# Community Nursing Service Review 2015/16

## AIM: To develop a model for community nursing in Oxfordshire that is an integral part of a multi-disciplinary out-of-hospital care team, sustainable and fit for purpose within available resources.

**Background**

A review of Oxfordshire's community nursing service was undertaken during 2015, primarily following concerns around the service's ability to adequately respond to the growing demands being placed upon it. These demands were coming from an increasingly frailer older population and more complex patients with multiple long term conditions. Furthermore, the service provider, Oxford Health NHS Foundation Trust (OHFT), was experiencing higher than average levels of sick leave and staff attrition rates.

OHFT has been working with Oxfordshire Clinical Commissioning Group (OCCG) to ensure the service is able to manage current demand and that it is fit for the future, supporting Oxfordshire's Care Closer to Home Strategy. With regard to current service provision, in a recent CQC inspection undertaken in June 2016, the Trust was awarded an overall rating of 'Good' indicating services are being provided in an effective, caring, responsive and well-led way but 'required improvement' to be safe. http://www.cqc.org.uk/provider/RNU

**The Review**

The community nursing review set out to agree the vision for community nursing in Oxfordshire to fully support care closer to home and agree a patient centred model that would;

- help to address the current concerns regarding the service
- be safely and effectively delivered within available resources to maximise patient outcomes and experience
- ensure co-ordinated care in tandem with Primary Care
- have a beneficial system impact
- be an integral part of the Integrated Locality Team model
- improve the interface with other community services and reduce duplication of effort
- improve working practices between District and Practice Nursing Teams to enable greater partnership working.

A modelling exercise was subsequently undertaken in order to understand how improved efficiencies and patient outcomes could be achieved within available resources. This modelling exercise was undertaken by Newton Europe with full staff involvement so as to understand the issues from their perspective and to engage them in the change process.

**Key Recommendations from Newton Europe**

- Improve internal productivity through increased use of standardised care pathways
- Fewer, larger teams with regular standardised interface with primary care, and reduced travel time (neighbourhood teams supporting GP clusters)
- Skill mix review against each new team's standardised caseload to maximise effectiveness and efficiency;
    - Increase Band 6 District Nurse (DN) with specialist practitioner qualification (to treat increasing cohort of complex/unstable patients)

Ann Griffiths Interim Community Services Development Lead Aug 2016

    - Appropriate administrative support in each new team (to maximise patient-facing clinical time)
    - Band 4 Assistant Practitioners to deliver non-complex care (to maximise overall clinical capacity
- Development of Care Notes and its interface with primary care electronic health records to maximise ease of clinical communication and reduce low value tasks

There are a number of further actions that OHFT have/are in the process of implementing (see table below) regardless of the wider joint actions highlighted above:

| | **Efficiency** | **Current baseline** | **Implementation approach** | **Indicative date for delivery** |
|---|---|---|---|---|
| **1** | Streamline handovers | Newton Europe identified average handover time is 34 minutes; aim is to standardise and reduce to 25 minutes | County-wide | Roll out to teams by **end April 2016**<br><br>Embedding May onwards and audit as part of Community Nursing Quality Assurance Tool (CNQAT) |
| **2** | Reduce travel time: start from home and reduce unnecessary return trips to base | Newton Europe modelling suggests release of approximately 75 minutes per team / day | Phased | 1 pilot site in place in each locality by end March 2016<br><br>Roll out complete **end August 2016** |
| **3** | Implement use of mobile electronic health record | EMIS (Egton Medical Information Sytem) Template being trialled in Chipping Norton: Carenotes app being trialled in MH teams for Trust prior to Trust-wide roll-out | Phased | TBC; pending technical configuration date, but **asap in FY17** |
| **4** | Extend use of standardised care pathways to maximise outcomes and efficiency | Venous leg ulcer pathway in place: early intervention leg wound care pathway under development; mixed aetiology wound pathway identified as next priority | Phased | Roll out complete **end December 2016** for early intervention leg wound pathway |
| **5** | Embed DN Duty Desk, and optimise rapid response across DN and MDT integrated locality hub teams | In place in SW and W GP localities | Evaluate and refine current implementation; then roll out to all localities | Evaluation completed end **March 2016**, county-wide roll-out completed by **September 2016** |
| **6** | Review each DN team caseload to ensure appropriate and timely discharge | Teams in North have started weekly caseload reviews with Band 7 Clinical Development Leads (CDLs). Other CDLs beginning implementation with their teams | County-wide | **End March 2016** |

**Locality Approach**

However, the key challenge from the review was to put into place neighbourhood teams supporting GP clusters, and for community services to support primary care in a flexible way that would enable all services to manage future trends/demands in a more integrated way.

As such, each locality now has a multi-stakeholder Locality Community Services Group with the overall purpose of:
*Working to the remit of the letter from OCCG's Clinical Chair (dated 4/3/2016) to OHFT's CEO (see letter to OHFT's CEO from OCCG's Chair – attached) to:*

- *Agree a patient centred model for locality community services that will:*
    - *Be safely and effectively delivered within the available resources to maximise patient outcomes and experience*
    - *Ensure co-ordinated care in tandem with Primary Care*
    - *Have a beneficial system impact*
- *Identify the collective community based out of hospital resource available to the locality*
- *Identify the GP practice clusters for the locality and supporting cluster teams*
- *Consider the relationships and interfaces with all community and primary care services to ensure duplication is reduced and patient experience is improved*
- *Consider how the working practices could develop to enable greater partnership working in the interest of patient care*
- *Encourage innovation and new ideas in order to provide effective care in the most efficient way, building capacity within the system.*

Each group, whilst working to the stated overall purpose, have agreed their own locality outcomes according to their specific needs, challenges and priorities and will be responsible for evaluating these. Whilst action plans and timescales are also being developed by each locality group the key date for evaluating the effectiveness of this approach is December 2016.