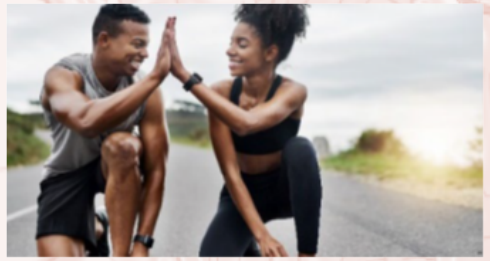
Cornwall and Isles of Scilly
Integrated Care System

Caring where it matters

PL12

Introduction



We want Cornwall and the Isles of Scilly to be great places to be born, live, thrive, and age well with connected, healthy, caring communities for one and all.

Babies, children and young people have the best start in life.

We all live well.

As we get older, we age well, living happy lives in a place we call home.

This is our plan as a system for what we will do in 2024/25. It is a year of continued improvement and accelerating change so that the right care is provided for the right people, at the right time, at the right cost.

We are accelerating changes to how and where we provide care to match the changing health needs of our local population.

During 2024/25 you will see us

- Shifting our system towards creating and maintaining population health and wellbeing.
- Building on the strengths of individuals and communities with personalised, out of hospital care at home and at place, with 24/7 urgent care in the community.
- Working together to focus our resources and efforts on an agreed set of priorities that will have maximum impact.

This system operating plan for 2024/25 blends together:

a) Delivering our five system priorities for transforming care at pace.
b) Delivering all the performance improvements required in 2024/25 by NHS England for operational recovery.
c) Cost improvements required to improve value and deliver a balanced budget for 2024/25.

Caring where it matters

When people are sick or feeling vulnerable, the things they crave are kindness and care they can absolutely rely on.

It sounds so simple. It's what we all believe in at the NHS. But sometimes the sheer complexity of the system and the planning it requires overshadow our focus on real life patients and what they hope for from us.

So this year we're going back - to our people and communities.

With the benefit of our integrated, system-wide perspective, we can see that so many of the challenges – from ambulance queues to overspends – derive from us providing care which is sometimes unsuitable and often in the *wrong place* for people in Cornwall and Scilly. Our traditional structures and pathways funnel patients away from home and their loved ones and into an acute system which provides exceptional care for so many people, but just doesn't suit everyone's needs.

That's why we need to change. Great colleagues up and down the region have been working innovatively for years on prevention and on ways of caring for patients nearer to where they live . But to have real impact this shift needs to go deeper and wider. 2024/25 will be the year when we make the precise, efficient investment in the parts of the system – such as primary care – where a focus on people's needs, closer to home, will really make a difference.

Let's make space for kindness, for caring where it matters.

The challenges we are tackling together

1. The ongoing impact of the pandemic

Surges in demand (physical and mental health), long waiting lists and times, delays in discharge.

2. Changing needs

A growing population: 83,000 more in 20 years

The baby boomer effect: 56% more people aged 75-84 and 87% more people aged 85+ (2019-2038)

An increase in health problems that can be prevented. More people have preventable illnesses and are having more years of ill health, often with multiple illnesses which can combine physical and mental health problems.

Increasing health inequalities: 88,000 people at greater risk of long-term illnesses, part of the 20% most deprived communities in England.

Climate change: We are at risk from more extreme weather events and need to reduce our environmental impact to improve overall health.

3. Challenges in providing care and support

Workforce supply: workforce demographics and labour market supply across health and care.

Finite resources to meet growing demand: we need to keep within our funding allocation and make every £ stretch further to respond to growing demand.

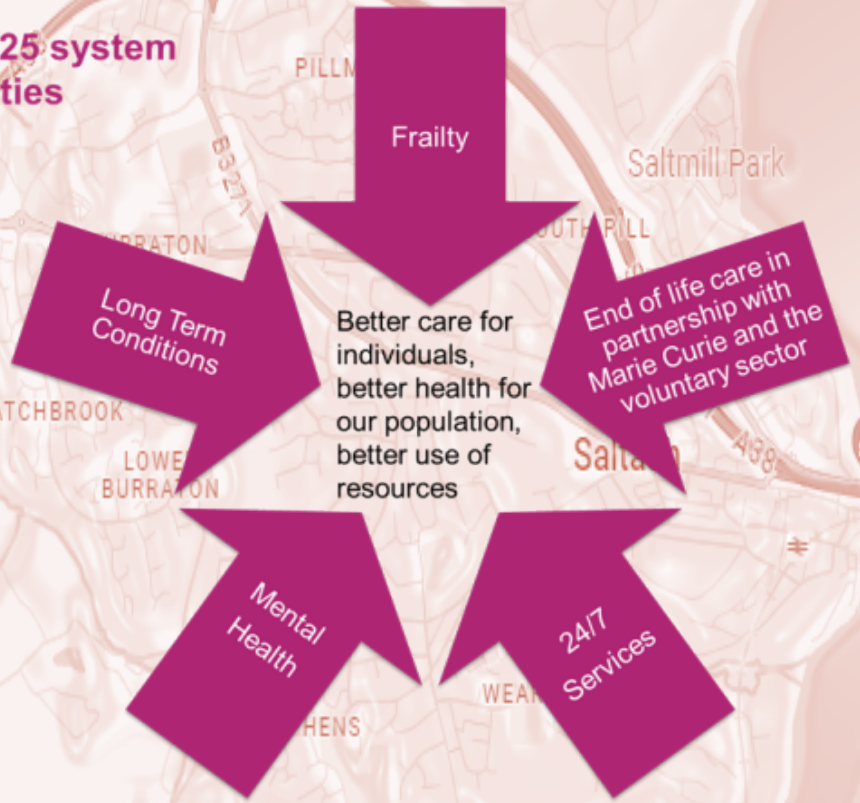
Our geography and settlement pattern: A peninsula and islands with 40% of people living in settlements of under 3,000 and only 5 larger towns with a population between 20,000 and 30,000 affects service provision.

We have to balance helping our children and young people start well with support for a rapidly growing number of older people.

A consequence of all these in combination is that our traditional way of providing care based around the acute hospital is no longer able to meet the needs of our population, as seen in delays in providing both urgent and planned care and ineffective use of our overall resources. Our model of care must change.

Sources: A growing population and the baby boomer effect 2019-2038, Cornwall and Isles of Scilly JSNA/ONS population estimates; Preventable illnesses, Cornwall and Isles of Scilly Population Health Profile 2021-22; Equality and Health inequalities, NHS Right Care, December 2018

System priorities to transform care at pace



Responding to the 'baby boomer'* challenge

We have identified two population groups for whom, because of our rapidly expanding older population, we must prioritise changing how we provide care and support:

a) People who are frail;
b) People at end of life.

Frailty becomes more common as a population ages. It is a national challenge that:

- More people living with frailty are attending emergency departments.
- Older people living with frailty are more likely to be delayed in hospital waiting for further care.

> ***"Up to 65% of older patients experience decline in function during hospitalisation. Many could prematurely end up in a care home because of loss of functional abilities in hospital."***
>
> ***- British Geriatrics Society***

*Baby boomers are the generation of people born from 1946 to 1964 during the post World War 2 baby boom.

Our aging population

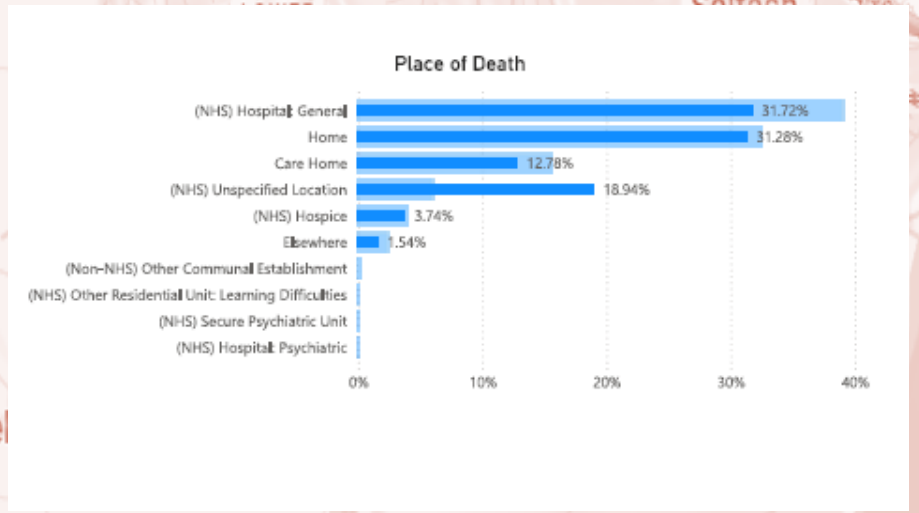
- **Baby Boomer effect:** 56% more people aged 75-84years and 87% more people aged 85+ (2019-2038)
- We have about 11,000 people who are frail, at highest risk of falls, disability, hospital admission, or needing long-term care. We admit about 74% of frail patients who attend the emergency department and they comprise 21% of inpatients.
- In Cornwall and the Isles of Scilly of people aged 65 or older:
  - 39.7% die in hospital
  - 35.5% die in care homes
  - 25.5% die at home
- Lack of support out of hours means many of our older residents are taken into hospital for end of life, and we need to reset the dial and provide our end of life care 24/7.
- At present nearly 21.9% of hospital bed days are in use for people in the last 90 days of life compared to a nationally recognised target of 12.7%.
- Given our rapidly ageing population we need to increase the number of people being supported to die in alternatives to hospital that are more comfortable for the person experiencing end of life and accord with their choice.

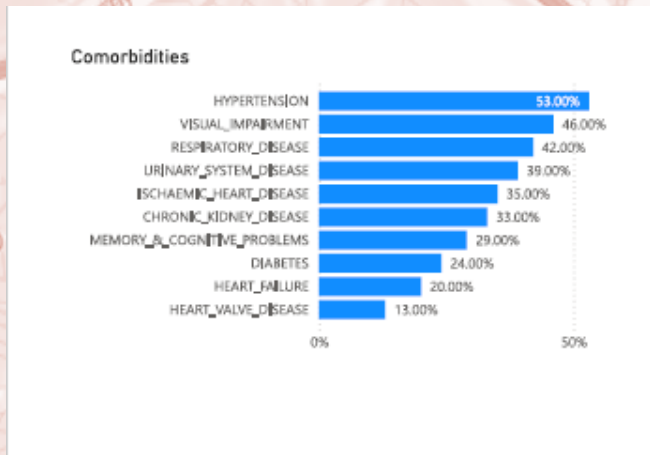
Last Winter, Saltash benefitted from new out-reach provision from St.Luke's Hospice

Saltash - End of Life care

- More people die at home (31%) than Cornwall average (25%)
- Fewer people die in hospital than Cornwall average
- Far fewer people (12%) die in care homes than Cornwall average (35%)
- Leading cause of death – Heart Disease. NB hypertension (high blood pressure) as co-morbidity

Cause of Death Diagnosis	Patients
Rejected Value	60
Chronic ischaemic heart disease	37
Malignant neoplasm of bronchus and lung	21
Other chronic obstructive pulmonary disease	18
Vascular dementia	17
Acute myocardial infarction	15
Alzheimer's disease	15
Pneumonia, organism unspecified	14
Stroke, not specified as haemorrhage or infarction	12
Malignant neoplasm of pancreas	11
Malignant neoplasm of prostate	11
Atrial fibrillation and flutter	10
Total	**477**





preventable diseases

Tackling the preventable diseases that become long-term conditions that people have to live with

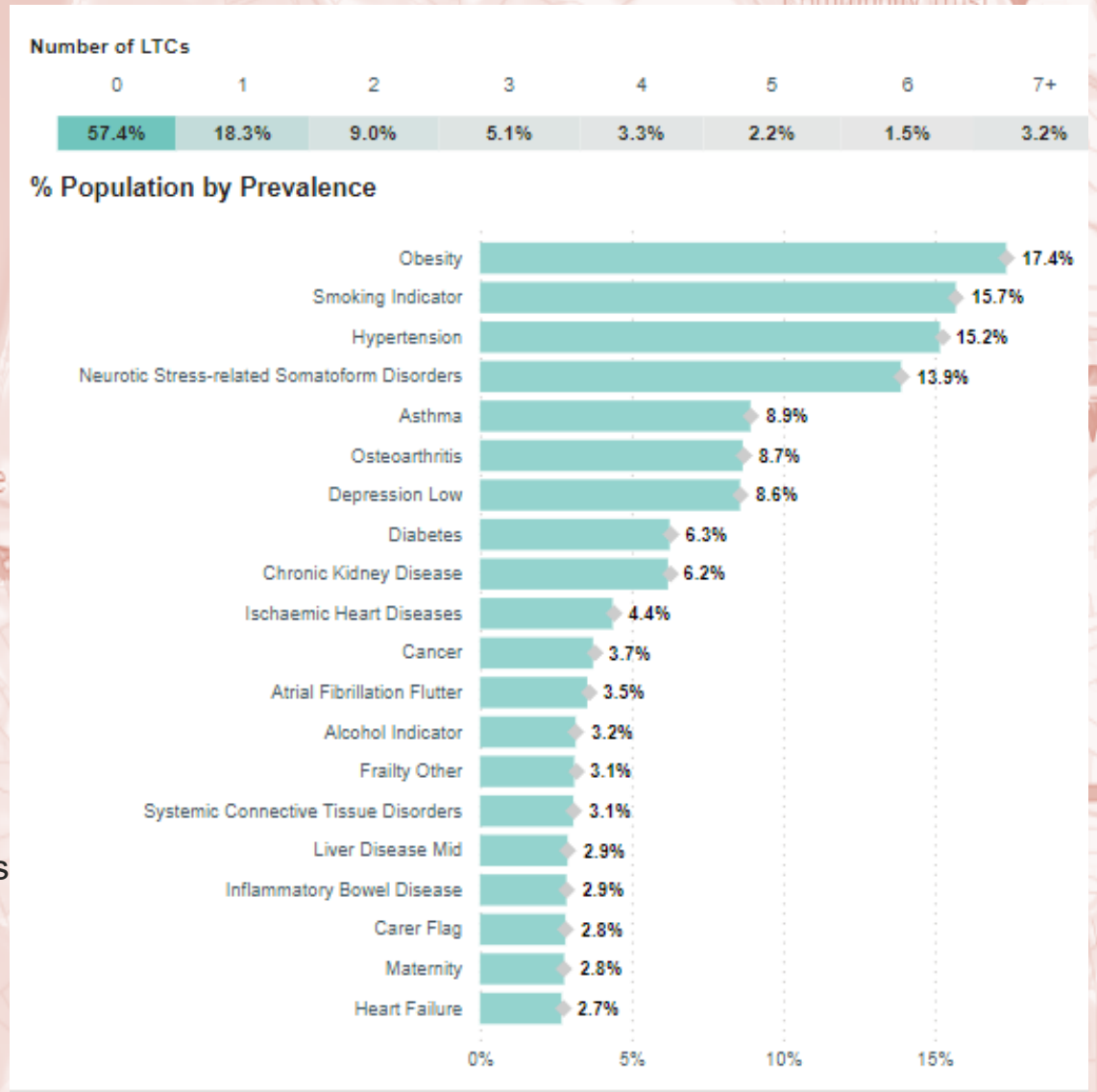
- In order to reverse the trend of more people of all ages living with major diseases that could be prevented, we must also prioritise people with long-term conditions and how we change from treating physical or mental ill health as it occurs to preventing it, stopping or slowing down the progress of diseases, and reducing their impact.
- We are starting with 3 major diseases that are long-term conditions people of all ages have to live with and have a significant impact on their physical health and mental wellbeing:

a) Cardiovascular disease

b) Respiratory disease

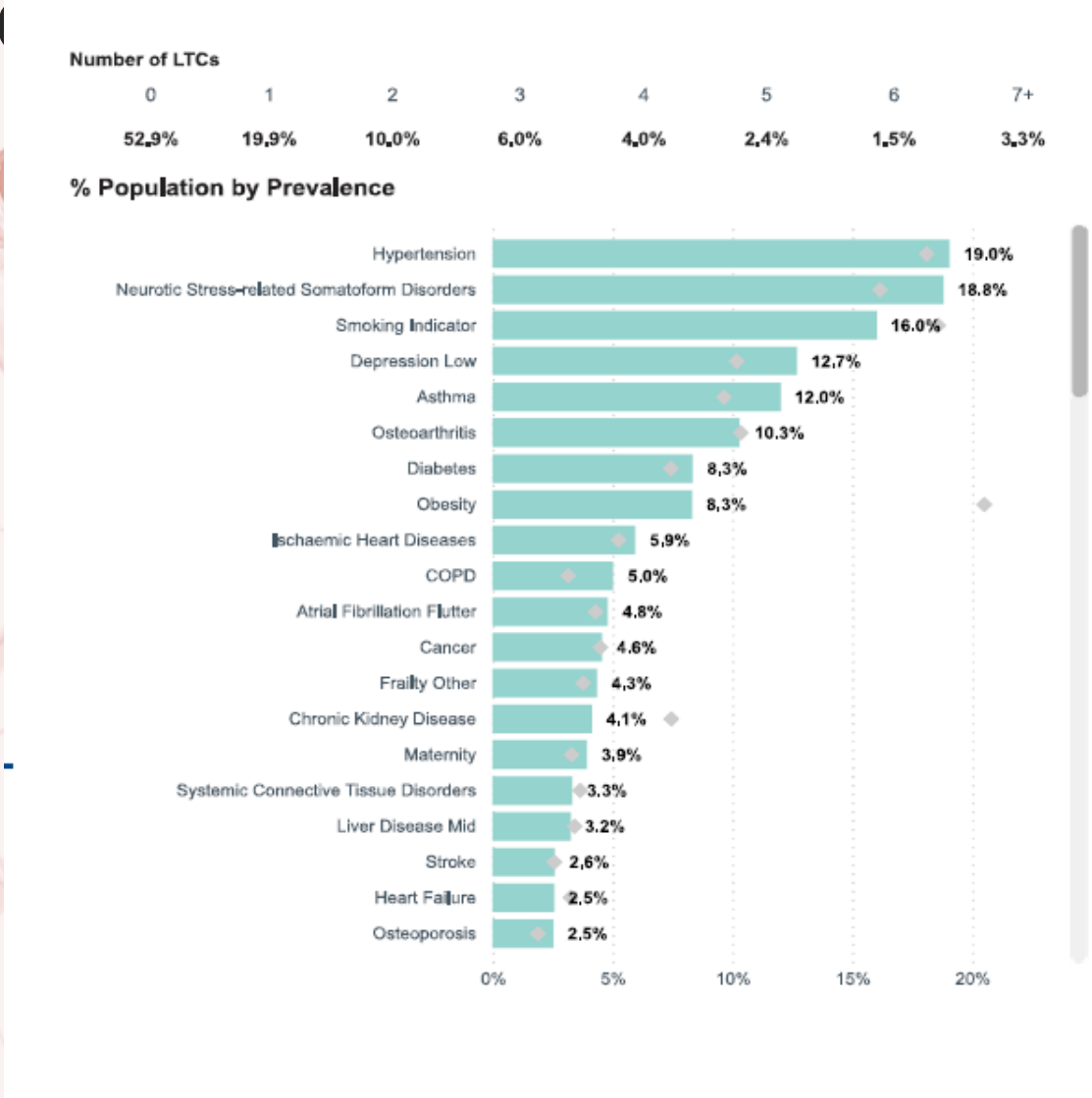
c) Diabetes

- The number of life years our residents lose, through either premature death or living with disease or disability is increasing.
- In order to reduce the life expectancy gap between the most and least deprived in Cornwall and the Isles of Scilly, the top two diseases we need to focus on addressing are cardiovascular and respiratory disease.



Source: Director of Public Health report: Cornwall and Isles of Scilly population health profile 2021-22.

Preventable diseases – Saltash GP registered P[illegible]



Data suggests we should be prioritising identifying people with high blood pressure – often symptomless until too late, but good medication management options available. Tackling high blood pressure also helps prevent heart attacks and strokes.

High rates of mental health related presentations – will require a multi-partner approach and increasing role of non-institutional, non-medical solutions – bio-psycho-social model. Opportunity to learn from Launceston Health Inequalities hub model

Respiratory and Diabetes conditions also feature highly and will need collaboratively developed primary and secondary prevention action plans to reduce rates. Would like to keep the group briefed on our progress.

Our System Operating Plan on a page

Making Cornwall and the Isles of Scilly a great place to be born, live and grow old

Our guiding principle:	**Providing the right care, for the right people, at the right time and in the right place**		
2024/25 objectives:	**Operational recovery**	**Improving value**	**Transforming health care**
	Improved access, shorter waiting times and lists	**A balanced budget**	**Care reshaped to be personalised, preventative, and local**
Our priority people:	**People who are frail** **People at end of life**	**People with, or at risk of, long-term conditions** **People who need support for mental wellbeing**	**People needing urgent care, that is right care for them, in the right place at the right time**
Our change programmes to deliver the objectives	• 24/7 integrated urgent care in the community • 24/7 end of life care • Extending primary care hubs	• Discharge to assess (reducing length of stay in hospital) • Transforming care for diabetes, cardiovascular disease, and respiratory disease. • Improving access to mental health services and equity with physical health	
Making more of what we already have:	• **Easier access to GP appointments and increased access to NHS dentists.** • **Increasing use of virtual wards so that more people can be cared for at home.** • **Faster hospital discharge.** • **Better access to mental health services – more talking therapies and care closer to home.**	• **Improving 111 times and clinical assessment calls.** • **Making the most of our urgent community response service.** • **Bringing together NHS council, and voluntary sector practitioners in teams providing a range of care.**	• **Community health and wellbeing workers in our most disadvantaged communities.** • **The high intensity user service.** • **Community gateway and hubs.** • **Community pharmacies and Pharmacy First.** • **24/7 community mental health facility.**
North & East Priorities:	• **Building specialist services at place** • **Women's Health**		
Improving performance:	• **ED: 83% of attendees seen within 4 hours** • **People with no criteria to reside reduce to 100** • **No one waiting 65+ weeks for planned care**	• **Joint commitment to 5.5% efficiency improvement and key cost reduction by reducing the need for temporary staff**	• **Cancer: 80% seen within 62 days** • **80% for the faster diagnosis standard by March 2025**
Tackling wider determinants of health inequality:	**Working with partners as part of the Working Well pilot to better integrate local employment and health support for disabled people and people with health conditions to start, stay and succeed in work.**		

Whilst we have change programmes to deliver the objectives, we are also asking all existing services to consider how they can optimise care for the people who are our priorities for 2024/25.

Cornwall and Isles of Scilly Integrated Care System

Why this is important

If we don't deliver on these priorities, we will see:

- higher attendance to our hospitals and emergency department
- which adds pressure to our hospitals
- which drives costs in escalation beds and agency cover
- which puts pressure on staff, reduces productivity and wellbeing
- which means people are waiting longer for their treatment
- hospital attendance itself can have negative health and wellbeing impacts
- which creates major cost pressures in budgets
- which stops us being able to invest in the upstream preventive agenda and in areas of health inequity which is key to stemming demand and keeping people healthier for longer

Getting ready for winter

Prevention

- Prioritising vaccination uptake – Flu, Covid, RSV especially in areas of deprivation/greatest ED attendance and admission rates
- Maximising community and voluntary sector capacity and hubs
- Identifying people with hypertension
- Identify people most at risk of admission and proactive care planning by GPs/Integrated Neighbourhood Teams

Admission avoidance

- Securing X-ray car provision
- Optimising access to Virtual Wards – behind the scenes work to enable Cornwall staff access to Derriford blood results

Step down capacity

- Optimising capacity in commissioned home reablement services – Home First, STEPS, CHAOS, Humans and Age UK. Filling vacancies, discharging from caseload, acting on CLEAR productivity review. STEPS working directly in Derriford to pull people home.
- Optimising provision of long-term home care. This is what most people are waiting for in Liskeard community hospital. Improving discharges out Liskeard (and Launceston) would allow more people to be admitted in for the bed-based reablement.

Acknowledging Your priorities

1. Optimising St Barnabas estate - eg dressings, scans, OP clinics, minor injuries, blood tests reducing need to travel to Derriford where possible.

2. Short-term recovery beds becoming available in the town again, say via a contract with a local care/nursing home provider.

1. Urgent action to improve local NHS dental services

2. Redevelop Saltash Health Centre, including a wider range of NHS primary and community services in a Health & Wellbeing Hub

Want to work with you to ensure the size of Saltash is recognised in service planning and design – given the time, attention and focus it deserves. Opportunity to spread good practice from elsewhere and grow what is available in Saltash – building on what is already good.