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BOD 00/2015

(Agenda item: x)

# Report to the Meeting of the

# Oxford Health NHS Foundation Trust

# Board of Directors

**Board Meeting**

**25 March 2015**

**Chief Operating Officer’s Report**

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**For Information**

This month’s report provides the Board with an update on:

* Children’s Community Nursing Service: Palliative and end of life care
* The Whiteleaf Centre Benefits Realisation
* Memory Clinics

**Recommendations**

The Board is asked to note the report.

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

1. **Children’s Community Nursing Service: Palliative and End of Life Care**

The Community Children’s Nursing (CCN) Service in Oxfordshire provides specialist nursing care for children aged 0-18yrs. The service consists of the Community Children’s Nursing Team, Respite Nursing Team, Clinical Nurse Specialist team and Community Play Specialist. Palliative and end of life care is part of the core service provided by the CCN service. The ROSY Charity works closely with the Service providing additional support and respite to young people with life-limiting illness and their families.

A large proportion of the caseload consists of children and young people with a life-limiting condition so a significant amount of the nursing workload is caring for children with palliative needs at home or school.

The service works collaboratively with other agencies particularly Helen House, the local hospice for children and young people, Oxford University Hospitals Trust and the Child Death Overview Panel (CDOP) to ensure that a combined advanced plan of care is established to support the child or young person and their family at the end of a child’s life. End of life care is an extremely important aspect of care for all age groups and is a key area of focus for the CQC when they inspect services.

When children, young people and their families make the decision that they would prefer that the child /young person is supported to die at home, the CCN service works with the acute hospital or hospice to facilitate their discharge home. The advanced plan of care is agreed, supported by our nurses through specialist nursing care in the home, providing pain relief and other symptom management as needed. They offer respite to families and the nurses also provide an on call service overnight to support the family. This ensures that families have a professional to contact for advice 24hours a day. Nurses will visit at night as needed and will continue this level of support until the child dies. The CCN service is committed to providing a compassionate, responsive service which enables children and young people to die at home where this is their wish.

Within the last year the CCN service has supported 10 children or young people at the end of their life and currently has 13 children/young people on the caseload who have an Advanced Care Plan (ACP). The nurses work very closely with GPs, paediatricians and social care providing much needed support for the young person and their family at an extremely difficult time.

The service is part of the Trust’s “One Chance to Get it Right” Taskforce and the End of Life Resource Group. The Service is represented at relevant county groups such as Child Death Overview Panel as well as maintaining regular collaborative working with other agencies such as Helen House and the OUHT.

In September 2014 a Palliative Care Audit was carried out. This highlighted the need to improve Advanced Care Planning including; communication, documentation and clarity around process/procedures when a child or young person comes to the end of their life and an ACP is completed.

Following this audit an action plan was developed and implemented. This has now demonstrated considerable improvement in these areas particularly in the distribution/coordination, documentation and communication of ACPs both within the CCN service and with other agencies. This improvement ensures that there is a much clearer understanding across agencies of the wishes of the child, young person and their family at this very important time.

1. **Benefits Realisation – The Whiteleaf Centre**

Following the successful move of inpatient and community services to the Whiteleaf Centre, Health and Wellbeing Campus in 2014, a benefits realisation has been undertaken to understand if the aims and objectives that were outlined in the original business case have been met. This appraisal has cross referenced information against the original business case, looked at models of best practice, sought feedback from patients and carers as well as clinicians to understand what the requirements of the service were and if these have been achieved.

The rationale for the move was always clear; the community teams were on an isolated industrial estate, wards were on different sites which were expensive to maintain and didn’t meet expected privacy and dignity standards. Furthermore, investment to maintain and update such facilities was not viable. The concept of combining the services allowed for the different functions to share facilities and enhance patient pathways and communication between services. It was clear that the Trust needed to make better use of its resources to maximise the quality of care that can be afforded and provide the opportunity to maintain or expand the services provided for the people of Buckinghamshire.

The evaluation demonstrates that the majority of the benefits outlined in the original business case have been realised. Patients and staff have given positive feedback about the new facility and have told us that it is easily accessible, welcoming and very user friendly. Having all the services located in one place has cut down on travelling between locations, reduced maintenance costs due to a new and efficient running facility and increased the interface between services promoting a whole systems working culture.

The design of the building has afforded patients greater space for recovery both within the building and within the carefully designed outdoor spaces. The design provides the opportunity to bring together all parts of the wider healthcare system, county council colleagues, social care and the voluntary sector both physically into the building and via the new clinical model. This enables us to reduce clinical risk by joint working as well as giving us the opportunity to facilitate shared training and education. Attention to detail and design has meant that wards have two bedroom wings with individual bedrooms with en-suites, centralised communal areas with easy safe access to gardens, spacious lounges, therapy spaces, and separate access to non-clinical areas such as family and rest room facilities. A discreet access to 136 suites within the acute wards allow for the safe reception of patients arriving on the unit maintains their privacy and dignity at a time where they may be very unwell.

There are still some areas where the benefits have not been fully delivered. The service remodelling and changes in structures should enable these to be realised this year. However, the project has successfully delivered a scheme that has enhanced patient care and service delivery by meeting its outline aims and objectives within the original business case and provides a safe, modern and very therapeutic environment for patients and visitors to visit and for staff to work.

For information the benefits and their current status are outlined below:

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| Benefits | Status | Evidence |
| 1. Co-location of inpatient, day care and community services to improve integration and multi-agency working. Delivery of agreed strategy within “Putting People First”. Delivery of Trust business strategy including improved services and comprehensive packages of care. Delivery of services which are sustainable within the Trust’s overall business plan. | Complete | Signed plans and schedule of accommodation. Agreement for proposal following “Putting People First” public consultation. Implementation of the new clinical service model. |
| 2. Delivery of Directorate service development strategy and model of care. Achieving target/benchmark lengths of stay and occupancy levels. Contributes to local delivery of the Trust’s ICT strategy. | Partially Complete | Signed plans and schedule of accommodation. Operational policy in place. Overall reduction in length of stay except Ruby which increased. (due to two complex discharges with very long ALOS). Dedicated Leadership Teams on every ward now in place.  Signed IT project input and IT strategy. |
| 3. Improved access to services for patients, family and staff. DDA compliance and approved service user access. | Complete | Signed schedule of accommodation plus floor plans and commissioning prior to moving in. Feedback from service users and carers – “easily accessible, reception and café area are welcoming, a place I feel happy to meet visitors now.” Contract from Kier and professional team. |
| 4. Improved morale resulting from modern and efficient service delivery and working environment. Suitable environment for users and visitors including one which promotes engagement of users and their families. Increased attraction to Trust for prospective staff. | Partially Complete | There are no surveys thus far that capture this data specifically although we should be able to capture this should it be required. Awaiting some data from HR. Feedback from the recruitment days held at the Whiteleaf has been very positive. |
| 5. Efficient ward staffing levels sufficient to deliver the agreed models of care. Standardisation of ward staffing levels to compliment delivery of model of care. Provision of sufficient capacity to respond to demand (including the impact of the growing, aging population). Designed-in Flexibility of internal layout and expansion to meet emerging best practice and changes in demand whilst complying with planning conditions. | Complete | Staffing levels were increased on all the wards. Flexibility in design, Older adult beds reduced from 2 wards to 1. Rehab ward moved in without need to change design or layout. Planning permission compliance. |
| 6. Improved quality of care through delivery of agreed service models within suitable accommodation. Delivery of high quality design. Improved and appropriate clinical adjacencies that benefit both patient/users and staff | Complete | Signed schedule, increased patient and staff satisfaction with regards to clinical care but whether this is directly linked to the design or accommodation the survey does not capture this data. Annual Health Check being carried out through CQC and AIMS process of reviewing standards. |
| 7. Improved training for staff through improved/appropriate facilities, appropriate staffing levels, supervision and support | Complete | Reduction in use of the Sivatech facility. Increase use of the conference room and learning zone for training. |
| 8. Optimised estate running costs, achieve national and local sustainability targets. Optimum use of land and estate, maximised capital receipt from the release of agreed sites and facilities. Achieve national and local sustainability targets. Achieve BREEAM excellent rating, demonstrating a sustainable environmental provision. | Complete | BREEAM excellent rating achieved (Building Research Establishment Environmental Assessment Method) BREEAM certificate as evidence. Used only land required and in compliance with planning permission. |
| 9. Deliver estimated revenue savings as part of the overall financial package. Property maintenance requirements minimised and eased where possible | Complete | There have been changes to requirements due to meeting demand, however overall costs are reduced and property maintenance has eased due to stores and estates & facility services being located on site. |
| 10. Continued Acute Services access to mental health opinion, advice and support. Health and Safety compliant. | Complete | PIRLS in place and contract all agreed. Signed schedule or accommodation plus floor plans and commissioning prior to moving in. |
| 11. Ensure local compliance with relevant consumerism standards, particularly patient privacy and dignity; and compliant with mixed sex standards. | Complete | Signed schedule or accommodation, services and leads signed these off. 2 of the 4 wards are mixed sex and comply with those standards set out in AIMS and CQC. |

1. **Memory Clinics**

This section provides a summary update on actions in both Oxfordshire and Buckinghamshire to continue to develop the memory clinic pathways provided by OHFT. Given the national focus on dementia diagnosis and care, as well as the Trust’s role in dementia research in partnership with Oxford University and the CHLARC, this is a key area of care pathway development for the Trust.

Demand into memory clinic pathways in both Oxfordshire and Buckinghamshire continues to increase, and rose by circa 7% in FY15. In Buckinghamshire this was mitigated by the CCGs’ investment of the Dementia Challenge funds to support increased memory clinic capacity; however there was no equivalent investment in Oxfordshire.

This is reflected in the access standards compliance across the two counties; Buckinghamshire is consistently achieving the 95% seen within 8 weeks as locally contracted; in Oxfordshire this remains challenging, although the current waiting list initiative has brought four / six GP localities to achieving this standard. For the two south localities, where demand is highest and where staff recruitment has proved most challenging, improvement actions are still underway, and currently 59% of patients are seen within 8 weeks.

Sustainably funding for increasing demand for memory clinics is part of FY16 contract negotiations with Oxfordshire and Buckinghamshire CCGs; and this is underpinned by a programme of quality and productivity improvements either within OHFT, or jointly with commissioners and partners. Actions completed to date include;

* Remodelling of the memory clinic pathway to create an integrated assessment process, whereby the patient will receive their diagnosis at the first assessment by the Trust. This brings together patient and carer assessments, and in Oxfordshire also includes follow up by the dementia advisors (commissioned by OCC and OCCG, and provided by a number of partners). This new pathway is being rolled out across Oxfordshire and Buckinghamshire, and aims to reduce patient waits for diagnosis; increase support and information at the point of diagnosis; and maximise clinical capacity to help meet increasing patient demand.
* Project to increase dementia diagnosis in care homes for Chiltern CCG; since January 2015 (11 weeks) the project has assessed 169 residents in 22 care homes used by Chiltern CCG and made 139 new diagnoses of dementia.
* Primary Care taking the lead in review of patients with stable dementia presentation and treatment in Oxfordshire; since August 2014, the OAMH service has supported the return of 1129 patients with stable clinical presentation to primary care requiring routine 6 monthly / annual review (as at January end), with the support of the CCG and GP practices; and is on track to achieve the expected level of 1500 patients by the end of March. This is crucial in releasing memory clinic resources to help meet increasing patient need and demand, and is already in place in Buckinghamshire.

Going forward, the service will continue to work with acute, third sector, primary care partners, academic partners and commissioners in refining this care pathway. Further initiatives will include;

* Ongoing contribution to the dementia-friendly communities project in Buckinghamshire.
* Development of non-medical prescribing, in line with national clinical evidence and guidance.
* Extension of the choose and book process to maximise patient choice in accessing memory clinics at a time and location of the patient’s choosing.