The Community Programme

THE COMMUNITY PROGRAMME
CLOSURE REPORT

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BACKGROUND

This paper describes specific work which has been undertaken by the Community Programme, what has been completed and identifies what has been handed over to others. The improvements are the result of collaboration between staff and organisations across health, social care and third sector partners, guided and supported by a shared improvement methodology.

Improvement Programme and Outcomes to Date

Following substantial engagement with citizens and staff, three initial areas were identified where there were significant frustrations with care, largely at interfaces between services. A '5-step' improvement process was used to develop and implement three 'bundles' of improvement projects, all of which focused on care of our frail, older citizens initially. Project scope, initiation and delivery were undertaken and co-ordinated by the Community Programme with financial support from transformation monies.

As a brief reminder, these initial bundles of improvement work consisted of:

- Comprehensive Geriatric Assessment (CGA) in a variety of settings which included the development of a CGA team on Ward D57 at QMC, CGA-style transfer plans for patients transferring to a care home and the 'transfer to assess' trial which involved the development of the Care Co-ordination Team (CCT). We also undertook some trials around social worker initiated CGA in the community.
- Working with the Care Homes sector to procure and implement a Leadership Development Programme for care home managers (My Home Life), the creation and delivery of a bespoke Clinical Quality Framework for all staff in care homes. The Clinical Quality Framework is currently being taken forward by Optimum in County CCG's and CityCare, who supported the development of the CQF, are delivering this training to care homes in the City CCG.
- The implementation of the Summary Care Record which gives hospital staff immediate access to information on medications, allergies and sensitivities from the primary care record. Implementation of the Clinical Record Viewer followed which provides additional, more detailed information from the primary care record to hospital based staff.

All of the above projects either provided a 'proof of concept' which was shared with all of our commissioner and provider colleagues or delivered significant improvement in their own right and are continuing to be developed. You will have received previous reports on the above. This report will focus on work underway since April 2014.

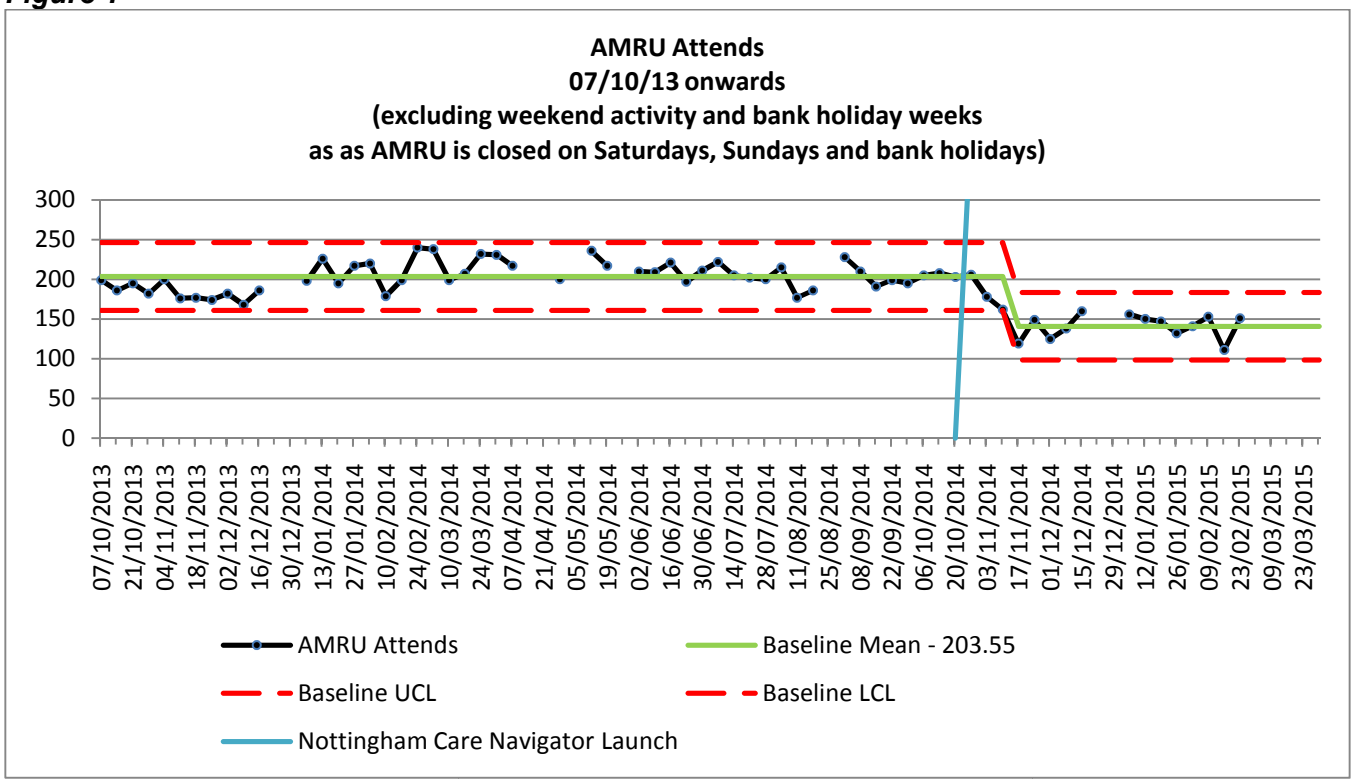
In April 2014 we focused on a broader range of initiatives that included Navigation, Transfer of Care and Readmissions. Work with the care home sector also continued with the 'trial' of the care homes SystmOne module and setting the foundations for the Care Homes Registered Nurse Development Programme.

Navigation

This programme was set up to ensure that patients were navigated to the right place, first time. The focus has been on the development of urgent telephone advice lines and urgent access clinics within Nottingham University Hospitals in order to reduce GP emergency admissions. In October 2014 the flagship Acute Medicine advice line was launched together with the Nottingham Care Navigator (a web-based navigation portal). All GP referrals to the Acute Medicine Receiving Unit (AMRU) now benefit from a GP to consultant discussion; ensuring only patients requiring ambulatory attendance or admission are referred to hospital (and where possible direct to the appropriate specialty).

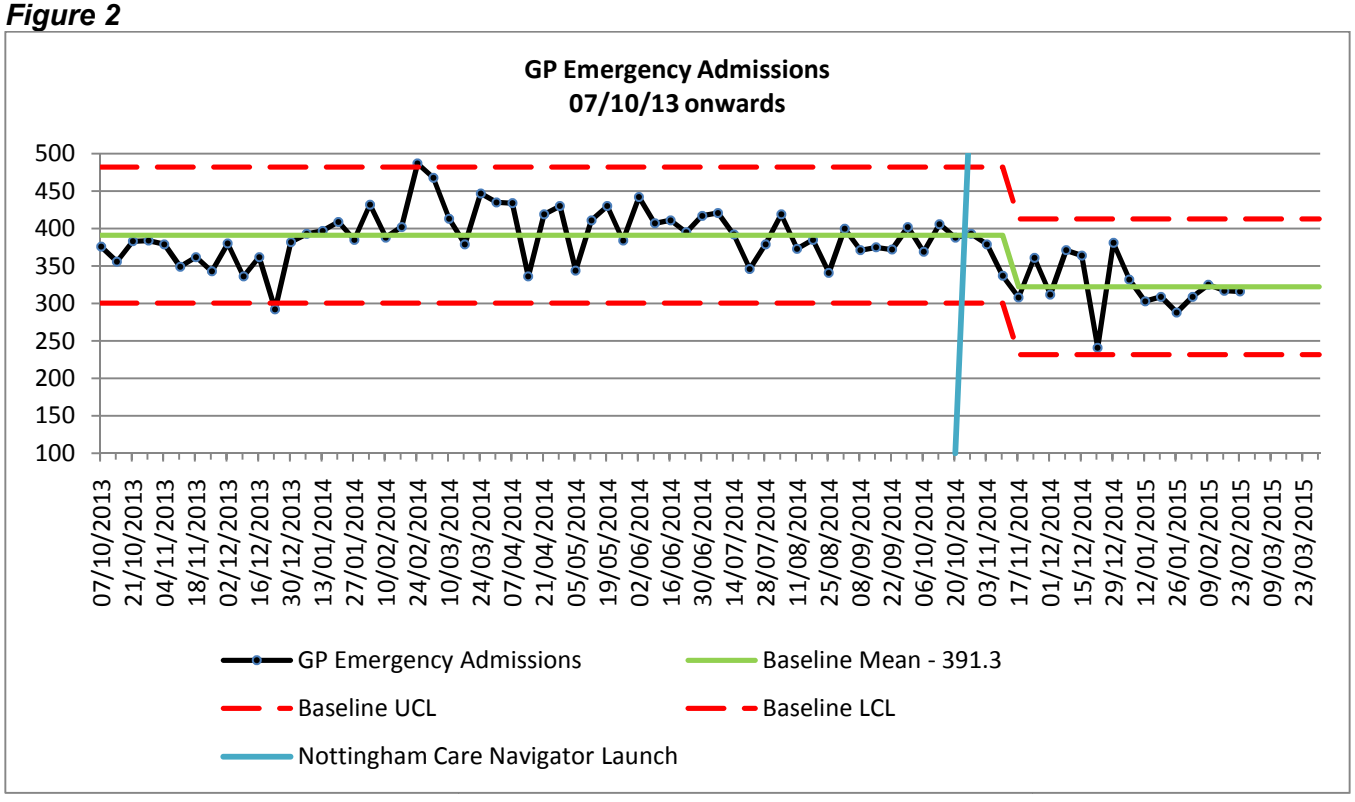
Attendances to AMRU have made a substantial and sustained drop (see figure 1).

Figure 1



GP emergency admissions have also reduced (see figure 2)

Figure 2



Marginal Rate Emergency Tariff (MRET) funds secured in January 2015 will ensure the team who have delivered this work in 2014/15 will continue to develop, refine, expand and embed this programme during 2015/16.

It is envisaged that the programme will be completed and integrated into 'business as usual' processes by March 2016. The individuals delivering this work will continue to be hosted by NUH under their Better for You Programme.

For additional information please contact: nottinghamcarenavigator@nuh.nhs.uk

Transfer of Care

This programme focused on the implementation of a new, streamlined supported discharge pathway to enable supported discharge patients to be transferred within 24 hours of being declared medically safe. This process was implemented in two stages: Stage 1 was the development of the Streamlined Supported Pathway and Stage 2 was Improved Board Round Adherence to the Discharge Pathway.

The new Streamlined Supported Discharge pathway has been implemented across Queens Medical Centre and City Hospital and all patients that require a supported discharge are taken through the new streamlined process. This ensures that:

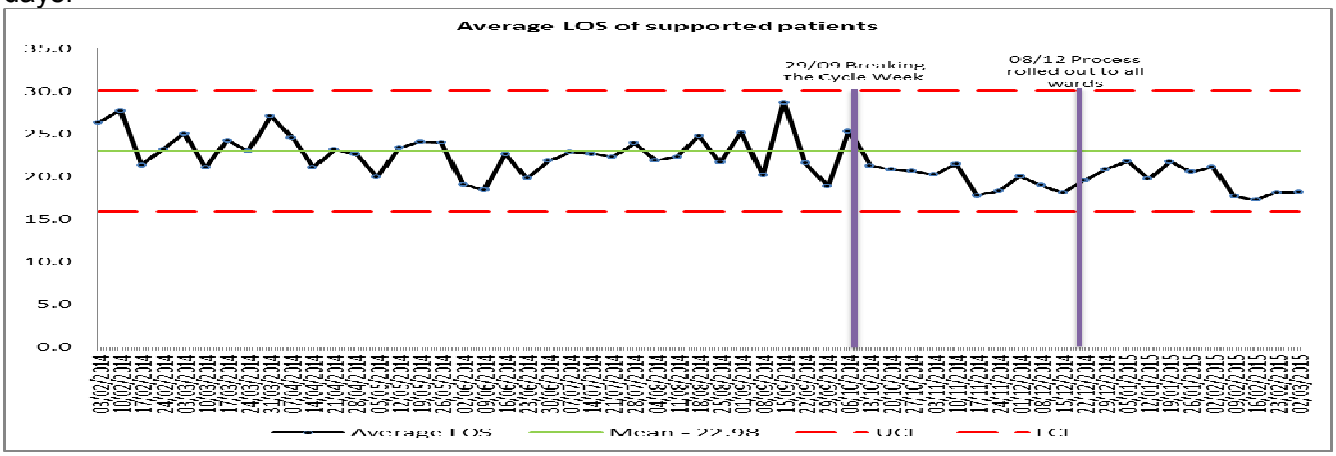
- Patients do not stay in hospital longer than is medically necessary, reducing length of stay by 3 days
- Patients return home sooner
- Risk of hospital acquired infection is reduced
- Duplication of assessments is removed by the implementation of the 'one referral' approach
- External organisations can identify appropriate care packages early.

Average Length of Stay of supported discharge patients (days)

The graph below shows the average length of stay for all supported discharge patients, broken down by discharge week to ensure that we have no time lag within the data.

	Average LOS
LOS Baseline	**23**
Post Breaking the Cycle	**20.5**
Post Roll Out to all wards	**19.5**

The graph below shows a decreasing trend in the LOS for patients that had a supported discharge between September and the end of February – reducing average LOS from 23 days to around 19.5 days.



Key areas for improvement within the Improved Board Round Adherence work are being taken forward by the Improving NUH Ward Processes project within NUH. A Change Agent has been identified from Social Care to help support health colleagues in NUH to:

- Increase understanding of social care functions and requirements for discharge planning and decrease the pressure on social care resources
- Build trust and confidence between organisations and teams

- Improve understanding of the pathway, roles and responsibilities of each team to seamlessly transfer patients through the system

Additionally, to support the above it is proposed that a Long Term Training Package is developed and is made part of the annual refresher training with organisations. It is anticipated that this work will follow on from the work of the Change Agent.

Going forward it is proposed that this work is overseen by Work-stream 2.

For additional information please contact: Paul.smeeton@nottshc.nhs.uk

Monitoring Supported Transfers (MST)

This work focused on the development of a 'proof of concept' spreadsheet that populated appropriate data fields in order to monitor patients who were waiting for a Supported Discharge. This development began in January 2014 and has undergone an iterative process, supported by NUH's Analysis and Intelligence (A&I) Team and the Community Programme. The MST spreadsheet is now in daily use by the CCT including assessment outcomes for all supported discharge (Integrated Health and Social Care Team) referrals. Reports developed within the 'proof of concept' CCT spreadsheet allow for operational performance reporting as well as system level reporting.

Going forward the proof of concept package will be handed over to NUH's Better for You Team (Nicky Ogden) for further development into the single dataset for Transfer of Care, which will be available within NUH to track patients. Operationally, the CCT will need to continue to input and monitor activity.

For additional information please contact: Carol.foster@nottinghamcitycare.nhs.uk

Work-stream 2 Co-ordination

The aim of this work-stream is to develop an improved, effective discharge process for patients that require support following their acute episode, ensuring high quality clinical care and patient experience is continually provided. The support provided to this work-stream included programme management, development and monitoring of the tactical improvement plan, co-ordination and administration of the work-stream meetings and weekly project reporting on updates, risks and issues to System Resilience Implementation Group (SRIG).

The Work-stream currently focuses on 6 work areas to create an effective discharge process:

1. Long Stay Patient Reviews
2. Streamlined Supported Discharge Process
3. Improving NUH ward processes
4. Care Co-ordination Team redesign
5. Improving Information Systems to support the discharge process
6. Leaving Hospital Policy

The Work-stream has also picked up additional work areas as issues have been identified:

- Trusted Care Home Assessments from Hospital
- Home Care improvements
- Continuing Healthcare process

Going forward the project/programme management role for Work-stream 2 will be handed over to the new Urgent Care Project Manager (Nottingham City CCG).

For additional information please contact: Paul.smeeton@nottshc.nhs.uk

Readmission Reduction

This programme was set up to improve patient care and experience through reducing avoidable readmissions. Our aim is to reduce the Nottingham University Hospitals NHS Trust (NUH) readmit rate from a 2013/14 baseline of 8.7% to a sustained position of 8.1% by end of 2015.

To date the programme has:

- Agreed a single, shared definition of a readmission that considers all patients that return to hospital as an emergency within 28 day (no exclusions)
- Developed timely, accessible and robust readmissions datasets that are shared across the local health and social care community to provide factual information and one version of the truth
- Supported NUH directorates and specialties to set readmission reduction targets and develop readmission reduction action plans
- Built performance dashboards to track current position against our baseline
- Supported NUH directorates in the development and implementation of improvement schemes and developed a programme approach to readmission reduction within NUH
- Provided support to community providers in reviewing and analysing the effectiveness of readmission reduction projects e.g. County Health Partnerships post discharge follow up service
- Developed, tested, refined and currently rolling out a patient centred readmission review process in order to identify 'avoidable' readmissions and why these have occurred. Approximately 250 reviews are now complete and the process is being expanded over more clinical areas at QMC and City Hospital.
- Engaged with stakeholder through a blend of communication methods. This includes:
    - Readmission reduction champions
    - Monthly newsletters
    - Twitter updates (@ReadmissionsNUH)
    - NUH intranet updates
    - 'Drop in' sessions
    - Attending key meetings within NUH and the community
    - Answering ad hoc enquiries.

The year to date readmission rate has reduced from the baseline position of 8.7% to 8.5%. There is still work to do and initiatives are launching that we believe will see further improvement to move towards out target position in 2015.

The Readmissions Reduction Programme has received funding from the Readmissions Fund and looks forward to maintaining focus and driving a reduction in readmissions in 2015/16, building on the foundations established to date.

For additional information please contact readmissions@nuh.nhs.uk.

TPP SystmOne in Care Homes

SystmOne launched a national pilot for care homes across the country to be able to access their resident's shared electronic patient records. The Community Programme submitted an application to TPP (developers of this healthcare software) and was successful in piloting it across Nottinghamshire. The aim was to improve the timely transfer of factual information about the health needs (past and present) of care home residents to support the delivery of effective care. The use of SystmOne would ensure care home staff have readily available, up-to-date health information on their residents whose GP practices uses SystmOne software.

The achievements of this work include:

- Buy in from CCGs across Nottinghamshire

- Engagement with GP's and care homes to participate in the pilot – 10 homes across Nottinghamshire have been set up with the demo system ready to go live with their own units.
- Identified a clear process for the set-up of care home units to go live for roll out per CCG.
- Encouraged GP practices and care homes to work together to agree the level of access the care homes would have e.g. read-only or read-write access.
- Overcome a number of obstacles and challenges within the set-up process. Unanticipated information governance and technical operational issues were resolved.
- Identified that the 'go-live' process is not as simple as SystmOne describe.
- The approval process covered all participating care home residents and GP practices in order to comply with Information Governance requirements.
- Registration Authorities' between the Parent and Host organisations were identified.
- Once the download of the care homes module was complete, staff were trained on its use.

Some of the key challenges with this work included the lack of technical support from TPP, the lack of trust between care homes and GP practices and finding care homes whose residents were registered with a GP whose practice was on SystmOne.

Looking ahead, this work will be handed over to leads within the individual Clinical Commissioning Groups. Currently, leads have been identified in City (Jason Mather), Rushcliffe (Steve Murdock), Nottingham North and East (Candice Lau), Newark and Sherwood (Sue Cox) CCGs. The remaining CCG's have yet to identify a lead.

For additional information please contact the appropriate lead in the relevant CCG.

All the above work has been or shortly will be either concluded, handed over to the identified individuals or organisations or will continue with the support of the identified funding streams.

Anita Astle intends to continue to deliver the Registered Nurse Development Programme for Care Home staff in her capacity as a care owner/manager. Support for this may be required by the local health and social care sector should you wish to provide it. Below is a brief overview of this work.

Registered Nurse Development Programme for Care Home Staff

The aim of this project is to create a Professional Development Programme for registered nurses working in care homes. There is support amongst key stakeholders to create a programme similar to that created for Practice Nurses – this programme is available at Masters and Degree level. Creation of this programme has increased nurses interest in working in general practice.

Nationally there is a recognised issue with the recruitment of nurses in nursing homes. Anita Astle (Care Homes Lead) has been offered a seat on a national working party which is being set up under the auspices of the Department of Health to address this issue.

The key performance indicators for this work will be to:

- increase the knowledge, skills and competence of registered nurses working in nursing homes
- and reduce the number of admissions from nursing homes to hospital.

Key accomplishments to date include:

- The development of a care home forum to help drive this work.
- The completion of a questionnaire by care homes. To date the responses received show that clinical skills are lacking by nurses working in nursing homes.

- The areas/topics/skills to be covered in the proposed development programme have been identified.
- Care home nurses and managers, universities, key clinicians, researchers, Health Education East Midlands, Local Education and Training Council, Royal College of Nursing (RCN), Skills for Care have been involved in the developments to date.
- Links have also been made with York University who are undertaking research funded by RCN Foundation regarding the development needs of nurses working nursing homes.

Anita Astle will continue to undertake this work in her capacity as a care home owner and manager, supported by Dr Adam Gordon and Sarah Goldberg (University of Nottingham).

CCG leads are asked to continue to support this work in whatever way possible.

For additional information please contact: anita@wrenhall.com

Closing Remarks

The work over the past few years has been both challenging and rewarding in the turbulent time being faced by the health and social care sectors.

We are pleased that much of the work we have undertaken is continuing in some shape of form and are proud to have played a part in initiating and progressing significant pieces of work for the benefit of local residents and patients/service users.

Sandra Hynes.

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