role of our hospitals?