DETAILED FINDINGS FROM THE EMBRACE CARE DIAGNOSTIC REVIEW

FRIDAY 16 AUGUST 2019
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
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?

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

- 2019: 141,629 (2%)
- 2020: 143,807 (11%)
- 2025: 157,402 (23%)
- 2030: 173,867 (39%)
- 2040: 197,051

Poor performance compared to national averages

- Delayed days, awaiting a care package, per 100,000 aged 18+
- Delayed days, awaiting a nursing home, per 100,000 aged 18+
- Delayed days, awaiting a residential home, per 100,000 aged 18+
- Delayed days, awaiting further non-acute NHS care, per 100,000 aged 18+

Cornwall Apr-19 Per 100,000 adults  England Apr-19 Per 100,000 adults

“I know it’s hard but we have to be more proactive in our discharge planning” – Discharge Coordinator

“But a team who are ready for change

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
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

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

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

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

So this is what we looked for.
ARE PEOPLE GETTING AN IDEAL OUTCOME FROM OUR SYSTEM?

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

**What impact does this have on outcomes?**

- The right service?
- The right time?
- The right professional?

**Are we using services effectively?**

*Do we work and make decisions in the best way to ensure people access the right services for them?*
WE’VE LOOKED TO UNDERSTAND THESE QUESTIONS ACROSS THE SYSTEM

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

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

3. What impact does this have on outcomes? 
   *The right service? The right time? The right professional?*
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?
AT THE FRONT DOOR
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?
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.
DO WE HAVE THE RIGHT MODEL OF CARE?
ACCESSING THE RIGHT SERVICES

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.

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.

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.

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

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

![Chart showing categories of support or services which attendees felt would have avoided attendance.

- Community-based reviews, diagnostics and treatment: 28%
- Home-based social POC or reablement: 17%
- Outpatient diagnostics and treatment: 14%
- Planning e.g. TEPs, CGAs: 14%
- Home-based health POC or reablement: 14%
- Rapid response: 3%
- Step-up bed: 3%
- Equipment: 3%
- Other: 3%

Non ideal admission, avoidable attendance: 10%
Non ideal admission, ideal attendance: 31%
Ideal admission: 59%]
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.

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.

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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.

- More timely GP review at place of residence: 62.5%
- OOH GP/community nurse: 25%
- Community-based imaging and diagnostics: 12.5%

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

- Non ideal admission, avoidable attendance: 31%
- Non ideal admission, ideal attendance: 10%
- Ideal admission: 59%
DO WE HAVE THE RIGHT MODEL OF CARE?
ACCESSING THE RIGHT SERVICES

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?

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

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?

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?”

![Bar chart showing the distribution of ideal and non-ideal admissions.]

- **31%**: Non ideal admission, avoidable attendance
- **10%**: Non ideal admission, ideal attendance
- **59%**: Ideal admission

Behaviour drives the top 3 reasons for non-ideal decisions.

- **Risk aversion**: 28%
- **Lack of time to make correct decision**: 18%
- **Lack of MDT approach**: 13%
- **No capacity in the service**: 8%
- **Ideal does not exist**: 8%
- **Family/friends wishes**: 8%
- **Other**: 5%
- **Awareness of the service**: 5%
- **Skill mix of decision makers**: 5%

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.
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?

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.

"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

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
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?

**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.
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

Are we achieving the best outcome for every older person?

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

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

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

Actual outcomes vs. ideal outcomes

Regardless of whether actual outcome was ideal

<table>
<thead>
<tr>
<th>Type of Care</th>
<th>Ideal</th>
<th>Actual</th>
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<tbody>
<tr>
<td>Voluntary</td>
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<tr>
<td>Home-based Reablement &amp; Rehab</td>
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<tr>
<td>Domiciliary - Social</td>
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<tr>
<td>Domiciliary - NHS</td>
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<tr>
<td>Critical block booked bed</td>
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</tr>
<tr>
<td>Bed-based reablement &amp; rehab</td>
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<tr>
<td>Community hospital</td>
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<tr>
<td>Placement - Interim</td>
<td></td>
<td></td>
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<tr>
<td>Placement - Nursing</td>
<td></td>
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<tr>
<td>Other</td>
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</tbody>
</table>

Are we achieving the best outcome for every older person?
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.

![Diagram showing the proportion of beds filled with patients who ideally would not be there.](chart.png)

- 78% Not delayed
- 2% Could be treated elsewhere
- 15% Recorded Medically Fit for Discharge
- 5% Recorded Delayed Transfer of Care
DO WE HAVE THE RIGHT MODEL OF CARE?
THE IMPACT OF PATHWAYS

Top 15 delay reasons

Whilst there are constraints outside the control of the Acute, there are significant opportunities that do not rely on other services.
DO WE HAVE THE RIGHT MODEL OF CARE?
THE IMPACT OF PATHWAYS

Understanding of Acute OT Assessment demand

- Total caseload: 100%
- Did not need to take place: 31%
- Did not need to happen in an acute setting: 69%
- Ideal caseload: 15%
- OT not enabled to do assessment today: 54%
- Actual work today: 78%
- Waiting for reablement service: 15%
- Awaiting step-down bed/CCB availability: 5%
- Awaiting transfer to community hospital: 2%
- Awaiting transfer to another hospital: 5%
- Social Care Assessment: 5%
- Best Interests Meeting: 2%
- Awaiting community hospital bed availability: 5%
- OT assessment: 0%

Top 15 delay reasons

- Understanding of Acute OT Assessment demand
- Did not need to take place
- Did not need to happen in an acute setting
- Ideal caseload
- OT not enabled to do assessment today
- Actual work today

Did not need to take place

100%

31%

69%

15%

54%
DO WE HAVE THE RIGHT MODEL OF CARE?
The Impacts of Capacity Challenges

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?

COMMUNITY HOSPITAL 1

08:00  Morning Whiteboard Review
Nurses, OTs, Physios, PC
Review patients with upcoming discharge dates or immediate issues, highlighting critical actions

09:00  OT/Physio Daily Planning
WM, OTs, Physios
Agree OT and Physio actions for the day, with patient progress targets towards discharge

10:00  Patient flow conference call
Matron, WMs, ASC Co-Ordinator, PC
Discussion of delayed patients, previous and upcoming discharges, assigning delay codes and generating actions, centralised

11:00  Weekly MDT
WM, ASC, OTs, Physio, Consultant, PC
Discussion of all patient progress, evaluation of EDDs, review and generation of actions

12:00  Senior Nursing Daily Review
WM, Nursing Teams
Review and escalate patient health issues, and discuss potential future discharge blockers to begin actioning

13:00  Monthly MDT
WM, ASC, OTs, Physio, Consultant, PC
Discussion of all patient progress, evaluation of EDDs, review and generation of actions

COMMUNITY HOSPITAL 2

08:00  Morning Whiteboard Review
Nurses, OTs, Physios, PC
Review patients with upcoming discharge dates or immediate issues, highlighting critical actions

09:00  OT/Physio Daily Review
WM, OTs, Physios
Review OT and Physio daily actions against targets set in the morning, evaluate rehabilitation plans and EDDs

10:00  Patient flow conference call
Matron, WMs, ASC Co-Ordinator, PC
Discussion of delayed patients, assigning delay codes and generating actions

11:00  Weekly MDT
WM, OT, Consultant, PC, Pharma
Discussion of all patient progress, evaluation of EDDs, review and generation of actions. Inconsistency of ASC and Physio representation limits effectiveness of review

12:00  Dysfunctional relationship between social services and nursing teams, debates over to whom delays should be attributed.
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.

**Daily Conference Call**

- **DATA**
  - Community Hospital 1: 1, 2
  - Community Hospital 2: 1, 2

- **ATTENDANCE & STRUCTURE**
  - Community Hospital 1: 1, 2
  - Community Hospital 2: 1, 2

- **ACTIONS & ACCOUNTABILITY**
  - Community Hospital 1: 1, 2
  - Community Hospital 2: 1, 2

- **ATTITUDE**
  - Community Hospital 1: Not Recorded, Recorded
  - Community Hospital 2: Not Recorded, Recorded

**DELAY REASONS FOR FIT-TO-DISCHARGE PATIENTS**

- **COMMUNITY HOSPITAL 1**
  - 38% Not Recorded
  - 62% Recorded

- **COMMUNITY HOSPITAL 2**
  - 77% Not Recorded
  - 23% Recorded
ARE WE USING SERVICES EFFECTIVELY?
HOW DOES THIS IMPACT PEOPLE?

**Discharge Delay Length of Stay**

*POST FIT FOR DISCHARGE*

- **Community Hospital 1**
  - Recorded Delayed Transfer of Care: 38%
  - Recorded Medically Fit for Discharge: 62%

- **Community Hospital 2**
  - Recorded Delayed Transfer of Care: 77%
  - Recorded Medically Fit for Discharge: 23%

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.

- **ACUTE STAY**
  - 18% of non-ideal decisions

- **COMMUNITY STAY**
  - 16% of non-ideal decisions

- **COMMUNITY CARE AT HOME**
  - 8% of non-ideal decisions

Diagram: [Diagram showing the decision-making process with percentages of non-ideal outcomes at each 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

at the front door

in short term settings
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

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?

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

SERVICES UNABLE TO MEET DEMAND

- Capacity of service, 37%
- Engagement with patient/family, 16%
- Lack of MDT approach, 13%
- Quality of current service not sufficient, 13%
- Other, 9%
- Risk aversion, 6%

Is this capacity challenge real or perceived?

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

HOMECARE DEFICIT FY 18/19

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?

The list is made up of; people who need care and are not receiving it, people who need a change in package, and those who would like to move provider.
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.

<table>
<thead>
<tr>
<th>Postcode</th>
<th>Home care packages currently delivered in that area</th>
<th>Number of providers working across that area</th>
<th>Packages delivered per provider</th>
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<td>TR4</td>
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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

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.

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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?

- **Belief that ideal service doesn’t exist, 27%**
- **Capacity of service, 18%**
- **Awareness of service, 20%**
- **Engagement with patient/family, 23%**
- **Risk aversion, 8%**

**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

Mrs S is an 86 year old female who was admitted to WCH on the 20\textsuperscript{th} 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.

\begin{itemize}
  \item 20\textsuperscript{th} April: PATIENT ADMITTED
  \item 25\textsuperscript{th} April: Referral received by ASC.
  \item 25\textsuperscript{th} April: The patient was allocated a social worker on the day that the referral was received.
  \item 8\textsuperscript{th} May: Patient declared MFD.
  \item 9\textsuperscript{th} May: Patient discussed at the daily progression meeting. It was decided that Mrs S would require a 4x a day package from Adult Social Care.
  \item 13\textsuperscript{th} May: First tender put out by brokerage.
  \item 14\textsuperscript{th} May: Second tender.
  \item 15\textsuperscript{th} May: Third tender - Third tender was un-successful and no package was accepted.
  \item 22\textsuperscript{nd} May: Mrs S was discharged with STEPS and Homefirst as the long term care package could not be sourced.
  \item 22\textsuperscript{nd} May: PATIENT DISCHARGED AFTER 32 DAYS
\end{itemize}

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

20th April: Patient admitted

25th April: Referral received by ASC.

25th April: The patient was allocated a social worker on the day that the referral was received.

8th May: Patient declared MFD.

9th May: Patient discussed at the daily progression meeting. It was decided that Mrs S would require a 4x a day package from Adult Social Care.

13th May: First tender put out by brokerage.

14th May: Second tender.

15th May: Third tender - Third tender was un-successful and no package was accepted.

22nd May: Mrs S was discharged with STEPS and Homefirst as the long term care package could not be sourced.

22nd May: Patient discharged after 32 days.
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 workshops, the number of people in residential or nursing placements where that was the **ideal outcome was only 56%**

Depending on where you live, you have a significantly different chance of getting the care package that you need

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?
Do we work and make decisions in the best way to ensure people access the right services for them?
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).
We reviewed 106 therapy visits with band 6 and 7 therapists to understand how patient-facing time was being spent.

13% of the visits were non-therapy visits.

10% did not get value from the therapy visit.

The majority of visits were effective for the people receiving therapy.

But is all this time spent effectively?

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

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

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

REASONS FOR UNECESSARY PATIENT VISITS

- Volunteer or mental health team would have been more appropriate: 25%
- No therapy value added: 9%
- Patient not ready: 5%
- Repeated visit: 4%

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.
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.
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?

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

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.

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

“There is a lack of recognition that frailty is a real thing.”
- CFT, Frailty Team

“There is a lack of recognition that frailty is a real thing.”
- CFT, Frailty Team

“It’s 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

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

What are colleagues saying about their work and support?

- Do you feel trusted and empowered to work in the best interests of the system? 75%
- Are your opinions sought, listened to and acted on by management/leadership? 66%
- Do you feel valued and are you able to demonstrate pride in your work? 73%
- Do you have face-to-face opportunities to discuss new projects/initiatives when they are first communicated? 63%
- Do you feel enabled and encouraged to communicate upwards and sideways? 71%
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

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

- In workshops, the number of people in residential or nursing placements where that was the ideal outcome was only 56%.
- Depending on where you live, you have a significantly different chance of getting the care package that you need.
- 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.
- 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 2% 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.
IMPLEMENTATION JOURNEY & NEXT STEPS

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- **Diagnostic**
- **Detailed Design**
- **Implementation & Sustainability**
- **Business As Usual**
- **Commissioning New Model & Next Change**

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