Improving Lives Programme

Scrutiny Board 5
10 April 2024

Improving Lives

The opportunity

37%

of acute hospital **attendances** could be avoided for older people

38%

of **admissions could have been prevented and treated in the community**

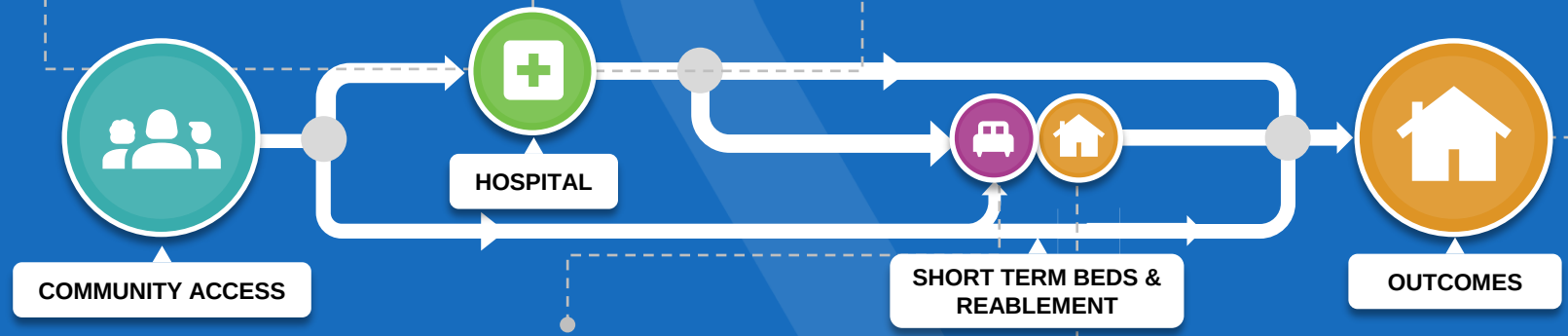
43%

Of our older patients are delayed in hospital **after being deemed medically fit to discharge**

Opportunity to improve outcomes for

50%

of older people supported by long-term carers



30%

Of discharge decisions to pathway 2 and 3 were considered non-ideal

40%

of **our P1 Domiciliary** capacity could be freed up

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A new model for the system

Local Integrated Teams built around localities coordinate an urgent response tailored to the needs of that patient, responding to urgent need in community and supporting discharge from hospital.

When patients attend the ED or are admitted to hospital, hospital processes support proactive discharge planning, and the Local Integrated Teams coordinate discharge/step down back into community-based services to provide ongoing support.

Personalised, goal focussed reablement to promote independent outcomes.

One Coventry Integrated Team responding in a coordinated way to urgent health and care needs

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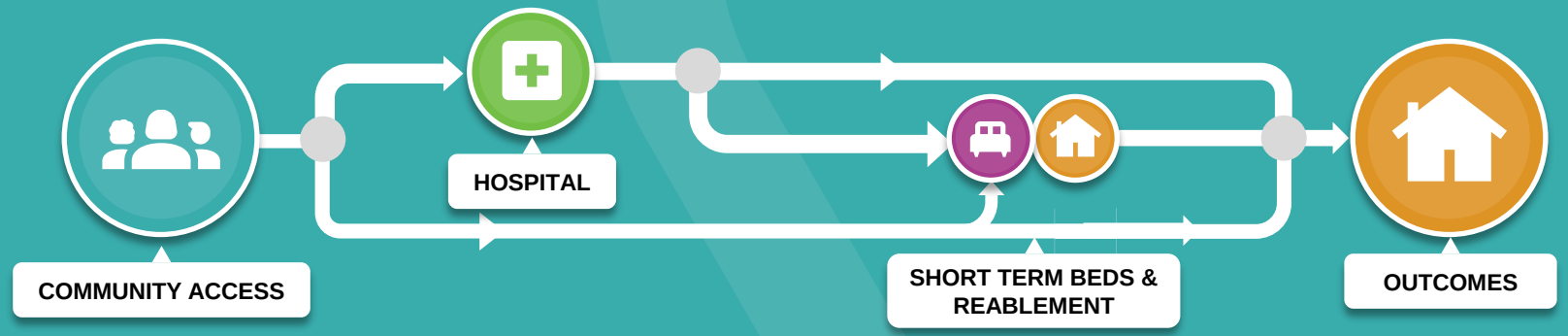
Designing the new model

Local Integrated Teams

Hospital Processes

Visibility and accountability



Workforce and Leadership

Digital

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Local Integrated Teams

Combines staff working from **9 existing services** across community services, adult social care and UHCW **to deliver urgent services** in locality integrated teams across Coventry Place.

Fundamental principles of **caseload visibility** and management, **responsive and coordinated care**, **reducing duplication** and meeting a **person's needs holistically.**

Using resource more effectively through better trust whilst minimising duplication and enables best use of skillsets

Pull Model

Planning discharge as soon as someone is admitted

Local Integrated Teams lead discharge, ensuring decisions are made by staff who have knowledge of community capabilities

Discharge activity moving out of the acute and shortened length of stay means we're able to move staff into the LITs

Workforce and Leadership

One trial team in place since September 2023 to achieve proof of concept.

Integrating three organisations into Local Integrated Teams for go live in **June -** significant change for 150+ staff.

Engagement with UHCW staff across the Front Door and multiple inpatient wards- embedding new processes.

Matrix leadership and governance model between UHCW, CWPT and CCC

How will we know it's working?

Coventry residents

Improved experience and outcomes

Coventry workforce

'this is the job I trained to do'

Operational Benefits

Front Door pressure
Ambulance turnaround
Acute flow
Right-sizing the emergency bed base
Adult Social Care capacity

Financial benefits

Bed day efficiencies
Adult Social Care home care and bedded spend reductions

Impacts on residents

Currently:

Over 350 residents have now been through our ‘trial’ model.

The majority of people are achieving more independent outcomes at the end of the trial

Feedback form residents and their families and carers is positive- people feel that services are focussed on what matters to them.

“the team were a lifeline to me- I feel like I got my family back” *Resident’s daughter*

When rolled out

When adults in Coventry have an urgent health or care need they will be supported in a responsive manner by one coordinated team:

- Telling my story once / reduce the need to repeat the same information
- Getting me the help I need, when I need it
- Focussing on supporting me in the place I call home
- Supported by a team who work together around *me*
- Working with me to support my independence
- Working with me on *what matters to me*
- Working together to get me back home as quickly as possible

Resident story

Kanchan speaks on behalf of her husband about the support they received from the OCIT trial team

: https://youtu.be/yY1orHzdPz8 (2min44sec)

Impacts on our workforce

Currently:

Social care staff, NHS community and hospital staff have been working together in a trial integrated team serving 30% of the city since March 2023.

Staff are co-located in the Opal Centre and work together around a shared caseload of patients.

A local care provider has joined the trial team to try out a new approach that raises the profile of carers in supporting residents reach their goals.

Staff involved in the trial report the benefits of working in an integrated team- improved communication, sharing skills and knowledge, a shared approach with residents in the centre.

When rolled out

There will be three Local Integrated Teams across the city. Teams will comprise social care professionals, nurses, occupational therapists, physiotherapists and admin and support staff. This will be a change for 150+ staff and a multi agency leadership model

Teams will work together to support the residents in their locality and will have a close working relationship with local care providers and GPs.

Impacts on our operational effectiveness

Currently:

- Currently the hospital is **above baseline occupancy** and is requiring **64 escalation beds**, and is **over 99% occupancy.**
- Hospital front door trial demonstrated a 10% reduction in admission avoidances.
- The different community services mean that residents **regularly stay in hospital longer than they need** to until the right provision is sourced, **approx. 4 days**. Our trial reduced this by over 50% in the acute.
- People going through the trial team generally experience a reduced volume of ongoing care and support

When rolled out

- Through admission avoidance, and reduced length of stay, we are aiming to **reduce occupancy** by almost 90 beds, improving flow through the hospital and better patient experience.
- Our locally integrated teams will reduce the length of stay in the acute for all discharges.
- Our multidisciplinary teams will allow us to support more people at home with a wider range of needs.

Impacts on our resources/finances

Currently in the trial team

- We are currently seeing **a reduction of almost 5 Long Term Weekly hours started per week.** Over the length of the average Long-Term package **this equates to almost 400 hours Long Term hours saved per week** which is **over £415k saved per year**
- We are currently seeing **a reduction of almost 2 short term beds** in use per week – this equates to **over £70k saved per annum**
- We are currently seeing **a reduction of almost 250 long term beds per year** – this equates to **almost £200k saved per year**

When rolled out

- **Overall system benefit £13.6m** (part cashable, part non-cashable)
- **Over 2000 long term care hours** could be saved each week
- **Over 16 short term beds** could be saved each week
- **Over 51 long term beds** could be saved each week
- **Releasing 90+ beds** in hospital

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Impacts on our resources/finances

Alongside potentially releasing 90+ beds in hospital, the pilots are demonstrating reductions in short term residential bed days, long-term residential bed days and long-term home support packages.

Whilst the pilots impacting beds have been of a smaller scale to that of home care (and work is being done to scale that further to improve the evidence base) if the success seen to date across the programme does scale up in line with the roll-out then the financial impacts that could be realised are shown in the table below.

Roll out 1st July	Short Term Beds Saving £000	Long Term Beds Saving £000	Long Term Home Support Saving £000	Total In Year Saving potential £000
2024/25	444	511	1,006	1,961
2025/26	641	1,342	2,130	4,113
2026/27	641	1,724	2,423	4,788

Feedback

“With an aligned workforce and collaborative leadership, we can unblock things that have previously been unfathomable. This programme has a voice and allows us to do things that the workforce have been wanting to do for years”

- Integration lead, Coventry and Warwickshire Partnership Trust

"I was really impressed; I honestly had no idea how quickly everything happens. They recognised she would require a PoC upon discharge even before she was MFFD, and they got the ball rolling. Literally everything was immediately put in place, PoC and equipment, it all just happened, we weren't waiting for things, she was discharged and then it all just happened. She was impressed herself; she didn't want to be in Hospital, she wanted to be in her own home. She came out on 4 calls a day, and now is on 2, and you probably reduced her LoS by at least 7 days based on all the complexities she had"

- Daughter of patient

“The benefit for me is that we’re working off one patient referral, one overall assessment and I don’t feel like I am repeating things that have been asked already”

- Physiotherapist, University Hospital Coventry and Warwickshire

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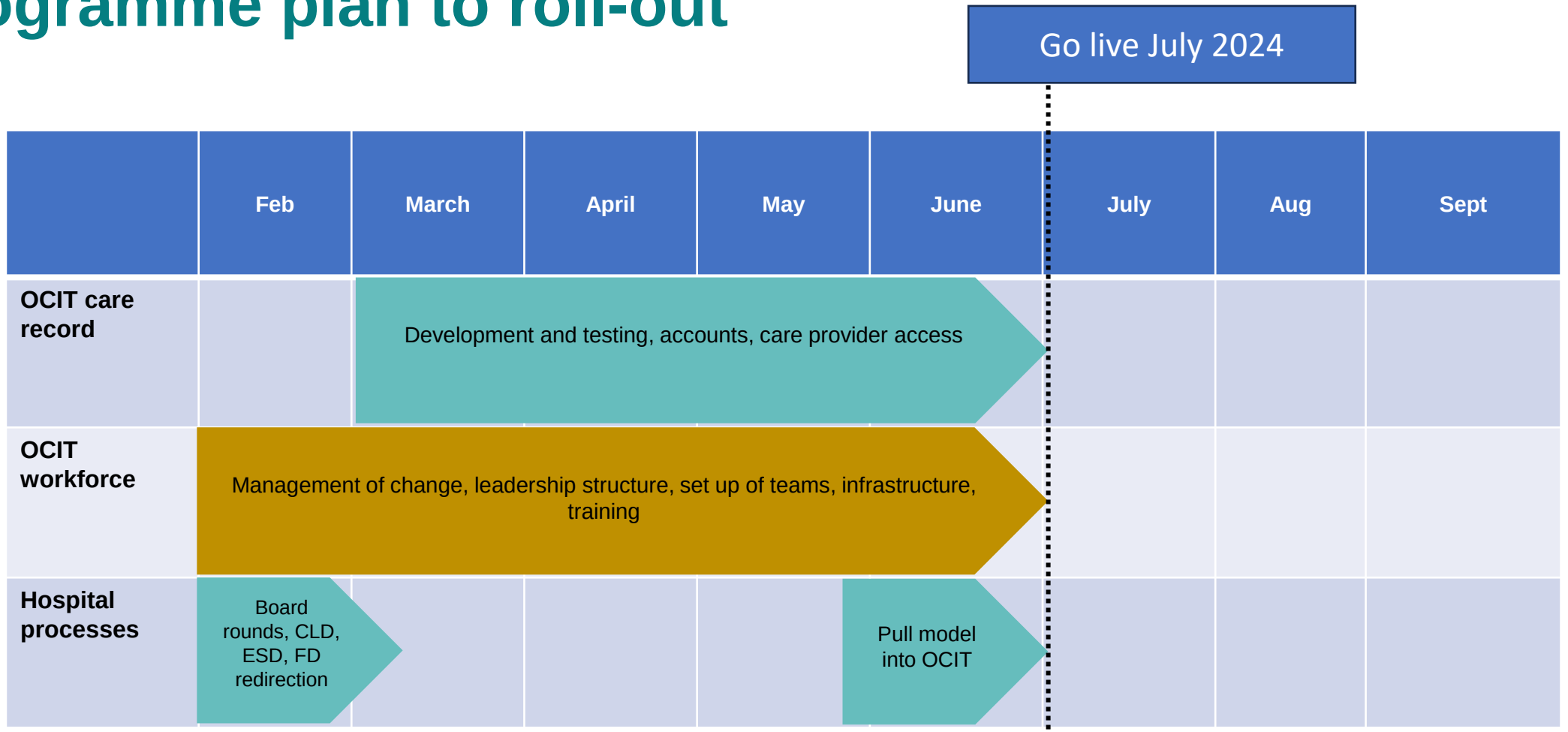
Programme plan to roll-out



Thank you and Questions