Care at the heart of Coventry and Warwickshire’s communities

- Continence Services
- Dietetics
- Community Nursing
- GPs
- Occupational Therapy
- Physiotherapy
- Social Care
- Specialist Nursing
- Speech and Language Therapy
- Voluntary Organisations

COVENTRY

WARWICKSHIRE
South Warwickshire NHS Foundation Trust (SWFT) and Coventry and Warwickshire Partnership NHS Trust (CWPT) became the lead providers Out of Hospital (OOH) services for our region in April 2018. This update explores how the programme is aligned to the outcomes in the national NHS Long Term Plan, as well sharing some of its biggest achievements so far and plans for the future.

The NHS Long Term Plan and Out of Hospital services

At the beginning of January 2019 the NHS Long Term Plan was published. The plan outlines key areas and priorities for all healthcare providers over the next 10 years and highlights some of the good practice that is already underway across the Out of Hospital programmes.

A key focus of the plan is prevention and developing care outside of the hospital setting, indicating that there will be increased spending of at least £4.5 billion in primary medical and community health services, without decreasing the hospital budget.

In line with the new Out of Hospital models of care, the plan sees urgent response and recovery support delivered by flexible teams working across primary care and hospitals, developed to meet local needs; these would include GPs, allied health professionals (AHPs), community nurses, mental health nurses, therapists and reablement teams.

New investment is planned to fund multi-disciplinary teams (MDTs) aligned to primary care networks, plus GP practices entering into network contracts. There will be a designated single fund through which all network resources will flow. Networks will benefit from shared savings by avoiding A&E attendances, hospital admissions and delayed discharges.

Going forward, there is a will to explore and develop new integrated models of care with the Primary Care sector for severe mental illness, which would include community mental health teams as part of place based care and the primary care network.

There is also a vision for a single clinical assessment service for both physical and mental health within the integrated NHS111, ambulance and GP Out of Hours services including specialist advice, treatment and referral, access to medical records and decision to support staff outside a hospital setting via a single point of access for urgent response from community services.

Another area the Long Term Plan also explores is technology and how to use digital solutions to secure a sustainable future for the NHS. Therefore, all staff working in the community would be equipped to access mobile digital services including the patient’s care record.

It is really pleasing to see that there is national recognition for the models of care we are implementing that support integration and working with colleagues across all health and social care organisations to ensure we are providing the right services, in the right places, for our local populations.

For more information about the NHS Long Term Plan please visit: www.longtermplan.nhs.uk
Place Based Teams

Place Based Teams are designed to be the heart of Out of Hospital services. They deliver services to people close to their place of residence and work in partnership with GPs and primary care. They operate with a multi-disciplinary approach, initially focusing on the top 5% of the population i.e. individuals with long term conditions.

Alcester, Atherstone, Rugby, Bedworth and North and South Leamington all have operational Place Based Teams and there are plans to launch in Camp Hill, Nuneaton, Stratford, Shipston and Warwick throughout 2019/20.

EMIS supporting Out of Hospital services

The EMIS web system supports the standardisation of processes and forms across the Out of Hospital programme.

Thanks to EMIS teams are able to work in a more agile and efficient way with the ability to complete records without returning to a base. They now have a single, shared patient record everywhere around the county.

The system has been implemented in a phased approach. HomeFirst, District Nurses, Diabetes Specialist Nurses are all live. Specialist Palliative Care, Heart Failure Specialist Nurses, Continence Services, Parkinson’s Specialist Nurses and Speech and Language Therapy and Dietetics are all due to be on EMIS by May 2019.

Leading the way on frailty

The Out of Hospital programme is leading the way in developing the pioneering pathways to ensure frail and elderly patients are being cared for in the best environment. Unnecessary admission to hospital has already been reduced and a general philosophy of “home first” is actively promoted.

The programme is fully committed to changing perceptions of how elderly patients are cared for. It is collaboratively working with hospital and community services, primary care and the local authority to develop a joined up approach. This ensures people are cared for in the right place, whether this is at home, in hospital or in a care home.
Evaluating our effectiveness

We see many examples of our staff working hard and applying their expertise to provide first class care in the heart of our communities. While we also have lots of positive feedback from patients, we feel it’s important to evaluate the Out of Hospital (OOH) programme ourselves to help us identify opportunities to continuously improve. As part of this, we are working with partners involved in the commissioning and delivery of health and social care across Coventry and Warwickshire to create a dashboard that brings together different measures of the effectiveness of the programme.

The dashboard will act as a tool to quickly and easily see the impact that the OOH programme is having on the local health and care system, highlighting things such as the number of people aged 65 years plus who are discharged from hospital within a week and reducing A&E attendances from care homes. It is currently being developed and the first elements of data are now live, with the full dashboard expected to be operational in May. After this point the dashboard will be further developed to include primary care related metrics such as the need for home visits to patients aged 65 years plus.

Feedback on how the programmes are developing...

“Working as part of the Alcester Place Based Team I can definitely see how it is enhancing patient care thanks to having a wider team including voluntary services and fire brigade involved. It feels like a very supportive environment and enables better collaborative working.”

Hannah Wilkinson, Occupational Therapist Homefirst South, South Warwickshire NHS Foundation Trust

“From my perspective I think that the way that the programme has been set up has allowed the Hospice to both have a voice which it did not really have before and also a much greater understanding of proposed change and service development / reconfiguration within Out of Hospital services with which we interface.

The programme has been one of the factors that has encouraged a more collaborative approach between partner organisations which is leading to improvements in care. More specifically the Rugby End of Life Care group has been developed through the programme which has filled a previous gap in the coordination of service planning and which at an early stage is already beginning to see benefits in improved understanding of partner working arrangements.”

Dr Mike Iredale, Myton Hospice

“I work as a GP in the south west of the city. Before 9am I got a call from a patient's informal carer indicating that things were deteriorating rapidly. I got in touch with the iSPA and a Nursing Team was at the patient’s house at 11am. Between us the patient was catheterised, given appropriate injections and we were able to explain what was happening to the patient’s wife and son. This is the sort of team work and communication that is essential to provide good care. I was proud to be part of a good team!”

Dr Peter O’Brien, Forrest Medical Centre, Coventry

“One of the biggest improvements we have seen in Community Nursing is the reduction in inappropriate home visits. The fact that the iSPA is manned by clinicians, means that each referral is allocated to the right team first time. From a Community Nursing perspective this means that we don’t have to find extra capacity for unplanned visits during our day. Instead, urgent requests go into the Central Hub for urgent response, meaning that we can provide more effective care to our patients.”

Vicky Hans, Place Based Team Leader North Sowe and South Sowe GP Clusters, Coventry and Warwickshire Partnership NHS Trust

For more information about either of the programmes please get in contact with the Programme Leads:

Warwickshire:
elaine.coates@swft.nhs.uk

Coventry:
martin.jones@covwarkpt.nhs.uk

South Warwickshire
NHS Foundation Trust

Coventry and Warwickshire Partnership
NHS Trust

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