SHAPING OUR FUTURE

Cornwall and the Isles of Scilly Health and Social Care Partnership

# Shaping our Future Assurance Report 18/19 Year End Progress Report

**Transformation Board**
**9th May 2019**

# Contents

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# Reflecting on 2018/19

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- Local health and care organisations have made significant progress in working as a cohesive system during 2018/19, enabling us to make real progress in developing our transformation plans whilst improving quality and performance and delivering on our challenging financial plans;
- Our collective efforts in managing winter effectively – for our emergency patients, patients receiving routine care and the wellbeing of our workforce - is testament to our progress in working more effectively as an integrated care system. Significant progress has been made in moving to eliminate 52 week waits and not a single person with an acute mental health condition has had to travel out of county for non specialist inpatient care in 2018/19;
- Over the last six months, we have also been successful in securing significant external system funds to support us in delivering on our ambitions on the back of credible and joined up system plans (c£40m capital for Treliske and West Cornwall Hospital, and £4m of digital funds over next 3 years to underpin our transformation plans);
- The progress we have made together has provided a strong platform on which to continue our improvement journey. To this end, we have developed a cohesive system operational plan for 2019/20, aligned with social care, and underpinned by a single set of system strategic objectives. This system plan tackles our quality, operational and financial performance in collaboration whilst taking significant steps forward in our transformation plans, moving towards a place based model of care. The system plan is aligned with the 'nesting' organisational operational plans, whilst also representing more than the sums of its interconnecting parts;
- This report focuses on the progress made in regard to our agreed system priorities in 2018/19. Our approach in 2019/20 will be informed by the following reflections on 2018/19:
    - Unsurprisingly, where sufficient and dedicated capacity has been secured, delivery of prioritised work streams has moved at pace. Conversely, some projects have made little progress due to lack of identified capacity and/or an unclear or poorly communicated mandate for those in assumed lead roles;
    - There has been some evidence of programme/project creep, with the focus on agreed system priorities often diluted as a result. Governance and transparency in this regard will need to be strengthened moving forward.
    - Whilst initial nervousness about the gateway process, in most cases there has been very constructive engagement and a strengthening of proposals as a result. Clinical engagement in the process has been particularly beneficial.
    - It has often been difficult to quantify the impact of schemes in 18/19, and therefore considerable effort is being focused at present to developing credible and clear PIDs with clear milestones and benefits to be realised.
- Overall 2018/19 has seen a maturing of our system working, as recently recognised by regional and national colleagues from NHSE/I, and we have strong foundations on which to build in 2019/20.

# Status as at March 2019

## *SoF projects summary overview*

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| Programme | Project | System Lead | SRO | RAG | | |
|---|---|---|---|---|---|---|
| | | | | Jan | Feb | Mar |
| Integrated Community Services (Model of Care) | Urgent & Emergency Care | Jackie Pendleton & Helen Charlesworth-May | Tryphaena Doyle | | | |
| | Improving Access to General Practice | | | | | |
| | Rehabilitation, Reablement & Recovery | | | | | |
| | Multi-agency Multi-disciplinary-team meetings | | | | | |
| | Integrated Care Teams | | | | | |
| | Personalised Care/Shared Digital Care Plan/End of Life Register | | | | | |
| | Single Point of Access | | | | | |
| | Rapid Frailty Response | | | | | |
| | Self-management | | | | | |
| | Healthy Weight | | | | | |
| | Social Prescribing | | | | | |
| | Isles of Scilly Health and Social Care Integration | | | | | |
| | Integrated Care Area Plans (linked to 19/20 system plan development) | | | | | |
| | Suicide Prevention | | | | | |
| | High Intensity User project | | | | | |
| | Integrated community services in Penwith/Edward Hain community hospital engagement | | | | | |
| | Integrated community services in Fowey/Fowey community hospital engagement | | | | | |
| | Integrated community services Saltash/St Barnabas community hospital engagement | | | | | |
| Planned Care | MSK (Hip & Knee implementation) pathway | Phil Confue | Ethna McCarthy | | | |
| | Cardiovascular Disease pathway | | | | | |
| | Respiratory pathway | | | not previously reported | | |
| | Cancer pathway | | | | | |
| | Falls and Fragility Fractures pathway | | | | | |
| | Outpatients Programme | | | | | |
| Complex Patients | Complex Patients/Medically Unexplained Symptoms (MUS) | Jackie Pendleton | Tim Francis | | | |
| Integrated Care System | ISC Mobilisation | Kate Kennally | Helen Childs | | project closed | |
| | ICP Mobilisation | Phil Confue (interim) | Tracey Lee | | | |
| | Enabling Services review | Phil Confue | Karl Simkins | no current rating | no current rating | |
| Workforce | | Phil Confue | Adrienne Murphy | | | |
| Estates | | Jackie Pendleton | Karl Simkins | | | |
| Digital | | Kate Kennally | Dave Thompson | | | |

# Integrated Community Services

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## Integrated Community Services

### Key achievements in 18/19

- Urgent Care Strategy produced outlining vision for three Urgent Treatment Centres in Penzance, Truro, Bodmin
  - West Cornwall Hospital Urgent Treatment Centre (UTC): the next phase of the project is to test the 111 Direct Booking technical solution, the roll out of this will be monitored closely to see the impact these slots have on the department.
  - Truro – will be fully designated as a UTC by December 2019. Estates work undertaken to stream patients into the Urgent Treatment Centre.
  - Bodmin – Announced as the site for the third UTC in October 2018, work currently underway to work with local stakeholders to draft the project plan.
- Improving Access to General Practice - different models have been tested in different places. 100% population coverage and 30 minutes per 1,000 population achieved.
- Rehabilitation, Reablement and Recovery - learning has informed the need for a system-wide diagnostic of these services now planned for 2019/20
- Multi-agency Multi-disciplinary-team meetings - different models have been tested in different places with better oversight and co-ordination than before.
- Integrated Care Teams strategy produced which broadly anticipated requirements of Long Term Plan and Primary Care Networks.
- Personalised Care Record - progress has been made in developing a business case for a personal care record
- Single Point of Access - different models have been tested in different places with better oversight and co-ordination than before
- Rapid Frailty Response test and learn pilot established in Penwith.
- Self-management strategy produced.
- Healthy weight strategy produced.
- Social Prescribing scheme launched: 29 GP practices now covered providing good foundation for further implementation aligned with primary care networks.
- Isles of Scilly Health and Social Care Integration - outline business case will be completed in May to support delivery of new model of integrated care (see separate Transformation Board assurance paper)
- Integrated Care Area Plans- each area has emerging leadership team and groups with locally determined priorities which are reflected in 2019/20 system operational plan
- Suicide Prevention - project manager appointed and range of projects started.
- High Intensity Users - new service started ahead of national requirements. Most frequent callers to SWASFT have been removed from list.

### Integrated Community Services and Community Hospital Engagement

- Three separate but linked multi-agency project groups established. Completion of various data set analyses, public health profiles and case for change documents developed in each area with local communities. Completion of NHSE stage one assurance and strategic sense check meeting in January. Agreed methodology for engagement (and consultation if required), and process for co-developing options and evaluation criteria in place. Regular updates provided to key stakeholders. First formal engagement workshop held to commence design of community model of care and what potential options that creates for the future of the local community hospitals.

# Integrated Community Services (continued)

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## North & East Integrated Care Area

**Improved primary care access using community pharmacy capacity** – Saltash practices and the 100 hour community pharmacies have worked together to scope providing improved access appointments through a local community pharmacy. Clinicians have met to agree process and discuss clinical conditions to be managed through the service. Plan is to commence appointments in July 19. Patients will benefit from additional appointments that are available during weekday evenings and weekends
**Primary care network** (PCN) – GP practices on track to identify PCN footprints by national deadlines
**Transformation funding** – practices in the North and East are now submitting applications in the locality for transformation funding with a number of innovative projects including **group respiratory clinics** which will increase peer patient support and reduce practice workload, a **teledermatology pilot** in the East which will reduce unnecessary patient trips to appointments and improve diagnosis and treatment.
**Multi agency working framework** – many practices have now signed up to greater integrated team working through their locality framework, this will see an increase in MDT approach with adult social care, community teams and voluntary sector.

## Central Integrated Care Area

Momentum is growing in Central Cornwall to harness community resources. The **Social Prescribing Project** covers three sites in Central Cornwall – Newquay, Truro and St Austell. GPs are reporting case studies showing the benefit to patients and practices. The Feock Community Connect project is going from strength to strength - supporting over 40 patients and engaging with numerous activity groups in the area to help them establish and thrive. Funding has been secured to expand provision to cover the rest of the Coastal cluster. A new social prescribing services provided by Pluss has just started in the four Falmouth and Penryn practices. A **Connecting Lives Home Visiting** service has also commenced in Falmouth, supporting people whose mental health is being impacted by loneliness and isolation. Practice Patient Participation Groups are getting involved to support this momentum, working with Volunteer Cornwall Community Makers to organise Community Events to raise awareness of what' is out there.

Another area of focus for Central Cornwall is Multi Disciplinary Teams – with all partners starting to articulate a shared vision for community services and a commitment to resourcing and empowering teams within local working units. Some new project management resource has started in Carrick to support team development and working arrangements. Planning is underway to run staff workshops to strengthen working relationships. St Austell have employed a Community Psychiatric Nurse, which is releasing GP capacity.

Mid Cornwall have established the Bloom project, providing an in reach children's support service.

Restormel are pulling together a meeting to close the gaps around frail patients. Looking at using community resources from GPs, Acute Care At Home, Home First, therapies and bed managers more cohesively to keep people at home when it is safe to do so. The first workshop took place in April to look at supporting their most vulnerable residents and seeing how they can "do things differently" to achieve their aspirations and ensure they remain well.

# Integrated Community Services (continued)

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## Integrated Community Services - continued

### West Integrated Care Area

***Model of care workshops*** Working with town and parish councils, lay representatives, voluntary sector as well as health and social care, these workshops are underway across the West and are identifying practical ways to support place-based working.
***Primary Care Networks*** Across the West, localities have been used to working together at scale and there are already established Primary Care Homes, which are a type of Primary Care Network. These existing relationships, as well as the Model of Care workshops, are an important foundation for building on, as Networks are formally registered from July this year.
***Edward Hain Winter Pilot:*** The pilot running from January and which gives older people access to rehabilitation and social interaction has been extended until the end of June..
***West Cornwall Hospital frailty clinic:*** After a slow start, the service is seeing and helping more people. For example, access to a same day CT scan can allow the early detection of tumours allowing the initiation of early treatment
***Isles of Scilly Health and Social Care Integration:*** See separate assurance report..

# Pathways

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**Key achievements in 2018/19**
- Pathways programme successful in development of cross system working;
- Right care methodology has identified short, mid and longer term actions;
- Secured support from NHSE to inform recent respiratory work.

**MSK pathway**
- Overall clinical lead and clinical delivery team including project management and IT in place;
- Piloted the MDT for hips;
- MSK website first version on line;
- 30 CFT physios trained in ESCAPE-pain in April 2018 and have implemented 3 patient cohorts;
- Benefits will be realised but over longer timescale.

**Cardiovascular Disease (including cardiology)**
- Cardiovascular Disease Risk Factors group in place;
- Cardiovascular Disease Risk Factor management in primary care business case supported by Planned Care Board.

**Respiratory**
- Initial workshops held and respiratory clinical team in place.

**Falls and fragility fractures**
- Workshop focus on Falls prevention using existing resources better
- A case developed, which identifies differing options – now under further review,

Pathways governance model is under review – duplicates Clinical Practitioner Cabinet

# Outpatients

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## Achievements in 2018/19

- Strategy for Outpatients Transformation Programme developed with three work streams in July 2018 and it now an integral part of the Planned Care Programme;
- The programme has secured broad clinical leadership, and engaged with key stakeholders;
- A number of initiatives have been developed with the expected impact of 5,500 fewer referrals and 5,400 fewer follow up appointments by the end of 2019/20
- Guideline reviews with Specialist Consultants completed for Respiratory, Dermatology, Cardiology, Ophthalmology, Pain Management and Breast Surgery;
- Practice Visits completed where variations in referrals have been identified, providing information and guidance;
- Pathway re-design completed for a fibromyalgia programme (Pain Management and Rheumatology guidance), a Calprotectin programme across CIoS and a full review of Respiratory and Neurology pathways;
- Twelve services within RCHT engaged, applying best practice for reducing waiting lists and improving quality of care;
- Supported RCHT in the establishment of a focused programme to tackle compliance, productivity and plans for system wide transformation;
- Projects including Minor Eye Condition Service and the Calprotectin programme have been developed and due to be implemented in Q1/2 of 2019/20 moving care closer to the patient, reducing unnecessary surgical procedures and creating capacity;
- Funding secured for the development and implementation of a video consultation system within RCHT;
- Services suitable for Patient Initiated Follow Ups have been identified, with Clinical Haematology due to be the first to implemented;
- Completed a review on the care of complex and frail patients and how their outpatient experience can be more efficient and care given closer to home. Key findings and proposals will now be shared with localities;
- Completed a review of consultant to consultant referrals after it was identified that numbers were increasing. Key findings and next steps will be shared with RCHT in order to inform policy change;
- The development of a new community Fibromyalgia enablement test and learn programme was completed in Q4, with the first patients to be seen in June 2019;
- 2019/20 planning objectives have been established with a target mid to long term to reduce new referrals by 15% and a 15% reduction in follow up appointments.

# Integrated Care System mobilisation

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**Key achievements in 2018/19**

**Integrated Care Partnership mobilised with focus on following:**

- Supporting development of three integrated care areas, delivering integrated care models closer to home, focusing on self-care and prevention and reducing our reliance on bed based care;
- Developing a system view of financial and quality performance, working together to drive improvement priorities and delivery of the three year financial plan.
- Commencing work on shared enabling services work with prioritised work streams.

**Maturing system leadership and governance:**

- Distributed system leadership model in place, with system leadership roles facilitating 'system first' culture;
- Number of system focussed roles and reciprocal arrangements increasing;
- Leadership arrangements for the three Integrated Care Areas being established;
- Ambition to be politically and clinically led, expertly managed;
- System priorities and prioritised leadership actions agreed;
- Framework of system governance established, including:
    - System Health and Care Leadership Board (Chairs and Chief Officers)
    - Quarterly SoF Leadership Forum (Board/Cabinet members/ICA leads)
    - System strategic objectives for 2019/20 informing system operational plan

**Update for March 2019**

- Cohesive system operational plan developed for 2019/20, shaped by strategic commissioning priorities, aligned with social care and underpinned by a single set of system strategic objectives adopted by all key partners.
- Independent chair recruitment about to commence.
- System governance arrangements have been refreshed for 2019/20, and embedded through the four system boards: the Planned Care Board, the A&E Delivery Board, the Integrated Community Services Design Board and the One Vision Board. The critical role of the Integrated Care Areas in both planning and delivery is reflected and embedded within the system governance arrangements.
- Adam Sewell-Jones, Interim Regional Director and Ned Naylor, Deputy Director, Primary Care and System Transformation, NHS England/Improvement, undertook a two day visit to the local health and care system across Cornwall in April. They met with senior leaders, local councillors and clinicians and were very positive about our evident progress in working as a cohesive system during 2018/19. Next steps in our development journey towards becoming a fully fledged Integrated Care System were discussed, and are being taken forward with active regulator support.
- Work is now commencing collaboratively on the development of the Long Term Plan, to be shaped by a refreshed Health and Wellbeing Strategy.

# Integrated Care System mobilisation

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## Integrated Strategic Commissioning – project closure

- The Integrated Strategic Commissioning Steering Group agreed on 25th February that the development of integrated strategic commissioning should be delivered through existing mechanisms, and that the current project should close;
- The next step is to take the proposal to the System Health and Care Leaders Board and then to ensure broader governance requirements are met;
- A Joint Councillor and CCG Governing Body development session took place on 9th April, supported by the national and regional NHSE/I teams, to review progress to date, and agree next steps in the context of the Long Term Plan and local aspirations. This will help shape the ICS readiness programme going forward;
- A key deliverable will be the development of a ten year Health and Wellbeing Strategy, which will provide the opportunity to take a longer term perspective on the key actions required to improve the health and wellbeing of the population and reduce health inequalities. The strategy will identify key priorities to bring about improvements in health and wellbeing across Cornwall and the Isles of Scilly and will link across to various key existing, and emerging strategies such as housing, economy, climate change, etc. It will also help shape and guide the NHS long term plan, and in turn will inform the key commissioning intentions of system partners.

# Enabling Services and Estates Strategy

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## Enabling Services

**Key achievements in 2018/19**

- Business case supported for integrated back office services

**March 2019 update**

- Enabling Services Programme terms of reference agreed;
- Programme human resources support agreed;
- Priority service areas for review identified and agreed;
- Enabling Services Programme governance arrangements developed and agreed;
- A programme timeline and resource plan remains to be agreed including any specialist resources that will be required

## Estates Strategy

**Key achievements in 2018-19**

- The Shaping Our Future Estates Group and system programme is well established and operating as a Programme Board;
- The programme of projects has been prioritised against STP Critical Success Factors which has enabled submission of two successful STP Wave 4 capital bids for c£40m;
- The draft estates strategy has been rated as 'good'.

**March 2019 update**

- During April appointment of dedicated Cornwall & IoS Strategic Estates Advisor finalised;
- Updated programme of work for 19-20 approved by Strategic Estates Group including:
    - Development of primary care estates strategy;
    - Formalisation of arrangements for 106/Community Infrastructure Levy planning gain optimisation role
    - Monitoring the 2 successful Wave 4 STP bid projects
    - Capacity to support development of Isles of Scilly care integration business case

# Digital and Communications and Engagement

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## Digital

**Key achievements in 2018/19**

- Successfully bid into the £4.2m central NHSE funding for Digital Programmes of work across the NHS within Cornwall. This has resulted in an investment of £1m for 2018/19 for RCHT to implement their Nerve Centre and Flow IT solutions. Further bids against this funding will be submitted to NHSE by the end of Q1 19/20.
- Cornwall and Isles of Scilly, along with five other STP areas across the South West. were successful in gaining wave 2 LHCR status. Business case under development to implement a "Shared Care Record" solution linking IT systems up across the whole of the South West. Once implemented, the solution will allow front line clinicians and other Health and Care Staff access to a single joined up view of patient and client information;
- Draft system digital strategy developed, with agreement on system strategic priorities;
- 'NHS app' now 'live';
- The specialist new self-care application called 'myCOPD', funded by NHS England's Innovation and Technology Tariff, has been rolled out to support people with chronic obstructive pulmonary disease in the east of the county.

## Communications and Engagement

- All partner communications and engagement teams have been increasingly working cohesively, with less duplication, and more sharing, of effort and resources with regular contact. A natural progression has been to look to creating a single NHS system-wide communication and engagement team and work has begun on developing that structure as part of the enabling services.
- Engagement activity has focussed on the Community Services Reviews happening in Penwith, Fowey and Saltash with other plans being worked on concerning Planned Care including out-patients, Urgent and Emergency Care, the Long Term Plan and Health and Wellbeing Board strategy, the emerging work being carried out by the Peninsula Clinical Services Strategy into hospital based clinical services and many other smaller campaigns of engagement with key stakeholders and the community about initiatives or minor changes in service. SoF Communications and Engagement are looking forward to working with Healthwatch with their Citizens Panel and with the Citizens Advisory Panel on developing and exploring new ways to engage further and more widely with the county's communities.
- Two professionally produced films have been made for RCHT and CFT showcasing their work and workforce. A third film, combining footage from both is in production to show partner working in the STP.
- From Crisis to Cure was a 12-part weekly written feature running in all local print media before being published as a 16 page free newspaper that has been distributed widely in the county. While this was mainly about RCHT, the importance of SoF and the STP work was included at every opportunity. A second System-wide 16 page newspaper is being produced explaining STP work, challenges and successes to date.

# Workforce

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**Key achievements in 2018/19**

- Development and publication of a System Workforce Transformation Vision document for the health and care system (published Sept 2018), Update report to be developed early 19/20. Opportunity to pursue new roles and new ways of working, for example, Clinical Associate Psychologists, Community Social Prescribing Link Workers, Apprenticeship opportunities.
- On-going development of a system development (Organisational Development) plan
- Increasing the spread of multi disciplinary meetings - focusing on activity at GP cluster level across the county
- Volunteer Cornwall - expansion from three to six community based Community Makers – supporting the identification and growth of social capital.
- Health and Social Care Skills Academy system sign up and scope being developed
- Workforce Transformation Clinical Leads – chairing area based multi-agency leadership forums - embedding a collaborative leadership approach to place based care at an area level.
- Workforce Transformation – staff based co-design (including Integration Sprints) - Countywide provision of multi-agency workshops focusing on system requirements to provide a person centred model of care. Workshops focus on skills required to meet the needs of the area. Workshops provide opportunities for establishing trust and forging professional relationships outside of organisational boundaries. This will enable our workforce plans to articulate our strength based assets.
- Institute of Health Improvement Quality Improvement – Patient Safety Kernow Quality Improvement (PSKQI) - Countywide collaborative designed to embed a single quality improvement methodology using the Institute of Health Improvement in partnership with the Academic Health Science Network
- Clinical Leadership (Kings Fund) - System wide programme providing system leadership skills and application to 24 multi-agency leaders
- Strategic System Leadership Programme (in partnership with Yale University) - Medical Director (CFT), Medical Director (St Austell Healthcare) and Chief Executive (Volunteer Cornwall) applied and were selected to be one of the ten places offered to all 44 STPs.. Opportunity for Cornwall's High Intensity User project to be developed using international expertise through this strategic system leadership programme.
- Staff at NHS Kernow are happy and feel supported to improve health services in Cornwall and the Isles of Scilly – the best staff survey results in four years.

# Workforce (continued)

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**March 2019 update**

- Penwith Model of Care Workshops supported
- Isles of Scilly integration workshops supported
- Commencing collation of system workforce data (March 2019) to support area profiling and feed into system workforce document update report
- Liaison with Kings Fund regarding Phase 2 of the leadership programme
- Planning for High Intensity User workshop (St Austell April 2019)
- Workforce leads identified for each of the system programmes
- Cornwall Council was shortlisted by the Local Government Chronicle in November 2018 for the following awards:
  - · 'Council of the Year' category
  - · 'Children's Services' category for Gweres Tus Yowynk (Helping Young People)
  - · 'Best Service Delivery Model' category for Leaving Care Service (16+): joint submission between Children's Services and Carefree
  - · 'Public/Private Partnerships' category for the Winter Wellbeing Partnership - Inclusion Cornwall
- RCHT was shortlisted in several national awards:
  - Health Service Journal Patient Safety Awards - two nominations for Pharmacy Teams
  - British Medical Journal – Epilepsy Team
  - Royal College of Nursing (RCNi) Awards – Colorectal Cancer 2 Week Wait Team; Student Nursing Times Awards – Phoenix Ward
- RCHT won the Paediatric team at the Patient Experience Network National Awards, recognising their work engaging young patients in improving care and services.
- Two other RCHT finalists came from the Specialist Palliative Care and End of Life Team for its Butterfly Cornwall scheme, which was shortlisted in the Support for Caregivers, Friends and Family category and the Bowel Cancer Team shortlisted in the Team of the Year Award for its two week wait service.
- Cornwall Partnership NHS Foundation Trust (CFT) has been shortlisted for four Health Service Journal awards.
  - twice for the 'Workforce Efficiency Award' for the development of its psychological workforce and transformation integration sprints
  - once for the 'Communication Initiative Award' for addressing mental health stigma in the community
  - once for the 'Mental Health Services Award' for its pioneering work with Clinical Associate Psychologists and transforming child and adolescent mental health services in Cornish secondary schools.
- SUDEP (Sudden Unexpected Death in Epilepsy) Action and its partnership of researchers and clinicians, have been shortlisted for the Education Team of the Year at this year's British Medical Journal Awards 2019.- recognising the success of two epilepsy safety tools; the digital app EpSMon, and the clinician tool, the SUDEP and Seizure Safety Checklist

# Devolution and Programme Management Office

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## Devolution

**Key achievements in 2018/19**

- Health and Social Care asks set out in New Frontiers building on success to date including improving 528 fuel poverty homes
- Phased approach to primary care commissioning delegation underway

## Programme Management Office (PMO)

**Key achievements in 2018/19**

- A Change Delivery Framework has been developed and endorsed by system leaders
- Work commenced with organisational PMOs to align processes and enable oversight of all relevant significant and aligned programmes of work.
- Programme Leads developed plans for years 4 and 5 of SoF and quantified the benefits that are to be realised. The ICP Mobilisation Group considered the contribution of SoF and other system change programmes and assessed this against achievement of the quadruple aim. This work then formed an integral part of the system planning for 2019/20 coordinated by the PMO
- The Outpatient Programme, the Cardiovascular Disease and Falls/Fragility Fractures projects all undertook positive gateway one reviews. A gateway one review for Frailty was held resulting in a lead for frailty being appointed to further develop this work.
- NHSE agreed to provide senior support to progress the development of a System Assurance Group, and the System Oversight Group is now in transition to support genuine system regulation.
- The benefits realisations framework was developed identifying the specific outcomes expected of work streams determined and then validated through the gateway process.
- With the involvement of system executive teams a set of system objectives based on the quadruple aim were agreed.

**March 2019 update**

- Discussions are taking place with regard to the evolving system support needs as we move into 2019/20, and the implications for the way in which the system is best supported.
- The PMO has overseen the 2019/20 operational planning round resulting the successful completion of the NHSE/I submission requirements

# Exception report
## *Amber and Red projects*

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| Project | RAG | Summary | Path to green |
|---|---|---|---|
| **Complex Patients/MUS** | | Lead for this programme not identified. Capacity offered by Public Health not optimised via ICS programme. | Approach now is to ensure the needs of patients with MUS are considered as an integral element of relevant pathways, e.g. neuro, gynaecology, gastroenterology, pain management. |
| **Self Management** | | Approach proposed but project lead has not been in place since September 2018.<br>No update since December 2018 | No update |
| **Shared Digital Care Plan and End of Life register** | | Insufficient funding for solution rollout | Finalise/sign the 12 month Memorandum of Understanding between Kernow Health CIC and NHS Kernow. Start contract negotiation discussions and joint working to produce a draft outline and full business case ready to be submitted at various system-wide transformation boards for adoption across all systems. |
| **Musculoskeletal pathway** | | Business case identified that benefits will be delivered in 2018/19, however due to delays in the project, benefits will not be delivered until 2019/20 | Clear leadership from CFT within system context<br>Refresh meeting held on the 11th April and follow up meeting arranged for 9th May<br>Benefits and recovery plan to be developed in line with revised delivery dates |
| **Falls and Fragility Fractures pathway** | | Business case highlighted financial investments were required to develop the existing services to support people and prevent falls<br>Funding not available to support investments and so expansion of services to prevent falls will not be delivered | Working with RCHT Care Group managers and CFT to identify if services/ falls prevention requirements can be expanded through existing resources<br>Community actions to be aligned with wider resources e.g. social prescribing |
| **Integrated Care System Mobilisation** | | Clear work plan to secure ICS status by 2020 to be developed, with input from regulators | Development of readiness assessment plan to be developed and discussed at STP stocktake meeting June 2019<br>Recruitment of independent chair in Q1 2019/20<br>Accountability framework in development |
| **Digital** | | SoF Digital Lead full time secondment finishes at the end of March 2019.<br>SW AHSN commitment to 3 days per week going forward. | Consideration / decision to be made as to whether to appoint a full time Digital Lead. |

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# Appendix 1

## 2018/19 System Financial Position Update

# 18/19 Financial Position Update

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## System Summary 2018/19 Forecast Outturn (NHS draft accounts position)

- The system forecast outturn at end of March 2019 (draft year end position) is a surplus of c£1.7m including NHS sustainability funding of £38.8m (NHS £1.9m surplus, Council adult social care £0.2m net deficit);
- The Cornwall health system has a c£1.9m surplus compared to a planned deficit of c£9.2m, a positive variance of £11.1m;
- Within this position, notified 'incentive' national sustainability and transformation funding improved the CIoS providers position by £9.2m (RCHT £6.7m, CFT £2.4m);
- Excluding CSF/PSF funding the draft year end position for the NHS is a deficit of c£36.8m compared to plan deficit of £38.8m (an improvement of £2m);
- The Council (adult social care and public health) is reporting a net deficit year end position of £0.16m overspend within Cornwall Council financial position (*draft outturn, subject to agreement by Cabinet members, before final outturn is agreed and published*);
- The NHS position is based upon latest draft accounts return submission of 23rd April 2019. Final positions remain subject to full external audit review.

***Excluding CSF/PSF funding***

| 18-19 FOT | Kernow CCG £m | RCHT £m | CFT £m | NHS Total £m | Council (ASC + PH) £m | Total £m |
|---|---|---|---|---|---|---|
| ***Plan surplus / (deficit) Pre-CSF/PSF*** | (20.0) | (20.8) | 1.9 | (38.8) | 0.0 | (38.8) |
| ***Current forecast*** | (20.0) | (19.8) | 2.9 | (36.8) | (0.2) | (37.0) |
| **Variance to Plan Pre-CSF/PSF** | 0.0 | 1.0 | 1.0 | 2.0 | (0.2) | 1.8 |

***Including CSF/PSF funding***

| 18-19 FOT | Kernow CCG £m | RCHT £m | CFT £m | NHS Total £m | Council (ASC + PH) £m | Total £m |
|---|---|---|---|---|---|---|
| ***Plan surplus / (deficit) Pre-CSF/PSF*** | (20.0) | (20.8) | 1.9 | (38.8) | 0.0 | (38.8) |
| ***STF financial plan funding (CSF/PSF)*** | 20.0 | 8.9 | 0.7 | 29.6 | | 29.6 |
| ***Plan surplus / (deficit) Post-CSF/PSF*** | 0.0 | (11.9) | 2.7 | (9.2) | 0.0 | (9.2) |
| ***Current forecast*** | (20.0) | (19.8) | 2.9 | (36.8) | (0.2) | (37.0) |
| ***NHS STP financial performance funding*** | 20.0 | 15.6 | 3.2 | 38.8 | | 38.8 |
| **Net I&E surplus / (deficit) Post-CSF/PSF** | 0.0 | (4.1) | 6.1 | 1.9 | (0.2) | 1.7 |
| **Variance to Plan Post-CSF/PSF** | 0.0 | 7.7 | 3.4 | 11.1 | (0.2) | 10.9 |

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# Appendix 2

## 2018/19 System Operational Performance Update

# Executive Summary

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| Area | Key points: 18/19 Benchmark Performance to latest available (m11-12) |
|---|---|
| | • The purpose of the dashboard is to provide the most recently updated benchmarked system level data on a range of key metrics, including key metrics across health and social care (including wider than Cornwall providers). It should be noted more up to date organisational level data is available through organisational performance reports for some indicators. The most recent data has been provided which can vary by indicator.<br>• Local trajectories have been included where applicable. The inclusion of trend lines for an indicator should not always be taken to indicate genuine change as indicator performance will vary with common cause variation. |
| Overall | • Of the 42 RAG rated indicators, 19 are red for the most recent month (17 for YTD), 10 amber (13) and 13 green (12).<br>• In year trends this year include a worsening in stroke pathway, cancer 2ww, safety thermometer and the proportion of LD service users supported in their own homes, whilst RTT long waiters, older adults supported at home and GP out of hours coverage have improved during the year. |
| Emergency care | • Winter 2018/19 A&E 4hr performance was better than last year but remained below the national averages.<br>• Emergency presentations are higher than planned. This pattern has continued throughout the year to date.<br>• Delayed transfers have remained higher than the national average and local trajectory, and closely matched 17-18 levels for the second half of the year having been lower in the first half. |
| Planned care | • For both RTT 18w pathways and cancelled operations rebooking standards, performance is better than 2017/18 but remains below the national average. The reduction in patients waiting over 52ww was met.<br>• The proportion of patients whose care meets the 2ww pathway standards has reduced during Q4 with the breast pathway issues at RCHT (expected to recover Q2 2019/20). |
| Mental health and community | • The IAPT recovery rate has worsened and is now below the national standard.<br>• The dementia diagnosis rate has slightly improved but remains below the national average.<br>• The FFT response and recommended rate in mental health services both remain low.<br>• However, performance against the Early Intervention in Psychosis standard remains strong. |
| Social care | • The proportion of older adults supported at home 91 days post discharge has improved during the year.<br>• The proportion of LD service users supported in their own homes has worsened and is below standard. |

# 2018/19 vs 2017/18 trends

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**Comparative national position**

**YOY Direction of travel - 18/19 vs 17/18**

| | Worse than average | Around average/ not known | Better than average |
|---|---|---|---|
| **Worse** | 1. Safety thermometer harm free<br>2. SHMI (at UHP)<br>3. Cancer 2ww<br>4. ED unplanned reattendances<br>5. Dementia diagnosis<br>6. Safety thermometer - catheters with UTI | 1. Emergency presentations<br>2. Cancer 62 day pathways<br>3. IAPT recovery rate<br>4. Adults with LD living in own home/ with family<br>5. Safety thermometer – pressure ulcers | 1. Emergency readmissions<br>2. 111 A&E referrals |
| **Similar** | 1. 6w diagnostics<br>2. Stroke 90% on stroke unit<br>3. FFT – MH Response rate<br>4. FFT – MH Recommended rate | 1. 111 Ambulance referrals<br>2. FFT – Community Response rate<br>3. Residential/ nursing home admissions | 1. FFT - Inpatient Response and Recommended Rates<br>2. FFT – Maternity Response Rate and Recommended Rates<br>3. FFT – ED recommended rate<br>4. FFT – Community Recommended rate<br>5. Safety thermometer – falls with harm |
| **Improved** | 1. Ambulance response times<br>2. ED 4 hour performance – Type 1 and all type<br>3. DTOCs (overall and social care)<br>4. FFT – ED response rate<br>5. RTT 18 week<br>6. 28 day cancelled operations breaches | 1. RTT 52 week waits<br>2. C Difficile<br>3. Superstranded patients<br>4. GP population coverage<br>5. Older people in own homes 91 days after discharge into rehabilitation | 1. EIP seen within 2 weeks |

# Shaping our future – acute scorecard

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Cornwall and the Isles of Scilly Health and Social Care Partnership

| Metric | National Target | Local Target (latest month) | Apr-18 | May-18 | Jun-18 | Jul-18 | Aug-18 | Sep-18 | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 | YTD |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ED 4 hour target (All Depts) | 95.00% | 83.75% | 90.43% | 92.07% | 92.10% | 89.23% | 88.52% | 86.02% | 87.31% | 87.42% | 86.00% | 82.78% | 82.61% | 85.55% | 87.73% |
| ED 4 hour target ( Type 1 ED Depts only) | 95.00% | 68.26% | 81.25% | 83.91% | 83.65% | 78.17% | 76.27% | 72.77% | 75.10% | 76.02% | 80.78% | 67.50% | 67.30% | 72.39% | 76.31% |
| Total Cornish emergency presentations to hospitals compared with last year (ie ED attenders + emergency admissions) | | 9477.06 | 10700 | 11470 | 11124 | 11282 | 10474 | 10661 | 10975 | 10918 | 10986 | 10983 | 10308 | Information in arrears | 10898 |
| DTOCS Days per 100k Population | 417.00 | 174.68 | 540.00 | 395.17 | 458.60 | 542.96 | 592.44 | 624.79 | 709.57 | 567.49 | 560.72 | 519.70 | 517.17 | 570.02 | 549.89 |
| ED Re-Attendance Rate | 8.45% | 4.82% | 8.05% | 9.67% | 8.92% | 8.28% | 9.40% | 10.19% | 9.68% | 10.06% | 9.71% | 10.29% | 10.25% | Information in arrears | 9.56% |
| 30 Day PbR Emergency Readmission Rate | 7.47% | 6.34% | 6.70% | 7.03% | 7.06% | 6.62% | 7.13% | 6.88% | 6.81% | 6.38% | 7.09% | Information in arrears | Information in arrears | Information in arrears | 6.85% |
| Friends & Family Test - A&E Response Rate | 12.70% | 12.81% | 9.37% | 9.00% | 9.08% | 6.69% | 6.53% | 5.24% | 8.53% | 7.92% | 9.23% | 8.24% | 10.81% | Information in arrears | 8.21% |
| Friends & Family Test - A&E Not Recommended Rate | 7.57% | 0.93% | 0.88% | 0.99% | 1.35% | 0.86% | 1.51% | 1.76% | 1.02% | 0.69% | 0.37% | 1.45% | 2.45% | Information in arrears | 1.21% |
| Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks from referral | 92.00% | 80.70% | 80.12% | 80.55% | 80.74% | 81.95% | 82.15% | 82.29% | 82.98% | 82.95% | 82.67% | 83.21% | 83.21% | Information in arrears | 82.19% |
| Patients waiting for a diagnostic test should have been waiting less than 6 weeks from referral | 99.00% | 97.11% | 91.99% | 91.07% | 88.73% | 87.71% | 89.92% | 93.22% | 94.76% | 93.95% | 91.33% | 93.11% | 95.57% | Information in arrears | 91.89% |
| Max 2 months (62 days) wait from urgent GP referral to first definitive treatment for cancer | 90.00% | 82.43% | 82.63% | 82.88% | 80.77% | 76.75% | 72.40% | 77.03% | 78.11% | 77.83% | 83.03% | 81.90% | 80.11% | Information in arrears | 79.33% |
| Max two week wait for first outpatient appointment for patients referred urgently with suspected cancer by GP | 93.00% | 94.63% | 93.40% | 95.07% | 95.47% | 96.25% | 94.91% | 95.79% | 95.27% | 95.09% | 93.67% | 90.07% | 89.52% | Information in arrears | 94.14% |
| Cancelled Operations 28 day breaches | 10.55 | 21.10 | 54.00 | 29.00 | 24.00 | 29.00 | 52.00 | 55.00 | 46.00 | 21.00 | 41.00 | 58.00 | 43.00 | 28.00 | 40.00 |
| MRSA per 100k Beddays | 4.45 | 1.64 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 3.86 | 0.00 | Information in arrears | 0.35 |
| C Difficile per 100k Beddays | | 24.42 | 30.24 | 24.95 | 8.41 | 27.17 | 16.26 | 8.35 | 11.35 | 19.49 | 7.89 | 14.86 | 7.87 | Information in arrears | 16.08 |
| % of people who spend at least 90% of their time on a stroke unit | 82.00% | 83.80% | 91.38% | 86.62% | 88.06% | 84.14% | 82.47% | 76.52% | 81.75% | 78.45% | 77.87% | 82.86% | 80.73% | 78.99% | 82.61% |
| Summary Hospital-Level Mortality (SHMI) | 1.00 | | 1.03 | 1.03 | 1.03 | 1.03 | 1.03 | 1.03 | Information in arrears | Information in arrears | Information in arrears | Information in arrears | Information in arrears | Information in arrears | 1.03 |
| Superstranded Patients (LOS > 21 days) | | 329.00 | 149.00 | 270.00 | 289.00 | 285.00 | 303.00 | 274.00 | 319.00 | 313.00 | 279.00 | 310.00 | Information in arrears | Information in arrears | 279.10 |
| Friends & Family Test - Inpatients Response Rate | 24.62% | 28.41% | 35.93% | 32.77% | 37.60% | 31.23% | 30.94% | 29.16% | 31.51% | 31.48% | 33.22% | 31.10% | 32.24% | Information in arrears | 32.43% |
| Friends & Family Test - Inpatients Not Recommended Rate | 1.64% | 0.81% | 0.63% | 0.65% | 0.69% | 0.80% | 0.69% | 0.67% | 0.49% | 2.08% | 0.64% | 0.50% | 0.57% | Information in arrears | 0.68% |
| Friends & Family Test - Maternity Response Rate | 20.85% | 25.95% | 29.83% | 26.17% | 28.90% | 18.81% | 28.05% | 22.01% | 27.29% | 26.35% | 22.75% | 29.02% | 26.63% | Information in arrears | 25.99% |
| Friends & Family Test - Maternity Not Recommended Rate | 1.33% | 0.40% | 2.04% | 0.00% | 1.05% | 0.81% | 0.00% | 0.00% | 1.02% | 0.00% | 0.00% | 0.00% | 0.00% | Information in arrears | 0.52% |
| Safety Thermometer - Harm Free % | 93.90% | 95.95% | 95.70% | 94.87% | 95.01% | 94.14% | 94.64% | 91.70% | 94.74% | 94.12% | 91.47% | 91.24% | 93.25% | 93.57% | 93.70% |
| Safety Thermometer - Pressure Ulcers % | 4.58% | 3.28% | 3.42% | 3.60% | 3.98% | 4.63% | 3.60% | 4.90% | 3.67% | 3.72% | 4.11% | 5.94% | 5.41% | 4.87% | 4.32% |
| Safety Thermometer - Falls (with harm) % | 0.49% | 0.28% | 0.36% | 0.31% | 0.55% | 0.39% | 0.29% | 0.35% | 0.43% | 0.67% | 0.30% | 0.49% | 0.42% | 0.42% | 0.42% |
| Safety Thermometer - Catheter UTI (new & old) % | 0.64% | 0.42% | 0.29% | 0.84% | 0.62% | 0.77% | 1.17% | 0.78% | 1.15% | 1.64% | 1.57% | 1.06% | 0.56% | 0.71% | 0.93% |

NHS Constitutional Metric

NHS Constitutional Supporting Metric

# Shaping our future
# Non-acute scorecard

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| Metric | National Target | Local Target (latest month) | Apr-18 | May-18 | Jun-18 | Jul-18 | Aug-18 | Sep-18 | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 | YTD |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| NHS 111 calls resulting in ambulance referrals | 10.00% | 14.40% | 13.40% | 12.79% | 13.44% | 13.43% | 12.22% | 14.14% | 15.97% | 15.58% | 14.13% | 14.82% | 13.37% | 12.32% | 13.75% |
| NHS 111 calls resulting in A&E referrals | 5.00% | 5.52% | 5.58% | 7.12% | 7.33% | 8.40% | 7.08% | 8.01% | 8.08% | 6.75% | 5.96% | 5.92% | 5.19% | 5.01% | 6.67% |
| Ambulance Category 1 Mean Response Time | 00:07:00 | 00:06:48 | 00:10:25 | 00:10:45 | 00:09:53 | 00:08:07 | 00:08:19 | 00:07:41 | 00:07:50 | 00:08:23 | 00:07:27 | 00:07:12 | 00:07:52 | 00:09:00 | 00:08:35 |
| Ambulance Category 1 90th Centile Response Time | 00:15:00 | 00:12:18 | 00:19:26 | 00:20:19 | 00:18:35 | 00:15:02 | 00:16:23 | 00:14:28 | 00:15:02 | 00:15:18 | 00:13:56 | 00:13:08 | 00:14:04 | 00:17:23 | 00:16:05 |
| IAPT: People discharged from services who achieved recovery | 50.00% | 46.47% | 53.86% | 52.64% | 52.04% | 51.31% | 51.71% | 53.14% | 51.49% | 53.65% | 50.09% | 50.35% | 48.90% | 49.57% | 51.56% |
| Dementia diagnosis rate | 66.66% | 55.36% | 52.39% | 52.13% | 51.18% | 50.96% | 51.93% | 51.65% | 51.89% | 52.03% | 52.12% | 52.10% | 52.55% | Information in arrears | 51.79% |
| More than 50% of people experiencing a first episode of psychosis will receive treatment within 2 weeks | 53.00% | 90.70% | 100.00% | 90.91% | 88.89% | 100.00% | 80.00% | 100.00% | 100.00% | 91.67% | 92.31% | 88.89% | 100.00% | 100.00% | 94.39% |
| % population coverage evening and weekend GP appointments | 100.00% | 20.25% | 0.00% | 0.00% | 5.40% | 11.04% | 11.04% | 36.70% | 99.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 55.27% |
| Friends & Family Test - Community Response Rate | 3.62% | 5.36% | 4.41% | 4.40% | 4.61% | 4.73% | 3.44% | 4.13% | 3.95% | 3.27% | 4.51% | 3.27% | 4.00% | Information in arrears | 4.06% |
| Friends & Family Test - Community Not Recommended Rate | 1.55% | 0.87% | 1.04% | 0.64% | 1.21% | 0.99% | 0.74% | 0.75% | 0.51% | 0.95% | 0.73% | 0.65% | 0.86% | Information in arrears | 0.83% |
| Friends & Family Test - Mental Health Response Rate | 2.77% | 1.62% | 1.18% | 1.71% | 0.94% | 1.06% | 1.03% | 1.32% | 0.98% | 1.29% | 2.38% | 0.80% | 1.54% | Information in arrears | 1.27% |
| Friends & Family Test - Mental Health Not Recommended Rate | 4.35% | 4.40% | 6.74% | 6.16% | 13.92% | 7.69% | 3.26% | 4.27% | 6.06% | 6.98% | 5.08% | 3.57% | 5.48% | Information in arrears | 6.07% |
| Social Care DTOCS per 100,00 18+ population | 7.40 | 7.40 | 10.40 | 6.00 | 6.80 | 9.20 | 10.30 | 10.20 | 11.00 | 9.10 | 9.20 | 6.50 | 6.10 | 6.20 | 8.40 |
| The proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services | - | 84% | 86.24% | 88.37% | 80.19% | 76.53% | 77.17% | 85.71% | 90.48% | 96.36% | 96.08% | 93.30% | Information in arrears | Information in arrears | 85.40% |
| Long-term support needs of older adults (65 and over) met by admission to residential and nursing care homes, per 100,000 population | - | 487.00 | 482.10 | 511.31 | 521.52 | 503.69 | 499.32 | 529.17 | 508.06 | 506.60 | 498.60 | 484.80 | 473.10 | 460.70 | 498.30 |
| The proportion of adults with a learning disability who live in their own home or with their family | - | 70% | 79.55% | 80.16% | 79.35% | 78.64% | 77.33% | 75.46% | 74.60% | 74.70% | 72.40% | 70.37% | 68.08% | 69.34% | 75.60% |

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# EMERGENCY ACTIVITY, IN HOSPITAL

# Emergency Activity, In Hospital

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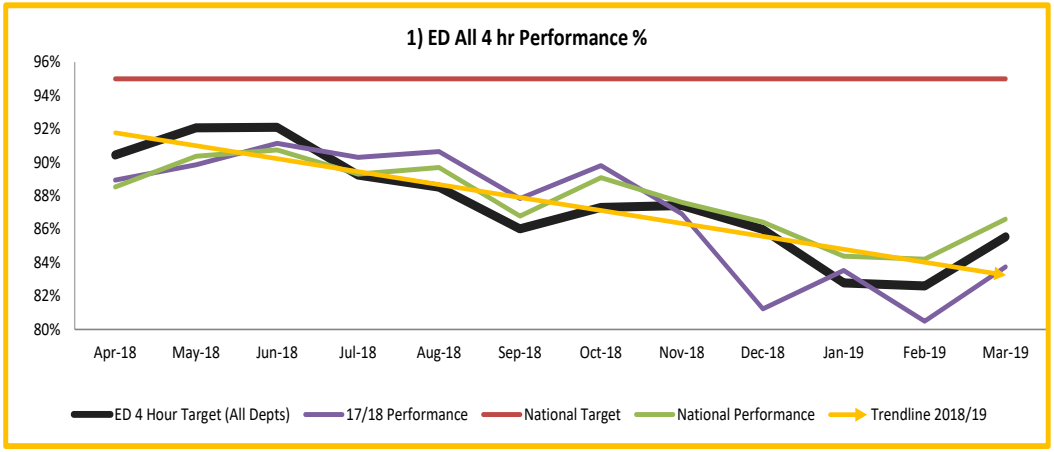


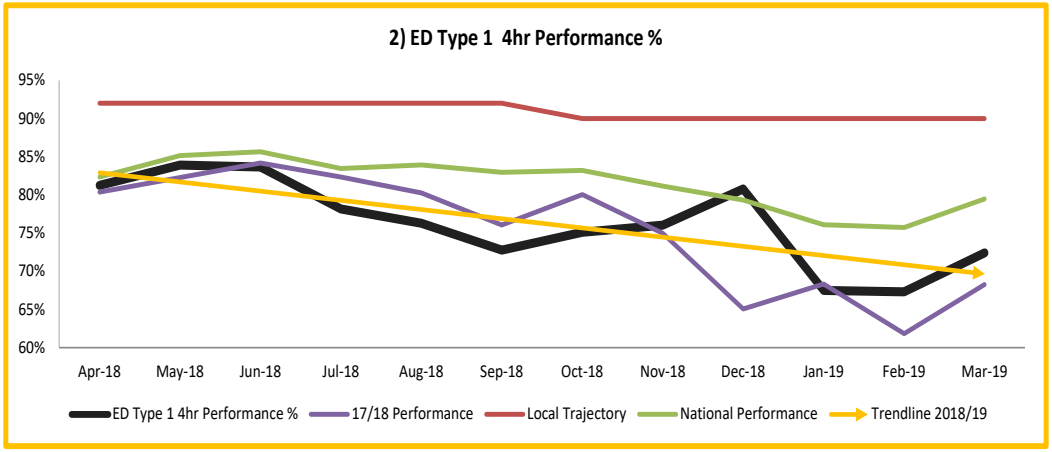


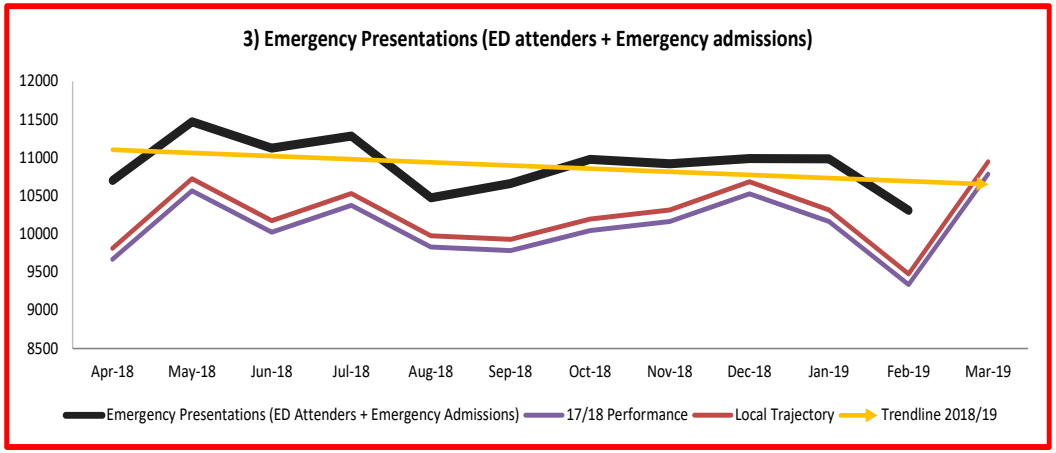


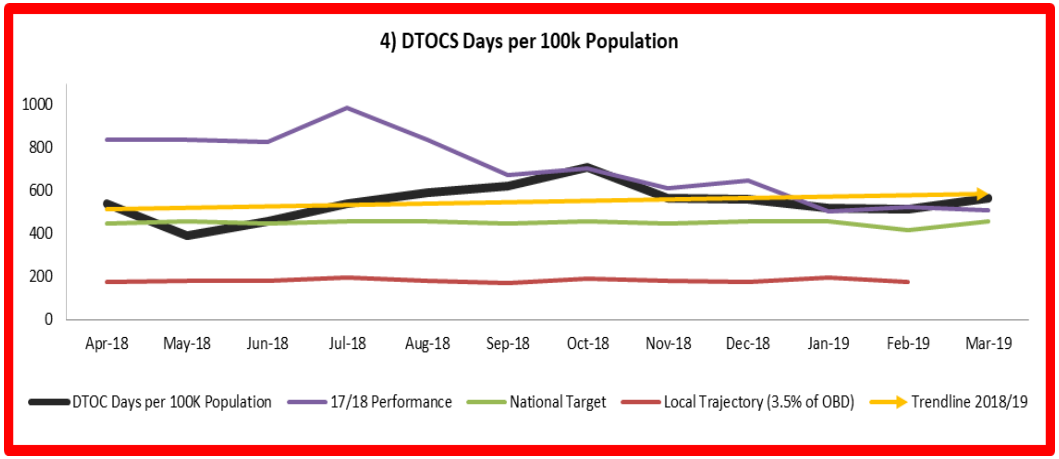


- The 2 charts show ED all type (including Plymouth, N Devon and RCHT, as well as the Cornwall MIUs in chart 2). The winter 2018/19 period has been considerably better than in 2017/18, though remains below the national average.
- Emergency presentations are higher than planned. This pattern has continued throughout the year to date.
- Delayed transfers have remained higher than the national average and local trajectory, and closely matched 17-18 levels for the second half of the year having improved compared with last year in the first half of the year.

# Emergency Activity, In Hospital - Continued

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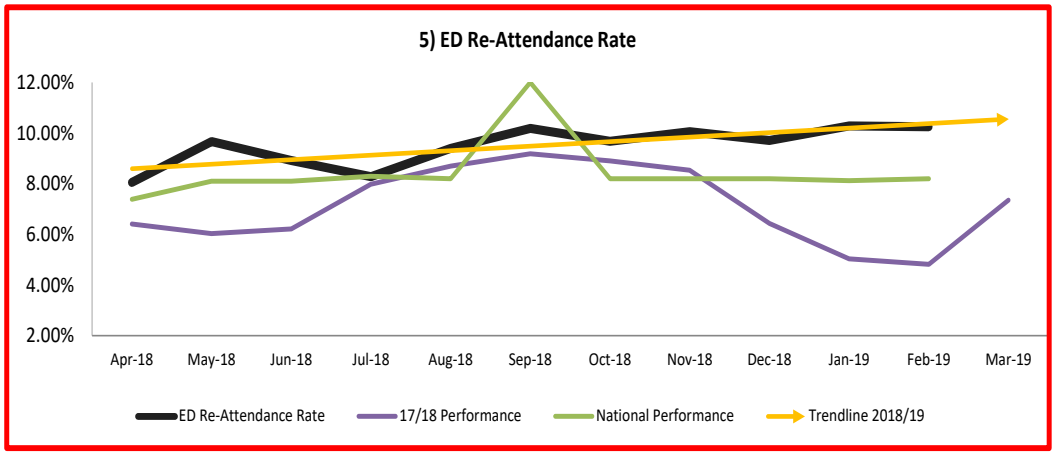


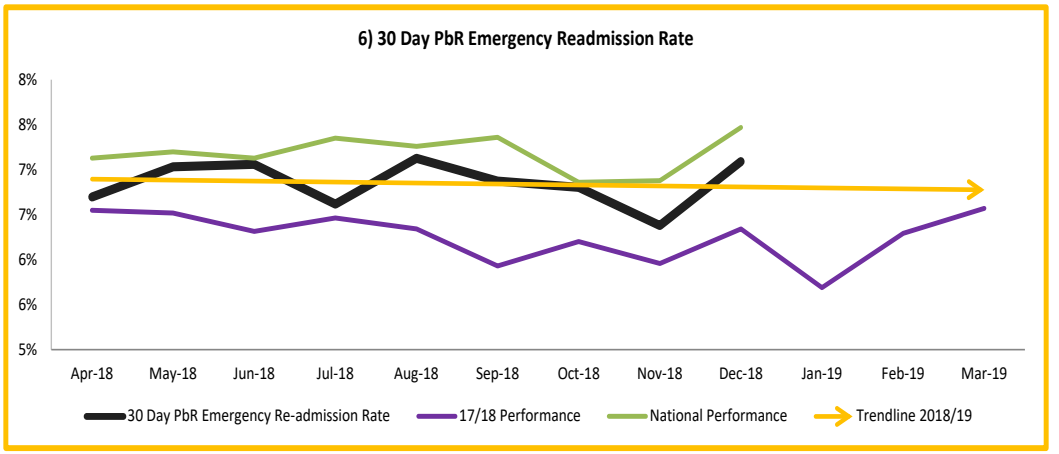


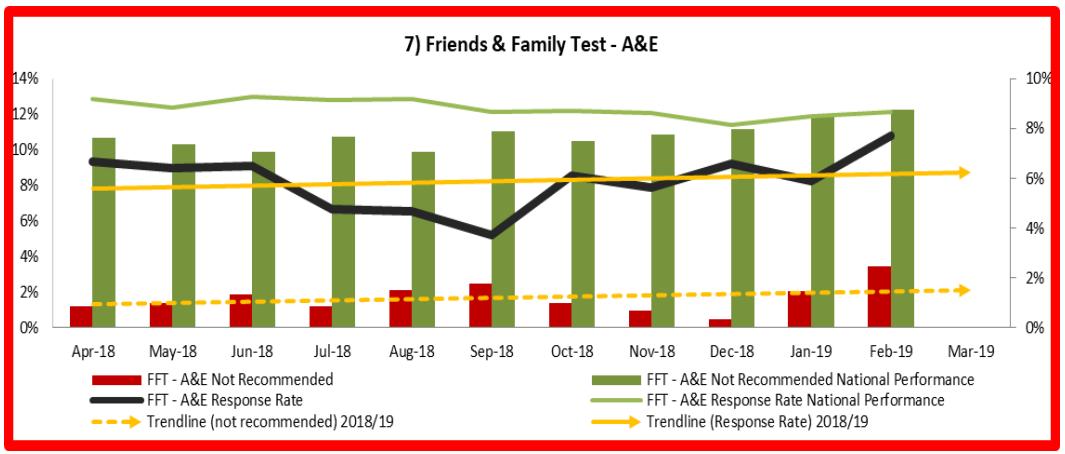


- The ED re-attendance rate has remained higher than in 2017/18 all year. There was some evidence of increase after the introduction of the RCHT UTC, which had a positive impact on other ED indicators (e.g. time to triage and treatment).
- The emergency readmission rate has remained higher than in 2017/18 all year, though it remains below the national average.
- The FFT response rate has tended to increase during the year and whilst it remains below the national average, it is now close. The not recommended rate remains well below the national average.

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# EMERGENCY ACTIVITY, OUT OF HOSPITAL

# Emergency Activity, Out of Hospital

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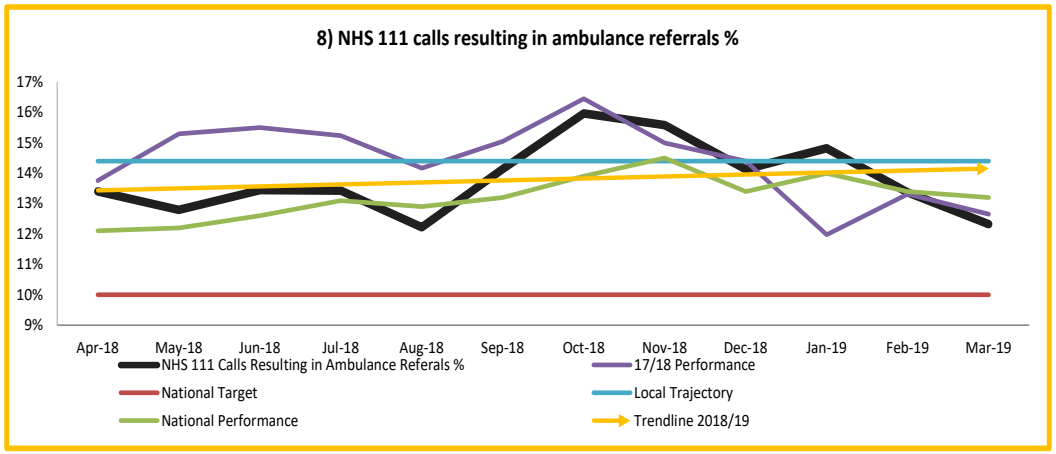


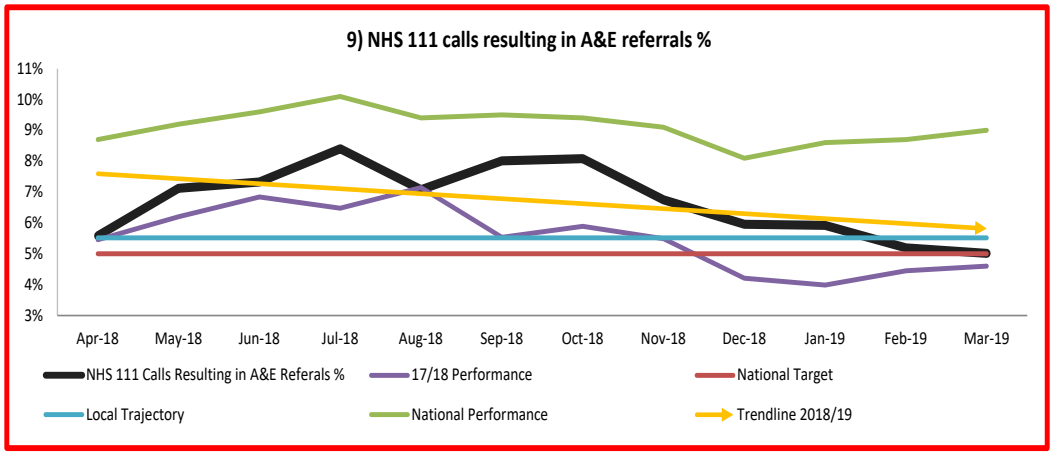


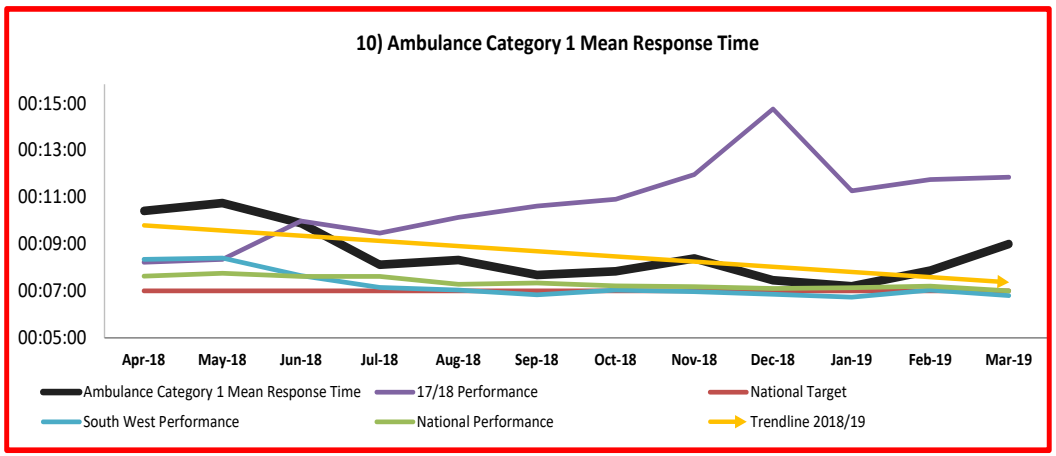


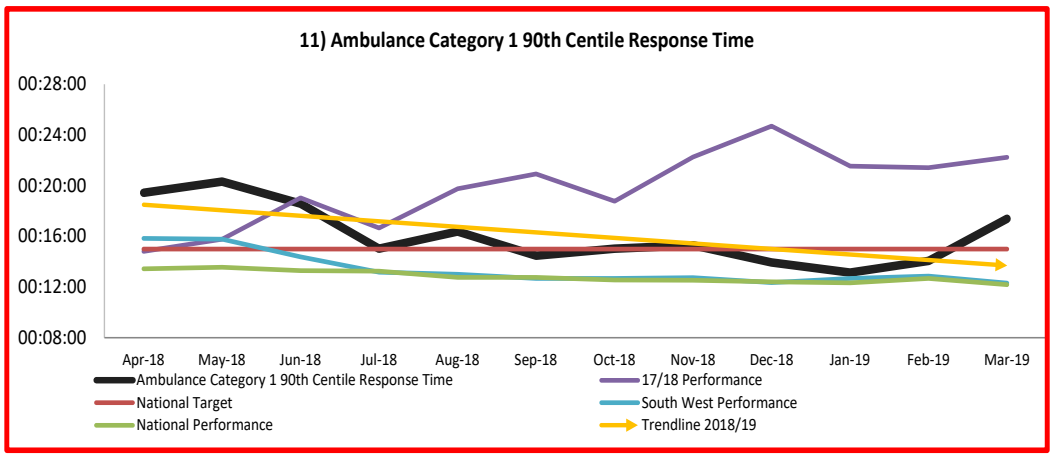


- 111 calls resulting in ambulance referrals were above the national target in month but below 17/18, the national average and the local trajectory.
- Calls resulting in A&E referrals were well below the national average and level with the national standard. They have reduced over the last few months but remain above 17/18; both years show a pattern of seasonal variation.
- Ambulance mean response rates have improved compared with last year, but remain above the national performance levels. The in-year worsening seen last winter was however avoided.

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# PLANNED CARE

# Planned Care

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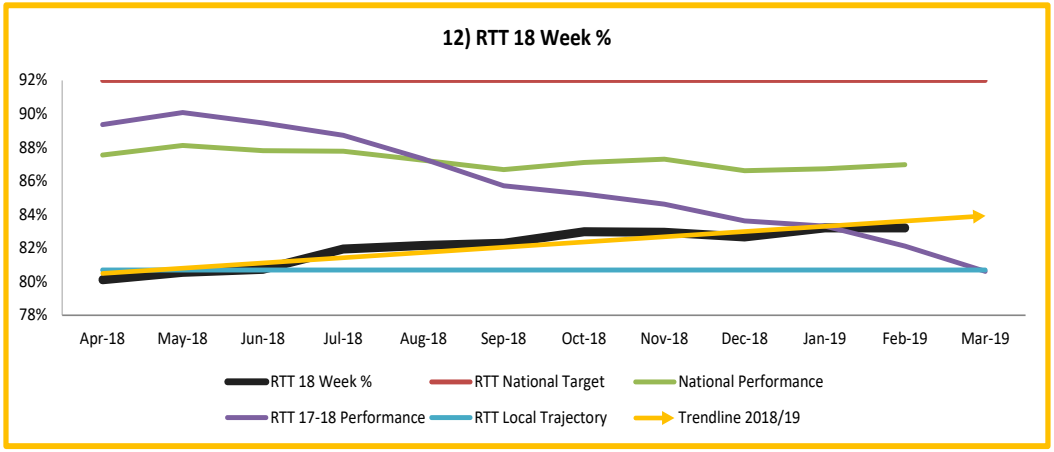


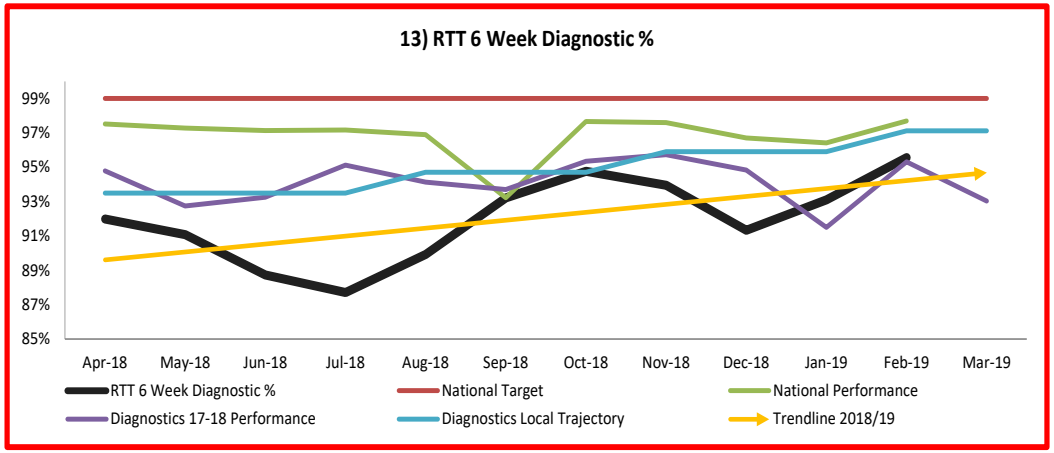


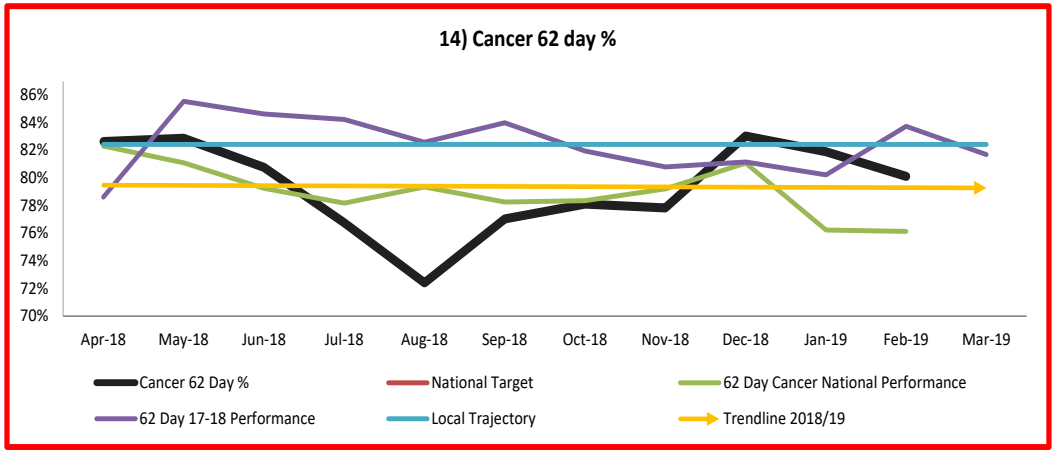


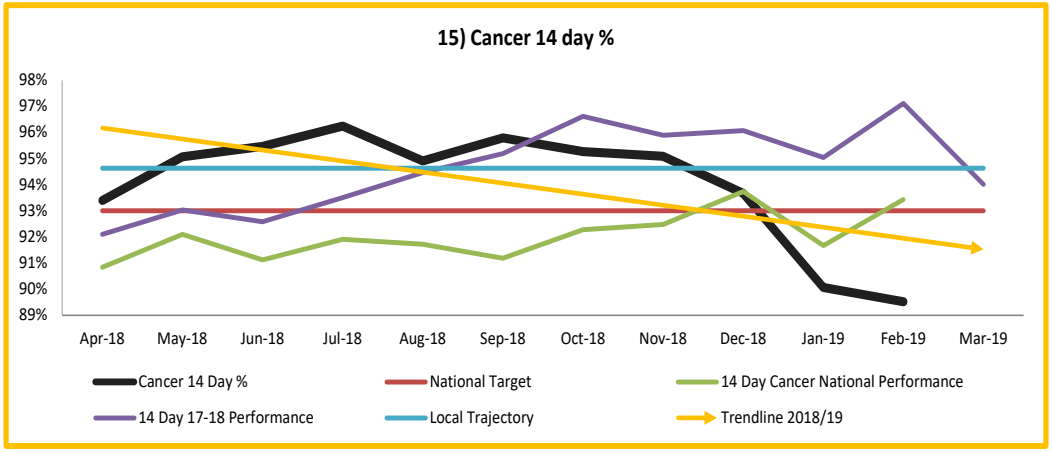


- The RTT local trajectory was met for m11 and this was the first month of the year at which year on year performance was better than 17/18 (this should be achieved again in March). The local 52 week reduction trajectory was also met at year end, though 18 week performance remains below the national average.
- 6w diagnostic access improved to the best position of the year but remained below the relevant benchmarks. This is likely to improve slightly further for year end.
- Cancer 62d performance recovered following the deterioration in Q2, and was above national performance (though below the standard and 2017/18).
- There was a sharp deterioration in 2ww performance, largely due to the issues with breast temporary staffing shortage and increased demand. This will continue in m12 and Q1 2019/20, with recovery expected in Q2.

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# OTHER KEY INDICATORS

# Other Key Acute Indicators

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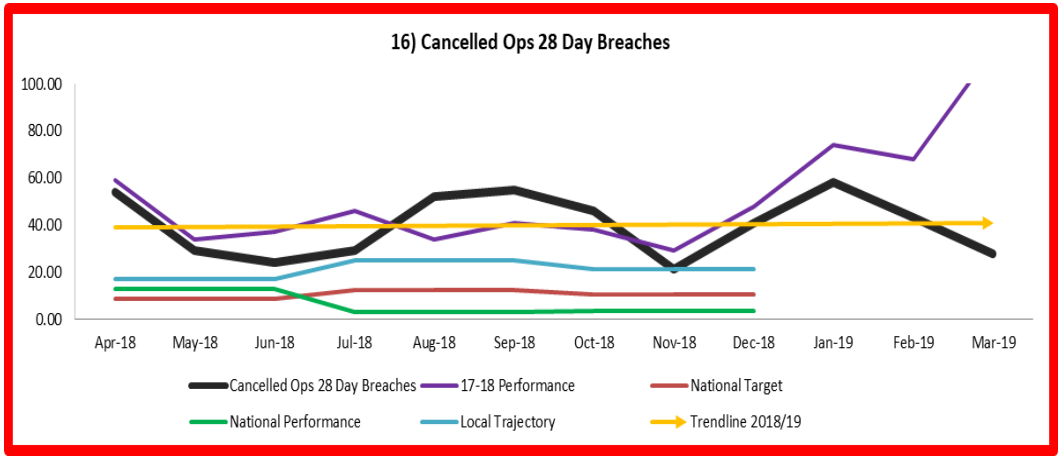


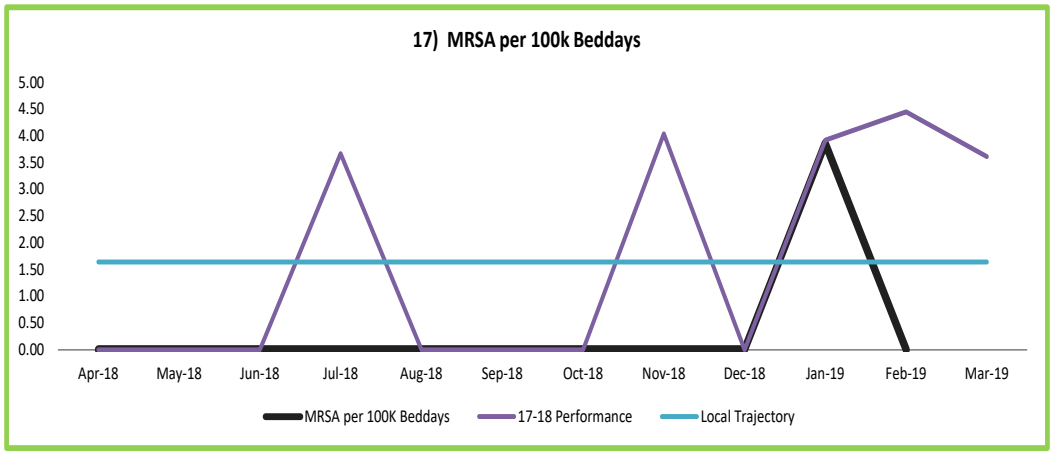


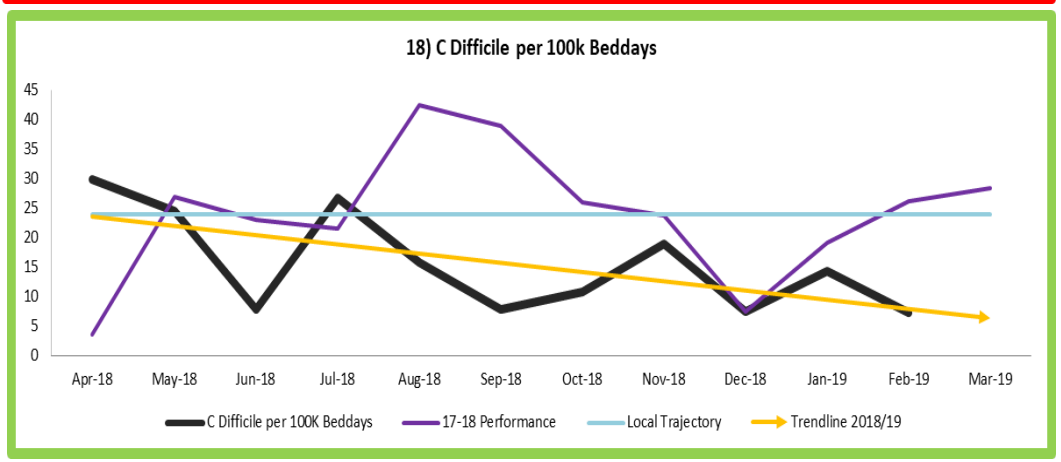


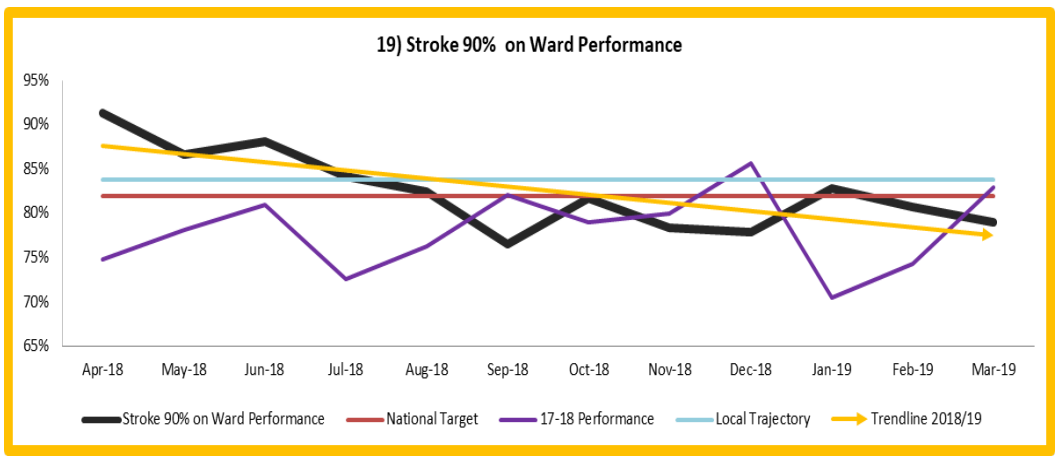


- Although the system remains an outlier, Cornwall's performance on cancelled operations re-bookings improved with the relatively improved winter flow position compared with 17/18.
- There were no cases of MRSA in the most recent month.
- Instances of C Difficile are volatile, but have improved compared with last year and are lower than the local trajectory.
- Stroke unit access has broadly worsened as the year has continued with increasing distance from the benefits of Gold Command, and performance over the last 6 months has closely tracked last year, reverting to being below the national average.

# Other Key Acute Indicators - Continued

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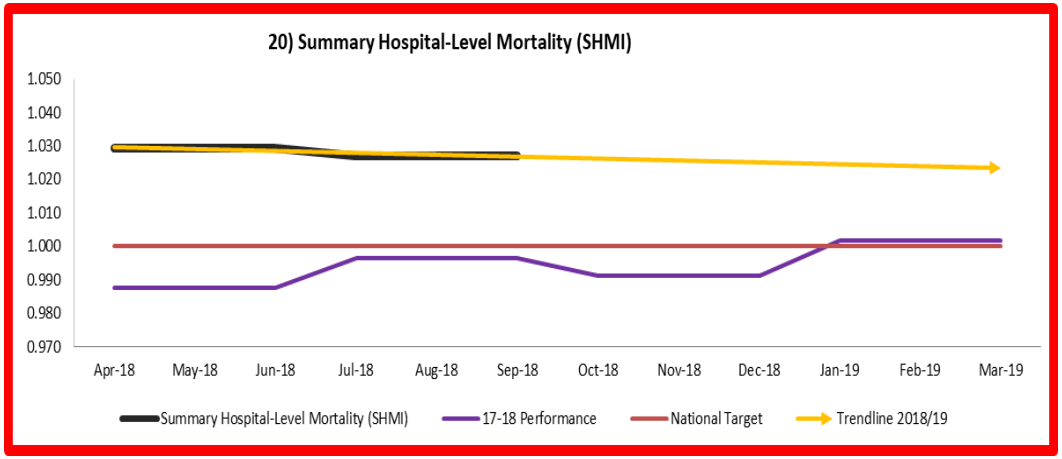


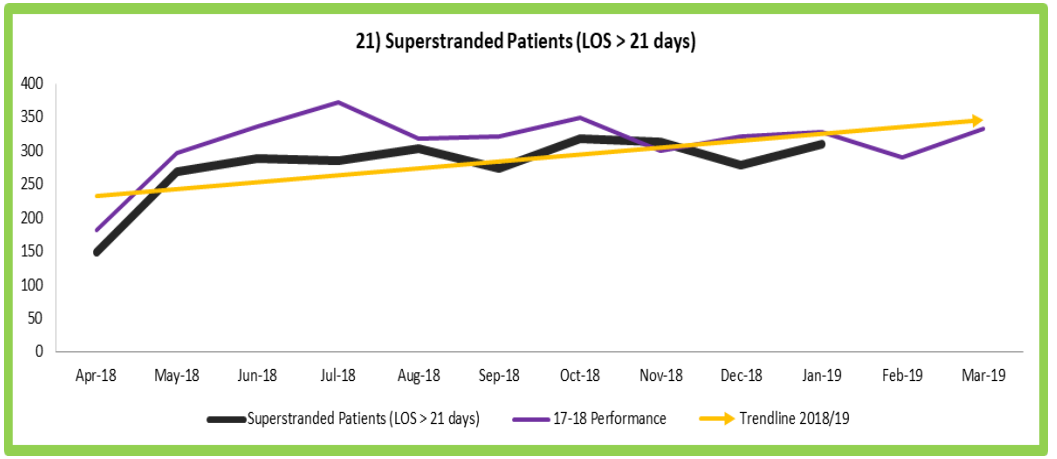


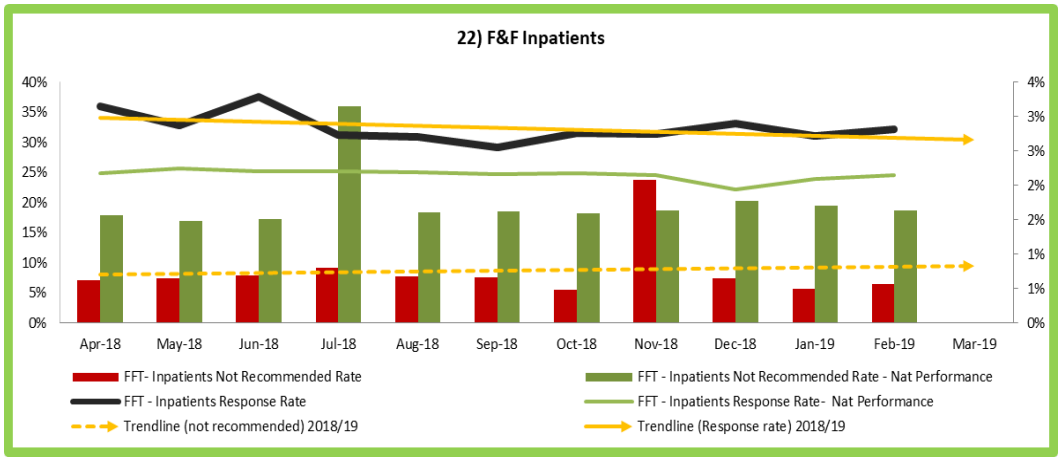


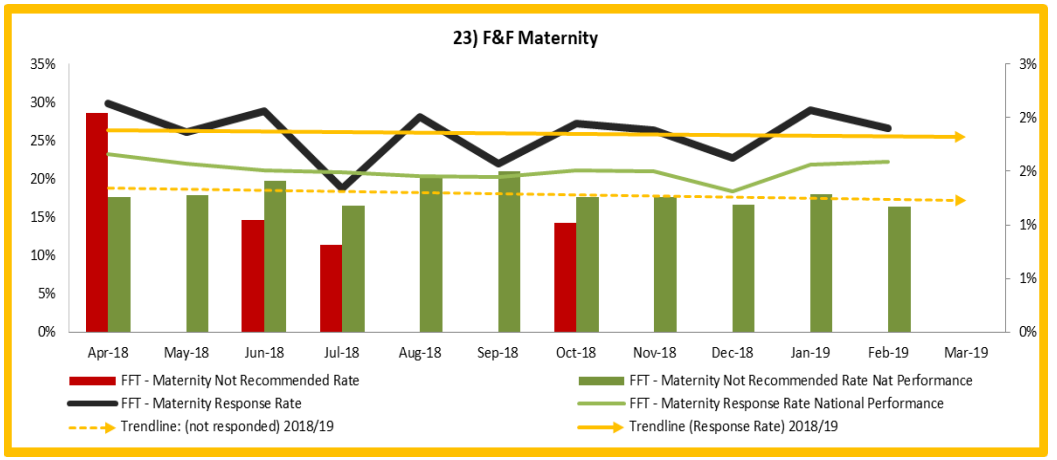


- SHMI mortality data remains significantly in arrears. The Q1 SHMI is 1.03, higher than the national benchmark of 1.0. This includes both UHP and RCHT data (it is UHP that is significantly higher than the national benchmark whilst RCHT is slightly below).
- The number of long stay patients has remained slightly lower than last year, but is tracking slightly upwards as the year continues; this is consistent with the DTOC picture of which this forms part.
- For the Friends and Family Test (inpatients), the response rate is steady overall and remains above national levels, and the not recommended rate remains below. For maternity, the response rate was slightly higher than the national average and the not recommended rate lower.

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# SAFETY THERMOMETER

# Safety Thermometer

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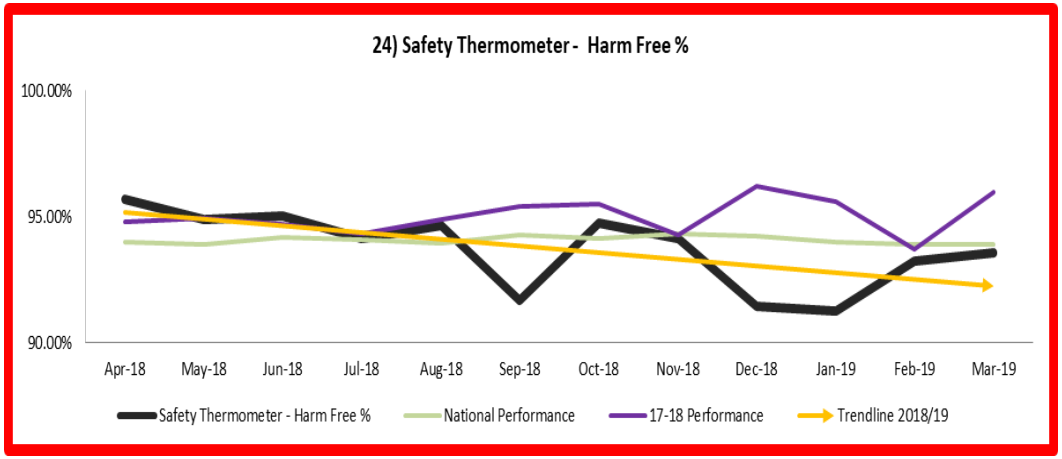


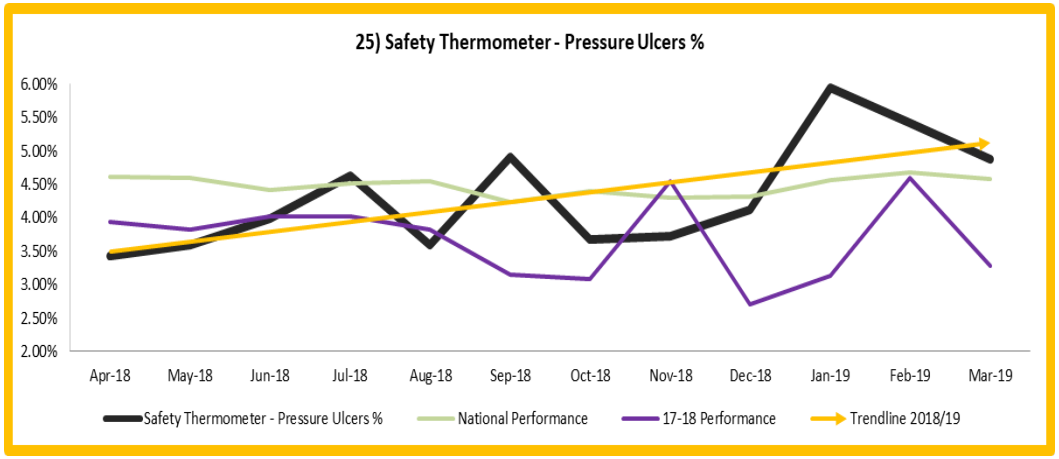


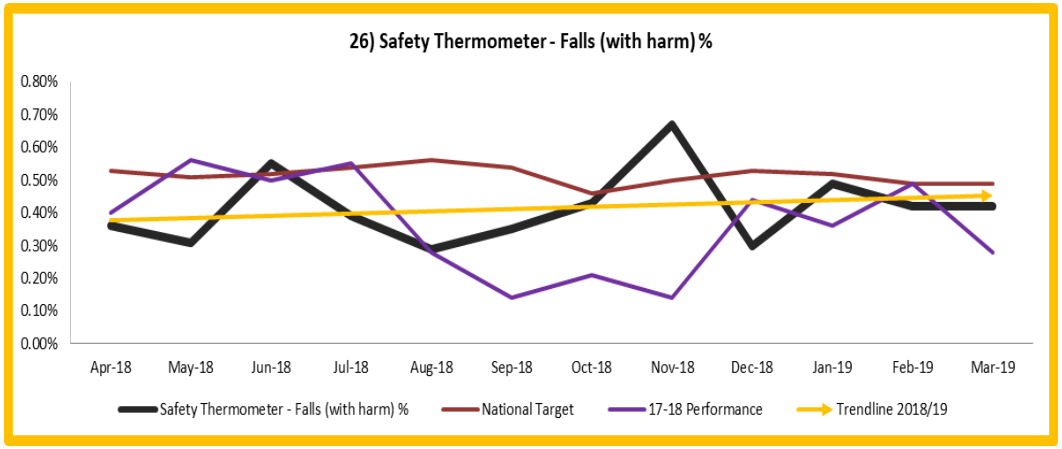


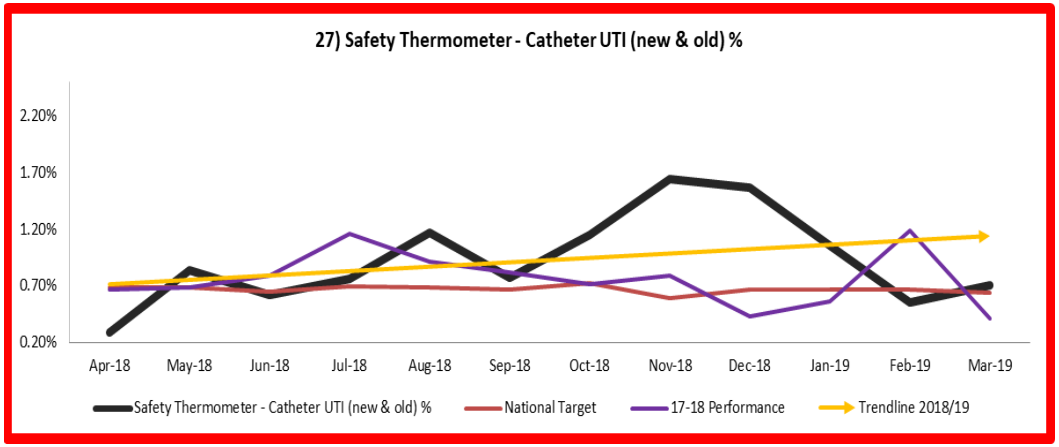


- The safety thermometer indicators show a slight overall deterioration during the year. Harm free achievement is lower than last year for the last 8 months and below the national average, though there are some signs of recovery in the last 2 months.
- There is variation (in the context of quite small numbers) on the triggers of harm within this broader indicator. Pressure ulcers seem to have increased in year and compared with 2017/18, whilst falls with harm have varied in year but tend to be slightly below the national average and similar to last year. Catheter UTIs saw an increase from October-January but the last 2 months have been around the national average.

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# MENTAL HEALTH & COMMUNITY

# Mental Health & Community

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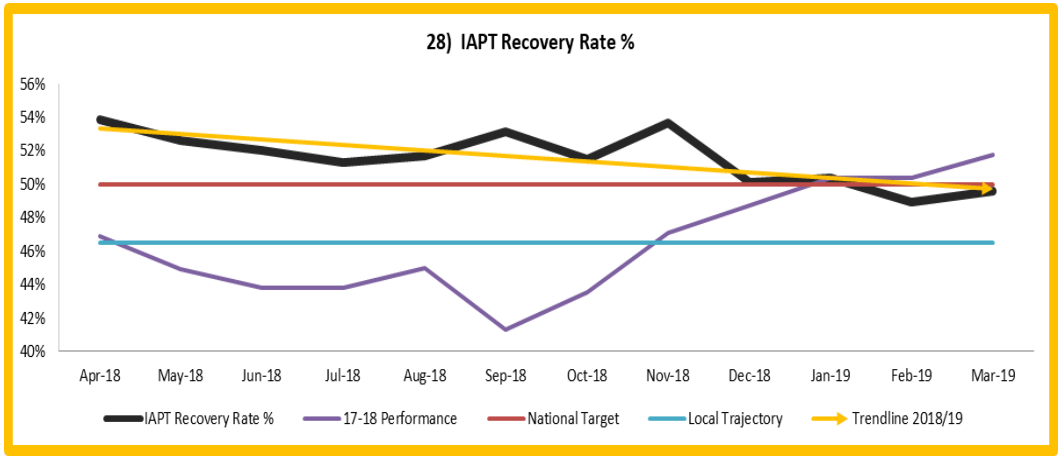


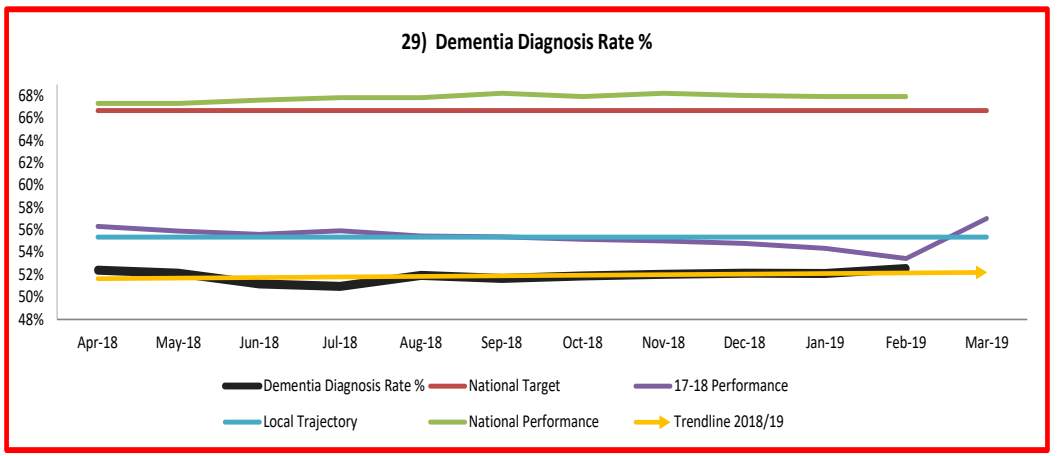


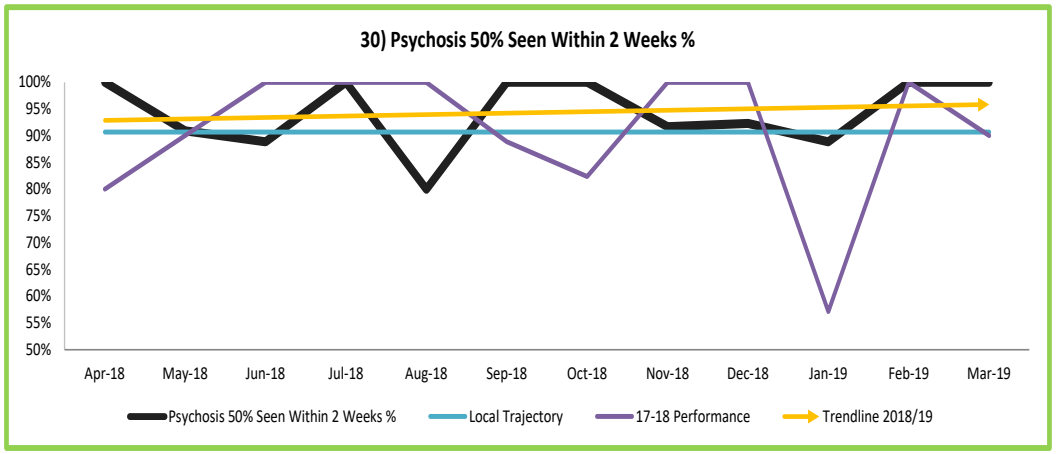


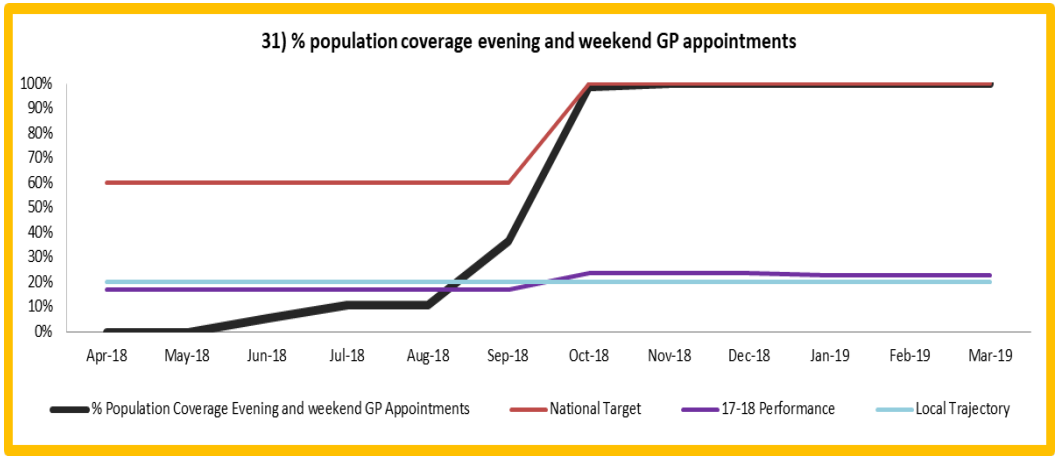


- The IAPT recovery rate, which had been above the national target over the last few months, has worsened over the last few months and whilst it is still meeting the local trajectory is now below 2017/18 levels month on month and is not meeting the national target.
- Cornwall continues to have negative performance on the dementia diagnosis rate, which also remains below last year, though the Feb '19 position is the most positive seen for the year to date.
- Access to psychosis care within 2 weeks remains positive and well above the national standard.
- Evening and weekend GP appointment access has significantly improved and now meets the trajectory.

# Mental Health & Community - Continued

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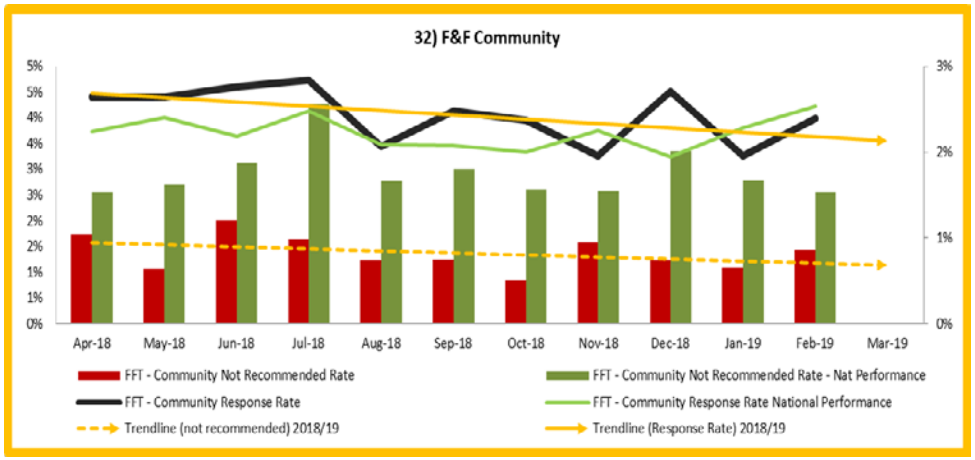


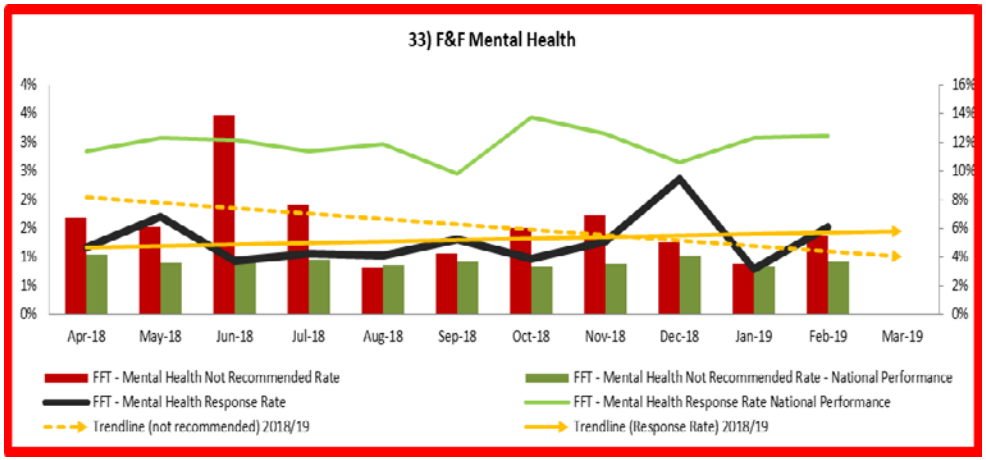


- For community services, the response rate has tended to reduce as the year has progressed. The not recommended rate has remained similar but remains well below the national average
- For mental health services, the response rate generally remains below the national average and the not recommended rate above, with no evidence of improvement. This remains an anomaly among the F&F returns for other Cornwall health services which otherwise show a lower than average not recommended rate.

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# ADULT SOCIAL CARE

# Adult Social Care

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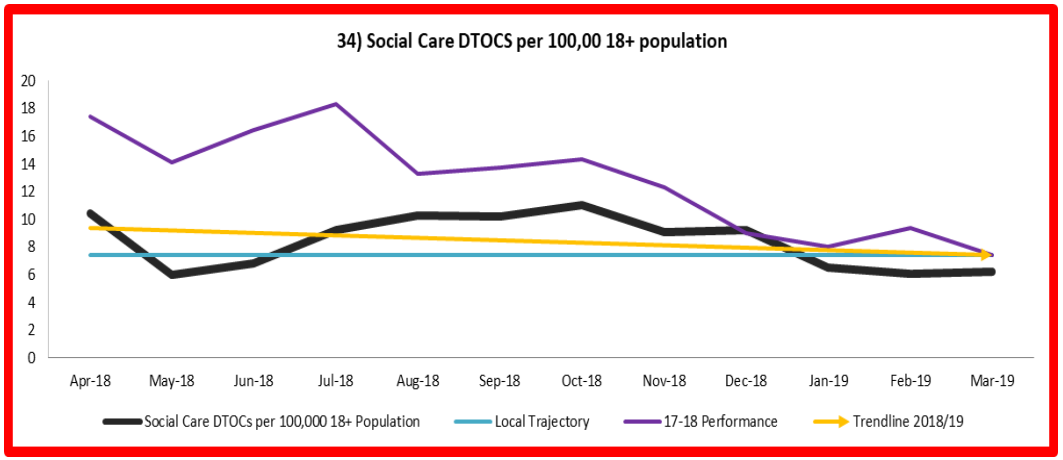


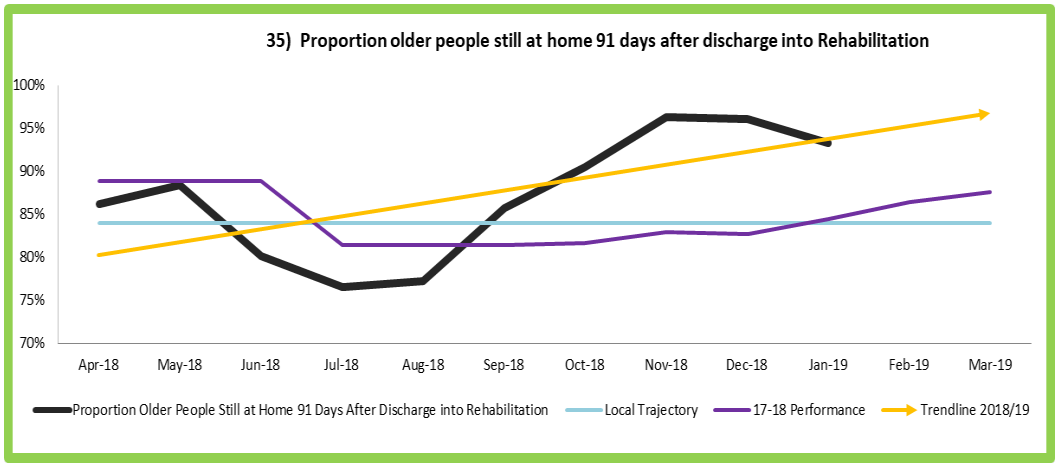


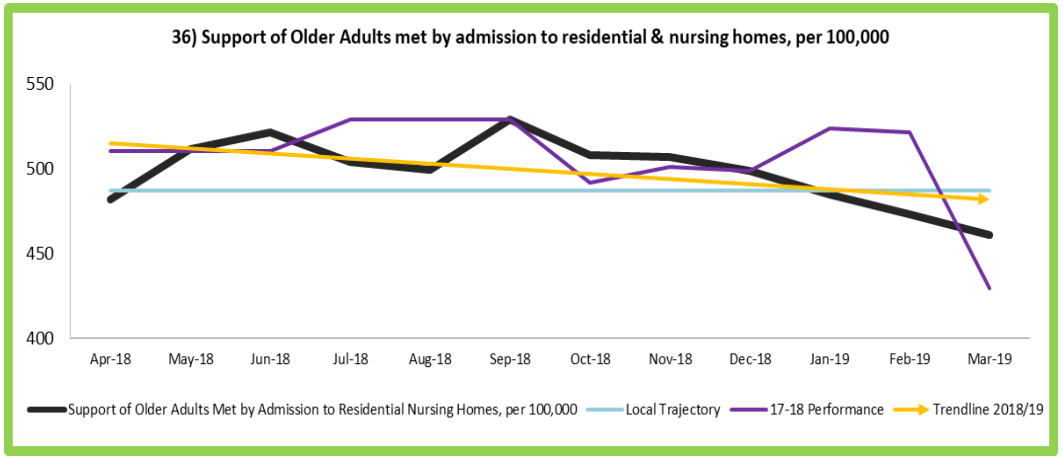


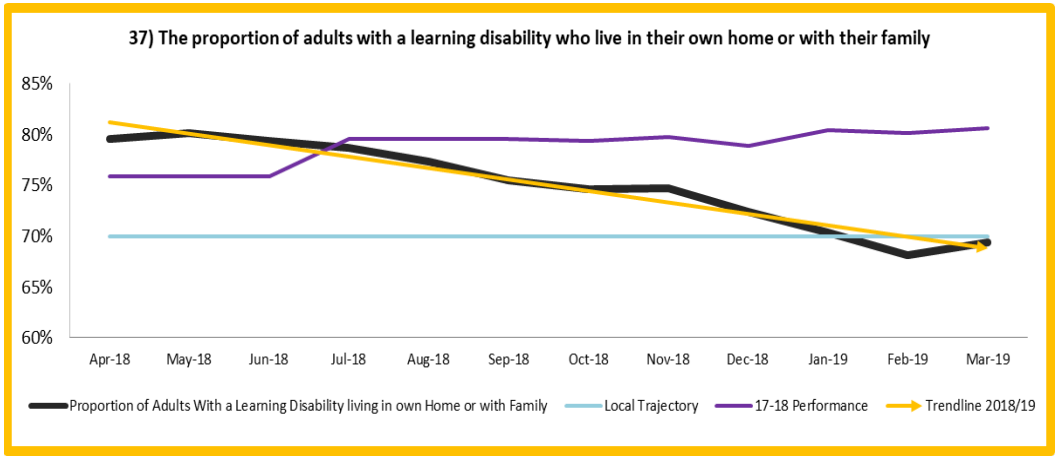


- Social care DTOCs have remained fairly similar for the last few months and during Q4 have been below the local trajectory.
- The proportion of older people still at home 91 days after discharge has increased and is above the local trajectory and 17-18 for the most recent data.
- Admissions to residential and nursing homes has reduced during the year and is below the local trajectory.
- The proportion of adults with a learning disability has reduced and has dropped below the local trajectory.