# Introductions

**Simon Williams**
Director of Adult Social Care Improvement
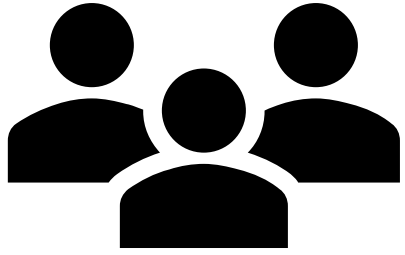Partners in Care and Health (PCH)

# Context

**Daniel McCabe**
Head of Integrated Urgent and Emergency Care
NHS Cheshire and Merseyside Integrated Care Board & Cheshire East Council

2.7m

9
Places &
Local
Authorities

Sefton
St Helens
Liverpool
Knowsley
Warrington
Wirral
Halton
Cheshire West
Cheshire East

17
Hospital Trusts

349
GP Practices

changeology®
change - transform - improve

NHS
Cheshire and Merseyside

Cheshire East
Council

Better Care Fund
Support Programme

# Reason for Support

**Understand The Barriers And Opportunities To Improve Capacity And Demand Planning**

**Help Enhance Overall System Resilience**

**Help Partners Understand The System Complexity**

**Bring together a plan which articulates and helps navigate;**
**1) barriers & opportunities,**
**2) System resilience and**
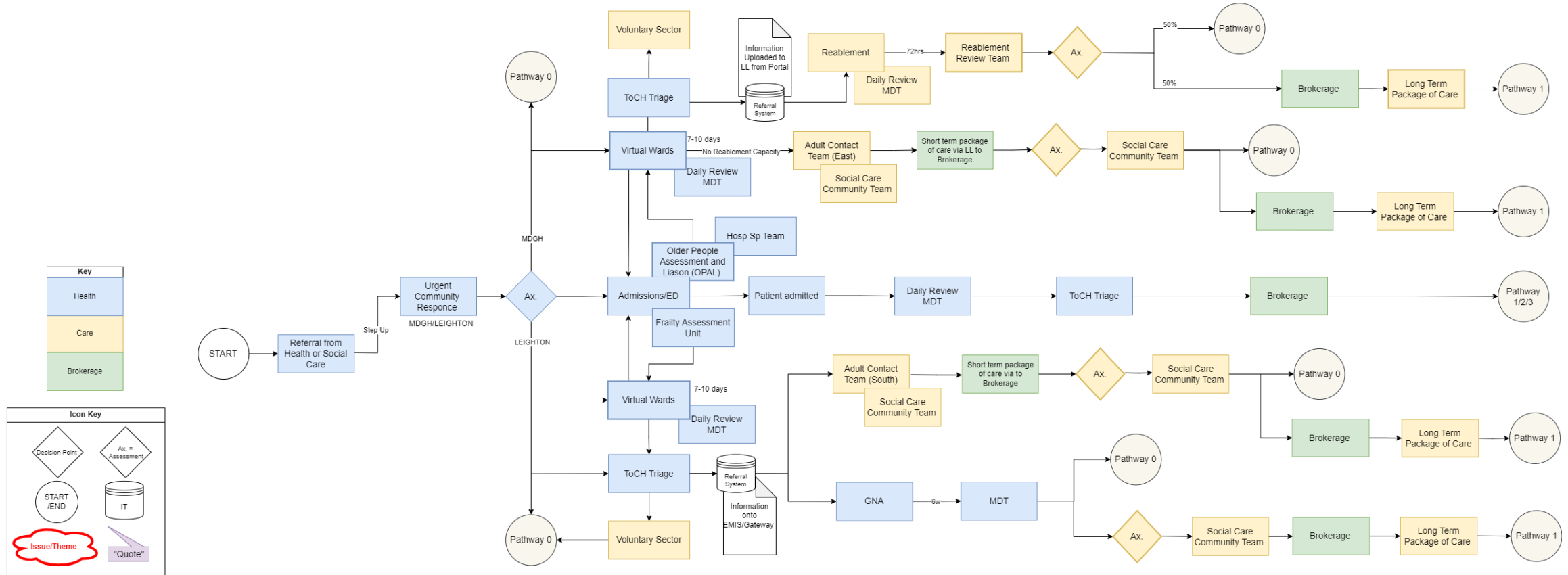**3) A set of actions/recommendations which accounts for complexity**

**Identify Cost Opportunities To Repurpose Funding That Supports Capacity And Flow And Prevention Models Of Support**
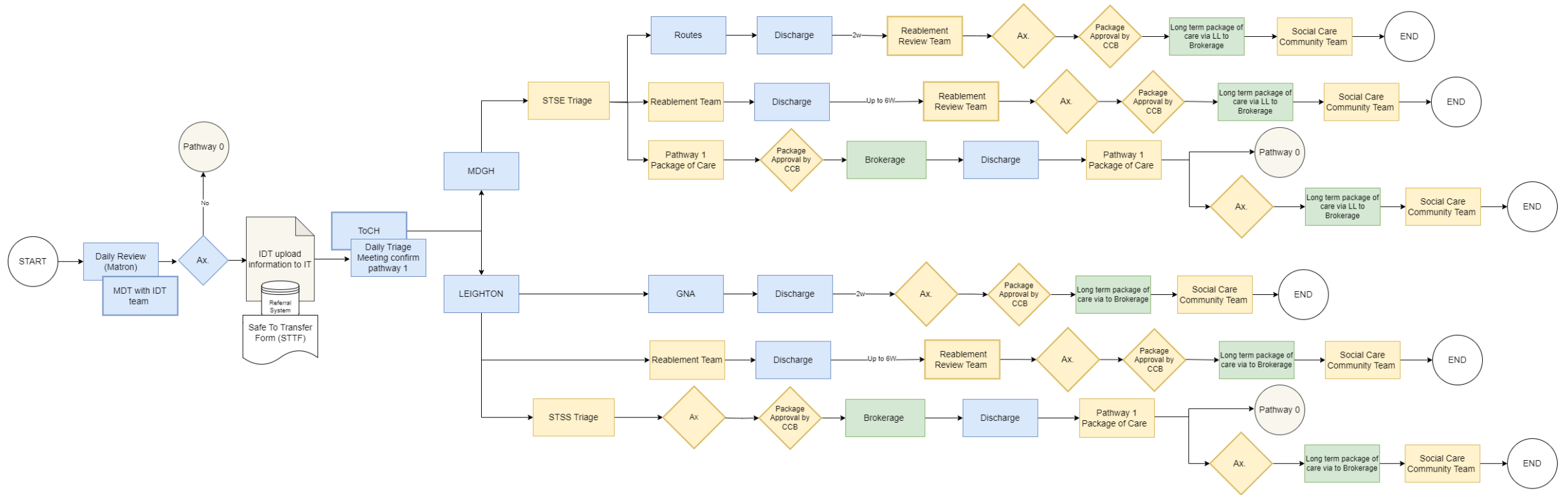
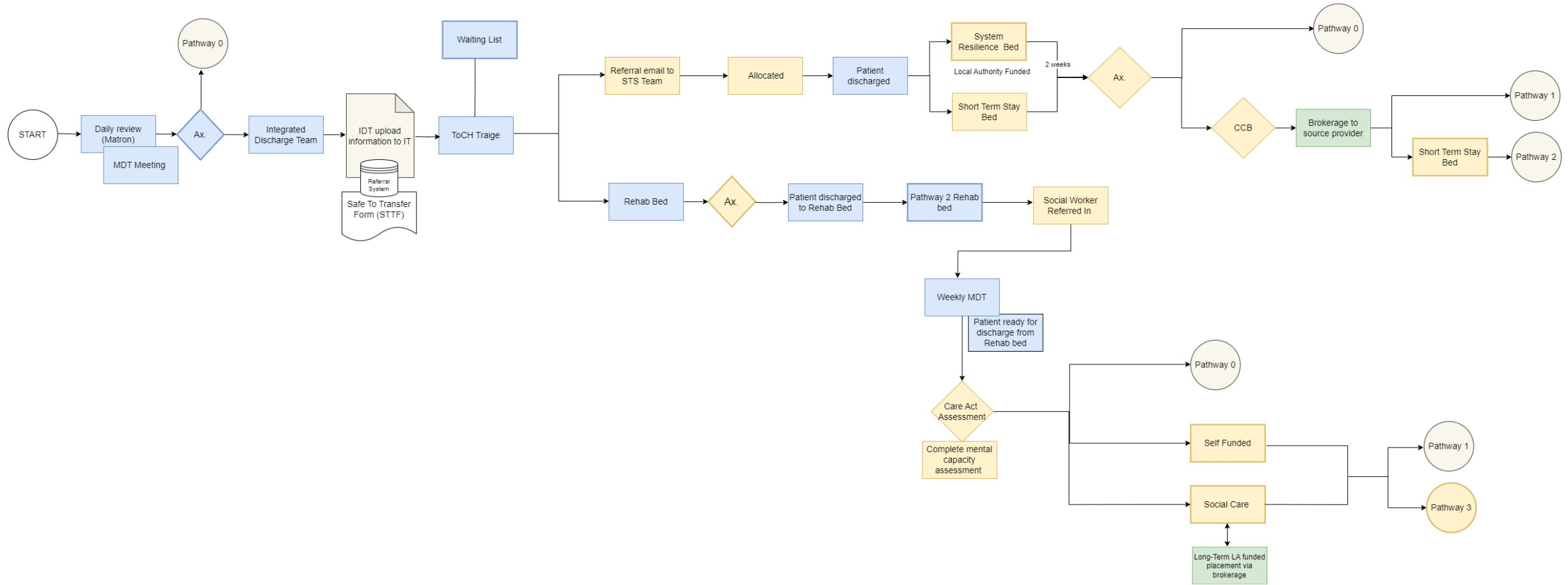# Changeology Methodology

**Raj Purohit**
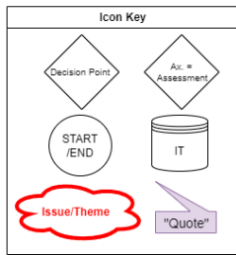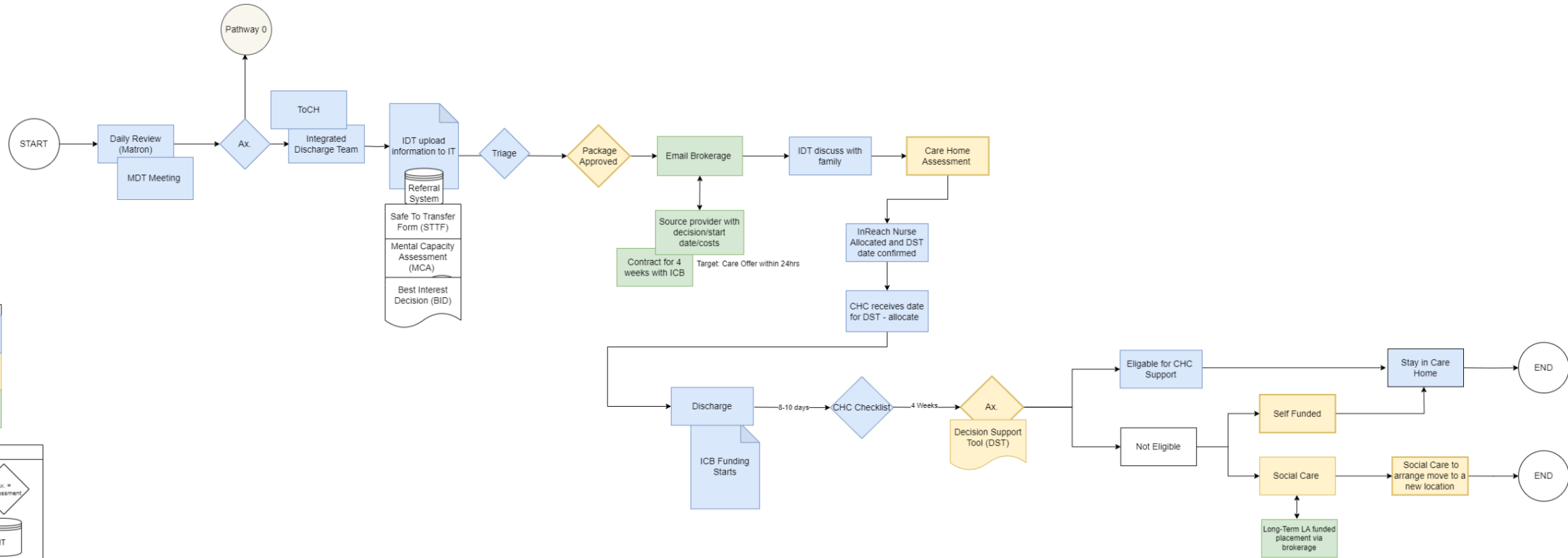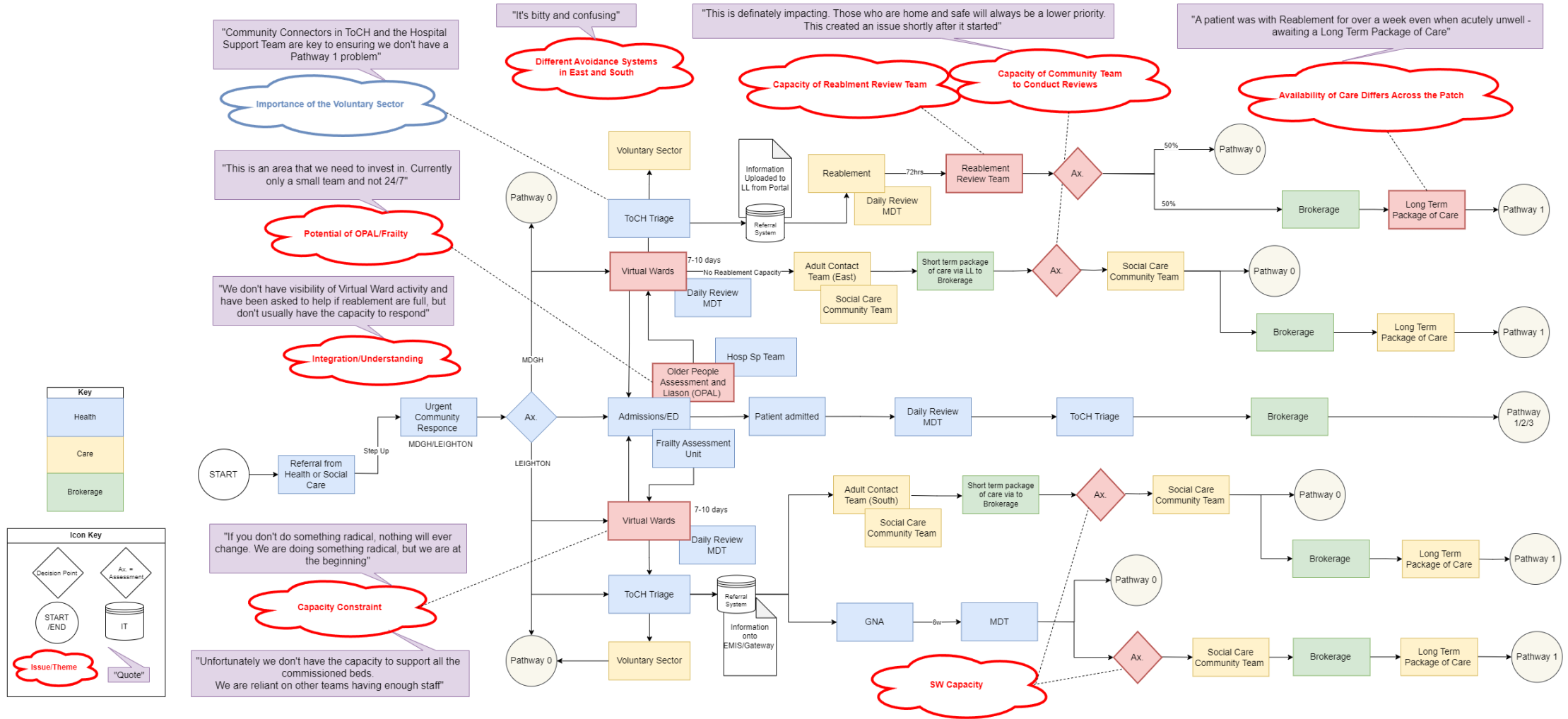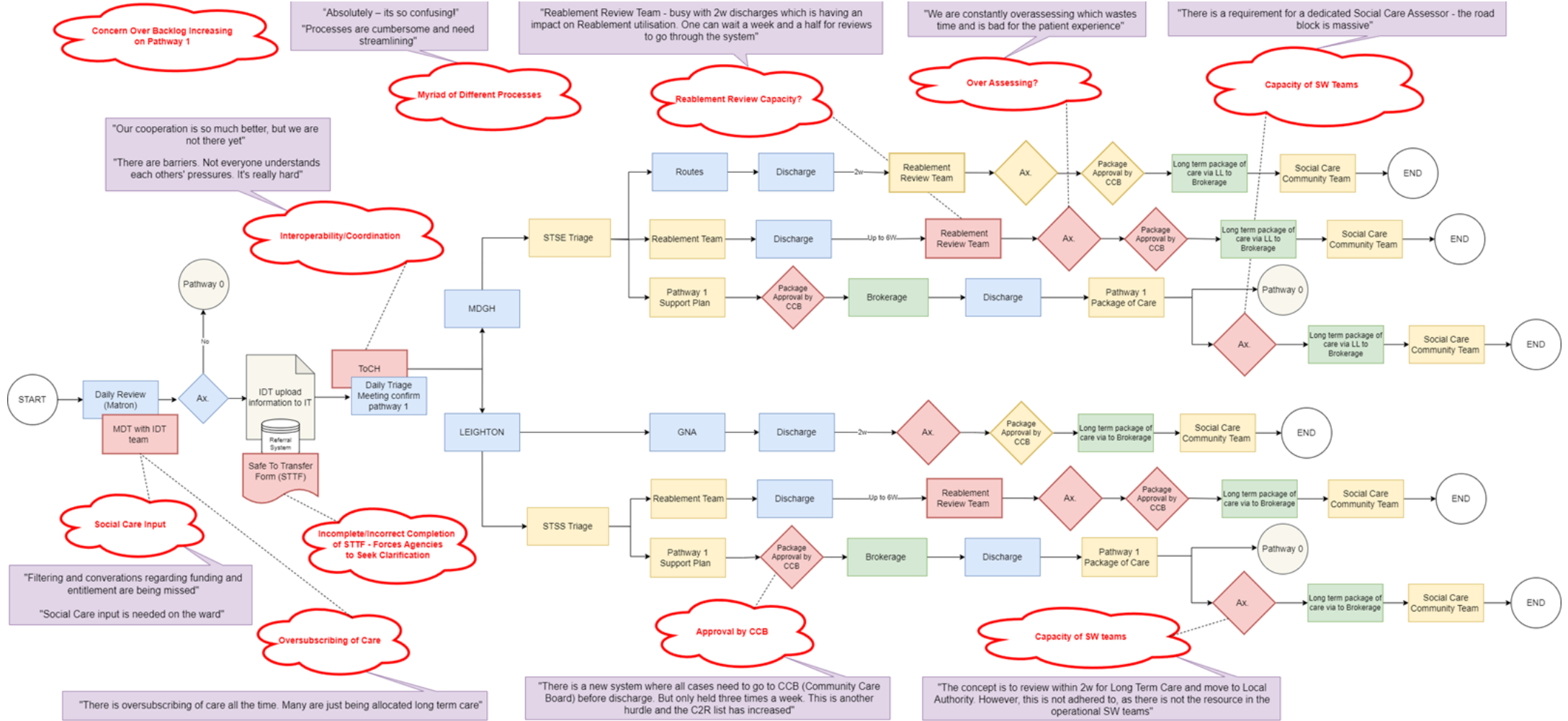Project Manager
Changeology

# Admission Avoidance

# Pathway 1

# Pathway 2

# Pathway 3

# Admission Avoidance

# Pathway 1

# Pathway 2



"A patient went from mobile self care into a rehab bed – going home did not appear to be a preferred option"

Oversubscribing of Care

"Use of System Resilience Beds does not feel equitable"

Efficient use of Resilience Beds?

"Patients get lost in the system. We need more visibility and coordination of the Cluster Bed Model"

Overall Visibility of Patients in the Cluster Bed Model

"Can be months and months. The average is about 1m but it can be longer than that"

Time in Short Term Stay Beds Length of Stay

Pathway 0

Waiting List

START

Daily review (Matron)

MDT Meeting

Ax.

Integrated Discharge Team

IDT upload information to IT

Referral System

Safe To Transfer Form (STTF)

ToCH Traige

Referral email to STS Team

Allocated

Patient discharged

System Resilience Bed

Local Authority Funded

Short Term Stay Bed

2 weeks

Ax.

Pathway 0

CCB

Brokerage to source provider

Short Term Stay Bed

Pathway 1

Pathway 2

Financial Impact

Incorrect Allocation

Poor Patient Experience

"People being discharged on Pathway 2 who should be Pathway 3"

Impact on Capacity in the System

Rehab Bed

Ax.

Patient discharged to Rehab Bed

Pathway 2 Rehab bed

Social Worker Referred In

Manager Review potential to slow the process

"Why spot purchase if we are not using full capacity?"

Utilisation

Weekly MDT

Patient ready for discharge from Rehab bed

Length of Time on Pathway

Amount of Rehab

"Perception that patients get more therapy on the wards than in the rehab setting" "Struggling to change the percepion that rehab is for a maximum of 6w"

Care Act Assessment

Complete mental capacity assessment

Pathway 0

Financial Conversation re Self Funding

Self Funded

Social Care

Pathway 1

Pathway 3

Long-Term LA funded placement via brokerage

Funding Implication for Social Care to move to New Location

Large Number of Patients Moving from Pathway 2 to 3
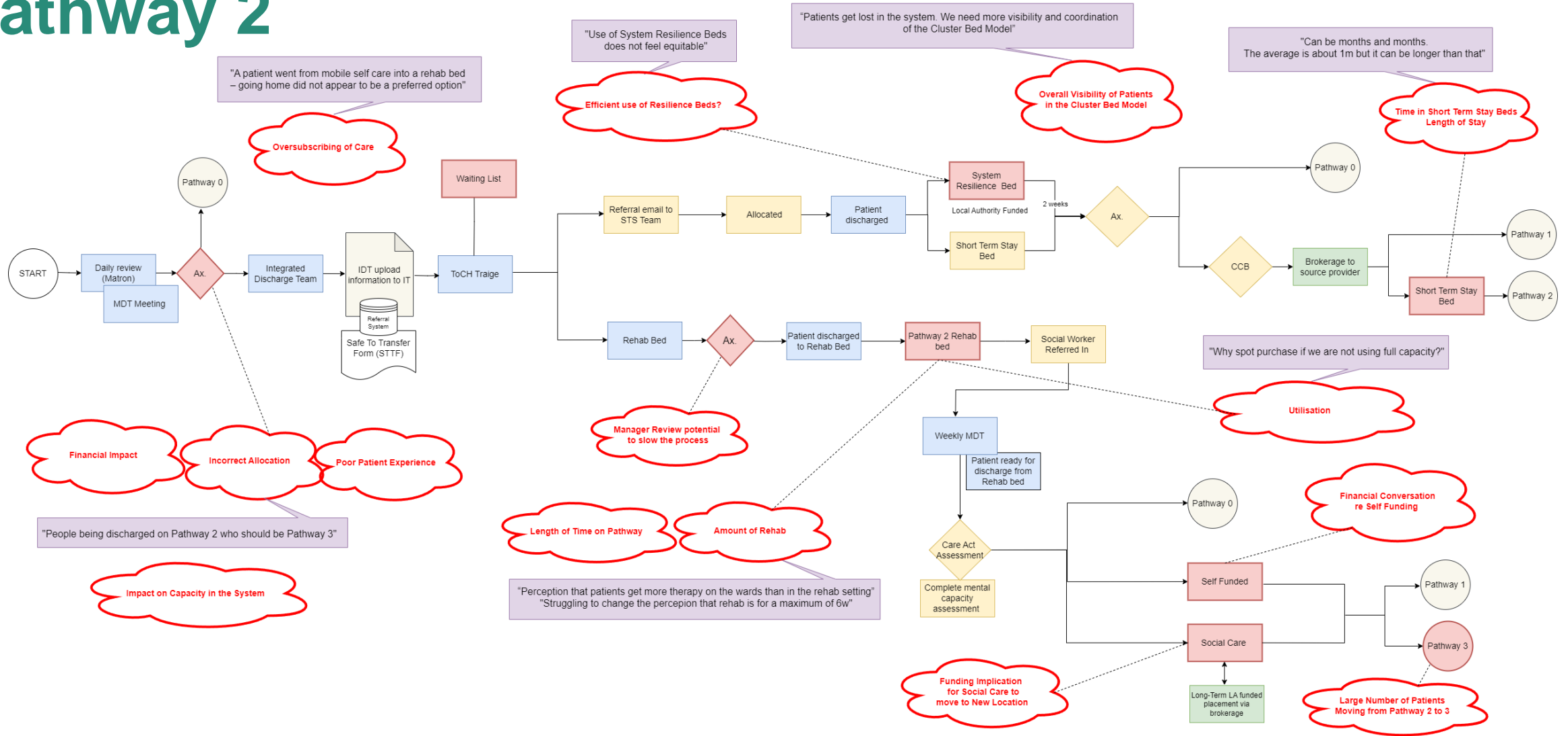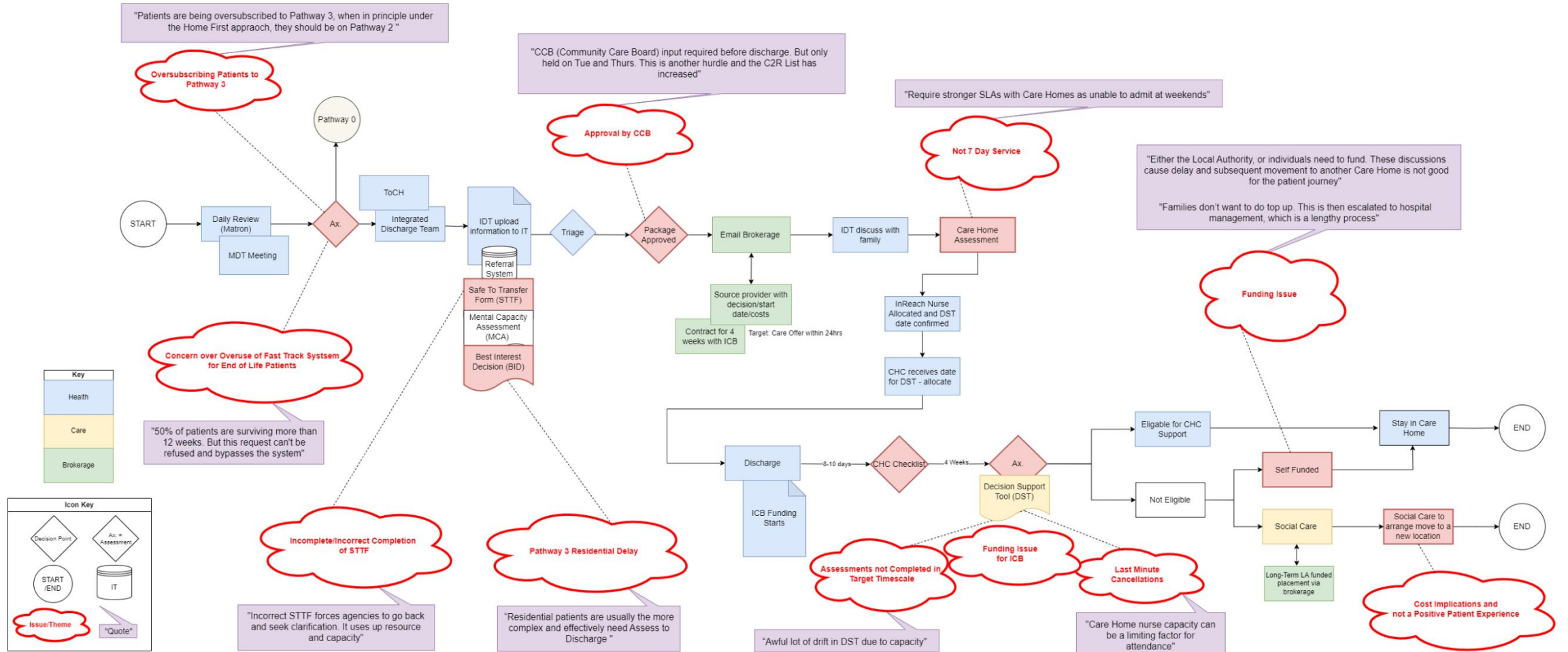
# Pathway 3

**No Criteria to Reside Growth and Cost Analysis**

**Capacity and Demand Planning Capabilities Assessment**

**HICM Assessment**

**Financial Modelling**

# Management Operating System Review

A Management Operating System (MOS) is a set of **tools**, **processes**, **behaviours** and **frameworks** by which organisations and Systems operate.
It exists to ensure everyone works together towards a **common goal** and supports **operational excellence** and **continuous improvement**.
We analyse organisation's current state, identifying **areas for improvement** and **opportunities for growth.**

**What are you trying to achieve?**
System Vision / Goals / Strategy / Budgets / Standards / Guidelines

Expectations

**How do you plan to achieve the goals?**
KPIs/ Capacity and Demand / Contracts Pathway Protocols / Data Integration

Planning

E

P



changeology.®
change - transform - improve

**Did we deliver? Do we need to amend the plan?**
System Reports / Performance Reviews / Variance Reports

Check & Change

C C

A

Allocation

**What resources do you require to deliver the plan?**
TOCHS / SPOA / Providers / Allocation and Utilisation of Resources and Flow

**Communication Flow and Structure
Leadership Behaviours and Control**

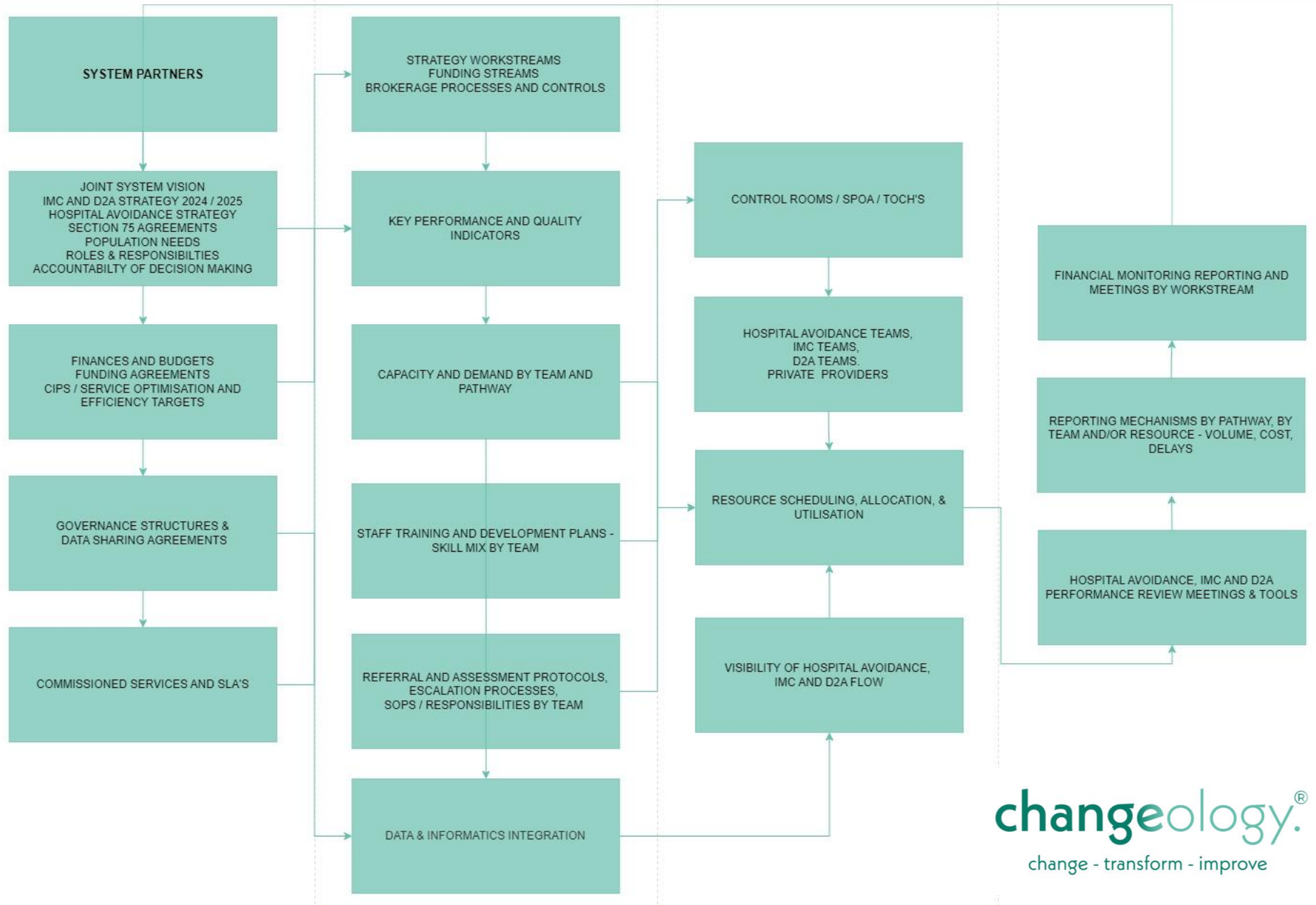changeology.®
change - transform - improve

| Expectations | Planning | Allocation | Check & Change |
|---|---|---|---|

**Expectations**

SYSTEM PARTNERS

JOINT SYSTEM VISION
IMC AND D2A STRATEGY 2024 / 2025
HOSPITAL AVOIDANCE STRATEGY
SECTION 75 AGREEMENTS
POPULATION NEEDS
ROLES & RESPONSIBILTIES
ACCOUNTABILTY OF DECISION MAKING

FINANCES AND BUDGETS
FUNDING AGREEMENTS
CIPS / SERVICE OPTIMISATION AND
EFFICIENCY TARGETS

GOVERNANCE STRUCTURES &
DATA SHARING AGREEMENTS

COMMISSIONED SERVICES AND SLA'S

**Planning**

STRATEGY WORKSTREAMS
FUNDING STREAMS
BROKERAGE PROCESSES AND CONTROLS

KEY PERFORMANCE AND QUALITY
INDICATORS

CAPACITY AND DEMAND BY TEAM AND
PATHWAY

STAFF TRAINING AND DEVELOPMENT PLANS -
SKILL MIX BY TEAM

REFERRAL AND ASSESSMENT PROTOCOLS,
ESCALATION PROCESSES,
SOPS / RESPONSIBILITIES BY TEAM

DATA & INFORMATICS INTEGRATION

**Allocation**

CONTROL ROOMS / SPOA / TOCH'S

HOSPITAL AVOIDANCE TEAMS,
IMC TEAMS,
D2A TEAMS.
PRIVATE PROVIDERS

RESOURCE SCHEDULING, ALLOCATION, &
UTILISATION

VISIBILITY OF HOSPITAL AVOIDANCE,
IMC AND D2A FLOW

**Check & Change**

FINANCIAL MONITORING REPORTING AND
MEETINGS BY WORKSTREAM

REPORTING MECHANISMS BY PATHWAY, BY
TEAM AND/OR RESOURCE - VOLUME, COST,
DELAYS

HOSPITAL AVOIDANCE, IMC AND D2A
PERFORMANCE REVIEW MEETINGS & TOOLS

changeology.®
change - transform - improve

COMMUNICATION FLOW AND STRUCTURE

LEADERSHIP BEHAVIOURS AND CONTROL

# Key Themes



- **Establishing Goals and Objectives That Align with their System Vision**

- **Enhancing Discharge Processes System-Wide**

- **The Need to Improve Resource and Utilisation Levels**

- **Ways of Working to Improve Communication**

- **Financial Understanding of Reduced Funding and Impact of Increased Demand**

- **IT Interoperability**

- **High Impact Change Model Recommendations**

Review of the Goals and Objectives.

SOPs in development, in particular for Pathway 3.

Capacity and Demand:

Active change to all pathways.

Shift Left Approach

KPIs being established

Improved barriers to seven-day discharges.

Providers now accepting patients over the weekend.

Patients will no longer need to wait until the next working day to be discharged.

Further investment into the community to support admission avoidance

# Care at Home Initiatives

- Care Communities
- Urgent community response
- Virtual wards
- Reablement, palliative care and short-term rehabilitation
- Community Nursing Out of Hours Service, GP Out of Hours, Acute Visiting Service
- NHS pathways for 999 and 111

# Enhanced Practice Development in Care Homes

- On average, 150 patients attend ED from Cheshire East Care Homes, of which 48% are discharged from ED back to their Care Home.
- We have committed to enhancing care delivery and are working on improving avoidable ED attendances from Care Homes.
- Goal: 40% reduction by September 2024.

- Development of new roles: Quality Matron for Community Beds, and Practice Development Nurse for Community Beds and Care Home Providers.

- Work with Care Homes and service Partners to improve Care provision in the community to mitigate attendance in the acute

# CWP Home First Initiatives

- Physical Health Community Out-Reach initiative,

- Provide timely, proactive, preventative cardio-metabolic screenings,

- Provide healthy lifestyle advice, smoking cessation, exercise and weight management. Information shared with Primary Care.

- Goal: Proactive and Preventative Care

- Workforce diverted to support behavioural and psychological symptoms of dementia (BPSD).

- Support Care Homes to manage symptoms of dementia to avoid compromising the patient's placement and admission into the hospital.

**Virtual Ward**
Hospital at Home

# Virtual Wards

- Since April 2023,

- 247 accepted into Frailty,
- 404 into Respiratory

- 651 patients benefitting from Hospital at Home service.

- Respiratory: 2477 bed days saved,
- Frailty: 3141 bed days saved

**Thank You**

**Q&A**

# Contact Details

**Simon Williams**
Director of Adult Social Care Improvement
Partners in Care and Health (PCH)
Email: Simon.Williams@local.gov.uk

**Raj Purohit**
Project Manager
Changeology
Email: Raj@changeology.group

**Daniel McCabe**
Head of Integrated Urgent and Emergency Care
NHS Cheshire and Merseyside Integrated Care Board & Cheshire East Council
Email: Daniel.McCabe@cheshireeast.gov.uk

**Alistair Hyde**
LGA Advisor
Better Care Fund
Email: Alistair.Hyde@local.gov.uk