Out of Hospital programme update to Stakeholders
January 2019

Introduction

Welcome to the latest issue of our Coventry Out of Hospital newsletter. At the beginning of January the NHS Long Term Plan was published which outlines key NHS priorities over the next 10 years. We are pleased that Out of Hospital services, plus a focus on prevention and integration across the health system, is a consistent objective throughout the plan. This month you can also read more about the how our Place Based Teams are getting on after their first three months, plus the independent evaluation of the Coventry care model by the University of Birmingham.

Place Based Teams take shape

Coventry Place Based Teams (PBTs) comprise nursing and therapy services which are aligned to GP clusters. In addition, the Central Hub comprises services including urgent response and specialist nursing services, like phlebotomy. This allows for a wider skill mix overall with the aim of facilitating a smooth hospital discharge and preventing avoidable hospital admission. Together the PBTs and the Central Hub provide urgent and planned care citywide.
Place Based Teams take shape cont...

PBTs and Central Hub have been properly established since October 2018. Each of these teams is supported by clinical leads and service managers above them. The teams consist of:

<table>
<thead>
<tr>
<th>Team Leader</th>
<th>GP Cluster / Team</th>
<th>Base</th>
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<tbody>
<tr>
<td>Sarah Barnes</td>
<td>Coventry Navigation and GP Connect</td>
<td>Paybody</td>
</tr>
<tr>
<td>Vicky Hans</td>
<td>North Sowe Valley and South Sowe Valley</td>
<td>Willenhall Primary Care Centre</td>
</tr>
<tr>
<td>Helen Green</td>
<td>Coventry North</td>
<td>Paybody</td>
</tr>
<tr>
<td>Sarah Cardall</td>
<td>Unity and Go West</td>
<td>Tile Hill Health Centre</td>
</tr>
<tr>
<td>Asma Bi</td>
<td>Urgent Response and Reablement Care</td>
<td>Paybody</td>
</tr>
<tr>
<td>Becki Tyler</td>
<td>Planned Therapy</td>
<td>Newfield House</td>
</tr>
<tr>
<td>Lauren Thorpe</td>
<td>Tissue Viability</td>
<td>Longford Health Centre</td>
</tr>
</tbody>
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The PBTs are settled in their new bases, and are beginning to embed into their GP clusters and associated groups of patients. With more interaction and discussion in a multi-disciplinary way, PBT staff have a clear understanding of all of their patients and are not working in silos; this ultimately improves patient care.

The development of the urgent care service is felt to be beneficial as it takes unplanned work as it comes through iSPA. In the past, community nursing comprised a mix of planned and unplanned work, meaning that capacity had to be found for unplanned, urgent work which came in on the day. Staff in PBTs are now more able to plan their work as the Urgent Care team will visit urgent cases the same day and then refer to the correct PBT or service for a planned follow-up visit. For the patient, this ensures that they are seen when they need to be, but also that any continuing care is undertaken by a familiar staff member from their PBT.

Care Navigators have recently joined the PBTs and are proving a valuable addition, providing an holistic approach and signposting to voluntary and charity sector organisations which can improve the life of some patients and prevent some health and social care related issues; for example helping a person to get support from a voluntary group which interests them could help prevent loneliness and depression. Care Navigators have already proved themselves invaluable in complex patient cases where they can navigate the patient to a variety of options that can support them to manage their own health and wellbeing.

Senior clinicians are feeling the positive impact of being part of a PBT as it allows them to truly understand complex patients.

The iSPA has had a greatly positive impact on PBTs by ensuring that staff are sent to patients who really need them. This means that demand and staffing levels can be more effectively planned as it is possible to account for where referrals have come from. The number of inappropriate referrals into Community Nursing has reduced as the iSPA are able to redirect them into a more appropriate pathway first time, which is beneficial the patient.

As GPs begin to see the benefit of their PBT, they are increasingly keen to come on board. Social Care are currently aligning themselves to GP clusters which means MDT meetings will truly be multi-disciplinary which can only be good for patients. Cluster meetings are beginning to develop as communication and engagement with GP cluster leads is being increasingly helped by the PBTs going from strength to strength.

Over coming months, focused development time is planned with GP cluster leads to focus on the development and establishment of MDTs for each of the PBTs and their primary care networks.
Integrated Single Point of Access (iSPA) activity

An analysis of iSPA activity between April 2018 and December 2018 showed the following referrals:

<table>
<thead>
<tr>
<th>ISPA Activity Summary</th>
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<tr>
<td><strong>Total Referrals</strong> (to date)</td>
</tr>
<tr>
<td>21248</td>
</tr>
<tr>
<td><strong>Average Daily Referrals</strong> (to date)</td>
</tr>
<tr>
<td>77</td>
</tr>
<tr>
<td><strong>Average Week Day Referrals</strong> (Mon-Fri)</td>
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<tr>
<td>90</td>
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</tbody>
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Amongst other data, the table opposite shows the reason for referrals into iSPA by GP cluster. It is clear to see that the main reason for referrals is for wound care, catheter problems/continence care and rehabilitation.

Reason for referral by GP Cluster

This reflects in well over half of patients being referred to their Place Based Team for nursing. Urgent response therapy also received many referrals into the iSPA.

The services to which referrals were allocated, by GP Cluster.
SWFT visit to our iSPA

On 8 January, South Warwickshire Foundation NHS Trust (SWFT) General Manager for Out of Hospital, Tracey Sheridan and Head of Nursing, Rosie McDonnell, visited our iSPA. The purpose of the visit was part of good practice sharing with our partners. Tracey and Rosie were talked through the way in which the iSPA works by Nicola Ward, Interim Business Manager.

The team explained to Tracey and Rosie that one of the biggest benefits was the reduction in community nursing workload because they were only receiving referrals which should have been sent to them and were not visiting people in their homes when it wasn’t necessary. They have found that around 18% of people could be helped with advice over the telephone, rather than visiting them.

The Place Based Teams mean that staff get to know people in their care and so the patients are more confident to talk to a nurse by phone instead of receiving a visit.

Tracey, Rosie and Nicola discussed how they could share experiences and lessons learned with each other to ensure the Out of Hospital services provided in both Coventry and Warwickshire were the best they could be, despite slightly different requirements from commissioners of the services.

At the end of the visit Tracey said: “Thank you for allowing us to visit your iSPA and share experiences. Our visit has been really valuable and we look forward to welcoming you to our services.”

Coventry Out of Hospital service –
A look back at 2018!

Below are some of the overall highlights from 2018 and our next steps

Achievements
• Our integrated Single Point of Access (iSPA) service is fully operational
• The clinical triage process in the iSPA is fully operational
• The Central Hub service (urgent response and specialist nursing services) is fully operational
• Text message reminders of clinic appointments are provided to patients
• Place Based Teams (Community Nursing and planned rehabilitation therapy services) are aligned to Coventry GP Clusters and in place
• A patient and carer engagement group is up and running to continually improve the services using patient and carer feedback
• Care Navigators have all started their roles and are building case loads
• The stakeholder engagement plan has begun
• A GP survey has been developed
• A staff survey has been developed and organisational development support was available to staff throughout the change process into the Out of Hospital way of working
• Approval was given to implement the EMIS patient record system in 2019 for Out of Hospital services, to better link with GPs for the benefit of each patient’s overall care

Next steps
• EMIS patient record system implementation plan to be developed
• Multi-disciplinary team design sessions to take place with our stakeholders.
As part of phase one of the evaluation, interviews were undertaken in 2018 with staff representatives from our Trust, UHCW, Coventry City Council, third sector organisations and Coventry and Rugby CCG.

The overall findings from the research found the rationale for the care model was very well supported, particularly in addressing the needs to:

- Re-configure community services to reduce fragmentation and duplication
- Take an holistic rather than a task-based approach to meeting patients’ needs
- Place multi-disciplinary team working at the heart of the model
- Improve patients’ experience of care by treating them in the right place by the right people first time
- Manage demand within the health and social care system
- Address recruitment challenges for community staff

Some early successes of the new care model were recognised including the development of the iSPA and good partnership working which reduce delayed transfers of care.

The areas to improve the care model include:

- Involving and engaging the workforce and workforce planning
- Smoother working with partner organisations
- Communication with stakeholders including patients and carers

In response to the research findings the Design Board will focus on the following key priorities:

- Establish multi-disciplinary teams (MDTs) with our system partners (GP clusters and social care)
- Communication of new care delivery model to our system partners
- Develop Place Based Team partnership working with system partners (GPs, social care, voluntary and charity sector organisation)

Get in touch:

If you have any feedback or suggestions regarding content for this newsletter, please email to communications@covwarkpt.nhs.uk and give your email heading ‘Out of Hospital Communications’. We would love to hear from you.

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