OPERATIONAL PERFORMANCE REPORT: November 2017

Swindon Community Health Services Overview

1.0 Introduction

This overview brings to the attention of committee members the key areas of Community Health Service performance in November 2017.

2.0 Community Nursing

2.1. Staffing:

Recruitment to Community Nursing posts has continued and there is now a corresponding reduction in the use of agency in line with our forecast position.

2.2 Service Transformation:

Admission Avoidance
Proactive management of patients with long term conditions is a priority to improve patient care, to reduce unnecessary acute admissions and to limit the time spent in hospital by this cohort of patients. Work to date includes

- Liaison with SWAST to identify patient show are frequent flyers and to agree multi agency management plans to reduce further attendances. On one occasion through timely communication with the ambulance service an ambulance on route to the hospital was intercepted and returned the patient home where the community matron took over care
- All patients known to the community matrons have flags on Medway to alert ED and Trust teams that the patients is known to community services. These alerts are all being reviewed and updated to ensure the information is reliable and current
- All non-elective admissions to the Trust are scoped every morning (including weekends) to identify any admissions / attendances by patients on a CHS caseload. This results in :
    - the alert being checked for accuracy, updated and passed to SCHS front door team who liaise with the medical teams to expedite early discharge
    - frequent attenders are identified and teams review care plans to put in place additional measures to reduce re-admissions

This work programme is a key performance indicator and will be reported in future months

Community Intermediate Care Team (CICT)
The Community Intermediate care team is made up of community nurses, paramedics, occupational therapists and physiotherapists. Working closely with community nursing the CICT provides same day and urgent responses and also works with social care colleagues to provide seamless care to patients who require multidisciplinary or high intensity support.

This team continues to transform to build capacity within the community to meet the needs of patients with complex needs at home. The team have also worked closely with acute colleagues to ensure safe and sustained discharges for patients with very complex needs.

Referrals for this service for a same day response is increasing in line with the overall increase in community nursing referrals with a rise from 60 urgent referrals in October to 74 in November. This has led to a fall in performance from 92% to 86%. This will be closely monitored as one of our 'winter KPIs' to ensure we remain responsive to patients and also in supporting system flow. A continued rise in the need for urgent response and the increasing need for this response to be within 4 hours has resulted in a review of this workforce. Vacancies have been reviewed and a recruitment plan includes adjustment to the skill mix to include more generic assistant practitioners as well as nurses and therapists to increase capacity and responsiveness

2.3. Operational delivery

The re-structure and re-design of the Community Nursing Service has begun to demonstrate improved performance and efficiency with the service now managing increased number of referrals and a greater number of patients on the team caseloads. This reflects the greater oversight of caseloads by the team leaders and band 6 staff and the impact of the high percentage of permanent staff.
Headlines include:

- Referrals to the Community Nursing service have remained high, 2853 year to date, up 5% from last year.
- 395 referrals were received in November reflecting a consistent upward trend since April (286)
- Service caseloads have also increased. 1478 patients were visited by the service in November, up from 1303 seen in November 2016
- The average daily number of completed care plans in November stood at 380, showing an increase of 12% compared to a similar period in 2016/17.
- Nurses attended patients at home on 7,410 occasions in November, the busiest month so far in 2017/18

The recent winter weather created some significant challenge for community nurses completing visits particularly getting out to the outlying villages.

- Support from Wessex 4x4 was invaluable and enabled all high risk patients and end of life care to be provided
- Staff off duty walked to patients in their home localities to provide care
- Admin staff who could walk to the orbital came in to support coordination of visits and to contact patients to rearrange visits and to provide safe and well checks
- On Monday despite continued challenges, the teams worked creatively to ensure every single patient was seen and completed 320 visits.
- The Community Equipment Service, delivering equipment to people's homes helping discharges dropped only one visit in the bad weather.
- Lessons were learned and we are now working with the Resilience team to refresh Business Continuity plans and I-respond cards.

3.0 Swindon Intermediate Care Centre (SwICC)

3.1 Older Persons Pathway and Patient Flow

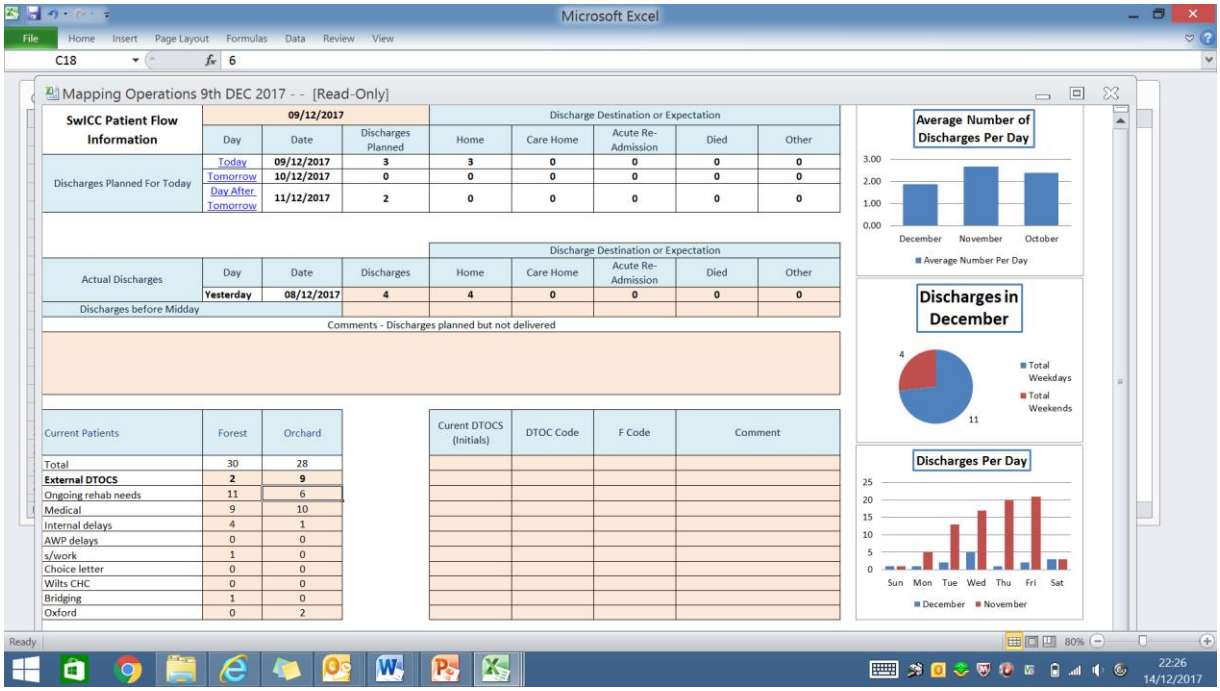
The future plan is for Orchard Ward in SwICC to play a key role in the pathway for Older People, providing appropriate rehabilitation and reablement to enable older people to be discharged home or to a low intensity environment.

A recent step change within the pathway has been to reduce the number of transfers occurring very late in the day and to prevent the inappropriate transfer of patients who have on-going medical management needs. A dedicated SCHS Liaison Team has worked with geriatricians, IDS and SwICC to match patients to the agreed criteria. This change has had a beneficial impact on patient flow

- 73% of transfers to SwICC now occur before 1700. Target 100%
- A total of 52 patients were transferred to Orchard Ward in November compared to 25 in May
- The average length of stay in Orchard Ward has fallen from 40 days in May to less than 18 in November reflecting the focus on patient flow.
- 37 of 51 patients were discharged from Orchard Ward within the target time of 21 days
- Forest Ward was at 96% Occupancy in November. Orchard Ward was at 96% Occupancy in November
- 14 of 20 Non-Stroke patients were discharged from Forest Ward within the target time of 36 days.
- In November, an average of 2.67 patients were discharged from SwICC everyday,

Week end transfers continue to be less than week days driving the daily average down so the patient flow team have been offered additional hours to provide week end cover. This resulted in five transfers during the first week end in December. A daily dashboard has been developed to track same day, next day and day after planned transfers and this became operational from 1 December 2017

Fig1: Snap shot of Daily Mapping Dashboard



Over the short to medium term, the recommendations that are due from the current ECIP review will focus a lot on frailty and we expect this to drive further changes in SwICC.

In the longer term, our approach to rehabilitation and how we use therapy to improve patient outcomes and support wider system pressures needs to be reviewed. Following a recent trip to Austria involving a small number of consultants and the Head of Integrated Services and Therapy, to look at new models for intensive rehab, it is clear that there are benefits to be gained from looking at the European model. In Austria we saw:

- Rehab being a central focus of the patient care plan
- Goal setting being central at the point of admission
- Less focus on length of stay with all patients receiving neuro rehab staying in hospital for a set 4 week and more on achieving the goals set in a very focussed and measurable way
- A lower reliance on social care placement post discharge due to the success of rehab
- A bed occupancy in the acute of circa 75% because patients are swiftly discharged into proper rehab settings with a big focus on the use of technology and 'normalising' the patient interactions within the unit i.e. communal restaurant rather than meals in beds, large circulation spaces, patients in regular clothes rather than hospital gowns

This work will be developed further as we refine the clinical model and look at the potential commercial arrangements of a model to see whether this is part of the solution to help us manage some of the capacity risks we are facing.

3.2. Delayed transfers of Care

The Associate Director of Community Health Services attends all Gold calls, in addition to the whole system review of delayed patients which takes place three times a week to focus on unblocking delays. Whist this forum concentrates on all medically fit patients within the acute wards it is essential for flow that SwICC bed occupancy is optimised with timely discharge. Despite increased focus, the number of days attributable to delayed transfers of care increased in November to 123 from 107 in October. Of these, 30% were attributable to social services, an increase from 18% in October. In 2017/18, the majority of delays (400 days, 24%) have been due to patients awaiting a social care package in their own home. In the last 3 months, 40% of delays have been due to Patient or Family Choice. It is therefore essential to scrutinise length of stay to ensure patients do not become "stranded" in SwICC as a result of the concentration on acute delays. It is clear that there are patients who are transferred to SwICC who should be in an alternative setting and we now need to ensure that we are truly removing the blockage rather than moving it further down the pathway. A daily dashboard is in development and will become operational by 1 January to provide real time information and transparency on length of stay and DTOCs.

3.3 Improvement Plan

The SwICC improvement plan whilst focussed on improvement of quality, safety and patient experience also has key actions to improve patient flow. Progress in the past month include:

- SCHS has appointed an Interim Associate Director of Nursing (Caroline Davies) who will have responsibility for all professional leadership and development of nursing and therapies within Swindon Community Health Services. This will include line management of the nursing team in SwICC
- 2 new Band 7 Interim ward managers are now in post. These interim leaders are experienced nurse leaders with the skills and knowledge to deliver improved standards of care and staff development

3.4 Equipment Audit

There has been an historical under investment in equipment within community services, and this poses a financial and clinical risk. This is a historic lack of investment which stems from before the Trust took responsibility for the service and we have advised the CCG that the Trust will require financial support to address the current and future shortfall. Following an initial report on Swindon Community equipment in March 2017, the Trust Equipment team has been asked to explore in detail the resource required to amalgamate the service. While this process took place, the team have mitigated any key safety issues and undertook an inventory assessment and condition survey. This is now compete and will be discussed with the CCG in order to secure funding for a replacement programme.

3.5 Stroke

Our key commitment is to ensure a reduction in % of transfers >24 hours when deemed medically stable for management at SWICC from Falcon. There are fewer transfers to Forest ward with approximately 10-12 stroke patients admitted each month. In November, all patients were discharged to their usual place of residence. Year to date, 89% of patients were discharged to their usual place of residence. 6 patients had stayed for longer than 31 days with the average length of stay among those discharged being 32 days. There are currently 8 stroke patients in Forest Ward who have stayed for over 31 days. 4 of these are DTOCs reflecting the high level of dependency and discharge reliant on availability of large social care packages or housing adaptation. The daily dashboard will provide increased vigilance on patients with extended length of stay

4.0 Specialist Services

COPD and Home Oxygen services
When the Trust took over community services the COPD and oxygen service was significantly compromised due to staff resignations and difficulty recruiting. The single handed oxygen nurse and part-time physiotherapist were unable to meet demand. Over the past year this service has redesigned and is now a team of four: Team Lead physiotherapist specialist practitioner, two respiratory nurses and an assistant practitioner (band 4). The team has reviewed the work load and the service now has greater resilience and capacity and is now starting to have a measureable impact on their caseload. They are proactively using performance data and patient outcomes to drive further improvement and work closely with respiratory colleagues in the Trust as well as supporting pulmonary Rehabilitation in the community.

COPD: Referrals for November are higher than Oct with an improvement in patient contacts on last month. Re-referrals are also lower this month, as patients are no longer discharged from the caseload when admitted to GWH. This ensures the team continue to actively support the patients and the acute team to ensure timely discharge once medically stable. Care has been initiated more quickly in November, for patients who are acutely unwell - whether referred from GWH, GP practices or patients phoning in (already on our caseload). This group of patients also incorporates those picked up from a daily check of COPD patients on our caseload who have accessed OOH/UCC/ED in the previous 24 hours.

OXYGEN: There has been a slight dip in contacts delivered Sept/Oct. This is due to 2 new members of staff requiring their specialist training in Oxygen. The new staff are starting to carry a small caseload in Nov, so contacts should start to rise, although they are still under supervision/training for this month.

5.0 Areas of Concern

Diabetes
The community Diabetes service is currently compromised as this is a service supported by 2 wte Diabetic Nurse Specialists (DSNs). There is one vacancy and the other staff member is on long term sick leave. This is an example of how small community services whilst effective lack resilience and even minor staffing issues can create significant service disruption. Working with secondary care colleagues an acute DSN has been able to take on additional hours to enable a weekly community clinic and all telephone queries have been transferred to the acute DSN team. The CCG have recently funded a community dietitian, psychologist and pharmacist and these professionals will work along-side the Community Consultant Diabetologist to hold MDT clinics in Eldene Health Centre. SCHS and the D&O Division are committed to collaboratively working to support the system wide transformation programme to strengthen a community led Diabetes MDT service. This work will include a review of existing resources and pathways so that the referral routes and workforce requirements support the move of non-inpatient services to be located in both community and secondary care settings determined by population need and geographical spread

Other services lacking resilience
There are a number of community specialist teams that continue to be threatened due to the lack of resilience and there is a need to develop proactively plans to support greater sustainability. An example of this is the recent transfer of the DCVT service to ambulatory care due to loss of community staff with the necessary skills and competencies. Services such as Dermatology, Tissue viability and Community IV Path to strengthen a community led MDT for the Diabetes serviceays are also under pressure within secondary care so the Interim Associate Director of Nursing is currently working proactively with secondary colleagues to scope opportunities to align secondary and community resources to achieve greater organisation-wide sustainability. The Committee will be updated in future reports

6.0 GP Out of Hours

We have now initiated the formal TUPE process for the 19 staff employed in this service and reviewing the financial implications of this service change to ensure this does not create an unintended financial risk to the Trust. Staff will transfer to Medvivo on 1st February.