Improving Lives For Older People

Programme Update

January 2022

Why Are We Carrying Out This Work?

What Are The Challenges Facing Our System?

To deal with the **elective backlog**, whilst maintaining care for non-elective demand, we need to shift care out of the acute, reducing the requirement for medical outliers and bed base, shifting the case mix of the acute to more elective/tertiary.

We are **underperforming against our comparators** when it comes to acute attendances, emergency admissions and emergency readmission for adults over 65. And these measures are all getting worse:

15,000 acute attendances per 100,000 population over 65 vs. 9,700 in comparators

8,600 emergency admissions per 100,000 population over 65 vs. 7,300 in comparators

22% of those over 65 readmitted to the acute within 30 days vs. 20% in comparators

Why?

We haven't established a **consistent and resilient alternative to the acute** hospital as a place of safety.

We have a high number of patients with a length of stay in and acute bed of 21 days or greater

We have **multiple fragmented services** across Coventry to facilitate admission avoidance.

We have made good progress in driving discharge improvement, however **key challenge remains of increasing demand** and our co-ordinated system response.

What Our Findings Showed

We have an opportunity to improve outcomes for older people in Coventry throughout our **entire system**

We have **strong foundations** in place to **improve outcomes;** we know where the problems are; a workforce who feel encouraged to improve the way they work; ownership of challenges by leaders

We have achieved a lot so far – we have showed there is a **commitment to start moving forward together** – rather than individually working to fix things in our own control

There are opportunities **across all services** that older people come into contact with when needing care:

- Better use of **community and primary care services** for older people who do not require hospital care
- Prevent number of **unnecessary admissions** to hospital by improving decision-making
- **Timely discharge** from hospital where acute care is no longer needed
- Promote faster recovery with better support in the community to maximise independent living

The fit – we will align this work with other programmes you might be working on that are **improving older peoples lives**

No single solution exists – all agencies need to **come together with robust plan to realise full scale of opportunities** – this is not about health, not about social care, it is about people's lives.

Why Cant We Do This Alone?

Workforce and citizen contribution to the diagnostic was critical to us understanding the opportunities and the programme will need further support going forward

Diagnostic – What did we do?

Workshops – participation in multi-disciplinary teams working without organisational boundaries allowed us to identify opportunities to improve outcomes for older people at each part of the system

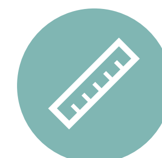
Deep Dives – citizens and the workforce supported the programme team to really understand the reasons why parts of the system weren't operating optimally through 1:1 conversations, shadowing and data. This gave us real depth of insight

Citizen Engagement – we listened to citizens who use the service to understand the experience from their perspective – this is crucial to designing a patient centred and outcome focused solution

Environment for Change – We asked you about the environment in which you operate to understand constraints and pressures that stop you being able to operate as you would ideally like

Design – What will we do next?

Workshops – We'll run workstream focused workshops to help us generate, iterate and select design ideas to take forward to testing and piloting in the next phase of work



Design Groups – We'll run workstream design groups with multi-disciplinary teams to design solutions to the opportunities we identified in the diagnostic.

Testing and Pilot planning – When we have our initial designs, we must test that these work. We'll form small pilot groups to test the initial design solution with and ensure it delivers improved outcomes for older people before implementing at scale

Planning and Implementation – with support, we'll plan how we are going to test the initial designs and then roll these out across the system

People Want To Collaborate And Make Improvements

There are three key enablers to mobilise people for positive change

#1
PROVIDE SYSTEM LEADERSHIP

"If we don't have our directors and executives aligned then it's very difficult to move this working together forwards without it being very bureaucratic, which is how it feels at the moment."

Believe that leaders are aligned on a shared vision for improving the health and wellbeing for older people.

60%

Believe that leaders recognize the challenges colleagues face to make improvements.

#2
ENABLE WORKING ACROSS ORGANISATIONAL BOUNDARIES

People want to collaborate but...

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"Our biggest challenge is to accept that we need to stop working in an organisational way and start to genuinely cut across our organisational boundaries."

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...of colleagues get access to information from other organisations.

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#3
FOSTER A CULTURE OF DOING THE RIGHT THINGS WELL & DOING THEM TOGETHER

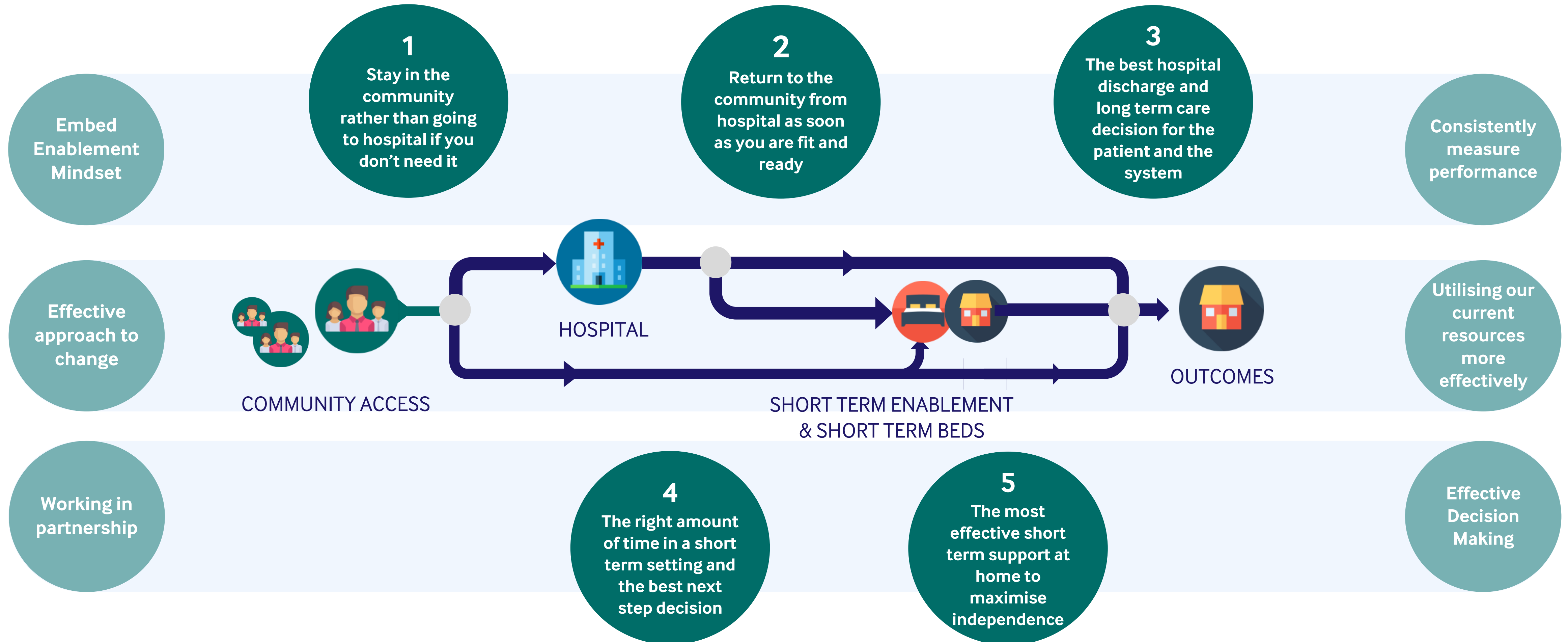
Colleagues see a future for a more collaborative, nurturing and team orientated culture.

DRAFT CONTENT

What Opportunities Did We Identify To Improve Outcomes?

What Does Ideal Look Like For The People Who Need Our Care?

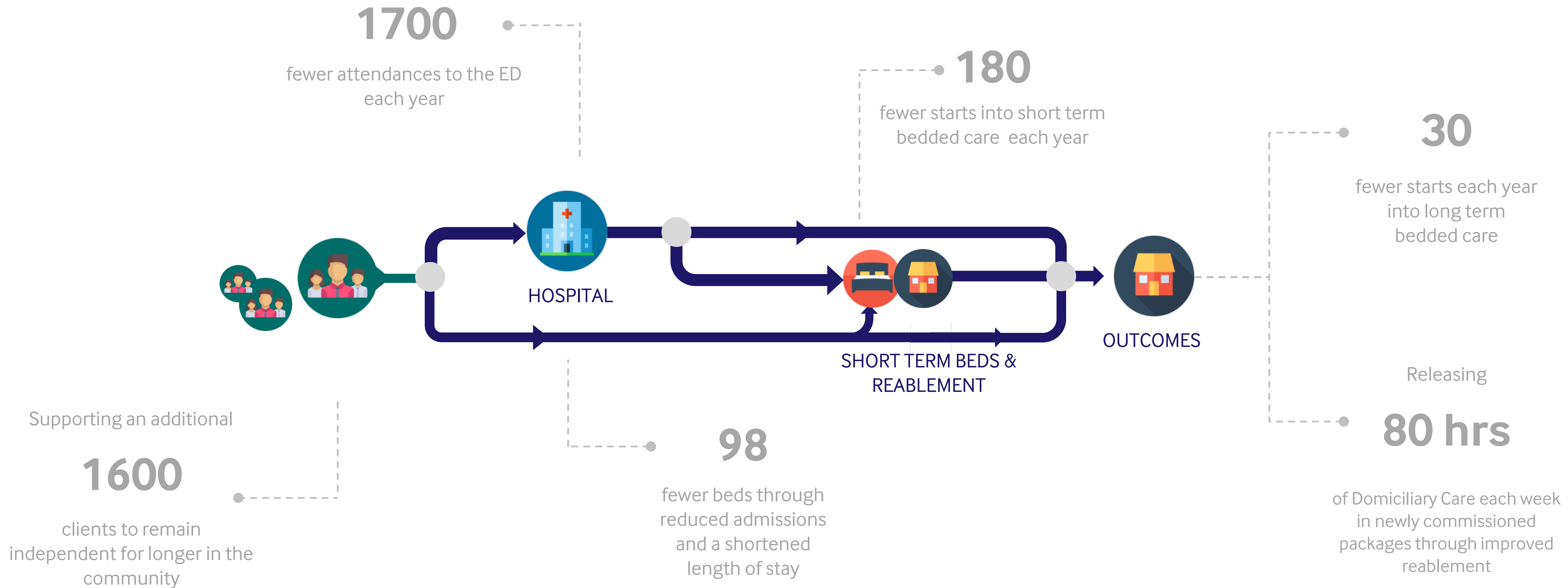
In an ideal world, how would our system function?



NHS Coventry City Council ONE COVENTRY NEWTON

DRAFT CONTENT

What Could The First Steps Look Like For The People Who Need Our Care?



There Are Good Foundations To Build From

"I had excellent care from the palliative care team and my GP"

"The leaflets for who can help are available are really good."

" I thought the green pathway [planned surgery] works well."

"The Speciality nurses are very accessible and experienced."

"111 works well once you get through and they generally route you to the right place."

Citizen Forums

...in **93%** of the cases that we reviewed, the service to prevent the attendance or admission already exists

"There's an absolute willingness and passion to make a difference."

"We achieved significant things as a partnership because we changed the way that we operated, and we took a much more user centric approach."

"During Covid we stopped focusing on our own organisational processes and started focusing on the user rather than the user having to navigate our processes."

95%

...of colleagues have good working relationships strengthened by Covid

92%

...of colleague's trust and respect those they work with.

94%

... of colleagues feel they are encouraged to improve the way they work.

System Colleagues

Anticipatory Care, Hospital Attendance and Admission

We have the opportunity to improve the our anticipatory care by improving access to community services before escalations in patients needs. We can also prevent non-ideal hospital attendances and admissions by better decision making at the point of need and providing services outside of the acute hospital

- 42% of all escalations in need could have been prevented prior to attending hospital
- Advanced care planning is critical to preventing these escalations, with practitioners citing that in half all cases, ACP's were a key measure to prevent this
- This advanced care plan should not stop at a respect form but should truly plan for the next stages of an older patients life.

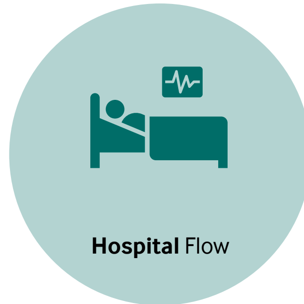
- 37% of all attendances were considered 'non-ideal' by practitioners
- In 46% of these attendances, a healthcare professional referred the patient to the acute setting
- In nearly all of the cases, the healthcare professional was making a risk averse decision or didn't know about the preventative service
- In 81% of non-ideal attendances, the person was conveyed to hospital by emergency ambulance

- We make non-ideal decisions, possibly driven by frailty and not just degrees of illness
- We need to support decision making in ED to reduce non-ideal admissions through better sharing of information
- Case reviews highlighted urgent response, community risk assessment and falls risk assessment/response as a key community service for reducing admissions
- We need to support decision making in the community by increasing knowledge of community services and which patients need to be admitted to A&E

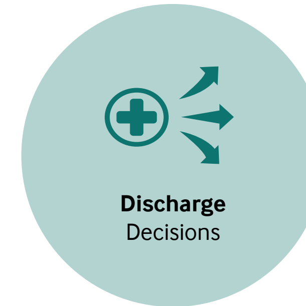
- Develop connected and collaborative partnerships with a data driven culture, where services are visible to decision makers and information flows between critical services

Hospital Flow

We have the opportunity to improve the time that a patient spends in hospital, both from admission to being clinically well enough to leave hospital and from being clinically well enough to being discharged



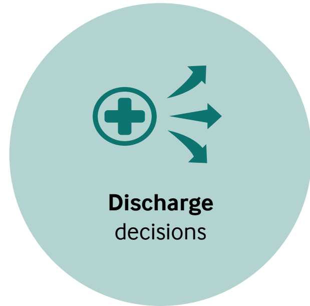
- We make fewer decisions on the weekends and not until 9am on weekdays. This causes a backlog of patients to build up, requiring more beds
- We need to support the decision making to happen sooner to ensure patients are not waiting longer than necessary when deemed medically fit
- Widening the scope and reach of the UH@Home can help support the decision to make patients medically fit sooner and help to bridge the gap between acute and community services. These services can also be used to help prevent patients from needing admission in the first place



- We are still performing assessments prior to discharging patients– this is contributing to delays in pathway 1, 2 and 3
- The IDT backlog is causing a delay after the patient is medically fit for discharge and is the most common reason that someone is waiting to be discharged
- If we were to do this prior to being medically fit, the package of care process could be started earlier – awaiting a POC and awaiting a placement contributed to 22% of all delays. The team can't currently do this due to the backlog of assessments created by the lengthy assessments
- Packages of care can't be sourced until this is completed – can we de-couple this process?

Discharge, Intermediate and Long-Term Care Summary

We have the opportunity to improve our discharge decision making, improve our reablement effectiveness and reduce the number of people leaving hospital with long-term packages of care, resulting in more people achieving their maximal levels of independence



- A third of people going to temporary beds could go home with the correct package of support
- Reduced dispersion of community therapists to non-core provider locations, increasing hours spent with patient
- 140 per year people going home with support rather than to temporary beds during the intermediate period

- Develop a reablement focused service with our partners and care providers
- Increase the effectiveness of reablement by 20%, reducing long term care needs
- Reduce intermediate care exit delays by package step downs, increasing carer capacity and improving independence outcomes for users

- Improving the patient time with physiotherapists who are referred for reablement will improve long-term outcomes for up to 50% of the people in P1
- A combination of discharge decision making and improving reablement effectiveness of P2 patients will result in fewer people going into a long-term residential bed

System **visibility & intelligence**

- Develop data driven culture, frontline teams and management using clear and accurate data to drive their daily decisions, enabling the outcomes above

How Will We Know We’re Making A Difference?

1

Opportunity Matrix

Throughout the diagnostic, we have spent time calculating the potential opportunities across the system. To understand current performance we have benchmarked a number of variables that are combined to quantify the opportunity to improve outcomes for older people

2

Identify KPIs

For the areas where an opportunity exists, we will identify the important KPI that is impacting the outcome of an older person adversely and we will design our solution to address this specific area.

Our initial design solutions will be focused on impacting this variable.

3

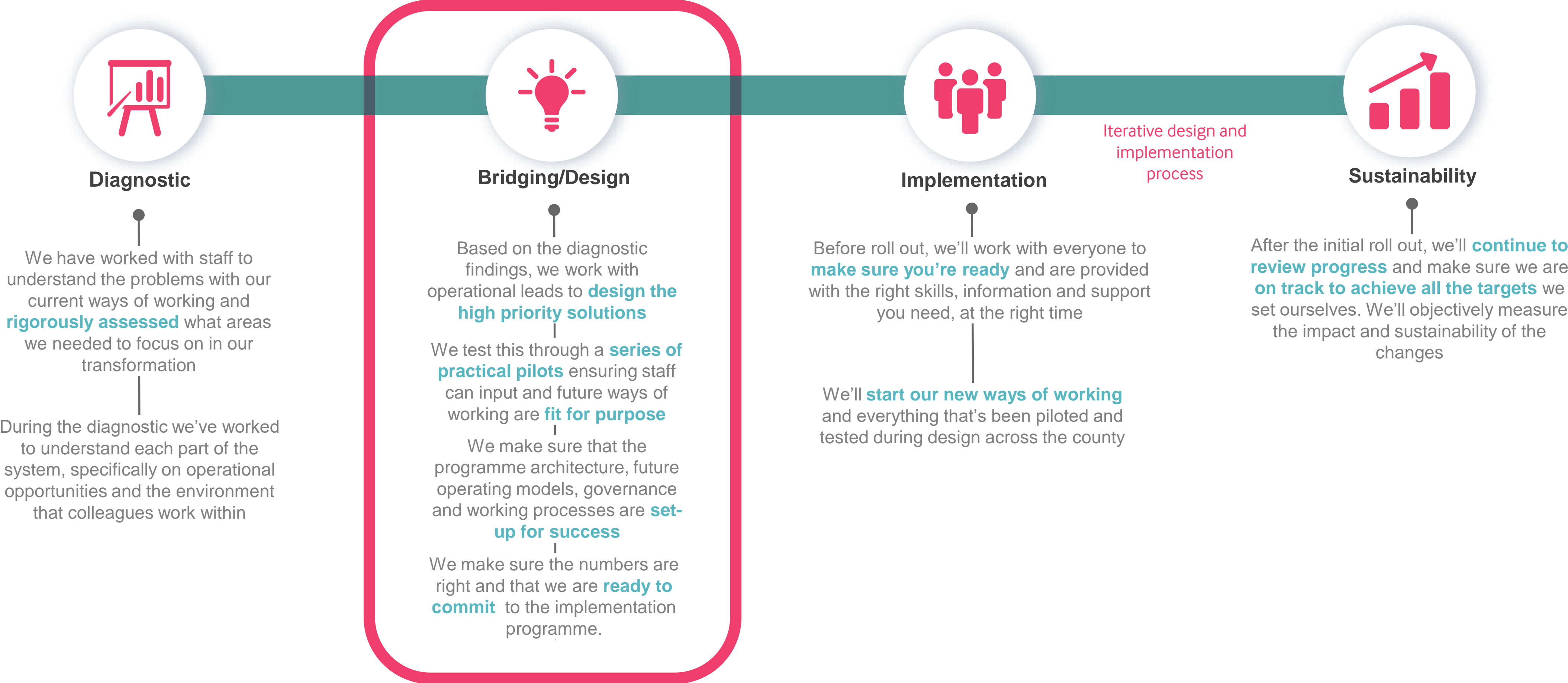
Monitor Performance

Throughout testing our design solution and implementation, we will carefully monitor the impact the design is having on the outcomes for the older person. This will be continually tracked, reported and the design will be iterated and improved to ensure that this continues to improve to an acceptable level

What is Next?

What do we do next?

We want to proceed to implementation initial designs that we can test and iterate to ensure they improve they outcomes for older people as we expect – to do this, we will undertake a bridging/design phase



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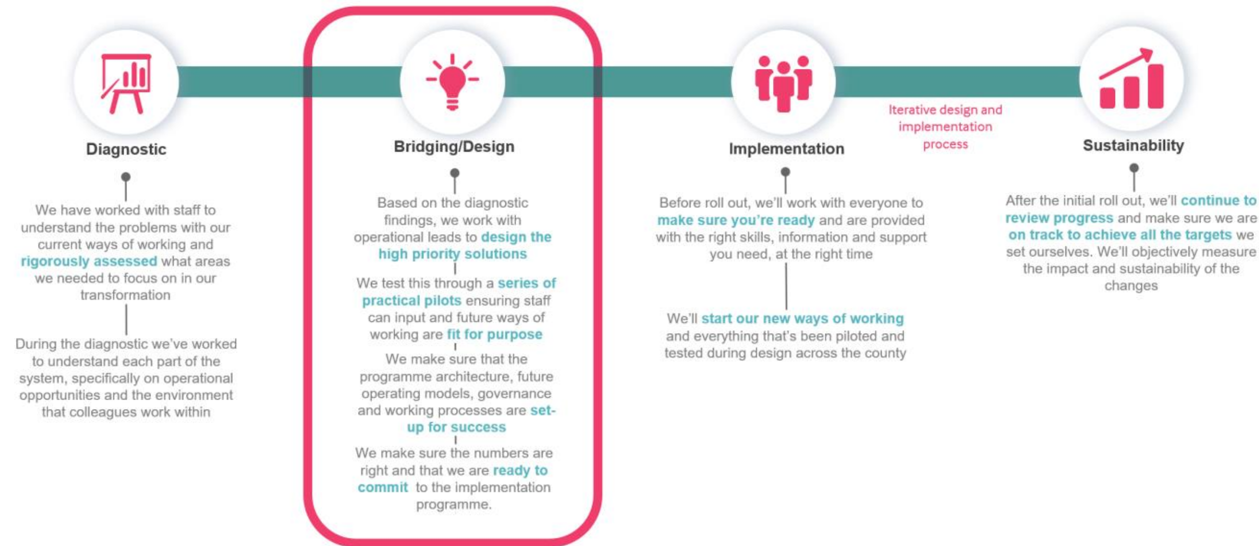

The bridging phase will be split up into the following steps:

We will spend time breaking down the opportunity areas into workstreams and identifying 'design teams' who will lead the way in creating a solution to improve outcomes for service users

We will host regular design workshops with multi-disciplinary attendees to seek appropriate solutions and new ways of working that will address the opportunity areas

We will peer review these options with front line staff and determine if they are feasible solutions – these solutions will then be taken forward to implementation for piloting

We will plan testing and piloting of the initial design to ensure they deliver the desired outcomes – we can iterate and retest at this point. Successful designs will then be implemented at scale in the next phase

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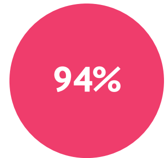
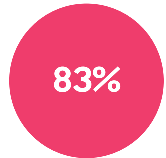
Are People Working Within The System Ready For Change?

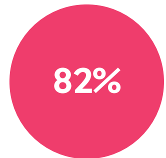
We asked people across all organisations in the system how they felt about change



Agree that they work force are encouraged by leaders to improve the way they work



Agree that they are encouraged to improve they way they work with other teams



Agree that a culture of continuous improvement is embraced with the people that they work with

People within the system say they want to improve outcomes for service users and are ready to embrace change!