NHS
Cornwall and Isles of Scilly

Private and confidential

5 January 2023

Chief executive office
Part 2S, Chy Trevail
Dunmere Road
Bodmin
PL31 2FR

The Rt Hon Steve Barclay MP
Secretary of State for health and social care

[redacted]

Dear Secretary of State,

Prevention of Future Death Report following inquest into the death of Mr Morganti and others

The Integrated Care Board (ICB) was made aware on the 10 November 20022 that a Regulation 28 report had been sent to your office from Mr Cox, HM senior coroner for Cornwall and the Isles of Scilly. The ICB has co-ordinated specific information related to the matters of concern raised from all health and social care partners across the system which I hope you will find helpful. If you have any points of clarification or would like to follow any of this detail up, I would be more than happy to follow this up with you.

Improving the capacity of intermediate care beds in the county

I am pleased that Cornwall Council has commissioned additional capacity at the Frances Bolitho care home, in West Cornwall with beds opening in October 2022. This has created 33 new residential and nursing dementia beds in West Cornwall in addition to the 12 previously provided. The local authority has completed a soft market test in relation to reprocuring the beds at Trengrouse care home, West Cornwall. Unfortunately, at this time and with the current condition of the estate, the market has not responded well to this, and the site will need to be redeveloped prior to reopening.

Cornwall Council has entered into a partnership with Sanctuary Housing Association which will give access to new affordable capacity. Up to 35% of the total Cornwall Care beds will be available to the Council inside the fee methodology. The Council has transferred the freehold of the care home building as part of this contract. In the long term, over a ten-year period Sanctuary will be building seven new care homes on existing sites and refurbishing four others. The Council and Sanctuary Housing Association have formed a strategic partnership board to oversee the programme of work and the partnership arrangements.

One of our challenges is the level of long-term care beds which have been used as short term rehab beds in response to system pressures. We have been actively reviewing these individuals to support them to return home wherever possible and started discussions in the system to stop using long term beds for short term rehabilitation. Multi-disciplinary working

has been re-established through our integrated transfer of care hubs (iToCHs) to prevent unnecessary delays for services which are not required and making best use of our valuable resources.

Cornwall Foundation Trust (CFT) are currently leading a project with Prism to optimise use of existing reablement capacity. We plan to deliver the discharge to assess aim whereby most post-acute medical episode assessments take place in the persons home/usual place of residence. Our place based iToCHs already co-ordinate the requests for care review, both in admission avoidance and discharge and we are working to develop a model of place-based collaboration in reablement with shared local outcomes. The work seeks to accelerate the development of this place-based service with an overarching co-ordination hub in place and a complex discharge team. We are developing data to ensure we are optimising productivity in the services we have and to inform the ICS intermediate care strategy and future commissioning plans.

In partnership, Cornwall Council and the ICB have held discussions with Cornwall Partners in Care, a representative body for the independent and voluntary care provider sector in Cornwall in relation to how we can better support admissions from hospital out of hours, particularly weekends. They will be coming back to outline what infrastructure needs to be in place to enable this to happen which will also be considered in our intermediate care strategy.

A joint commissioner's day was held in November 2022 and agreed to reset the discharge to assess way of working in Cornwall, with a clear policy position which provides clarity around roles and responsibilities, addressed the high numbers of discharges on pathway 3 with an aim to support more people to return home from hospital as opposed to making long term care decision in an acute environment. There has been significant work completed on pathway 1, utilising voluntary sector support and this has seen a reduction of people waiting for services. There is also ongoing work to develop our specification for accommodation with care and support-which will include dementia. The local authority is at pace developing its technology enabled care offer to mitigate risk for people living at home and has started work on the re-procurement of community based services and reviewing the equipment services to ensure we are maximising the use of technology and equipment to keep people at home.

Further mitigation can also be seen through our use of virtual wards. CFT are developing the Cornwall and Isles of Scilly @home service which seeks to co-ordinate community services to offer hospital level care at home, including digital monitoring and intravenous treatments at home (virtual wards). We currently have a respiratory ward; a care home ward and our frailty ward has just commenced. Current capacity is respiratory (25); frailty (5) and care homes (20).

We are working with the acute 'emergency village' in RCHT and with CFT bedded care services to optimise a step-down model of care into this service. Once training complete, staff will be regularly working with colleagues to identify people suitable for the virtual ward service and increasing occupancy of the existing capacity. We expect to see this steadily increase over the next 2 months.

The ICB has now commissioned the 'Community Gateway' in response to increasing living costs and pressures across the health and care system in Cornwall and the Isles of Scilly. This is a unique partnership of more than 50 voluntary organisations working with the ICB to offer ongoing support to communities across the Duchy. The Community Gateway is a dedicated telephone line available for everyone and provides a single point of access to a wide range of professional voluntary sector support. It will provide a 'gateway to

independence', working with people to identify their needs and put appropriate packages of support in place. The Gateway aims to create personalised plans that mitigate admissions, reduce social isolation, and improve wellbeing. It will also connect people to mental health support, community activities, the community hub network and wider winter support including hot food and warm spaces.

People can access the Gateway via a dedicated telephone line (01872 266383), open 8am to 8pm, seven days a week, 365 days a year where they can speak to trained staff and find local support that's right for them. In addition, staff members in the community will be available to offer one to one and group support. A bespoke email has also been activated: gateway@ageukcornwall.org.uk

The ICB has also co-created and commissioned a network of more than 50 Community Hubs which are places and spaces that act as a central point of voluntary, community and social enterprise (VCSE) contact and support for their communities. Hubs can be buildings based or consist of virtual connected networks working together to increase community capacity and resilience. They are connectors of people, communities, local groups and voluntary sector organisations and activities.

They are also a place where people can find friendship, positive things to do, acquire new skills and share their expertise, and get help and advice on aspects such as food, employment, housing, finances, health, and wellbeing. They are a place where social capital is enhanced, a place for strengthening local bonds, where new ideas are formed, and where community initiatives are launched. Community hubs are already developing in some areas and are essential to our place-based delivery of local health and care support.

Finally, Cornwall Council has contracted for 750 new units of extra care housing, providing care and assisted living for people in later life. The Council has made available many owned freehold sites to expand this new capacity over the next 5-year period. The Council is doing all it can to expediate these developments in the challenging financial climate. Work continuous to develop the local proposals for the £500 million the UK government has allocated for adult social care to support discharge/hospital flow, and these will be signed off and submitted on 16 December.

How the delays that are currently manifest can be mitigated in the intervening months, particularly given the likely increase in demand for ambulances/hospital admissions during the winter months.

System control centre: the ICB established a system control centre (SCC) through November to be fully operational by 1 December 2022. The SCC is led by the ICB chief nursing officer, senior responsible officer, to achieve collaboration of system performance and risk through senior system level operational leadership and strategic oversight.

The model ensures that efficient flows of intelligence on operational pressures and risks across the system are visualised in a single live data pack which will drive actions in response and highlight areas of concern or increasing risk profile. Provider organisations are operating their own incident control centre function to manage the winter/surge response which links into the SCC.

The model ensures that there is a concerted effort on existing and emergent issues which impact patient flow including ambulance handover delays and delayed discharges. Other key benefits include improved situational awareness and lessen the risk of non-delivery of holistic,

real-time management of capacity and performance. By employing live data flows and creating a four-week rolling average performance metrics, the SCC can monitor trends and emergent issues and allow support to be focused on the area of greatest or risk.

The overarching aim of the SCC is to ensure alignment and delivery of the areas covered by the NHS England assurance framework across the core domains:

- improving the support and service response for patients
- aligning demand and capacity
- improving discharge
- improvements in ambulance service performance
- improving NHS 111 and 999 performance
- admission avoidance and alternative 'in hospital pathways' to improve flow
- preparing for new Covid-19 variants and respiratory challenges
- workforce and communications

In terms of early operational impact and benefit, the SCC has:

- provided an emergency preparedness resilience and response (EPRR) structured approach to patient flow through our escalation processes
- co-ordinated our response to Strep A demands with our primary care cell driving actions
- galvanised an improved system response to falls resulting in falls car increased availability and ability to provide improved pain relief
- enabled the ICS to "get ahead" in terms of our response to the cold weather with earlier action on our stroke and respiratory pathways in particularly
- enabled system plans to respond to planned industrial action and other workforce opportunities such as redeployment
- a renewed partnership approach between our care home nursing specialists and South West ambulance Foundation Trust (SWAST) to keep people in their own care home bed rather than being conveyed to hospital
- overseen commissioning of additional community capacity (domiciliary care, hubs and community gateway)
- stroke improvement board reinvigorated and working on system wide improvement plans

System dynamic risk assessments are updated weekly by the SCC and used to guide system response and action by the ICS clinical advisory group. These dynamic risk assessments inform decisions such as redeployment of staff, cease or stand up services in response to current operational pressures.

Falls prevention/ improvement: a significant number of actions and improvement in falls and long lies have been initiated and completed to mitigate further risk, especially as we move into winter. SWAST have completed a review of the availability and utilisation of 'lifting' equipment with 28 Raizer chairs available across Cornwall for the 61 trained CFRs has been completed and the SWAST tri-service resources (13) now have a Raizer chair as does the Cornwall SP-UEC team. A Raizer chair can be operated safely by one person and can be used in small spaces. In addition to SWAST, in 2022 every care home in Cornwall was supplied with a free Raizer chair to safely support people up off the floor. It has been well received and the need for urgent response has already reduced.

As part of SWASTs fall improvement work, the Falls in Older Adults clinical guideline and the pressure ulcer clinical guideline has been updated for staff with a focus on holistic assessment and shared clinical decision making. There is regular engagement with care homes to signpost to the tools available to prevent and manage falls. A post-falls guidance pack, a free to use resource for all system partners e.g., care homes has been produced post fall guidance for care providers with further information available via the SWAST website SWAST falls information

The system collaborated with the introduction of the repose pressure relieving mattress to improve the care and outcomes of patients who required conveyance and who are in the ambulance handover queue. This is supported by the development of a training package around enhanced skincare management for staff dealing with extended handover delays which will be rolled out across Cornwall.

All of the above is supported a single point of access (SPOA) for care settings in Cornwall which operates 24/7. This is staffed by senior clinicians in the care home support service, who can support care staff to triage, assess and manage falls using video consultation. 70% of the calls to this line don't require onward referral. Sharing risk combined with advice and guidance can support care staff to help people up off the floor or advice on best urgent response option to mitigate long lie. SWAST crews are able to utilise the 24/7 care home support line to undertake shared clinical decision making and arrange support to the care staff to keep the resident at home. The SWAST emergency operations centre (EOC) are also able to refer to a system falls response via ITK, and frontline crews are able to refer to urgent care response teams where conveyance following a fall may not be holistically indicated.

Referrals can be made to falls practitioners who work in collaboration with the care home support team, clinical nurse specialists (CNS), to review the factors implicating falls risk to work with care staff to mitigate as far as possible. This includes medicines optimisation, environmental and physical factors. Promoting physical activity, strength, balance and purposeful mental activity are priorities for enhancing health of care home residents. Funding has been agreed to increase the care home support service team with falls prevention being a priority area. Recruitment is expected to be achieved and plan for an allied health professional to be in post by February 2023.

For the system a significant improvement in falls and long lies can be seen through the falls response service hosted by Cornwall Ambulance Service (CAS) which can be dispatched to care homes. In December 2022, following feedback from system partners, the operational hours of the falls response service have been increased with immediate effect to 0800am – 0200am, 7 days a week until 31 March 2023 as part of an expanded winter resilience package and demand management mitigation for SWASFT during peak demand over the winter period.

Further improvements in development include the extension of the Major Trauma and Resuscitation Advice Line (MTRAL) to include provision of advice for clinicians dealing with older adults who have fallen ("silver trauma") as well as the roll out of the SWAST admission reflection tool, to aid staff in making the right decision around conveyance of clinically frail/older adults.

Intermediate care improvements: the ICB is currently commissioning community enablement capacity from Age UK, Humans Cornwall, a person-centred support brokerage and micro provider as well as CHAOS (Community Helping All Of Society) a domiciliary care

agency provides a variety of support services to all ages to support up to 40 discharges per week.

A market testing exercise is currently underway to commission additional regulated community enablement capacity to support a further 30 discharges per week from February 2023. Finally additional funding has been identified to provide enhanced intermediate care offer in community hospital beds.

Palliative care consultants are available to all health care professionals 24/7 via the specialist palliative advice line to support managing people in their preferred place of care to improve end of life care.

GP representatives have drawn to my attention the extreme pressures in primary care

General practice across Cornwall and Isles of Scilly continues to face increased levels of demand and the expectation is that this will increase further during the winter months. Practices immediately contact our generic primary care team inbox if they are unable to deliver any aspect of their core contract – for example, having to offer urgent appointments only if for example their staffing levels are depleted due to sickness or if demand outstrips capacity for other reasons. The primary care team will regularly check in with practices and have held a number of meetings with them recently to better understand their current concerns so that we can work on additional offers of support. A specific meeting on business continuity in relation to potential power outages was held on 5 December 2022 and contingency plans to consolidate services at primary care network (PCN) or integrated care area (ICA) level are being developed as a result.

The primary care team at the ICB continue to work closely with GP practices across Cornwall and Isles of Scilly to offer support that will help to reduce or manage demand for appointments or increase the capacity of the teams. Recent schemes over the winter period have included securing additional remote (video and telephone) GP and Advanced Nurse Practitioner sessions with an external company Livi, a coordinated GP locum response through Kernow Health CIC, options for additional weekend and bank holiday appointments and offers to fund digital systems that streamline internal business processes or support triaging of calls. There have been several comms campaigns launched recently to support practices and provide clarity to the public about where to go for support. We continue to commission successful schemes with community pharmacists to offer additional services such as minor ailments and walk-in consultations. We will be looking to develop additional schemes over the winter period based on feedback from practices – for example we are currently working on additional resources for practices to be able to provide more time for care homes.

A new OPEL escalation process has been implemented by the LMC in November 2022 which includes weekly reporting by practices on their OPEL status. Practices reporting OPEL 4 status are immediately followed up by the LMC and the ICB are contacted with any issues that we can address from any of the practices submitting a return. The primary care cell meets weekly currently as a formal group and feeds into SCC. As well as weekly escalation issues for SCC a dynamic risk assessment for primary is also updated.

Appropriate level of staffing

Cornwall Council has relaunched the proud to care Cornwall recruitment campaign. The website has been relaunched Home - Proud to Care Cornwall and currently supporting circa 100 providers with their recruitment of care staff.

Royal Cornwall Hospitals NHS Trust (RCHT), University Hospitals Plymouth (UHP) and CFT review safe staffing levels against the National Quality Board guidance on safe staffing ratios and provide direct reporting to Trust Boards twice yearly to ensure that rotas have the correct numbers of nurses on each ward establishment.

These staffing models are reviewed regularly to ensure that they remain supportive of the needs of patients in terms of acuity and dependency. Both providers monitor the workforce against acuity and demand on every shift, using a redeployment model, where necessary, to move staff as a priority to ensure safest staffing against sickness/absence/vacancy rates.

All our providers have complied with national guidance on the need for healthcare staff to self-isolate during Covid peaks, often causing sudden loss of significant staffing numbers, which more recently has become less of an issue.

We are actively engaged in the adoption of all national recruitment and retention programmes to recruit and keep our nurses and have developed new roles and flexible ways of working to support safer staffing.

I hope that you find this information helpful in your response, if you require any additional information then please don't hesitate to contact me.

Yours sincerely

[redacted]

Chief Executive Officer, ICB

CC [redacted], Strategic Director, Care and Wellbeing, Cornwall Council
[redacted], Chief Executive Officer, CFT
[redacted], Chief Executive Officer, RCHT
[redacted], Chief Nursing Officer, UHP
[redacted], NHS England, Medical Director