

**Newton Europe Project – overview and progress**

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| **Executive Lead** | Ros Alstead, Director of Nursing and Clinical Standards | Start date | 01/02/2016 |
| **Project lead** | Lucia Winrow, Head of Integrated Localities | End date | 20/01/2017 |
| **Project Manager** | Sarah Lee, Business Manager | Overall Status | **Complete** |

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| **Background** | Oxfordshire Clinical Commissioning Group (OCCG) commissioned Newton Europe in November 2016 to undertake an assessment to answer the question ‘*What is the optimal model for community nursing which can be delivered within the available resources?’* and to quantify potential clinical, financial and operational impacts.    Services assessed included district nursing and specialist community nursing services, e.g. diabetes; tissue viability; end of life community matrons; heart failure and core respiratory.  There were three key elements of the assessment:   1. What is the opportunity for capacity increase through delivering an improvement in operational efficiency with the current constraints (geography, systems, team structures, quality of care)? 2. What is the opportunity for capacity increase through optimising the balance of capacity and demand (including team size and configuration of teams) across the region? 3. What is the opportunity for capacity increase through challenging the layout across the region and further developing integrated working across the teams?   The assessment commenced on 2 November 2016 for six weeks. It involved 1:1 studies and conversations with a number of nurses, managers and GPs, as well as analysis of historical capacity, demand and performance data. Oxford Health NHS Foundation Trust worked closely with Newton Europe to ensure they had access to all information and identified key stakeholders. The work included clinical oversite to ensure a balance between efficiencies, quality and continuity of care.  Newton Europe worked with Oxford Health Foundation Trust to produce the final report for OCCG which is embedded within this report. |
| **Newton Europe Findings** | There are indications of a 2% pa growth in over-65s for which it is necessary to create headroom in the community nursing service. Patient survey and workshop outcomes indicated very low unmet demand in the current caseload.   * Demand itself could be reduced by **4.4%** to **8.6**% through reducing inappropriate caseload and optimising pathways * Capacity could be increased by **10.7%** to **17.3%** through productivity improvements, changing the skill mix and changing the structures of teams * Anecdotally staff are struggling to meet demand, this seems to affect some quality aspects of the service. Oxford Health recommends quality improvements to improve patient care, staff training and support and communication with GP practices. Together this requires **9.3%**of capacity * Implementation of these changes will require significant investment in time and   resources |
| **Newton Europe**  **Recommendation** | The full Newton Europe report is embedded which details all options. Their recommendation was option 2; to **optimise team structures whilst maintaining link with GPs;**   |  |  | | --- | --- | | Operational | * Implement demand and productivity improvements * Reduce number of teams from the current 40 to larger teams clustered around a number of GP practices | | Patient | * Increased independence through self and family care * Personalised care planning | | Staff | * Standardisation of non-face to face processes * More appropriate skill mix within the service to match the complexity of the demand, this will be supported by having the larger teams in place * Increase in skilled band 6 with the specialist DN course | | Clinical | * Standardising clinical processes * Retain links to GP’s but not necessarily within physical locations * Increase GP contact time with the named band 6 | | Capacity Release | * 4.1% to 13.7% * (13.4% to 23.0% without quality improvements) | | Note: 10% of capacity equates to approx. 85 visits per day | | | Capacity opportunities are based on running a large transformation programme with dedicated and experienced resources working on the implementation for 12 to 24 months. | | |
| **Project Description** | Followingthe recommendations from Newton Europe, Oxford Health NHS Foundation Trust discussed and agreed with Oxfordshire Clinical Commissioning Group five key priority areas. The Trust has made a commitment to start to implement these priority areas, they are as follows;  **Standardising Handovers -** Handover is a daily occurrence where patient information is exchanged between the team.  Savings in time  Newton Europe identified that handovers were taking on average 34 minutes. By standardising handovers and holding them daily across the county this could be reduced to 25 minutes. 6 pilot teams have been measured and demonstrated that the average time saved is just over 10 minutes. Which was in line with Newton Europes predications.  District nursing service work in units of 20 minutes with work allocated in units depending on the needs of the patient.  Across the county it meant: 129 units countywide, 21.5 units per locality, 3.22 units per team per day.  Implementing the standardising handover across the county means it produced a saving of 0.5 of a 20 minute unit which equates to just over an hour of time for each team. This would mean:   * An additional 4 simple patient visits per day or * One complex patient or holidatic assessment or first assessment or * One PDR or clinical supervison.   Staff feedback  The SOP was tested and changes were made based on staff feedback, e.g. staff were concerned that they only discussed patients where handover was required, some teams struggled with this and a patient ‘roll call’ was introduced, just the name of the patient is given and if nothing to handover the team do not discuss in detail and move on to the next patient. This has been rolled out across the county and the District Nursing teams are in the process of embedding, handovers will be monitored by the quarterly CNQAT audit and has been handed over from project to ‘business as usual’  **Caseload Reviews -** A detailed review of all patients on the caseload to ensure that they are receiving appropriate care and are being discharged at the right time.  It was identified that demand could be reduced by 2.9% to 5.5% by reducing inappropriate caseload. 80 open cases were reviewed to identify whether they were being appropriately delivered. This identified 28% of activity that could be met through self / family care, or by referral to a more appropriate service. This included 13% of patients who are transport bound. Having piloted 3 district nursing team with different demographics and localities, it has been identified that 5% of patients could be discharged from the district nursing caseload in accordance to the recommendations made by Newton Europe. This would equate to 4% of units saved when looking at the capacity and time saved for these identified patients.  However 110 of these cases out of the 111 patients would need external factors to influence their discharge from Oxford Health services, due to the support systems not currently available, e.g. practice nurses not having the skills to change catheters/care of PICC lines. Therefore only 1 case (0.05% of total cases) could have been discharged from the district nursing case load as resources currently stand. This equates to 0.1% of time saved. 2% of the identified 5% are relating to transport restrictions, this is in relation to the caseload rather than activity level that Newton Europe worked from as stated above. Recognised as good clinical practice rather than effiencies , the project has tested and rolled out a SOP across the county with a recording tool that measures and monitors the pathway of patients. The method of recording works foremost as an operational tool and data collated informs KPI’s, the number of patients for who care can be alternatively met and information for future commissioning.  from home, any overlapping visits, any unnecessary journeys back to base, the planning time involved and staff feedback to identify risks and working through how to minimise these. These exercises and findings will be reviewed together with learning from teams who already have a method for managing this process to agree if a ‘live’ pilot should be implemented within Horsefair, if this should be extended to other DN teams and consider the feasibility of rolling out to DN teams across the County. This work also includes discussions with other Trusts and working with IT on an options appraisal to fully support with team allocation, route planning, communication, care notes and flexible working.  through how to minimise these. These exercises and findings will be reviewed together with learning from teams who already have a method for managing this process to agree if a ‘live’ pilot should be implemented within Horsefair, if this should be extended to other DN teams and consider the feasibility of rolling out to DN teams across the County. This work also includes discussions with other Trusts and working with IT on an options appraisal to fully support with team allocation, route planning, communication, care notes and flexible working.  **Standardising Clinical Pathway -** To ensure evidence based care is used to optimise patient outcomes  By optimising pathways, demand could be reduced by 1.6% to 3.0% and reduce the number of visits relating to wound care. In response to this opportunity we have |
|  | The teams have gone through a data cleansing exercise where they have discharged any patients who are not active on their caseload from Care Notes. Monthly caseload reviews will give the ability to data cleanse and maintain accurate caseloads. District Nursing teams are in the process of embedding to ensure that there is strong challenge and good clinical support to encourage patients families and carers to self-care/self-manage in their own environment or for onward referral to primary care. This will be monitored by the quarterly CNQAT audit and has been handed over from project to ‘business as usual’  **Reducing Travel Time -** 30% of travel time could be reduced through optimal allocation, reduction in non-essential returns to base and starting from home. From the assessment carried out by Newton Europe on travel of three nurses in each team in one day 318 minutes could be saved.  A paper exercise has been completed in the Horsefair and Summertown teams based in Banbury and Oxford to identify the number of patients who could be seen by the DN starting from home any overlapping visits, unnecessary journeys back to base, the planning time involved and staff feedback to identify risks and working through how to minimise these. The pilot teams successfully completed the following as part of this pilot;   * Amended coordinator role to maximise starting from home and safety around lone working and patient changes * Principles for starting from home * New guidance regarding taking patient’s notes home * A patient notes signing out sheet * Improved workshare   The feedback from staff is positive, however included that there was not sufficient IT to support this method of working e.g. route planning and mobile working. This issue was also acknowledged by Newton Europe. The overall feedback/findings are below;   * Feeling improved control over their workload and ability to manage during the shift due to time saving in the morning and staggered start times, leading to many more opportunities to see patient’s straight from home * Higher efficiency, nurses having time to complete admin and going home on time  since implementing starting from home (started pre Newton Europe) * Unable to determine from the pilots if there is any time saving as the teams piloted are small and the number of patients that could be seen were limited   The pilots were reviewed together with learning from the teams who already have a method for managing this process and it was recommended to the project board that it was not feasible to continue with the pilot or roll out to District Nursing teams across the County at this stage, for the following reasons and also due to the need to have more understanding of the neighbourhood teams and the requirements of moving to larger clusters.   * Unable to determine if there is any time saving from the above pilot teams * Competing District Nurses priorities   + Mobile working is not yet available   + Time involved in planning did not support the time saved   + Lack of automated route planning system |
|  | o Timings of visits vs. District Nursing operating hours  o Developing neighbourhood teams  Project Board agreed to put this workstream on hold and that it will re-start as a project in March 2017, the group will include IT and other stakeholders who can identify options to fully support with team allocation, route planning, communication, care notes and flexible working. This work also includes discussions with other Trusts  **District Nursing Duty Desk**  This worksteam was not cited in the Newton Europe report as an opportunity. This is an initiative that the service started to put in place in the West DN locality in September 2015 to primarily improve the staff morale and reduce the number of unplanned visits allocated at the end of a shift. Newton Europe observed the duty desk during their 2 week assessment and liked the idea. Following this assessment the project implemented 3 duty desks to evaluate the Duty Desk model for roll out across the County. Duty desks have been successfully implemented in 6 localities, North, West, North East, Central, South West and South East. Standardised processes and procedures, roles and responsibilities and a recording tool have been put in place to improve efficiency across the duty desks and to facilitate and share learning. Feedback from staff has demonstrated that this has been received positively and staff morale has improved. A capital bid is in progress to request funding to develop a call handling recording tool. The current recording method is based on an excel spreadsheet that is proving not to be robust for the needs of the Duty Desks. This piece of work will continue with IT to develop a robust recording method and a project team will be formed if necessary. The duty desks will be reviewed in 3 months.  **Standardising Clinical Pathway** - To ensure evidence based care is used to optimise patient outcomes  By optimising pathways, demand could be reduced by 1.6% to 3.0% and reduce the number of visits relating to wound care as well as being good clinical practice. In response to this opportunity we have identified mixed aetiology pathway as a priority toimprove healing times and reduce visits and the cost of dressings. The Tissue Viability Team are implementing a pilot for the mixed aetiology pathway and re-visiting the Venous Leg Ulcer Pathway. A baseline audit was carried out in May 2016 to identify the number of patients who have a mixed aetiology leg ulcer and current healing rates. Patients were identified across a number of teams countywide and training sessions were carried out for staff during July and August, 30 staff attended countywide. The mixed aetiology pathway pilot was implemented on Monday 19th September. As part of the roll out teams were requested to submit a report detailing patients who had a mixed aetiology leg ulcer and were on the pathway. The number of patients reported was significantly lower than the number of patients submitted as part of the audit and lower than the clinical team anticipated. A focus team which included the Tissue Viability Lead and Community Matron were asked to cross reference reports and work with 4 teams to identify the reasons for the low numbers reported. Following the findings from these audits the project recommended that a project team is put in place to implement a ‘ Back to basics’ leg ulcer improvement strategy with a focus on achieving competence in leg ulcer mixed aetiology |
| **Project Description** | assessment establishing aetiology before the mixed aetiology pathway pilot is implemented. To start the mixed aetiology 24 week pathway pilot in stages at the beginning of April 2017 and data to be analysed at the end of March 2018.  Project Board approved this recommendation and a project team has been formed that initially meets fortnightly. This group will report to the Older People’s Directorate Quality Committee and update the Business, Performance and Quality report. A full report with key milestones has been prepared for the CCG as this has an impact on two quarters of the CQUIN scheme and is included below.    **Co-locating District Nursing Teams into larger teams**  Background work is being carried out, pilots/ testing of models for different ways of working are being carried out in areas within some localities where there is the support of GP’s and other key partners. This is moving at a slow pace due to political reasons and being sensitive to where there is challenge from GP’s. |

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| **Achievements /**  **Results** | **Standardising Handovers** - **Newton Europe identified that handovers were taking on average 34 minutes. By standardising handovers and holding them daily across the county this could be reduced to 25 minutes.**   * Baseline data demonstrated an average time saving of 10 minutes and 17 seconds per nurse across 6 pilot teams. * This is 0.51 of a 20 minute unit which is a saving approx. 129 units countywide, 21.5 units per locality, 3.22 units per team per day, which is a saving of just over an hour of time, which is equivalent to a PDR or an additional 4 unit complex visit per day. * Rolled out across the county and the District Nursing teams are in the process of embedding, handovers will be monitored by the quarterly CNQAT audit and has been handed over from project to ‘business as usual’   **Caseload Review - It was identified that demand could be reduced by 2.9% to 5.5% by reducing inappropriate caseload.**   * Piloted 3 district nursing teams with different demographics and localities, identified that 5% of patients could be discharged from the district nursing caseload in accordance to the recommendations made by Newton Europe. * This equates to 111 patients and 4% of units saved, approx. 55 units per team, 18.5 hours per week. * 110 of these cases would need external factors to influence their discharge from Oxford Health services, due to the support systems not currently available, e.g. practice nurses not having the skills to change catheters/care of PICC lines. * Therefore only 1 case (0.05% of total cases) could have been discharged from the district nursing case load. This equates to 0.1% of time saved. * 2% of the identified 5% are relating to transport restrictions; this is in relation to the caseload rather than activity level that Newton Europe worked from as stated above.   **Standardising Pathways** - **Standardising Clinical Pathways - By optimising pathways, demand could be reduced by 1.6% to 3.0% and reduce the number of visits relating to wound care**   * Completed baseline audit in May * Staff training programme completed * Carried out audit in 4 teams to identify reasons for reporting low numbers * Implemented a ‘back to basics’ leg ulcer improvement strategy as unable to start pathway pilot * Established the Leg Ulcer Improvement project group   **Starting from Home - Reduce Travel Time (Starting from Home) - 30% of travel time could be reduced through optimal allocation, reduction in non-essential returns to base and starting from home**   * Completed review of table top exercises with Horsefair team in Banbury and Summertown in Oxford and Learning from Faringdon team who already have a starting from home method * Unable to determine if there is any time saving from the above pilot teams * Identified that without IT support the planning and management reduced the levels of effieciency |

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| **Achievements /**  **Results** | * Re-start as a project in March 2017, the group will include IT and other stakeholders who can identify options to fully support with team allocation, route planning, communication, care notes and flexible working.   **Duty Desks -** **This worksteam was not cited in the Newton Europe report as an opportunity. This is an initiative that the service started to put in place**   * Agreed a Duty Desk model * Implemented duty desks in 6 localities, North, West, North East, Central, South West Central, South West and South East. * Standardised processes and procedures, roles and responsibilities and a recording tool * Shared learning. * Feedback from staff has demonstrated that this has been received positively and staff morale has improved. * Capital bid is in progress to request funding to develop a call handling recording tool. * Regular reporting in place to monitor the duty desk and support development |
| **Objectives/Project Status** | **Objectives**  The overall aim of the project was to maximise efficiencies and measure the opportunities to release clinical time to care within the District Nursing Service, by standardising methods and processes, piloting, reviewing, and implementing the improvements identified as part of the Newton Europe District Nursing review. Decisions relating to the outputs of this project aligned where appropriate to the Care Closer to Home Strategy. Specific objectives are;   1. Ensure a greater consistency of care and potentially reduce the time spent on handovers by adopting a standard format aligned to the principles outlined in the handover SOP across District nursing teams countywide 2. Regular caseload reviews in place with a strong challenging team lead and good clinical support to encourage patients, families and carers to self-care/self-manage in their own environment or for onward referral to primary care 3. Identify the opportunities for increasing capacity by 1.6% by optimising clinical pathways within the District Nursing Service 4. Pilot within a team the possibilities of reducing travel time through allocation, non-necessary returns to base and starting from home, (instead of base) allowing the nurses to start their day at their first visit. 5. Increase efficiencies and staff morale by implementing a standardised DN Duty Desk model across the county that reduces the level of interruptions and unplanned work within the DN teams 6. Assess, review available information and share learning to establish baselines and agree the methods and processes for implementation 7. Establish any financial benefits and impacts   **Project Status**  It was recommended to the Project Board in January 2017 that the project in its current format is closed due to the majority of actions complete snd objectives achieved. Where actions or objectives have not been achieved the following plan has been agreed. |

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| **Action to be taken forward** | **Person Responsible** | **Report progress to** | **By When** |
| Review and implement CNQAT audit SOP to include admin and monitoring | Gabbie Parham and Sarah Leahy | Lucia Winrow | 28/02/ 2017 |
| Identify the DN teams who need to data cleanse their caseload by cross referencing reports | Sarah Lee | Lucia Winrow | 28/02/ 2017 |
| Launch Excel training through L&D portal | Amanda Jones | Lucia Winrow | 28/02/ 2017 |
| Set-up a group to review ‘reducing travel time’ | Lucia Winrow | John Campbell (Chair) | 28/02/ 2017 |
| Leg Ulcer Improvement Group to take forward   * PSAG Boards * Start to test the pathway * CQUIN Reporting | Mary Applegate | OPD Qaulity Committee and BPQ report  Lucia Winrow  Martyn Ward | Monthly from January 2017 |
| IT solution for DN Duty Desks | Lucia Winrow | John Campbell and Ros Alstead | 31/03/2017 |