Community Areas of Sustainable Care and Dementia Excellence in Europe

CASCADE

Baseline Case Study Report

The Rich Picture

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Acknowledgements

Thanks go to PP 2,3,5,6 and 8 who supplied the materials for this baseline rich picture case study document.

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1. Introduction

The purpose of this report is to construct a Rich Picture as a method of gathering the background story about PP 2,3,5,6 and 8 looking at:

- Structures
- Processes
- Climate
- People
- Issues expressed by people
- Areas of challenge/concern

This will help us to co-create an evaluation that is tailored to each partner's needs as well as providing information about each partner organisation as case study site to facilitate cross site analysis and sharing of best practice during the course of the four year project. The template used to gather information is available in Appendix 1 and this framework has been used by partners to send their rich picture. It is not at this point meant to be comparative.

"Rich pictures" were developed as part of Peter Checkland's Soft Systems Methodology (SSM) for gathering information about a complex situation, often displayed diagrammatically (Checkland 2000). In SSM, there are two interacting streams of enquiry that attempt to understand how the systems and processes within organisations interact and intrinsically affect each other.

2. Rich Picture Summaries for each Partner

2.1. PP2 East Kent Hospitals University Foundation Trust

- **Location**
  - East Kent, England
- **Organisation type**
  - NHS Foundation Trust
- **Patient population served, number and characteristics**
  - EKHUFT provides a range of core and specialist healthcare services to a population of more than 750,000 across east Kent. The Trust receives more than 200,000 emergency attendances, 100,000 inpatient spells and 750,000 outpatient attendances per year.

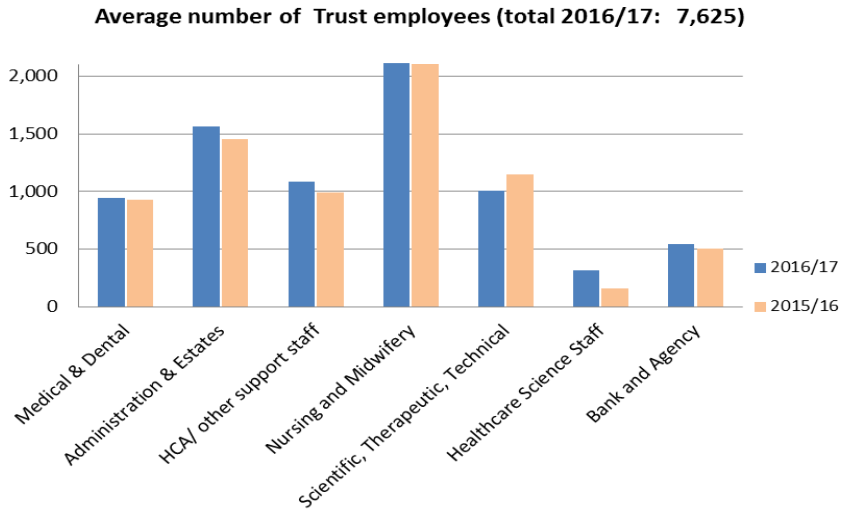
- **Number of beds**
  - The Trust has more than 1,000 beds spread over 3 hospital sites, providing 27 critical care beds, and other specialist wards for maternity, paediatrics, and neonatal intensive care.

- **Number of sites**
  - The William Harvey Hospital (WHH), Ashford is an acute hospital providing a range of emergency and elective services as well as comprehensive maternity, trauma, orthopaedic and paediatric and neonatal intensive care services. The hospital has a specialist cardiology unit undertaking angiography, angioplasty, a state of the art pathology analytical robotics laboratory that reports all East Kent's General Practitioner (GP) activity and a robotic pharmacy facility. A single head and neck unit for east Kent includes centralised maxillofacial services with all specialist head and neck cancer surgery co-located on the site. WHH has a postgraduate teaching centre and staff accommodation.
  - Kent and Canterbury Hospital (K&CH), Canterbury is an acute hospital providing a range of elective and urgent care services including an Urgent Care Centre. It provides a central base for many specialist services in east Kent such as renal, vascular, interventional radiology, urology, dermatology, neurology and haemophilia services. K&CH has a postgraduate teaching centre and staff accommodation.
  - Queen Elizabeth the Queen Mother Hospital (QEQM), Margate is an acute hospital providing a range of emergency and elective services and comprehensive trauma, orthopaedic, obstetrics, general surgery and paediatric services. The hospital has a specialist centre for gynaecological cancer and modern operating theatres, intensive therapy unit (ITU) facilities, children's inpatient and outpatient facilities, a cardiac catheter laboratory and cancer unit. QEQM has a postgraduate teaching centre and staff accommodation. On site there are also co-located adult and elderly mental health facilities run by the Kent & Medway NHS and Social Care Partnership Trust (KMSCPT).
  - Buckland Hospital (BDH), Dover is a community hospital that provides a range of local outpatient services. Its facilities include a minor injuries unit walk-in centre, outpatient facilities, renal satellite services, day hospital services, child health and child development services and diagnostic facilities.
  - The Royal Victoria Hospital (RVH), Folkestone is a community hospital that provides a range of local services. The hospital provides a minor injuries unit with a walk-in centre, a thriving outpatients department, the Derry Unit (which

offers specialist gynaecological and urological outpatient procedures), diagnostic services, and mental health services provided by the KMSCPT.

- **Number of staff and skill mix- ratio of qualified and unqualified staff**

Figure 1: Trust employee skill mix



- **Regional specialties**
  - The Trust provides some services to an even bigger catchment area e.g. Primary Percutaneous Coronary Intervention (PPCI) to a catchment area of 1.2million people, as well as Vascular and Renal services.

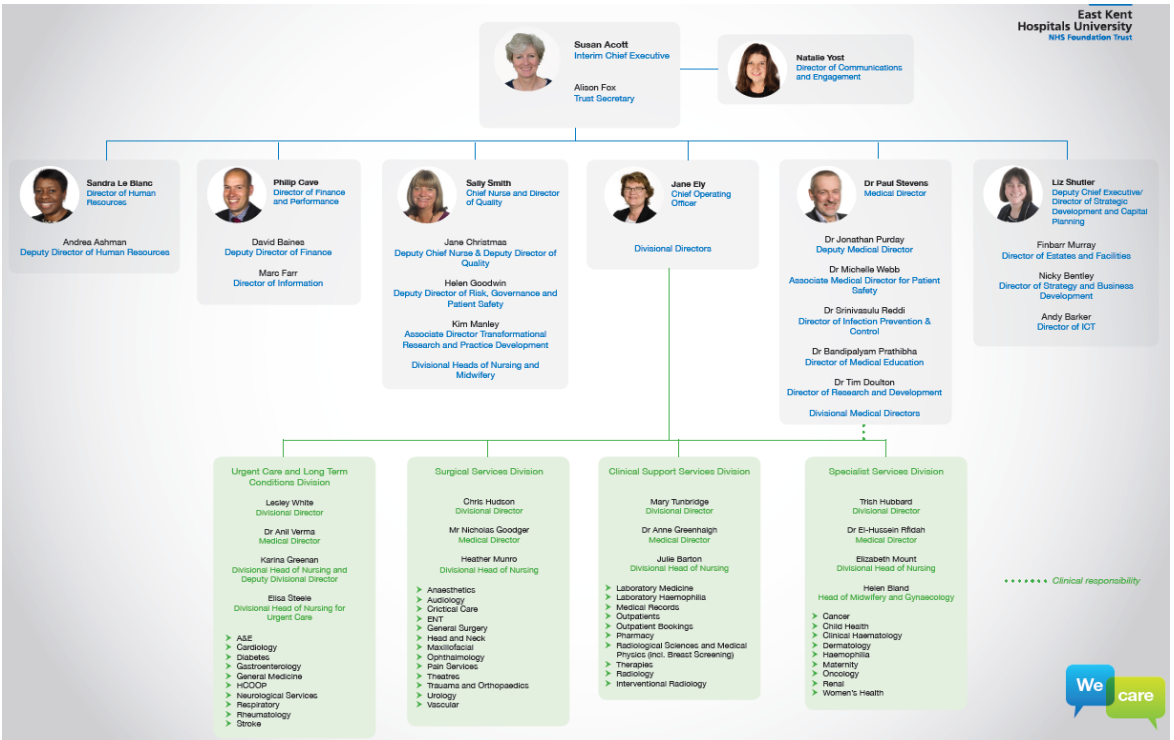
- **Vision and values**
  - Vision, mission and values
    - Our mission: *Together we care: improving health and lives*
    - Our vision: *Great healthcare from great people*
  - Values - We care so that:
    - People feel cared for as individuals
    - People feel safe, reassured and involved
    - People feel teamwork, trust and respect sit at the heart of everything we do
    - People feel confident we are making a difference
  - Strategic priorities
    - Patients – help all patients take control of their own health
    - People – identify, recruit, educate and develop talented staff

- Partnerships – work with other people and organisations to give patients the best care
- Provision – provide the services people need and do it well

Figure 2: Vision, mission and values hierarchy

- **Key staff, support and governance structures**

Figure 3: Trust senior management organogram



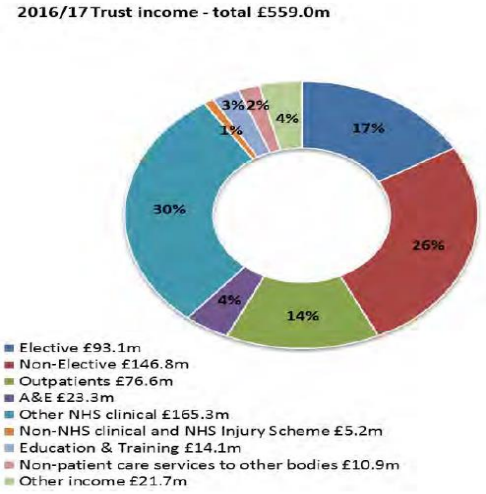
- **Funding and commissioning model and headline figures on income, turnover & expenditure**
  - The Trust achieved Earnings before Interest, Tax, Depreciation and Amortisation (EBITDA) of £2.1m. The Trust achieved an actual deficit, on an NHS breakeven duty basis, for the year of £24.3m.
  - The Trust submits an annual plan to its regulator NHS Improvement, each financial year.

Table 1: Trust Performance (including Healthex Limited, excluding East Kent Hospitals Charity)

Heading	Actual Performance	
	Plan	Achievement
Total income	£565.7m	£565.4m
Income & expenditure surplus/(deficit)	£0.3m	£(31.2)m
Reported savings	£20m	£18.8m
Closing cash balance	£3m	£5m
Trust Capital programme	£12.3m	£12.2m
EBITDA	£29.9m	£2.6m

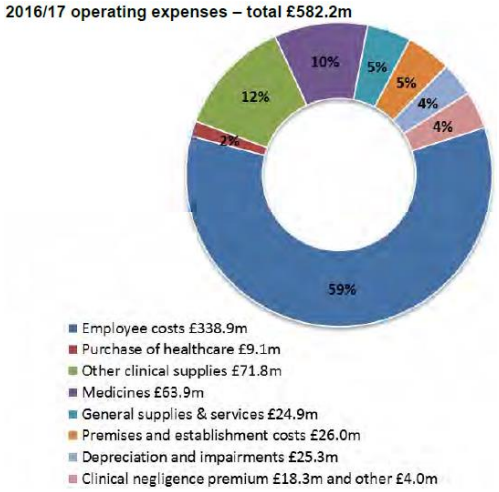
  - Income: Total Trust income £559m (2016/17) was 0.05% higher than the previous year as income has been generated based on activity performed (see figure 4). The NHS Act 2006 requires that income for providing patient care services must be greater than income for providing any other goods/services. The Trust can confirm that 92% of total Trust income comes from providing patient care services. Any surplus made on the remaining 8% of income is used to support the provision of patient care. The majority of income for patient care came from NHS commissioners, mainly the East Kent Clinical Commissioning Groups (CCGs) and NHSE specialist services, secondary dental and screening programmes, which together accounted for £499.8m of the Trust's income in year.

Figure 4: Trust income 2016/17



- Operating expenses: Total Trust costs increased by 4.5% (£25m) compared to the previous year. Fifty-eight percent (58%) of the Trust's expenditure is for employees' salaries and payment of temporary staff. Clinical supplies and medicines together account for 56% of non-pay costs. In 2016/17 operating expenses were £582.2m (see figure 5).

Figure 5: Trust operating expenses 2016/17



- **Any cross border partnerships or collaborations central to delivery of the model of care**
  - N/A

Why is your organisation involved in the CASCADE project?

- **Local focus of the project**
  - The high number of people living with dementia (PLWD) is placing a burden on EKHUFT in terms of taking up capacity, decreasing efficiency and increasing costs. In 2015 there were 6,667 bed-days used by PLWD who were on the

caseload of the integrated discharge team (the team who organise the safe discharge of patients who no longer have a medical need to be in hospital), this equates to 18 beds.

- New financially sustainable methods of providing nursing care for patients living with dementia will be vital if the challenges presented by the rapidly increasing elderly population are to be addressed.
- Following a trip by EKHUFT staff to Hogewey[1], a purpose built dementia village in Holland, the potential for a similar development in East Kent was examined. Unfortunately, the capital requirements for such a facility were prohibitive. An alternative approach using existing EKHUFT housing in a modular fashion was developed. It showed the potential for a new approach to providing nursing care for PLWD that more closely integrates with acute and community care and which benefits from the specialist skills that are available in geriatric medicine within EKHUFT. The overall aim of the dementia village project is to develop a low cost operational model based on existing, low value housing, in deprived areas.

Reason for looking at this area

- Currently elderly care and care for PLWD is provided by organisations using large facilities to exploit economies of scale. This requires high capital input at a time when access to capital is restricted in the UK healthcare sector.
- A number of recent reports have highlighted the shortcomings in the current provision of dementia services in the UK. Dementia presents a huge challenge to society, both now and increasingly in the future. In 2015 there were 850,000 people living with dementia in the UK, by 2025 this will have grown to 1,142,677[2]. Dementia now costs the UK economy £26.3 billion a year, with this figure set to rise.
- Demographic trends in East Kent point to large increases in the elderly population over the next 10 to 20 years. It is anticipated that these demographic changes will result in increased pressure on EKHUFT, since the elderly population place a disproportionately high demand on acute hospital services. This view is endorsed by the Royal College of Physicians who have stated, “our hospitals are struggling to cope with the challenges of an ageing population

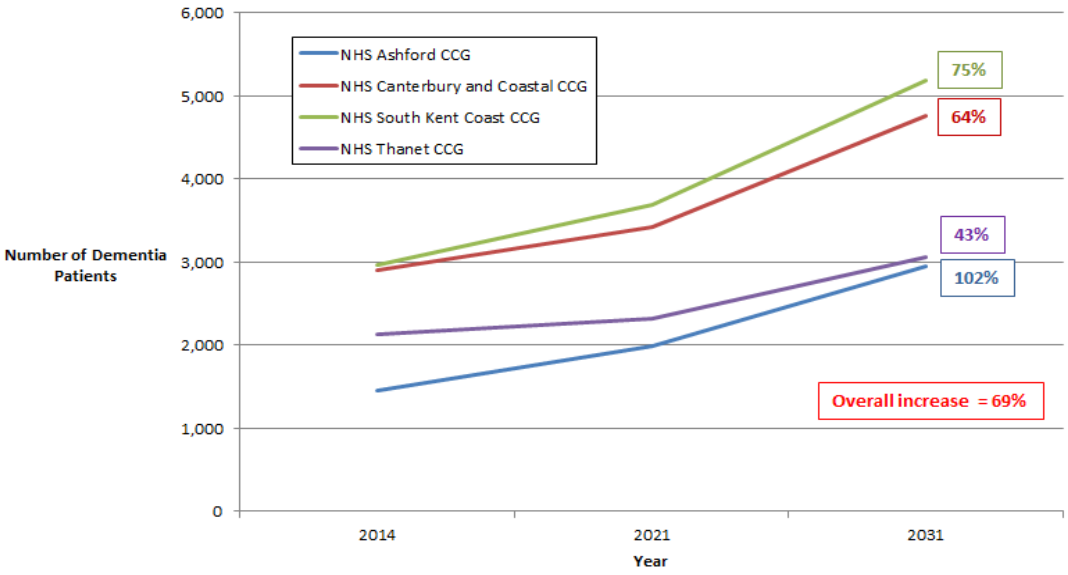
[1] http://www.vivium.nl/hogewey

[2] “Dementia 2015: Aiming higher to transform lives” (2015) Alzheimer’s Society

and rising hospital admissions"[3].

- Using 2014 prevalence rates of PLWD as a baseline[4] Kent County Council (KCC) age band and gender population projections[5] were used to calculate the future numbers of people living with dementia in the east Kent CCGs (see figure 6).

Figure 6: Number of PLWD in East Kent 2014-2031



- The data shows that the total number of PLWD across the four east Kent CCGs will rise from 9,458 in 2014 to 15,941 in 2031, an increase of 69%.

- **Who is involved**
  - Clinical staff
    - Consultants, junior doctors, nurses, therapists
  - Other staff
    - Operational and strategic development, human resources, finance, estates and procurement
  - Other stakeholders
    - Community clinicians
    - East Kent dementia transformation group
    - Dover GPs
    - South Kent Coast Clinical Commissioning Group

[3] David Oliver (2012) "Are acute care pathways fit for our ageing population? How do we need to improve?" ECIST Conference. Birmingham

[4] "Projecting older people population information" http://www.poppi.org.uk/

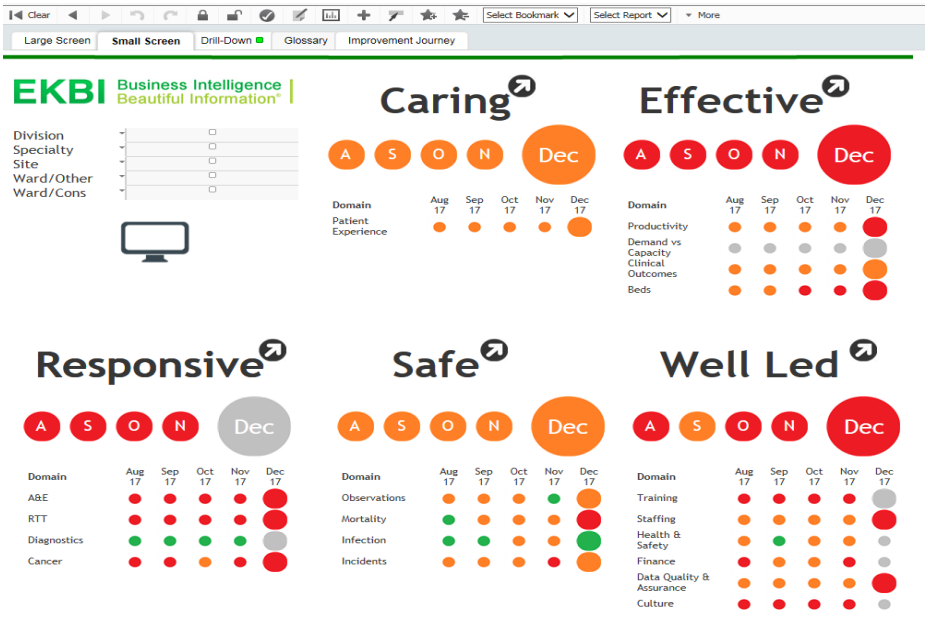
[5] "Kent Adult Accommodation Strategy: Evidence Base - Interpretation of the report to Kent County Council, Social Care, Health and Wellbeing by the Health and Housing Partnership" (2014) Health & Housing Partnership LLP https://www.kent.gov.uk/__data/assets/pdf_file/0014/14252/CHv-Adult-Accommodation-Evidence-Final-Report.pdf

- Various voluntary groups/charity's e.g. Alzheimer's Society, including patient and carer representatives

How is quality of care and services measured?

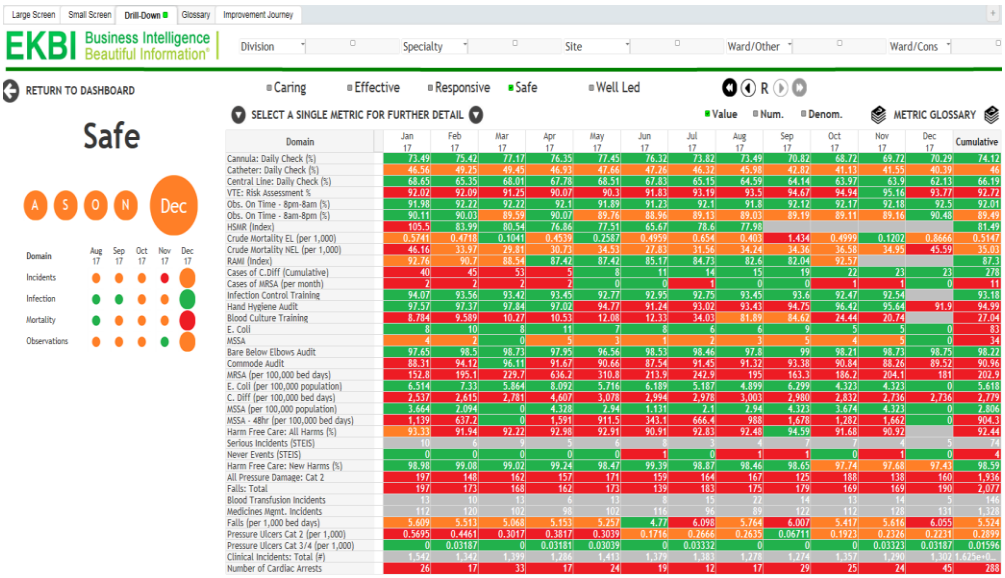
- **Dashboard data collected monthly including staff metrics**
  - Comprehensive metrics are collected and reported via a bespoke online system (see figure 7 for a snapshot of the user interface).

Figure 7: Trust performance metrics dashboard



- **Local care quality metrics collected related to safety**

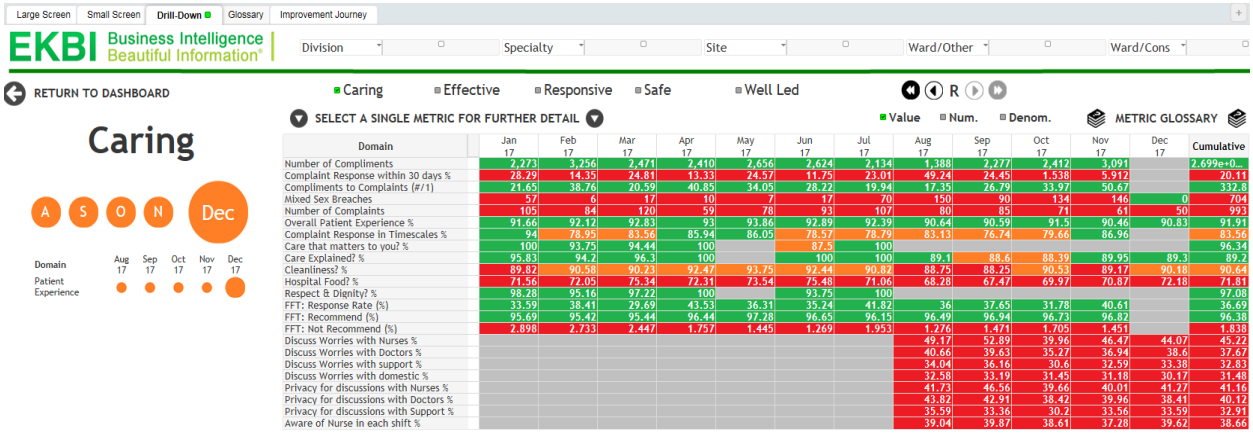
Figure 8: Safety metrics dashboard



- **Local patient safety challenges over previous year (e.g. never events, care quality inspectors feedback, International Prevalence Measurement of Care Quality (LPZ) etc.)**
    - The Trust was placed in special measures by NHS Improvement in 2014 when the Care Quality Commission (CQC) rated the Trust 'inadequate'. A year later, the Trust was upgraded to 'requires improvement' because of "bigsteps forward" witnessed by the CQC. The Trust remained in special measures to allow more time to embed the improvements fully.
    - The CQC re-inspected the hospitals in September 2016. This was the third inspection for the Trust since 2014 and looked in detail at four areas - emergency care, medical services, maternity and gynaecology and end of life care - at three of the Trust's five hospitals.
    - While the overall Trust rating remains 'requires improvement', the CQC report, published in December 2016, indicated a number of areas in which further significant improvements have been obtained, notably that there are no longer any elements rated inadequate.

- **Patient /staff complaints/compliments**

Figure 9: Complaints/compliments dashboard



Domain	Jan 17	Feb 17	Mar 17	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Cumulative
Number of Compliments	2,273	3,256	2,471	2,410	2,656	2,624	2,134	1,388	2,277	2,412	3,091		2.699e+0..
Complaint Response within 30 days %	28.29	14.35	24.81	13.33	24.57	11.75	23.01	49.24	24.45	1.538	5.912		20.11
Compliments to Complaints (#/1)	21.65	38.76	20.59	40.85	34.05	28.22	19.94	17.35	26.79	33.97	50.67		332.8
Mixed Sex Breaches	57	6	17	10	7	17	70	150	90	134	146	0	704
Number of Complaints	105	84	120	59	78	93	107	80	85	71	61	50	993
Overall Patient Experience %	91.66	92.12	92.83	93	93.86	92.89	92.39	90.64	90.59	91.5	90.46	90.83	91.91
Complaint Response in Timescales %	94	78.95	83.56	85.94	86.05	78.57	78.79	83.13	76.74	79.66	86.96		83.56
Care that matters to you? %	100	93.75	94.44	100		87.5	100						96.34
Care Explained? %	95.83	94.2	96.3	100		100	100	89.1	88.6	88.39	89.95	89.3	89.2
Cleanliness? %	89.82	90.58	90.23	92.47	93.75	92.44	90.82	88.75	88.25	90.53	89.17	90.18	90.64
Hospital Food? %	71.56	72.05	75.34	72.31	73.54	75.48	71.06	68.28	67.47	69.97	70.87	72.18	71.81
Respect & Dignity? %	98.28	95.16	97.22	100		93.75	100						97.08
FFT: Response Rate (%)	33.59	38.41	29.69	43.53	36.31	35.24	41.82	36	37.65	31.78	40.61		36.69
FFT: Recommend (%)	95.69	95.42	95.44	96.44	97.28	96.65	96.15	96.49	96.94	96.73	96.82		96.38
FFT: Not Recommend (%)	2.898	2.733	2.447	1.757	1.445	1.269	1.953	1.276	1.471	1.705	1.451		1.838
Discuss Worries with Nurses %								49.17	52.89	39.96	46.47	44.07	45.22
Discuss Worries with Doctors %								40.66	39.63	35.27	36.94	38.6	37.67
Discuss Worries with support %								34.04	36.16	30.6	32.59	33.38	32.83
Discuss Worries with domestic %								32.58	33.19	31.45	31.18	30.17	31.48
Privacy for discussions with Nurses %								41.73	46.56	39.66	40.01	41.27	41.16
Privacy for discussions with Doctors %								43.82	42.91	38.42	39.96	38.41	40.12
Privacy for discussions with Support %								35.59	33.36	30.2	33.56	33.59	32.91
Aware of Nurse in each shift %								39.04	39.87	38.61	37.28	39.62	38.66

Figure 10: Historical data on compliments and complaints

	Date Received				
	2012/13	2013/14	2014/15	2015/16	2016/17
Total number of formal complaints received	768	894	1,036	873	1,076
Informal concerns received	2,729 (combined with PALS)	3,521 (combined with PALS)	843	828	605
PALS contacts received	-	-	2,787	2,677	3,252
Compliments received	15,391	17,076	31,860	30,855	36,747

- The number of compliments has increased by 19% in 2016/17 (30,855 for 2015/16 compare to 36,747 for 2016/17).

- **Incident reporting**
  - The Trust have a patient safety team who monitor report and investigate all incidents (see also dashboard in figure 8).

- **Tools and measurements used to track financial, quality of care and service improvements**
  - The Trust's 2016/17 contracts with the four East Kent CCGs were agreed on a payment by results basis meaning the Trust was paid for the actual clinical work delivered. This is a change from 2015/16 when the Trust was paid on a managed contract basis. The Trust continues to operate in financial special measures and the Trust's regulator required it to prepare plans to stabilise its financial performance during the year and improve this performance in future years.

How are these reported and to whom?

- Integrated Performance Report (IPR), contains reporting against the five CQC domains i.e. Safety, Caring, Response, Effective and Well-led. The reports are produced on a monthly basis and there is a visible intranet platform using Qlikview. A comprehensive report goes to Management Board every month, which is then also reported at the Trust Board, Quality Committee and the Executive Performance Reviews. All information is in the public domain, and with the Trust's commissioners. All the metrics have an agreed target and tolerance built-in and there is a narrative within each domain section to explain any variation.

What mechanisms of care quality regulation (external) are in place and how are these monitored? (e.g. International Prevalence Measurement of Care Quality (LPZ)

- The Trust is regulated by the Care Quality Commission and they produce a monthly performance report, which gives a measure of quality and national performance comparative data; it's called Insight. Regulation is through a legal framework and the CQC have the ability to apply enforcement notices should there be quality concerns. This is in addition to their sanction of special measures. European partners will have different care quality measures, which do not have a legal framework.

What if any, are the key areas for concern or challenge within the organisation currently?

- The Trust was placed in special measures by NHS Improvement in 2014 when the CQC rated the Trust 'inadequate'. The CQC re-inspected the hospitals in September 2016. This was the third inspection for the Trust since 2014 and looked in detail at four areas - emergency care, medical services, maternity and gynaecology and end of life care - at three of the Trust's five hospitals.
- While the overall Trust rating remains 'requires improvement', the CQC report, published in December 2016, indicated a number of areas in which further significant improvements have been obtained, notably that there are no longer any elements rated inadequate. Due to the sustained improvement seen, the CQC Chief Inspector of Hospitals, Sir Mike Richards, made the recommendation following the visit when the Trust was removed from Special Measures. NHS Improvement confirmed the Trust's exit from Quality Special Measures in March 2017.
- The Trust remains in financial special measures, which imposes direct reporting requirements to NHS Improvement, and stringent governance of capital spend and budgets.
- The Trust has a new improvement plan, through which it is working with the other NHS and social care organisations in East Kent to keep improving services. The areas the Trust is particularly focusing on are: recruiting and retaining more staff, enabling more patients to access treatment sooner, improving the flow of patients through our hospitals, fully embedding early signs of improvement in maternity and end of life care, and making financial savings.

- Like many hospital trusts across the country, the Trust has continued to see significant pressure on emergency care services. The winter period was particularly pressured, with all our hospitals seeing unprecedented levels of demand for services. The balance of delivering care and treatment whilst maintaining good financial and operational performance has continued to be challenging.
- Improving emergency care performance remains a key priority and a challenge to ensure more patients are seen, treated and discharged or admitted within the four-hour standard. There are a number of issues around this, including increasingly complex healthcare needs and patient flow through our hospitals. We have introduced new technologies to speed up some of our processes in the emergency departments, and working with staff and partners to enable efficient discharges into the community when a patient is clinically fit and able to leave hospital. The dementia village is aligned with this approach.
- The Trust is working closely with NHS Improvement as part of financial special measures to continue to rebuild its financial health.
- Recruitment of clinical staff to the Trust is an on-going area of concern across most specialties and services e.g. lacking in stroke consultants in East Kent and the whole K&M region.
- The Trust has struggled to recruit permanent consultants in some specialties at K&CH, which was leading to a quality of junior doctor training at the hospital that was below the standards required. In March 2017, Health Education England recommended that 38 out of 76 trainees be moved to the Trust's other two acute hospitals - the WHH and QEQM - to continue with their training.
- The Kent and Medway Health and Social Care Sustainability and Transformation Plan (STP) was jointly developed by the NHS, KCC and Medway Council. It sets out a vision for better health, wellbeing and standards of care for people in Kent and Medway, and achieving more with the staff and funding available. The vision in the STP is about preventing people from becoming unwell in the first place; enhancing people's mental health; providing as much care locally as possible and using hospital care appropriately. The Trusts six priority areas to focus on in 2017/18 are:
    - Quality improvement
    - Clinical strategy
    - Continuous improvement of performance standards

- Financial sustainability
- Organisational culture and development
- Workforce redesign.

2.2. PP3 Medway Community Health Care CIC

Information required	Detail
Location (Headquarters)	Medway Community Healthcare MCH House, 21 Bailey Drive, Gillingham Business Park, Gillingham, Kent ME8 0WG
Organisation type	**Social Enterprise CIC (Community Interest Company)**
Patient population served, number and characteristics	The latest mid-year estimate indicates that the population of Medway reached **278,542** in June 2016 – 2,050 persons (0.8%) above the 2015 mid-year figure. **Characteristics (Information taken from the Index of Deprivation 2015)** In the overall measure of deprivation, the most 'relatively' deprived communities are concentrated in central urban areas in Medway – most notably in Chatham Central, Gillingham North and Luton & Wayfield. Medway is relatively worse off in the 2015 index - compared to the 2010 index - with a general widening and worsening of Medway's central most deprived neighbourhoods. Medway is ranked 118th most deprived Local Authority of 326 in England in the latest index (2015). This is a relatively worse position than in the previous index in 2010, when Medway was ranked 136th most deprived of 325. While Medway has many areas, which fair relatively poorly on income and employment deprivation - the two major themes in the multiple index – crime stands out as a particular weakness, with Medway ranking 53rd most deprived Local Authority in England for crime. After that, 'education, skills and training' has a ranking of just 86th most deprived. In the 2015 index, Medway has thirty-two neighbourhoods ranked in the 20% most deprived nationally and 12 ranked in the 10% most deprived. Medway's most deprived neighbourhood, in River ward, is now ranked in the most deprived 1% of areas nationally. **Income** Medway is ranked in the 32% most deprived local authorities in England for income. This is worse than Medway's overall position for multiple deprivation, being in the 37% most deprived local authorities in England overall. Medway has twenty-nine neighbourhoods ranked in the 20% most deprived nationally and within those ten are ranked in the 10% most deprived. This is up on the 2010 index position, with an extra five neighbourhoods in the most deprived 20%. **Child Poverty** Medway is ranked in the 28% most deprived Local Authorities in England for Child Poverty - this is worse than Medway's income ranking, being in the 32% most income deprived Local Authority and below Medway's overall position for multiple deprivation being in the 37% most deprived Local Authorities in England.

Information required	Detail
	Employment Medway is ranked in the 33% most deprived local authorities in England for employment - this is worse than Medway's overall position for multiple deprivation, being in the 37% most deprived local authorities in England. Medway has thirty-two neighbourhoods ranked in the 20% most employment deprived areas nationally and within those nine are ranked in the 10% most deprived. This is up on the 2010 index position, with an extra eight neighbourhoods in the most deprived 20%. **Disability** Medway is ranked in the 43% most deprived local authorities in England for health and disability – this is better than Medway's overall position for multiple deprivation, being in the 37% most deprived Local Authorities in England. Medway has twelve neighbourhoods ranked in the 20% most health deprived areas nationally, within those four are ranked in the 10% most deprived. Three less neighbourhoods are in the most deprived 20% compared to the 2010 index, but one extra is in the 10% most deprived. **Education & skills** Medway is ranked in the 27% most deprived local authorities in England for 'Education skills and training' - this is worse than Medway's overall position for multiple deprivation, being in the 37% most deprived local authorities in England. Education skills and training is Medway's second weakest theme (after crime). 'Education, skills and training' is broken down into two sub-themes, one covering educational attainment of younger people and another covering adult skills. It would appear that Medway fairs worse on young people's qualifications over adult skills. **Adult Skills** Skills amongst the adult population in Medway appear to be relatively less of an issue than young people's education. However, ten areas are ranked in the 10% most deprived nationally. Three of these areas are located in Twydall. Adult skills appears to be an issue across quite a wide area of Medway, with a wide central band as well as a number of areas on the Hoo Peninsula being most deprived. **Barriers to Housing & Services** The Barriers to Housing and Services deprivation measure relates to 'the physical and financial accessibility of housing and key local services'. Medway is ranked in the 27% least deprived local authorities in England for 'Barriers to Housing and services' - this is Medway's strongest deprivation theme. **Housing & Quality** Housing quality under the indoors environment theme measures housing in poor condition and houses without central heating. Thirty-six areas are ranked in the 20% most deprived nationally for housing quality. Air Quality & Road Traffic Accidents A total of forty-four areas are ranked in the 20% most deprived nationally for air quality and road traffic accidents.

Information required	Detail
	Ref: http://www.medway.gov.uk/planningandbuilding/planningpolicy/factsandfigures.aspx
Number of beds	Darland House (Nursing Home)– 40 Wisdom Hospice – 12 Endeavour (Stroke Rehab) - 15 Britannia (Rehab) - 20
Number of sites	10
Number of staff and skill mix –ratio of qualified and unqualified staff	1372 staff Approximately 66% clinical, 34% non-clinical
Regional specialities	MCH provides a variety of community services for Medway including physiotherapy, speech and language therapy, dietetics and nutrition, intermediate care, community nursing, learning disability, phlebotomy, dermatology, tissue viability, cardiology, stroke including rehabilitation, respiratory and Diabetes. MedOCC which is an out of hours GP service is provided by MCH and based both at our local acute trust and our headquarters MCH has very recently been awarded the Children's Service tender for Medway, which means we will be providing children's community services. This contract has an income of £52.5m over a 5 year period. We have a Dementia Crisis Support Service, which is unusual for a community provider. These teams usually exist within Mental Health organisations. We currently manage 2 GP surgeries within Medway and aim to grow our primary care provision
Vision and values	**Our vision** Our vision describes how we see MCH in the future, as: - A successful, vibrant, community interest company that benefits the communities we serve. Whilst our purpose sets out the primary focus and direction of our business: - To provide community health and social care services, principally across Medway and the surrounding areas. **The strategic aims set out the key actions for achieving our vision:** - • To continue to provide integrated community health services and expand other health provision • To expand our provision of personalised care • To diversify to other service areas linked to health e.g. support services • To diversify income streams • To expand deliver of primary care

Information required	Detail
	Our values As a social enterprise, it is vital that we have a shared understanding of the values we need to underpin everything we do. To achieve this in consultation with staff and stakeholders, we developed our organisational values. These are: • we are caring and compassionate • we deliver quality and value • we work in partnership Our values have been agreed by our Board and form the basis for ensuring that we all adopt and work to the same shared behaviours. In March 2014, the Board again listened to staff when refreshing the values, simplifying the behaviours to give focus. We will use our values to illustrate what makes us different from other healthcare providers and employers and support our vision. Our values circle illustrates the central behaviours that underpin all of our values around which sits our key organisational values and then the behaviours that bring our values to life.
Key staff, support and governance structures	Please see attached, some of the names have changed but the structures are basically the same executive-structure-(with-pictures)-2017. finance-structure.pdf operations-structure-2017.pdf quality-structure.pdf corporate-structure.pptx
Funding and commissioning model and headline figures on income/turnover/expenditure	Medway Community Healthcare is a £57 million business providing a wide range of both planned and unscheduled care in local settings. NHS Medway commissions the majority of our services within a block contract. Community Services within Medway are soon to be re-procured (2020) and MCH is working with NHS Medway as part of this project
Any cross border partnerships or collaborations central to delivery of model of care	**We work closely with** • NHS Medway – Commissioners • Medway NHS Foundation Trust – Local acute trust • Kent & Medway Partnership Trust – Local Mental Health provider • Virgin Care – Local service provider • Swale CCG – Commissioners • Avante – Host for intermediate care ward • Local charities As a social enterprise we are part of a consortium, Albion which consists of two other social enterprises providing health care services
Local focus of the project	Provision of high quality respite care for people living with dementia and their families. Ability to utilise available land/space owned by MCH Utilisation of services already available on proposed site
Reason for looking at this area	2015 Gap analysis carried out by Partnership Commissioning at Medway Council clearly highlighted need for good quality respite care Anecdotal evidence from Dementia Community Crisis team highlighting need for respite and the impact the availability would have on people staying in their own homes for longer
Who is involved	• Tracy Webb

Information required	Detail
	• Samantha Robinson • Jody Howie & Laarni Fajardo – Clinical Lead • CASCADE project team
Dashboard data collected monthly including staff metrics	♦ CQUINs – including appraisal, statutory and mandatory training, nutritional assessment, falls ♦ Service specific KPIs used to provide quality assurance ♦ Operational performance suite – provides service data relating to quality and HR ♦ Service performance against contract - includes data for each team showing referral and contact information against planned ♦ Clinical Quality Data – as mentioned in section below
Local care quality metrics collected related to safety	Patient safety data is collated on a monthly basis and includes customer experience, complaints and compliments and audit compliance. The following is reported: **Infection Prevention & Control** Hand Hygiene Compliance Infection Prevention & Control Training Compliance MRSA Screening Incidence C. Diff infections Incidence Norovirus Incidence Influenza **Patient Safety** Achieving zero avoidable pressure ulcers Total incidents Total incidents with harm Serious incidents Total falls Falls with harm Total medication errors Medication errors with harm Uninvestigated incidents Lessons learnt recorded Duty of Candour training compliance Wrist band errors **Clinical Effectiveness** Documentation audit compliance Braden assessment Falls assessment MUST assessment Personalised care planning Measurable goals GAIN (Goveranance, Advice and Information Network) representation Research portfolio studies **Patient Experience** Family & Friends Community score Family & Friends Primary Care score Complaints Lessons learnt recorded
Local patient safety challenges over previous year	Issues relating to IPC including surveillance (MRSA, Norovirus, C Diff) Pressure sores – acquired in our care and inherited Management of falls

Information required	Detail
	Reporting of Serious Incidents – ensuring effective investigation and root cause analysis, along with the sharing of lessons learnt and embedding changes to practice
Patient/staff complaints/compliments	Feedback given by patients about their experience of care and treatment is important to MCH and helps to make improvements to services. Patients are actively encouraged to provide feedback and share their comments, compliments, concerns and complaints. This is promoted through the patient experience programme, Tell Us leaflets and via the website. During the year, we invited patients to be interviewed and share their experiences. These interviews were not just focussed on negative experiences but also the positive feedback from patients and are shared to boost staff morale, encourage more of the same and will be used in training scenarios. All complaints and grumbles received by the Customer experience team are recorded on our risk management system (Datix) which provides standard categorisation of complaints. The categories detailed on Datix are used to inform MCH, our commissioners and the Department of Health of the number and types of complaints received. The trends and lessons learnt from our complaints and compliments are shared at the Governance Assurance and Information Network (GAIN), identifying key learning points for dissemination to services and teams.  c-e-report-(final).pdf Attached is the Patient Experience report for 2015/16. The report for 2016/17 is currently being written however I can report that for 2016/17, 96.3% of our patients would recommend MCH as a place to receive care
Incident reporting	All incidents are reported via the DATIX system. Clinical leads and senior managers investigate the incidents and report on findings and lessons learnt. Lessons learnt are shared with team and wider organisation Serious incidents are reported via Datix and STEIS
Tools and measurements used to track financial, quality of care and service improvements	As per my comments above
How are these reported and to whom?	Reported as per our governance structure and appropriate meetings: • Business Unit Meetings – review of services within the business unit including scrutiny of budgetary and contractual issues. • Preventing Harm Oversight Group – oversee and review patient safety issues, reporting against CQUINs, potential harm and risks • Quality Assurance Committee – oversee and review all areas involving quality • Infection Control Sub Committee – reports into Quality Assurance Committee and Exec • Medicines Management – reports into Quality Assurance Committee and Exec • Infrastructure Group – reports to Exec • Performance Oversight Group – reports to Exec
What mechanisms of care quality regulation are in place and how are these monitored?	♦ Friends and Families ♦ Compliments and complaints ♦ CQUINs (local & national) ♦ CQC monitoring and assessment ♦ GAINing Insights – an internal programme of mock CQC inspections
List of current challenges or areas of concern and	Maintaining and building on collaboration with external partners in a world of competition

Information required	Detail
how these are being addressed	Negotiating contracts in their various forms, offering realistic service provision Finance and budget setting Engagement with our community – this is reviewed by our clinical quality team and alternative approaches trialled

2.3. PP5 ZorgSaam

Location:

- *De Honte, Terneuzen (the Netherlands)*

Organisation type:

- *Care/*Cure

Patient population served, number and characteristics*:*

- Estimated 200.000 visitors, 12.500 multiple days of hospital treatments and 10.000 day-time treatments (Cure), 210 patients in residential Care Centres and 4.650 Home Care clients.

Number of beds:

- *Care (210 clients)*

Number of sites:

- Care (Coensdike, Emmaus, Bachten Dieke and Vremdieke*)* – four sites

Number of staff and skill mix- ratio of qualified and unqualified staff:

- Cure/Care 1613 FTE employees, 100 medical specialists, 50 ambulance employees and 400 volunteers*.*

Regional specialties:

- *Hospital, Ambulance, Home- and Elderly Care for the region Zeeuws-Vlaanderen.*

Vision and values:

- *ZorgSaam Zeeuws-Vlaanderen is the biggest health-care provider and employer, providing care and cure for clients in this region.*

Key staff, support and governance structures

Funding and commissioning model and headline figures on income/turnover/expenditure

- *Not available*

Cross border partnerships or collaborations central to delivery of the model of care:

- *Regional Partnerships considering; Welfare and Health with Belgian Partners such as; UZ Gent and Maria Middelares (Gent) - Cure*

Why is your organisation involved in the CASCADE project?

Local focus of the project:

- The local focus is on the elderly with dementia and the vulnerable elderly.

Reason for looking at this area

- This area of ZorgSaam has an increasing population of elderly combined with a decreasing total population. This gives a great opportunity to carry out the project and to see what the chances are to develop and implement an care model that is sustainable for the future.

Who is involved?

- In this region ZorgSaam en HZ.

How is quality of care and services measured?

- Dashboard data collected monthly including staff metrics

Every year a quality plan and quality report is drawn up, in accordance with the quality framework for nursing home care. Herein, the following items are included:

- Local care quality metrics collected related to safety: Quality control through process audit; qualitative and quantitative dossier control on outcome indicators (including medication, decubitus, freedom-restricting measures, etc.).
- Local patient safety challenges over previous year (e.g. never events, care quality inspectors feedback, International Prevalence Measurement of Care Quality (LPZ) etc.): Incident investigation / supervision of VIM trends and complaints analysis.
- Patient /staff complaints/compliments: *Employees (Work Council), Patient and client (Participation Council)*
- Incident reporting: Client satisfaction: continuous follow-up through the care card of the Netherlands.
- Tools and measurements used to track financial, quality of care and service improvements: Employee satisfaction: periodically (1x 3 years).

How are these reported and to whom? The personnel composition and formation

- This quality plan and quality report is published internally and externally. (IGJ / Zorgkantoor / Zorginstituut Nederland)

What mechanisms of care quality regulation (external) are in place and how are these monitored? (e.g. International Prevalence Measurement of Care Quality (LPZ)

No information.

2.4. PP 6 Emmaus Elderly Care

The Emmaüs group consists of two general hospitals, 7 facilities for mental health care, 4 to support persons with a disability, 6 for children, youth and families and 4 in elderly care. Facilities of Emmaus are rooted in a Christian tradition.

Emmaus is located in Ten Kerselaere, Hallaar, a municipality of Heist-op-den-Berg and has a surface of 6.9km² and approximate 3.341 inhabitants6. Heist-op-den-Berg has 42.000 inhabitants and is a town in the province of Antwerp, Belgium.

The patient population are elderly (65+) with physical (chronic, multi-morbidity) and psychical (Parkinson, dementia) care needs, persons with young dementia, people with Multiple

[6] https://nl.wikipedia.org/wiki/Heist-op-den-Berg

Sclerosis (MS) /Amyotrophic lateral sclerosis (ALS), patients in a coma and frail elderly. Almost all admissions are due to a crisis in home care. Most elderly who are admitted already receive home care.

The facilities have the following number of beds and places:

- Residential care: 107 beds, of which 91 are RVT (including 7 for coma and 5 for MS patients) and 16 ROB.
- Short time relief/ short stay centre (kortverblijf): 10 beds.
- Day care centre: 45 places in total: 30 places for people with a physical disability and 15 places for people with dementia and young dementia. The day care centre is open 6 days a week (from Monday to Saturday).
- In 2019-2020 Emmaus will have 36 houses of assisted living (GAW).

All services of Ten Kerselaere are located at the same site in Hallaar, Heist-op-den-Berg. The other (elderly care) facilities of Emmaus are located in different places.

The organisation has the following number of staff and skill mix- ratio of qualified and unqualified staff

- For the whole organisation 131.13 FTE, including staff of service cheques.
- At the moment, Emmaus has three clusters of houses (two cluster for people with dementia and one for people with physical problems).

Each cluster has one FTE team coach (= head nurse).

Nurse	heads	FTE
houses 1/2/3 for people with physical impairments	14	9,36
houses 4/7 for people living with dementia	6	4,9
houses 5/6 for people living with dementia	7	3,5
total	27	17,76

Care officer (responsible for care (e.g. washing, bathing, dressing, …)	heads	FTE
houses 1/2/3 for people with physical impairments	17	10,18
houses 4/7 for people living with dementia	16	10
houses 5/6 for people living with dementia	16	10,26

Module assistant (provide assistance during meals, are responsible for grocery online, cleaning, …)	heads	FTE
houses 1/2/3 for people with physical impairments		6,3
houses 4/7 for people living with dementia		5,4
houses 5/6 for people living with dementia		4,6

Each cluster has 0.5 FTE occupational therapist and 0.63 FTE animation

For residential care, Emmaus has 2.369 FTE physiotherapists and 0.5 FTE speech therapists.

Staff employed in the Day care centre:

- Nurses: 6 nurses (4.40 FTE)
- Care officers (verzorgenden): 9 (6.42 FTE)
- Animation: 5 (4 FTE)
- Physiotherapists: 3 (2.15 FTE)
- Speech therapist: 0.5 FTE
- Occupational therapist (2 (1.25 FTE)
- Team coach: 1 (1 FTE)

For the whole organisation, we have the c-team with 4.43 FTE.

Regional specialties

- Ten Kerselaere is one of the four elderly care facilities from Emmaus elderly care. Ten Kerselaere is the oldest and most well-known residential elderly care facility in Heist-op-den-Berg. Ten Kerselaere operates according to the concept of small scale and normalized living. The focus is on living, well-being and care.

Operational principles are:

1. Integration and participation;
2. Person centred – demand driven;
3. Quality of life;
4. Quality of relations;
5. Balance between autonomy and security.

The concept combines safe and comfortable housing facilities with assisted living facilities and state of the art care. Emmaus think of elderly care as being holistic. This leads us to a care concept with emphasis on housing, living and care dimensions in the neighbourhood.

Vision and values

The mission of Emmaus is to:

- offer high-quality and professional healthcare and welfare services;
- rooted in a Christian tradition;
- tailored to the needs of and in consultation with care recipients;
- at an affordable price;
- with specific attention for those most in needs of care.

Emmaus develops a wide variety of care functions and related facilities and uses them in the most flexible manner. If required, this is done in collaboration with local health care partners. The diverse and flexible range of care services is beneficial to everyone who relies on services. Care recipients can easily switch from ambulatory to semi-residential and residential types of care and vice versa as well as from one sector to another. This allows Emmaus to tailor their care services to patients' individual requirements in all phases and circumstances of life. Emmaus is a value driven organisation with the following care values: **hospitality, equality, solidarity, cooperation, quality, sustainability, openness, integrity**.

The mission of Ten Kerselaere states

> "we are an easily accessible residential care junction where the elderly can come home with respect for their individuality and self-esteem. Care and support demonstrate hospitality and equality, solidarity and cooperation, quality and sustainability, openness and integrity. We want to design a care program, tailored to their needs and requirements, with particular attention to the most vulnerable through a transparent communication and in dialogue with the elderly, firmly anchored in the local and wider environment by working with various care partners in a network."

Key staff, support and governance structures

Inge Vervotte is the deputy director of Emmaus elderly care. Paul Van Tendeloo is our general director and Armand Hermans our financial and administrative director. Each of the four elderly care facilities has its own local director. Veerle Nys is the director of Ten Kerselaere. Each week the **board of directors** meet at another location. There are also overarching steering groups, e.g. for quality, dementia, palliative care, ethics,

Ten Kerselaere has three clusters of houses (one cluster for people with physical problems and two clusters for people living with dementia). Each cluster and day care has a team coach. These coaches together with social services meet every week to discuss complex care cases and follow up complaints.

Each month there is a meeting with all executives to discuss policy. Participants of the **policy committee** are the local director, head nurses (=team coaches) of the cluster of houses for residential care and day care centre, quality coordinator, head of social services, logistic executive and an administrative employee. They discuss care related topics, human

resources, policy and quality aspects of the organisation and preparation of advice for policy related topics to the board of directors.

Weekly there is a **"living-care-meeting" (**woonzorgoverleg) with the local director, social services, team coaches, coordinating and advising physician (CRA), logistic executive, employee KELA team, administrative employee, responsible short time relief and employee of technical department. The goal of this meeting is to have a frequent and short briefing about daily living in the organisation like admissions, discharges, illnesses, hospital admissions, absences employees, practical info data residents' meetings data family boards, and any other practical problems encountered.

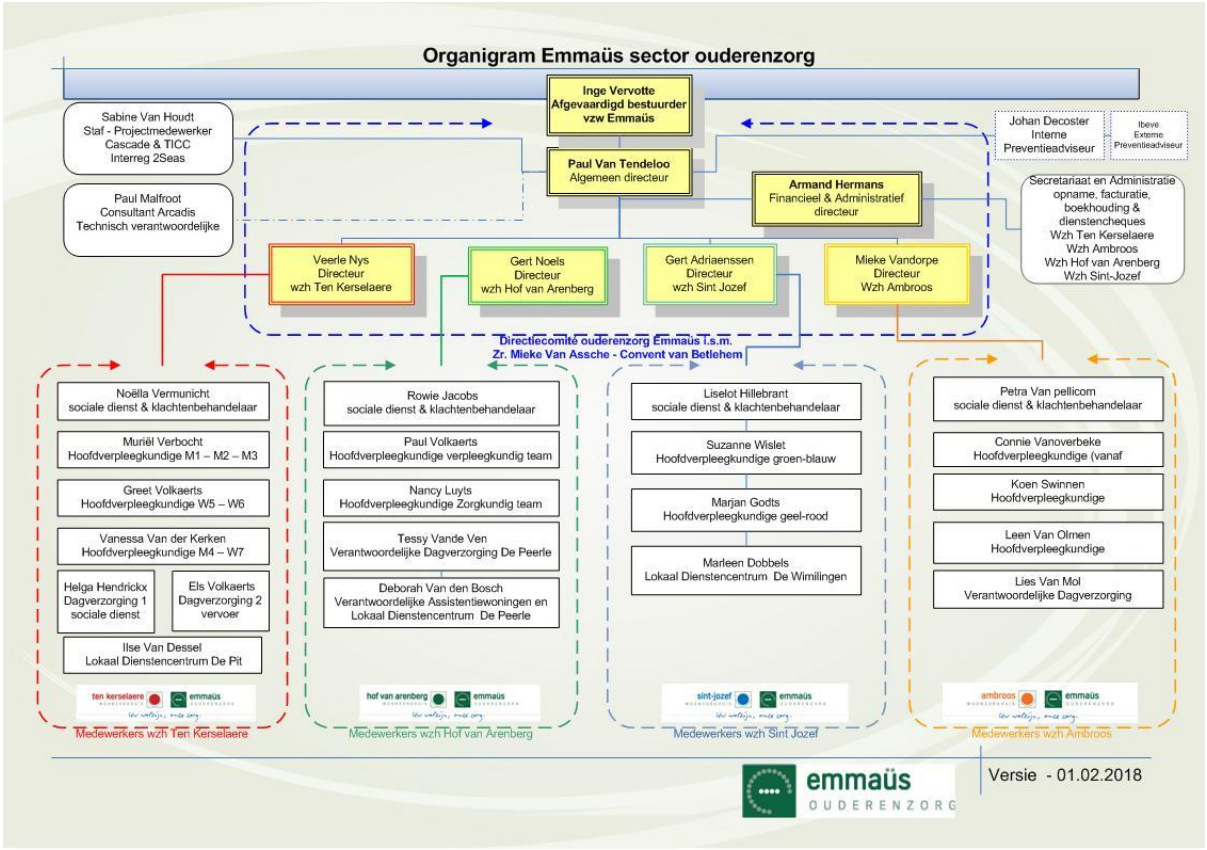
The admission commission with the local director, head of social services, team coaches and CRA discusses possible admissions and the waiting list.

The monthly steering group committee **quality of care** PREZO consists of the director, quality care coordinator, team coaches and social services. We also have monthly quality working groups with changing members depending on the topic discussed.

Every three months there is a **user council** for family, residents and clients.

Each house has a weekly meeting to discuss care and living arrangements of the residents. Four times a year there is a service meeting with all employees of the cluster to discuss agreements and decisions of the policy committee, new procedures, education, complex cases,

Ten Kerselaere organises induction and information sharing sessions for new employees twice a year.



Funding and commissioning model and headline figures on income/ turnover/ expenditure

Emmaus receives a forfeit from the federal government for each resident depending on the type of bed (RVT or ROB) and the degree of care needs (zorgzwaarte) measured with the KATZ-scale (73.80 euro). Residents also have to pay a price per day (58.42 euro per day). Visitors of the day care centre pay 20.67 euro each day.

For the local service centre, people pay 4.32 euro in the morning, 5.75 euro in the afternoon and 10.60 euro for lunch. Emmaus also receive from the federal government a forfeit for the day care centre (=49.59 euro).Service cheques are bought by our clients at 9 euro and cost 6.30 euro after tax refund.

Cross border partnerships or collaborations central to delivery of the model of care

Emmaus have a neighbourhood committee and collaborate with:

- Hospitals (AZ Maarten, Lier, Imelda Bonheiden and to a lesser degree with Herentals),
- palliative network,
- home care:
- white and yellow cross = organisation of home care nurses

- Familiehulp = organisation for home help
- Landelijke thuiszorg = organisation for home help
- Sickness fund – also providing care for patients who are ill, but also prevention
- SEL (overarching organisations of home caregivers and home care services)
- ORION (centre of expertise dementia in Antwerp)

Overview of why Emmaus is involved in CASCADE and what it hopes to achieve in terms of improving the services locally.

Local focus of the project

Emmaus want to provide state of the art care for elderly, tailored to their needs in small scale housing environment that feels like home. They will pilot the concept of guest houses for people living with dementia and their caregivers in a rural setting and provide touristic facilities. Benefits for Emmaus would be to

1. implement a model of integrated care for people living with dementia.
2. implement an education program for dementia care providers and caregivers.
3. in the guest house combine their expertise in dementia care and small scale living with tourist facilities for people living with dementia and their caregivers in a rural environment.

Reason for looking at this area

Ten Kerselaere wants to provide innovative care. They are located in a rural environment, while Sacred Heart in a urban environment. This provides an opportunity to compare between rural and urban care environments. They also have touristic opportunities like the Averegten.

Who is involved?

Core group:

- Director of Ten Kerselaere,
- General director Emmaus elderly care,
- Project manager.

Involved employees:

- team coaches of houses for people living with dementia,
    - when starting the pilot also employees of the houses for people living with dementia
- team coach day care centre,
    - when starting the pilot also employees of the day care centre
- employee of social services,

- responsible for local service centre,
- reference persons dementia care.
- quality coordinator

Information and updates about project is given to:

- the policy committee of Ten Kerselaere,
- the board of directors,
- board committee,
- user council (clients, residents and family)

Information and updates are also provided by the newsletter of Ten Kerselaere to all employees and Facebook to all followers. They also share information about the project on their website.

How is quality of care and services measured?

Dashboard data collected monthly including staff metrics

For each resident and client in Ten Kerselaere data are collected **at time of admission** in the digital system and updated continuously:

- Administrative data
    - reason admission and discharge,
    - origin (where is the person coming from: hospital, home)
    - marital status,
    - partner
    - residence
    - contact persons
    - general practitioner / representative (vertegenwoordiger) / administrator (bewindvoerder)
    - additionally for clients of the day care centre:
        - distance to Ten Kerselaere
        - using own transport or not.
- Personal data:
    - Food: diet, allergy, preferences, …
    - Habits, life history, interests, …→ these are updated on a regular basis by the attention person in the care file and the care team / animation in the diary. The team also has a tool “behoeftenanalyse” available to identify these (see attachment)
- KATZ-scale:

    - All items give a status of independence or assistance needed with
        - Washing
        - Clothing
        - Moving
        - Going to the toilet
        - Incontinence
        - Eating
        - Time
        - Place
    - The score of the KATZ-scale (which provides an estimation of the care level)
- Activities of Daily Living – support needed, what can person do independently
- Physiotherapy:
    - yes/no
    - If the elderly follows physiotherapy, then there is a file with the exercise schedule.
    - On a regular basis there is feedback about the mobility of all residents via the diary in the digital system (see also care plan)
- Animation
    - Participation to what activities of Ten Kerselaere
- Care plan
    - Mobility
        - Independent, use of aids
    - Going to the toilet
    - Food
        - Mixed food or not / swallowing disorders
        - Assistance needed while eating – which assistance
    - Activation (living habits, …)
    - Comfort zoned
    - Psyche
    - Hygiene
    - Use of oxygen
- They also register the care path people follow (e.g. starting in day care, short time relief, back to day care, residential care, hospital admission, …)
- Care planning
    - All activities are signed for

In their digital file Emmaus have a link to **BelRA**I. BelRAI is a pilot project for the uniform and online assessment in various care settings. In order to promote an interdisciplinary approach, all, sometimes divergent, opinions of different users (care providers) for one particular client can be registered by the system and saved afterwards. The assessment tools enable users to

assess the functioning, health, social support and use of client services. After answering all the questions in the various items of the interRAI assessment tool and overcoming the differences between the users, the assessment manager can have the results calculated by the system. The generated, transparent potential problem areas and guidelines can ultimately be used autonomously by users in different care settings in realizing holistic, high-quality care planning and quality monitoring.

Staff data collected by Emmaus are:

- Monthly detailed discussion in the board of directors: budgeted versus real (effective) and compared to RIZIV standards – overview nominatives
- Monthly on the work council: budget versus real, overview employees in service and leaving, overview time credit, situation social Maribel,
- Quarterly for the board of executives (raad van bestuur): follow-up of of effectives: budgeted and real in FTE – follow –up of wage costs.
- For the annual accounts: detailed discussion: men, women, age pyramid, part-time full-time, funded statutes, information social balance, such as training, etc ....
- for the various annual reports activities for the Agency for Care and Health by accreditation partially the same data
- For the federal administration (RIZIV) per reference period 01/07 / XXXX to 30/06 / XXXX + 1: nominative list per contract per job-time per employee per qualification: paid days (full-time) or paid hours (part-time)
- Per semester (and / or quarterly reports) for the Social Maribel Fund for employees with social maribel status: performed and assimilated hours.
- Web application for follow-up of employees with a Gesco status: performed and assimilated hours
- Web application for follow-up for employees in the animation norm: performed and assimilated hours
- Web application for follow-up and invoicing of the performance of the employees Home care recognition
- Web application for follow-up recruitment of job students
- Dimona declaration (NSSO) when recruiting new employees
- Web application for recording the performance of employees with service cheques contracts

Local care quality metrics collected related to safety are:

- Medical data like

    - medication (name, doses, timing)
    - diabetic
        - yes/no
        - glycemie
    - Only for people in residential care:
        - saturation
        - blood pressure
        - weight
- Fixation:
    - Motivation
    - What fixation measures are in place
- Incontinence:
    - Yes/no
    - What for
    - Material used
- Wound care:
    - Kind of wound
    - Wound care
    - Evolution of wound
    - If decubitus:
        - Degree
- Mini-mental + additional information of assessor (assessment only when KATZ deviates or anxiety exits about cognitive functioning)
- Infectious diseases like MRSA, diphtheria, whooping cough, lice, gastroenteritis, …

Local patient safety challenges over previous year

The Flemish Health care department organises inspection. They come unannounced and check to what extent the standards are being adhered to. They focus on a number of point such as:

- the organisation (number of residents, capacity, occupation),
- infrastructure, (e.g. rooms, common space, common sanitary,
- room for files, medication and inquiry),
- comfort, safety, dignity / homeliness and privacy,
- space outside,
- facility management, food,
- staff,

- care (care file, care plan, registration delivered care, observations, fixation, medication, wound care, physio/occupational therapy, participation resident and family, safety, care practice, qualified staff, continuity of care, hand hygiene, registrations (like decubitus, nosocomial infections, fall incidents, incontinence, fixation) and
- cooperation with CRA.

After the inspection, the organisations receive a report with the observations and points for improvement. The organisation can then respond (e.g. points of disagreement, how areas for improvement will be addressed)

Dealing with Patient /staff complaints/compliments

Emmaus are client oriented and use **bodies and initiatives to enhance participation**, like user council, satisfaction surveys, meetings together with clients and family to discuss care and living. Initiatives include:

- A postal or online **patient satisfaction survey** measured by informal caregivers (for people living with dementia) in 2014 carried out by an independent organisation Dimarso in the context of the Flemish Indicator Project. This survey is not used within the organisation itself. Items covered are physical wellbeing and health, living environment, integration and social activities, demand driven, participation and negotiated care. Feedback was given on safety, privacy, autonomy, respect, demand driven, meals, having a bond with staff, information, personal interaction, choice of activities. In 2018, they are planning a satisfaction survey for residents carried out by BING. This questionnaire is validated and integrated with the PREZO tool.

- Emmaus have a general **procedure for complaints**, but each organisation can have its own terms, and arrangements for follow-up of the complaints. This procedure is included in the contract with their clients and discussed by social services with the client. It is also noted on a regular basis during the user council and on the website of the organisation.

Complaints can be submitted in different ways:

  - At the reception, they have a register for complaints.
  - Persons who have a complaint can address everyone in the organisation.
  - Complaints can also directly addressed to the head of social services

The head of social services is responsible for handling the complaints.

Each complaint is registered on paper and in an online tool called Quint (the advantage of the online tool exists in the easier follow up of the complaint). The complaint is then discussed in the weekly "living-care-meeting" (woonzorgoverleg) with the local director, the heads and the CRA to decide if it is a complaint, a notification, incident or an insurance matter.
A complaint is defined as *"a reaction of a client (user, his care system and involved others) who uses a product of service of the organisation and is not satisfied with it. It is a reaction or report of a shortcoming where the client expects from the organisation to do something with it. It is no congratulation, no demand for information or no suggestion*." A notification can be solved together with the head of the concerned department (e.g. broken closet). When a complaint is submitted, there is more to it.

The head of social services is responsible for the follow-up of the complaint. First, the persons who submitted the complaint are invited to discuss the complaint. Then the complaint is investigated by the involved heads, e.g. by looking at the processes, to understand where it went wrong. The digital registration of data about their clients are often a source of useful information and insight. For some complaints, the input of the managing board is necessary, e.g. overarching topics like purchased material or the pricing management. Third there is feedback to the team by the responsible head (and / or a personal conversation when it concerns only 1 employee). Each year there is an overview of the complaints (number and topic) which is discussed in the policy committee and provided to each head of department. Many complaints can be avoided with better communication. Therefore, Emmaus organise training for all employees about attitudes and behaviours in the workplace. Finally, there is a check if the complaint is resolved. This information is noted in the online complaint registration. The result is also communicated to the person who submitted the complaint (after care).

There is also a **procedure to protect staff** against psycho-social risks, including stress, violence, bullying and undesirable sexual behaviour at work which are the result of the work organisation, job content, terms of employment, working conditions or interpersonal relationships at work. Each staff member can discuss this with the employer, head or member of the committee for protection and prevention at work or the union representative. If this does not lead to the desired result or if the staff member does not wish to address these persons, the confidential adviser or the prevention advisor of the organisation (or other organisations of Emmaus) can be contacted. The employee is heard and informed within 10 days about possible interventions, more specifically an informal and formal intervention.

Compliments are mostly communicated to the person concerned, often directly (face-to-face) or sometimes by mail (then the mail is forwarded to the person concerned).

Tools and measurements used to track financial, quality of care and service improvements

Internal Procedures

Emmaus uses PREZO Woonzorg which puts the client in the center of the quality system. The care and support provided start from his or her needs and expectations. Processes and procedures are geared to this, not the other way around. PREZO Woonzorg works around 60 quality themes, each time linked to a specific objective. This is translated into concrete actions that the employees and the organisation undertake achieve their goals. For each theme the system provides clear instructions about how to measure and demonstrate outcomes. By juxtaposing results and self-evaluation, the system enables the user to gain insight into possible improvement actions and processes. There are care-related themes, such as medication care, fall prevention, intimacy & sexuality, but also policy-oriented themes, such as corporate social responsibility, strategy and policy, client and employee participation. The care file, communication and care continuity are also discussed.

A core group of involved employees is created membership of which depends on the topic under review. Each group reviews the current process and procedures based on an evaluation tool with critical questions for reflection. A PREZO coordinator and our director support the process. After the self-evaluation and critical reflection, actions are formulated.

In the past the following topics were (re)viewed:

- medication which resulted in a new procedure
- pressure ulcers which resulted in a week focusing on (prevention of) pressure ulcers providing information via different channels and reference persons who build their expertise through internal training;
- falls → after self-evaluation no actions were needed. Keys were installed to stay alert.
- “food and drinks” which resulted small scale projects
- spirituality

At present Emmaus are working on communication and more specifically the admission procedure for residents in Ten Kerselaere and the integration of new employees (this last topic is being reviewed for Emmaus elderly care as a whole). After testing, the new procedure will

be evaluated and implemented for the whole organisation (if there is a proven effect and support).

Every year Emmaus submits a report to inform the (quality) projects accompanied by figures about :

- the organisation
  - number of beds,
  - prices,
- staff
  - number and FTE,
  - ratio male/female,
  - age,
  - function,
  - special contracts,
  - training),
- number of volunteers,
- residential care
  - new admissions,
  - referrers (home, day care or service flat, short time relief, hospital others),
  - evolution of admissions over the years,
- residents
  - mean age of residents (female and male)
  - level of care needs of residents,
  - days in hospital, deaths,
- time reliefs,
  - number of clients
  - number of days in short time relief,
  - care needs of people in short time relief,
  - occupancy rate,
- day care
  - Number of clients with a forfeit in day care,
  - number of visits in day care,
  - number of discharges in day care
  - reason discharge (short time relief, hospital, going home, admission in our residence, admission in another residence, death, service flat,
  - number of visitors without a forfeit
  - number of visits of visitors without a forfeit

Data from the digital register of their clients / patients is used for the quality improvement project (PREZO) or to investigate complaints. Complaints are discussed in the living-care meeting, addressed with the team / persons concerned and an annual report of the complaints is provided at the policy meeting.

External mechanisms for care quality regulation

Ten Kerselaere participates on the Quality Indicator Project of the Flemish Government. For each indicator there is a description how it should be measured. After delivering the data, feedback about the data and benchmark with other organisations is provided by the project. Measured indicators are:

- Quality of care and safety
  - decubitus (on 20/04/2018),
  - unintended weight loss (between two measure points)
  - fall incidents (from 1 till 31/05)
  - fixation (on 19-20-21/02)
  - medication incidents (from 14 till 20/06)
  - place of death (year registration)
  - care plan around end of life
- Quality of health personnel and organisation (on 20/03)
  - Influenza vaccine (1/12)
  - Volunteer work (year registration)
- In 2018 some indicators are reviewed and will not be submitted:
  - Medication use
  - Absenteeism
  - Staff turnover

Key areas for concern within the organisation currently

Plan 2020 consists of the challenges that will be addressed in the next years. This plan is based on the input of the policy committee and survey of all staff members and current challenges of the organisation. In 2018, Emmaus will work on:

- meaningful daily activities.
- Partner relationships- intimacy and sexuality
- Sufficient and qualified staff

In 2019 the focus will be on psychical well-being and problematic behavior, handling / treatment of residents (bejegening) and in 2020 on cared for body (verzorgd lichaam).

2.5. PP8 Holy Hart Elderly Care

Holy Hart is a not for profit organisation located in Kortrijk. It offers specialised care through 2 residential care sites (Kortrijk and Roeselare), 1 for disabled and 2 for assisted living care:

- physically dependent older people (127 beds)
- elderly people with dementia (150 beds)
- coma patients (5 beds)
- persons with Huntington's disease (5 beds)
- persons with MS (5beds) / ALS (5 beds)
- disabled people (40 beds)
- Assisted living (170 beds)
- Day Care (50 clients)
- Family Care (80 clients)
- Domestic Care (300 clients)

It provides unique regional specialist care for people living with MS/ ALS and Huntingtons disease and care for people with non-congenital brain damage. They also have an expertise centre for dementia (ECD Sophia), as part of ECD-Flanders.

There are 1128 employees in total with 316 staff employed across residential care, disabled care and assisted living facilities. Of these the skill mix ratio is

- Nurses: 113
- Care assistant: 170
- Physical therapist: 15
- Occupational therapist: 6
- Living assistant: 7
- Speech therapist: 4
- GP (coordination and advise): 1
- Back office staff: 15

Vision and values

The management objectives of Holy Hart are

The art of care

- The art and skills to guide and care for the care-dependent client / resident. The term 'art' refers to the pursuit of an added value to the demand for healthcare.

Centre of excellence

- Striving to distinguish oneself is not an objective in itself, but a mean to respond to the fast-evolving healthcare market and the evolutions in long-term healthcare. Care programmes and Service Level Agreements are important spearheads.

Differentiation, diversification and track vision

- From within the core competence of "intensive healthcare", track guidance for the client is one of the most essential objectives; the demand for healthcare is defined as early as possible; in this way, an optimal track can be realised. The demands for healthcare are refined in function of differentiated and diversified care.

Performant and integrated quality policy

- We pursue a quality policy borne by all echelons of the organisation. This vision is also written out in full.

Oriented human resources policy

- A clearly visible integral personnel policy with specific and transparent targets guaranteeing consistency and work/life balance.

Financial policy

- A transparent and clever financial-economic policy is an essential pillar. Advanced follow-up, direction and audit are the tools to realise this objective.

Experience-based attitude

- The care and service provision starts from the individuality and the world of perception of each client/resident. Respect and dignity are key terms.

Networking

- An open attitude towards the environment results in an interaction at the regional level or supra-regional level.

Corporate identity

- The new healthcare policy is given shape both internally and externally. On the basis of a conscious communication policy, the perception and the profile of H. Hart are elaborated.

Vision for the future of vzw Woon en Zorg H. Hart

For some years, vzw Woon en Zorg H. Hart has been convinced that achieving organisation objectives and an effective healthcare organisation is only possible by actively participating in a network. To that end, it was decided in 2009 to integrate the professionalism and efforts of the Board of Directors of our various non-profit organisations to the benefit of the healthcare network Zorgnetwerk 'Zorggroep H. Hart'. Their description of the choice and the idea behind the healthcare network 'Zorggroep H. Hart' is provided here:

Integral healthcare network

Definition

The term is borrowed from Kodner en Spreeuwenberg (2002). They define an integral healthcare network as a unit of models and methods, which contribute to commitment, collaboration, integration and coordination of healthcare and service provision at the functional, professional, administrative, organisational, service providing and clinical level.

This integral healthcare network is based on the following findings:

- There is a changing demand for housing, healthcare, well-being and family support.
- Consequences and results of housing, healthcare, well-being and family support are interdependent.
- There is a changing demand for social integration of vulnerable groups in society.

This integral healthcare network is a tool to:

- improve the quality and continuity of housing, healthcare, health, well-being and family support.
- improve the accessibility and satisfaction of the user and his/her healthcare service provider.
- improve the return of the service provision system, which must lead to higher efficiency and effectiveness.

This integral healthcare network model is designed to impact on four levels of integration:

1. **Functional integration** at the macro-level of the healthcare service provision system aims to make more efficient and effective use of the management and the organisation of the financial means within the regulations regarding housing, healthcare, well-being and family support.

2. **Organisational integration** at the meso-level aims at making more efficient and effective use of the management and the organisation of the different clusters and the financial means by entering into cooperation agreements.

3. **Professional integration** at the meso-level aims at improving knowledge and skills of these professionals via team meetings, intervision, focus groups and training.

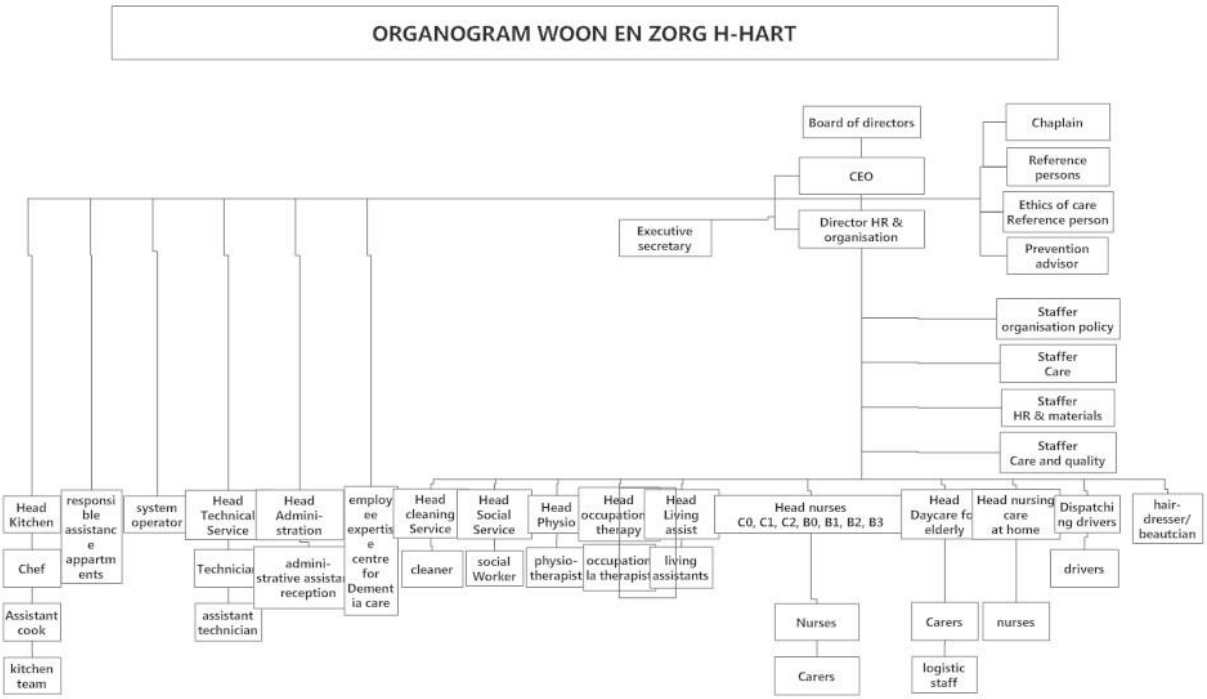
4. **Service provision integration** at the micro-level aims at improving the individual level of healthcare service provision via the concept of the continuity of healthcare service provision.

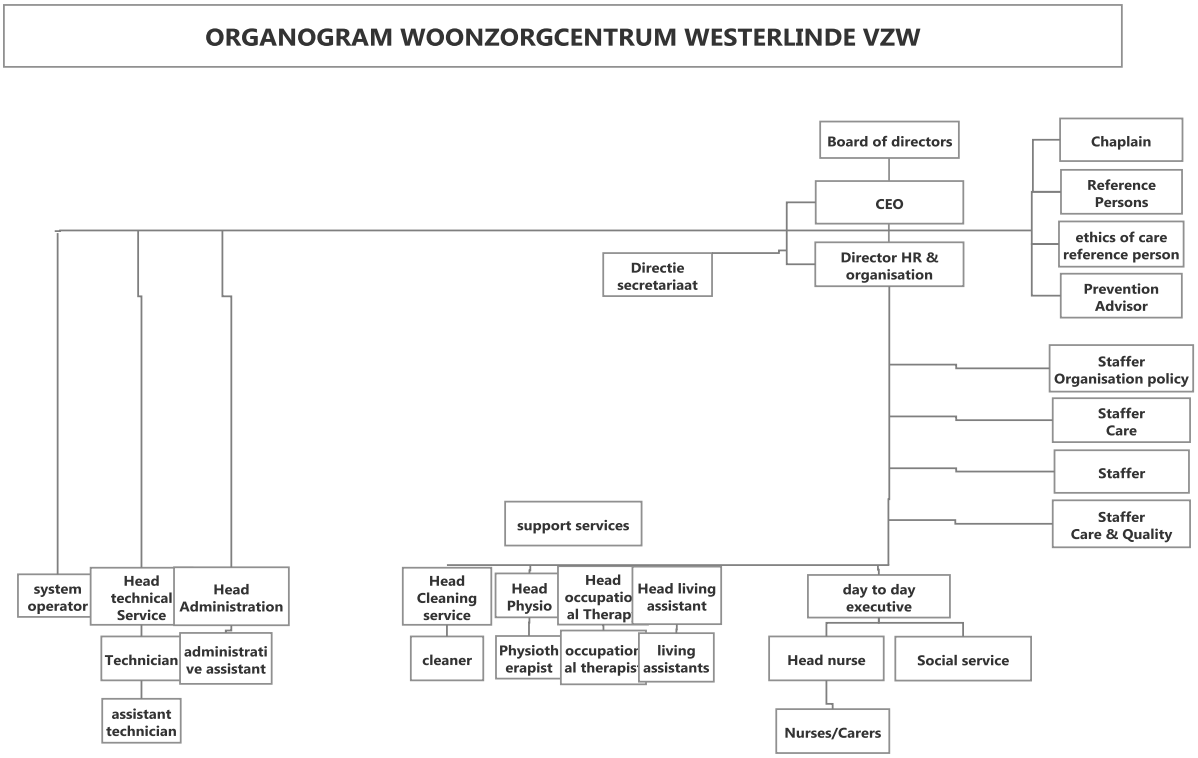
Their organisational values are presented here with a descriptor:

Professionalism
Integrity
Responsibility
Respect
Innovation

Integrity:	We say what we do and do what we say.
Respect:	We respect and take everybody into account, both colleagues and clients, irrespective of their religion, origin, culture, sex or age.
Professionalism:	We pursue a healthcare service provision in which emphasis is put on the wishes and the quality expectations of our clients.
Innovation:	We want to constantly improve our actual healthcare service provision and we strive to respond to the actual needs and trends to develop new models, methods, procedures, techniques and services.
Responsibility:	We take our individual, collective and social responsibility.

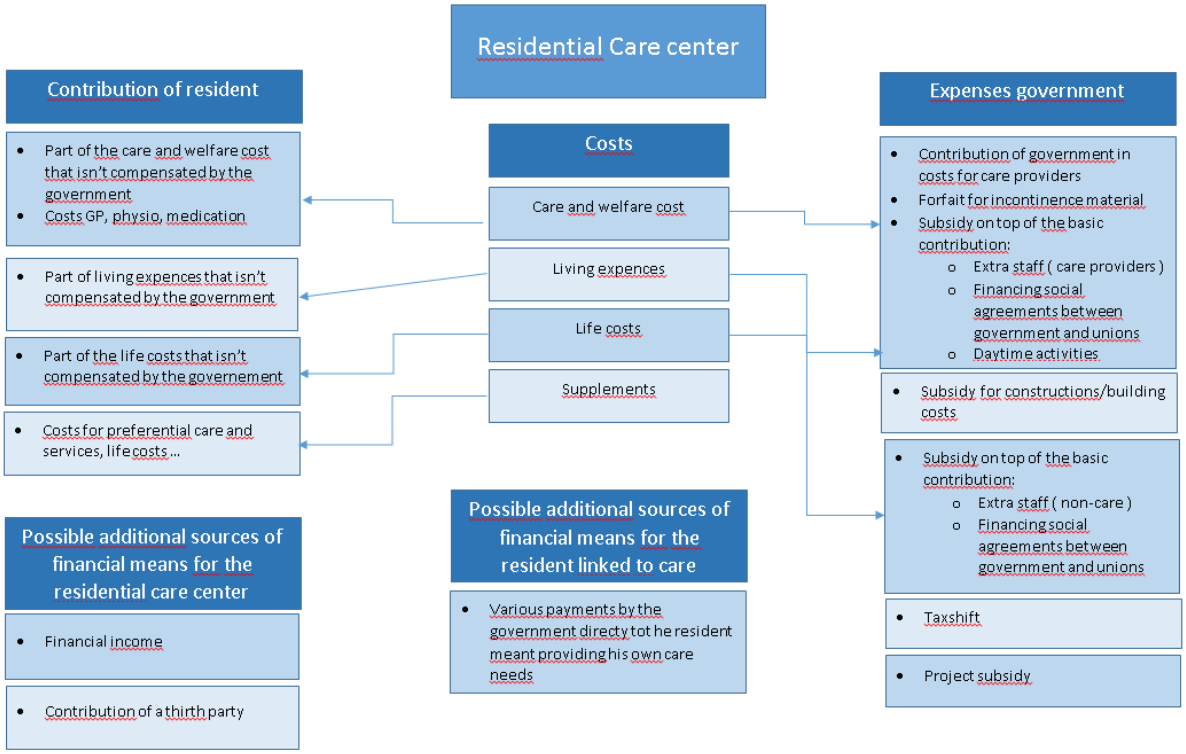
Key staff, support and governance structures





Funding and commissioning model and headline figures on income/turnover/expenditure

Income:



General principal of social security in Begium

Every working Belgian, has to contribute 13.07% of his or her income to the federal institute for social security (RSZ) to cover most of the expenses for social security.

Also every employer pays +/- 32% of the bruto income to the RSZ.

That institute divides the money to the various institutes that take care of all the social security costs.

The federal service for illness and disability payment (RIZIV) covers the vast majority of the healthcare costs. Therefore there's only a small part of the actual costs at the expense of the civilians.

The basic principal for residential care is that the resident pays for he "hotelcost" and the majority of the costs for care are contributed by the RIZIV.

Tabel 17: budget ouderenzorg 2017.

Budget 2017- cijfers begrotingsaanpassing 2017	In duizend euro
RIZIV financiering ROB/RVT/CVK/ Werkingstoelage animatie	1.664.899
Sociaal akkoord	302.040
RIZIV financiering CVD	29.965
Werkingstoelage kortverblijf en dagverzorging	15.014
ex-gesco	5.017
ex-dac	3.609
netwerken voor de zorg voor personen met dementie en hun omgeving	1.656
Projecten	332
Totaal	**2.022.532**

Bron: Vlaams Agentschap Zorg & Gezondheid 18/09/2017.
Bij volledige realisatie van de erkenningskalender (uitbreiding woongelegenheden woonzorgcentra en centra voor kortverblijf) 2015-2025 is een budgettaire inspanning vereist van ruim 283 miljoen euro.

Since the sixth state reform of 2014, Flanders has authority in the fields of both the programming, prior license and recognition, and the financing of the healthcare cost of the residential care facilities, centres for short stay and day-care centres. This offers the opportunity to adopt a homogeneous policy as regards this partial domain of healthcare for elderly persons. Several transition protocols among the regions and the federal government make sure that the actual transfer of competences is progressive. Flanders has chosen to embed, in a first stage, the competences and the regulations and the financing connected thereto in existing or, where necessary, new structures. In this way, the financial part of the transferred competences (RIZIV zorgfinanciering and THAB) should be integrated in a system of Flemish social protection with a Flemish Agency of Flemish Social Protection (Vlaams Agentschap Vlaamse Sociale Bescherming) (the transformation of the healthcare fund IVA Zorgfonds). In addition, the federal RVT regulations on nursing homes shall also be integrated in the implementation decision of the “woonzorgdecreet” (the decree on residential care homes) for the residential care homes.

In consultation with the umbrella organisations of residential care for elderly people, the continuity of the adopted policy was guaranteed in a first stage. In a second stage, an important transition was proposed in the fields of healthcare, organisation, administration and finance. The objective is to come to a more demand-driven, personalised care and support and financing of elderly care. The state reform offers Flanders the opportunity to transform the merely medical-RIZIV model into a holistic model, a model in which attention is paid to both the physical, social, psychological and existential needs of the clients of the residential nursing

home. In this model, the quality of life, the autonomy and the control over the own life of the care-dependent person is a priority. Without losing out of sight that there is also a substantial group of elderly people who do not can or even want to assume control over their own lives.

The intended transition assumes a track which needs time and which will have to be realised in consultation with all the actors involved. This inevitably comes together with insecurity, concern and nervousness with the care providers. The major lines are clear, the practical realisation and implementation still holds many unknown aspects and will require a lot of investigation and try-outs in pilot projects. At the integration of the new competences in the field of elderly care, a durable and constructive consultation with the federal government is of utmost importance. The policy measures on both policy levels mutually influence one another. In this way, for example, when Flanders will continue the conversion from ROB into RVT housing facilities, the Flemish government will take on in a progressive way the financing of physiotherapy services. For a person residing in a ROB, physiotherapy services are charged via (federal) nomenclature. This means an additional expenditure for Flanders and a reduction in expenditures for the federal government. This and other subjects will have to be debated upon with the federal government.

Cross border partnerships central to delivery of the model of care include

- Local border: partnership with all the long term care facilities
- Regional border: collaboration with the hospital networks
- National border: collaboration with long term care facilities in the Flemish community
- Federal border: collaboration with hospital networks and long term care facilities working with people with MS/ALS/Huntington disease and non-congenital brain damage.

Overview of why Holy Hart is involved in CASCADE and what it hopes to achieve in terms of improving the services locally.

Holy Hart are involved in CASCADE in order to complement a model of integrated care for people with dementia; implement an education program for dementia care providers and caregivers and in their guesthouse; combine their expertise in the field of dementia care and small scale living with tourist facilities and for caregivers in an urban environment.

How is quality of care and services measured?

Holy Hart provided a powerpoint presentation of how quality and safety is measured in their organisation (Appendix 2).

Conclusion

This report provides a rich picture of each of the partner organisations, which will form the basis for evaluation reports using a case study approach in the future.

References

Checkland P (2000) Research Paper.Soft Systems Methodology: A Thirty Year Retrospective,In *Systems Research and Behavioral Science Systems. Research*. 17, S11–S58. doi:10.1002/1099-1743(200011)17:1+<::AID-SRES374>3.0.CO;2-O

Community Areas of Sustainable Care and Dementia Excellence in Europe

Appendix 1. Rich Picture Document for Case Study Sites

Background

"Rich pictures" were developed as part of Peter Checkland's Soft Systems Methodology (SSM) for gathering information about a complex situation, often displayed diagrammatically (Checkland 2000). In SSM there are two interacting streams of enquiry that attempt to understand how the systems and processes within organisations interact and intrinsically affect each other.

For the purpose of the CASCADE project, the construction of a Rich Picture will be used as a method of gathering the background story about your organisations

- Structures
- Processes
- Climate
- People
- Issues expressed by people
- Areas of challenge/concern

This will help us to co-create an evaluation that is tailored to partner needs as well as providing information about each case study site.

Checkland P (2000) Research Paper.Soft Systems Methodology: A Thirty Year Retrospective,In *Systems Research and Behavioral Science Systems. Research*. 17, S11–S58. doi:10.1002/1099-1743(200011)17:1+<::AID-SRES374>3.0.CO;2-O

Please compile a report which uses the following template:

1. About your Organisation

Provide description to summarise the background information about your organisation.

- Location
- Organisation type
- Patient population served, number and characteristics
- Number of beds
- Number of sites
- Number of staff and skill mix- ratio of qualified and unqualified staff
- Regional specialties
- Vision and values
- Key staff, support and governance structures (include an organogram if you have one)
- Funding and commissioning model and headline figures on income/turnover/expenditure if available
- Any cross border partnerships or collaborations central to delivery of the model of care

2. Why is your organisation involved in the CASCADE project?

Brief overview of why your organisation is involved in CASCADE and what it hopes to achieve in terms of improving the services locally.

- Local focus of the project
- Reason for looking at this area
- Who is involved

3. How is quality of care and services measured?

- Dashboard data collected monthly including staff metrics
- Local care quality metrics collected related to safety

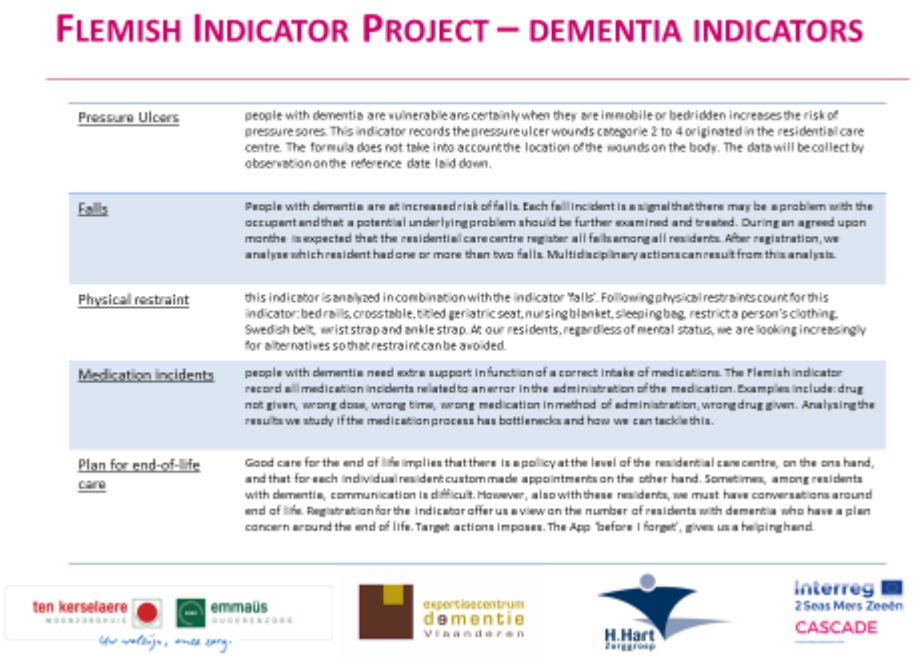
- Local patient safety challenges over previous year (e.g. never events, care quality inspectors feedback, International Prevalence Measurement of Care Quality (LPZ) etc.)
- Patient /staff complaints/compliments
- Incident reporting
- Tools and measurements used to track financial, quality of care and service improvements
- How are these reported and to whom?
- What mechanisms of care quality regulation (external) are in place and how are these monitored? (e.g. International Prevalence Measurement of Care Quality (LPZ)

4. What if any, are the key areas for concern or challenge within the organisation currently?

- Please provide a brief list of current challenges or areas of concern and how these are being addressed in terms of an action plan

Appendix 2. PP6 Emmaus needs analysis

(Source: Lifestyle Redesign - Implementing the Well Elderly Program, F.A.Clark)
Depth interview
1. What do you do every day?
2. What barriers do you think you are experiencing or do you experience when doing the things you want to do or do?
3. Which things you do are very important to you?
4. Are there things in your daily life that are bothering you right now?
5. What causes you to experience stress in your life?
6. What is essential for your quality of life?
7. Throughout one's life, people choose to do certain things, activities they like to do. Can you describe which activities have been important to you in your life? We can start with your childhood and end with what you find important now.
8. What exactly is this activity doing that makes you happy to do it?
What makes them so attractive?
9. Do you have daily habits or routines? How important is habit for you?
10. Which aspects of aging were the most challenging for you? The hardest?
11. What activities did you enjoy when you were younger?
12. Do you still do this? Why yes / not?
13. If you could change something in your situation, what would you change?
14. What would you like to do (eg activities, daily ...)
15. What do you find important that we know about you?



BACKGROUND FLEMISH INDICATORS

- Indicators on the quality of care and safety:
  - Decubitus (blemishes)
  - Unintended weight reduction
  - fall incidents
  - Daily physical freedom limitation
  - drug incidents
  - flu vaccination
  - medication use
  - place of death
  - Care plan life end

  Indicators about the quality of caregivers and healthcare organizations:
  - absenteeism (short-term per staff member)
  - care staff leaving home care center
  - volunteer work

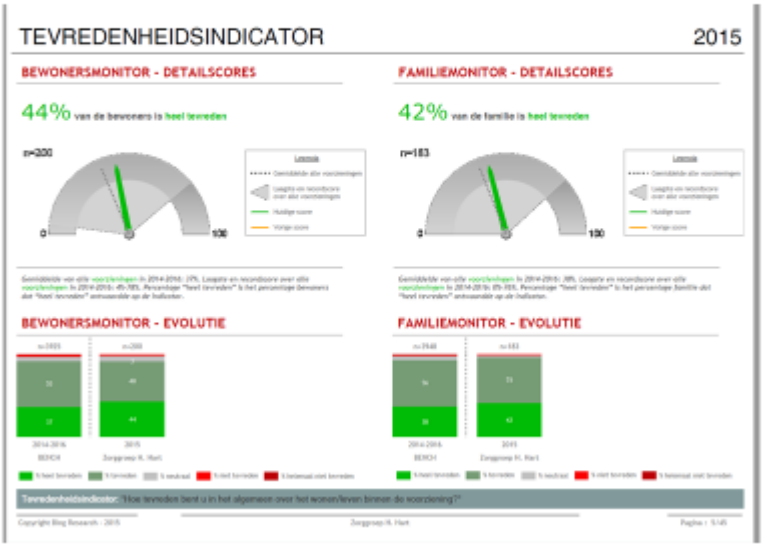
PREZO TOOL AS INTEGRAL QUALITY SYSTEM FOR RESIDENTIAL CARE CENTERS

- Within PREZO there are '60 prestations' related to quality of care. Each prestation has double focus: employee and organization. The difference between people with dementia and people without, is not included in the development of this tool. Using the PREZO-tool, we need within the working groups explicitly pay attention to an interpretation in the context of persons with dementia. In orde to do that, we compose the working groups as much as possible from employees who work on an open or closed section of the residential care centre.
- Some examples of het PREZO-items are:
  - Content of het Flemish indicator
  - Feel secure and at ease
  - Feel at home
  - The experience of eating and drinking
  - Practical accessibility
  - Continuing the social contacts with the environment
  - Integration of the client in the residential care centre
  - Own life interpretation
  - Psychological well-being and problem behavior
  - Physical well-being
  - Human dignity and integrity
  - Continuity of care and service
  - Strategy and policy
  - Organizational culture and structure
  - ...

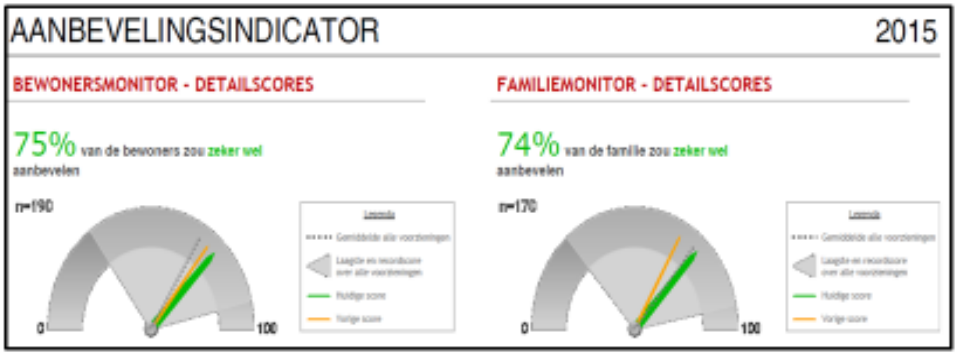
SATISFACTION MEASUREMENTS AMONG RESIDENTS WITH DEMENTIA AND THEIR FAMILY

- We use the Bing Research residents and family monitor
- Residents who aren't able to answer are queried through the family
- The result are presented in a report. This report provides the basis for the preparation of specific action points.
- Council of residents

BING RESEARCH - GLOBAL RESULTS



BING RESEARCH - GLOBAL RESULTS



KERNINDICATOREN						
Algemene tevredenheid	43%	NA	59%	NA	//	NA
Aanbevelingsgraad	75%	5%	74%	9%	//	//
KWALITEIT VAN LEVEN						
Aangenaam woonverblijf	26%	NA	24%	NA	//	NA
Mate van geluk	24%	NA	24%	NA	//	NA
Mate van veiligheid	30%	NA	45%	NA	//	NA
Dag zinvol invullen	20%	NA	21%	NA	//	NA
De vloer	28%	NA	33%	NA	//	NA
Respect voor privacy	30%	NA	44%	NA	//	NA
ONTHAAL						
Onthaal op eerste dag	33%	NA	47%	NA	//	NA
Uitleg over werking centrum	33%	NA	47%	NA	//	NA
Uitleg over financiële voorwaarden	NA	NA	//	NA	NA	NA
ACCOMMODATIE						
Accommodatie in het algemeen	23%	NA	23%	NA	//	NA
Gezelligheid kamer/flat	33%	NA	44%	NA	//	NA
Schoonmaak kamer/flat	47%	NA	56%	NA	NA	NA
Gezelligheid leefruimte/gem.ruimtes	23%	NA	23%	NA	//	NA
Schoonmaak leefruimte/gem.ruimtes	33%	NA	40%	NA	//	NA
Aantrekkelijkheid omgeving rond gebouw	21%	NA	17%	NA	//	NA
Kwaliteit herstelling defect	27%	NA	27%	NA	//	NA

ten kerselaere emmaüs
expertisecentrum dementie Vlaanderen
H.Hart Zorggroep
interreg 2 Seas Mers Zeeën CASCADE

BING RESEARCH - GLOBAL RESULTS