

# PAPER

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# Report to the Meeting of the

# Oxford Health NHS Foundation Trust

# Board of Directors

**27 November 2013**

**Chief Operating Officer’s Report**

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**For Information**

This month’s report provides the Board with updates on:

* District Nursing
* EMU and Interface Medicine Developments
* Older People’s Service Remodelling
* Winter pressures
* Psychological Medicine Service Developments

**Recommendations**

The Board is asked to note the report.

**Lead Executive Director: Yvonne Taylor, Chief Operating Officer**

1. **District Nursing**

The District Nursing (DN) service forms the backbone to all community nursing and is vital to local residents and Oxford Health NHS Foundation Trust. This service has seen a significant increase in patient need and demand, which is adding considerable pressure to teams. This pressure has two elements: capacity to deliver front line care, and the capacity of local clinical leadership to support DN teams in managing a higher number of complex patients at home.

This pressure is across the service as a whole: but has a greater impact on teams where there are vacancies or sickness, particularly where it is proving difficult to recruit.

Community Division are taking a number of actions to address these pressures; some specific to the DN service have already been implemented: others require planning with wider community services to ensure that we are addressing this demand pressure and not simply moving pressure elsewhere without capacity to manage given a rise in demand pressure across all community health services. Some actions also require discussion and agreement with commissioners, and this is underway.

In the immediate term we have implemented actions to

* Freeing up clinical leadership time
* Draw support from our other services such as Care Home Support Service and the Integrated Front Door (targeted to those teams with greatest demand / capacity pressures)
* Improve access to local and rapid training on specific clinical competencies (for example, male catheterisation, tissue viability)

We have also secured £420k in short term funding (winter pressures monies) to enable increased capacity to be recruited into the district nursing service. This money is being targeted on extra hours for staff, sessional staff and some permanent and fixed term contracts (e.g. weekend only contracts) recruitment to help with demand.

We are also in negotiation with the CCG as to how we ensure the service is on a sustainable footing into the future. National and local policy is to move care closer to home which we are supporting through the range of service developments in community services. It is important that the money follows the patient since current investment and incentives in primary care and community provision will not be sufficient to sustain such a change.

The Division is also working with HR to improve recruitment approach and timescales. A critical aspect is effectively inducting new starters as the current team-based approach to this adds to the pressure of individual teams. An intensive county-wide induction/ preceptorship programme for new staff is under development that will support new staff to be able to work to capacity more rapidly and reduce pressure on individual teams. This will become operational during January.

We are reviewing progress on actions weekly and the impact that our actions are having, and make further changes to ensure we address this gap between demand and capacity as effectively as possible.

1. **Emergency Multi-disciplinary Assessment Units (EMUs) and Interface Medicine**

The three new EMU pathways at Witney Community Hospital and jointly with Oxford Universities Hospital Trust at the John Radcliffe and Horton will commence “soft launch” during the last two weeks in November.

These pathways centre on the rapid multi-disciplinary assessment and treatment for adults at immediate risk of acute admission, and build on the success of Abingdon EMU in providing a rapid alternative to acute admission.

The décor of Witney EMU (which required estates works to convert to this new function) have been informed by the King’s Fund principles for dementia-friendly environments and feedback from a local group of patients and carers supported by the Alzheimer’s Society.

Clinical and operational staff from OUH and OHFT have worked together effectively to co-produce the EMU pathway through reconfiguration of existing urgent (acute and community) services for the JR and Horton pathways.

Liaison with primary care is well established, with an audit programme of outcomes under development and a review of early case histories planned for the primary care education event on the 28th November.

Recruitment to the Interface Medicine Physician role continues, with the next interview date on 18th December.

**3. Older Adult Mental Health Service Remodelling: Staff Consultation**

As with physical health services, there is a challenge to move more care closer to home to improve outcomes for patients and reduce acute admissions where this is clinically appropriate.

Currently older adult mental health community teams work Monday-Friday, 9am-5pm, with an on-call response responding to urgent need during the out of hours period.

The new model of care for older adult mental health will increase the number of staff working in a community setting, as well as extending the hours of service delivery to seven days a week, and to 8pm weekdays.

This will provide greater capacity for community older adult mental health practitioners to respond proactively to escalating mental health need in older people (dementia and functional illness such as schizophrenia) and provide more treatment and support in the home. For people with dementia this will be augmented by better joint working across physical health, mental health care and social care (for example, Hospital@Home, community therapy, district nursing, reablement and crisis response) to assess, treat and stabilise both physical and mental health crises at home wherever clinically appropriate.

This additional resourcing will be achieved by improving MDT discharge planning on Older Adult Mental Health wards to reduce the average length of stay closer to the national average (currently Oxfordshire is an outlier, with an average length of stay of 100 days). Together with increasing the ratio of inpatient staff to patients, this will enable improved bed use allowing overall bed numbers to reduce (and the staffing resource to be deployed in community settings) without reducing capacity for number of inpatient episodes.

This is a significant development of the older adult model of care, which has been extensively clinically developed and reviewed.

Formal consultation on these proposals is due to commence in Buckinghamshire in late November 2013 and in Oxfordshire in January 2014, with the intention of implementing this model of care during 2014.

These changes will be a significant contribution to the implementation of integrated locality working.

**3. Winter Pressures**

OHFT is broadly on track with delivery of all of its additional clinical capacity, including:

* 12 additional community hospital beds
* Increased rehabilitation capacity (community therapy)
* Clinical lead on-call for winter pressures
* Additional capacity into district nursing for winter pressures, including flu vaccinations for house-bound patients

Community Hospitals have worked very hard to reduce average length of stay through improved discharge planning, and this (excluding DTOCs) is now 19.5 days average (down from 22 days FY13).

Reablement episodes are beginning to increase from the summer plateau of circa 230 new episodes a month (up from 170 / month August 2012) but are currently approximately 15% below the expected contract activity (contract target increased in October 2013). This is despite the ongoing delays at the back door of Reablement, which currently hover around 25 / week and account for circa 690 hours of care each month.

OCC are currently increasing long term domiciliary capacity to address these delays, and clarity is being sought as to whether this will be fully in place and have addressed existing delays by 27th December when the major surge in winter demand commences.

Patient demand into acute settings is beginning to increase as expected as part of seasonal variation: and the EMU pathways will be a critical component in maintaining patient flow during the coming months.

1. **Psychological Medicine Service Developments**

In collaboration with Oxfordshire and Buckinghamshire CCGs, acute and University colleagues we are expanding the range of psychological medicine services within the Trust. Oxfordshire CCG has commissioned the Trust to provide a psychological medicine service in the Emergency Departments at the John Radcliffe and Horton Hospitals which will operate on extended hours across the week. They have also commissioned an innovative community psychological medicine service to primary care in Oxfordshire. Professor Michael Sharpe and Dr Rob Bale are the academic and clinical leads respectively and a clinical academic group has been formed which is overseeing the development of the community service. Dr Stephen Richards has been appointed as the GP lead for the service and a workshop with GP colleagues from the first wave of practices who will receive the service will take place in November to refine the service model and to agree the next phase of this development.

Buckinghamshire CCG have also commissioned a psychological medicine service to work into the Emergency Department and wards of Buckinghamshire Hospitals Trust.

These developments are extremely important in enabling high quality psychiatric care across organisational boundaries to ensure that patients with mental health issues who present to emergency departments, or who are admitted to acute wards receive appropriate care. They also enable primary and secondary care colleagues to have timely, specialist advice about managing patients with a broad range of co-morbid psychiatric presentations.

National research has demonstrated that it is possible to reduce the spend in acute hospitals by ensuring that complex patients who present with acute symptoms but who have co-morbid psychological or mental health issues and are frequent users of acute secondary care are assessed by expert psychological medicine services with risk assessment and joint care plans developed with primary care and acute hospital staff. GP colleagues can be managing highly complex patients who have a range of symptoms which often result in expensive but inconclusive physical interventions which have little impact or outcomes for the patient.

These services will be evaluated for their effectiveness both in terms of outcomes for patients but also the economic impact of reducing acute hospital referrals. The Trust is advertising for 5 consultants psychiatrists with experience in psychological medicine and we are pleased to be developing these services with partners in both counties.

Psychological Medicine is one of the CLARHC workstreams and the joint approach to developing these services with Oxford University Department of Psychiatry, ensuring that research is embedded from the outset. We will be offering a post with combined clinical and academic sessions, which will strengthen the research element of the service and will increase the opportunities to bring in research funding to this increasingly important branch of psychiatry.

1. **Improvement Champions Development Programme**

A number of key papers including ‘Innovation Health and Wealth’ and the recent ‘Berwick report’ stress the importance of building skills and knowledge in quality improvement across the workforce. One of our responses to this is the popular and successful development programme, designed and facilitated by Sharon Fennell and Sigrid Barnes of the Improvement & Innovation Team.

The programme has just concluded its second cohort with a learning and sharing event held on 13th November. At the event delegates gave poster presentations about the improvement projects they had conducted during the course of the programme and gave group feedback on what they had learned in the five modules and how they had applied the learning in practice. The event was attended by the delegates’ line managers and other invited specialists and managers from the Trust in order to share and spread learning. Line manager support is a critical factor in enabling front line staff to make improvements in service. Lyn Williams (Non Executive Director) and Jackie Thomas and Lucia Winrow (Heads of Service within Operations) acted as ‘judges’ for the event and prizes were given to the best poster presentation and best group feedback. A newsletter is being prepared for wider circulation which will enable further sharing of learning.

Feedback from the delegates throughout the programme has been positive and each module has rated highly among the delegates, as was the case for cohort One.

A third cohort is currently underway and half the available places are already filled for a fourth cohort which commences in March 2014. One of the features of the programme which delegates consistently say is of benefit is the opportunity for staff of different professions, grades and service areas to come together to learn and share their ideas. The programme is appealing to staff of all grades (bands 3 to 8a have attended so far) and most Directorates have had delegates on the course as illustrated below:



We also recently completed a follow up review of impact of the programme with delegates from cohort 1 who completed in February 2013. A number of questions were asked including: “Would you say that the programme has changed your thinking or approach at work? If so please give us some examples of how” and “what would you describe as the impact of the programme for you personally and in your job?” – responses included:

* Yes absolutely. I now remind myself a lot more to plan things better instead of jumping head on.
* I see that it is very important to monitor change and developments and to be able to show improvements rather than just know they are there.
* Yes, in keeping in mind how to factor others’ points of view, especially when it comes to selling an idea/project.
* Definitely. I have become more systematic and holistic in my approach to projects, problems, and challenges and am more aware of the areas I need to work on. For example, I approached the Transition project I was involved in last year differently to how I had approached other projects in the past, and am now focussed on measuring the outcomes.
* The entire programme has had a massive impact on my own personal development.  It has helped me personally, giving me confidence to look at continual service improvement and the methodology required to get things done.