REVIEW OF COMMUNITY NURSING SERVICES

JUNE 2013
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EXECUTIVE SUMMARY

In April 2013 Sedgwick-Igoe and Associates Ltd. were commissioned by NHS West Cheshire Clinical Commissioning Group (WCCCG), to undertake a review of selected Adult Community Services provided by Cheshire and Wirral Partnership NHS Foundation Trust (CWP). Anecdotal feedback from GPs and commissioner concerns regarding the perceived lack of change in service provision since Transforming Community Services (TCS) combined with the results of a desktop review produced by Cheshire and Wirral Commissioning Services Unit (C&WCSU) prompted the need for greater understanding of the services provided to inform future commissioning. In addition, contracts with provider organisations are due for review and possibly re-tendering.

The community services to be included were:

- District Nursing;
- Community Nursing;
- Specialist nursing; and
- Therapies excluding Podiatry, Adult Musculoskeletal and Speech and Language Therapy.

Our approach has relied primarily on meetings with commissioners, GPs, Practice Managers, community nurses, therapists and senior service managers. This qualitative data has been complemented by the C&WCSU analysis and additional analysis of data provided by CWP completed by us. Benchmarking community services is notoriously difficult due to the diversity and complexity of service provision and delivery. However, an exercise completed last year by the NHS Benchmarking Network\(^1\) using 2011/12 data has attempted to map community health services in some detail with submissions from 66 community service providers; we have used this to provide comparison where possible. Again the reader should note that not all 66 providers have provided data for the comparisons presented and this is noted alongside the appropriate data.

The report:

- highlights the instability in the Health and Social Care economy as a result of organisational changes over the last two years;
- Discusses the changes to community services as a result of TCS
- Describes services and benchmarks them where possible;
- Summarises feedback from GPs and CWP staff; and
- Recommends improvement to the Ageing Well programme.

A detailed breakdown of recommendations is contained in Appendix C.

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\(^1\) Benchmarking community services benchmarking report – Validated July 2012
COMMUNITY SERVICES SUMMARY

The District Nursing Service appears to be comparatively well resourced, being placed at the upper end of the Benchmark inter-quartile range. However, whilst contacts are below the average, they are well within the inter-quartile range. The fall in performance in 2012/13 is attributed to increased complexity of patients with the requirement for more than one staff member to attend still recorded as one contact. Duration of visits has also increased and is now being recorded. It is also of note that the reduction in District Nurse contacts occurred in the same year that the Community Matron Service changed its service model to include the provision of direct patient care.

The Community Matron/Clinical Case Manager (CM/CCM) Service is very well resourced, exceeding the upper range of the benchmark group and reflects the low commissioned caseload per whole time equivalent (WTE). It appears that there is considerable available capacity within the service to accommodate the introduction of lower risk patients if direct patient care were referred to the District Nursing Service. Community Matrons are also the first point of call by Single Point of Access) SPA to visit patients and avoid hospital admission.

Specialist Nurse Services receive low levels of resource and have generally been commissioned to fill identified service gaps. The service does not appear to have been reviewed in the light of other service developments. As a consequence there appears that there is overlap in the provision of Chronic Disease Management. It is recommended that these services should be reviewed in the context of the Patient Journey with clear lines of responsibility, referral criteria and ‘hand back’ arrangements.

The Community Therapy Service appears to be comparatively well resourced, being placed at the upper end of the benchmark inter-quartile range. Community Therapy contacts are below the average but towards the middle of the inter-quartile range. However, it should be noted that the CWP Community Therapy service also provides services to Ellesmere Port Hospital. Wait times for Therapy services appear unduly long; work practices need to be reviewed to produce a more responsive service. It is also recommended that GPs be informed of Therapists’ initial assessments and treatment plan in a timely manner and not to rely solely on the Discharge summary.

Many of the specialist/multidisciplinary services including COPD, Continence, and Heart Failure have been commissioned and provided to fill identified service gaps. As a result they continue to operate independently of the underlying core services. In general, GPs do not know how to access these services.

The new Rapid Response Team has been created from the merger of the CWP Rehab Link Team, the Crisis and Re-ablement Team and Countess of Chester Hospital (CoCH) Discharge Liaison Team to enable timely access to therapy services and social care packages. However, these teams continue to work in parallel and work is required to establish a common vision for the service and to agree changes in working practices by each former team to deliver the new vision.

Currently, the service is not provided after 6pm yet many elderly people presenting in A&E could avoid hospital admission if this service was available until later into the evening. It is recommended that the business case for the extension of SPA services might be enhanced further with the inclusion of Therapy and Social Care services to support an extension of the newly formed Joint Rapid Response Team.
Single Point of Access (SPA) is making a considerable contribution to the avoidance of hospital admission and is exceeding its target of 25% admission avoidance. However, CoCH staff appear unaware of the contribution that CWP is making in measured hospital avoidance. It is recommended that this information is shared regularly with CoCH so that all parties recognise the contribution that each is making to alleviate a shared problem.

In summary, Community Services in Western Cheshire compare favourably to other services in the Benchmarking club in terms of numbers of staff and contacts achieved:

- Further work is required to assess the District Nursing contacts and if work is being completed by other services;
- Policies and procedures need to be consistently applied. GPs to be made aware of the policies and procedures;
- Issues have been highlighted with Therapies which the general manager is continuing to address. In addition, access times to therapies should be reviewed. A review of the Rapid Response service indicates that the nurses are not delivering nursing care but passing that onto the District Nurses to complete. A review of the Rapid Response process should take place to map out the process highlighting barriers and agreeing action plans to address.

Communication with GPs is key and improvements should be seen as integrated teams are implemented as this will lead to:

- The identification of named community nurses and team leaders for each practice; and
- Provide a communication route for GPs to raise concerns with CWP and vice versa.

The addition of a board level GP will support communication and marketing of CWP services to the primary care community.

The organisation should develop a more commercial approach to dealing with the commissioner considering how to ‘account manage’ the commissioning team in the first instance.

In common with other Community Services organisation there had been little investment in technology which in turn reduced the information available to commissioners, management and operational teams. This is being addressed in CWP through the implementation of EMIS however further work is required to resolve remote access issues amongst other things.

The majority of community staff have integrated well into CWP with considerable benefit from effective professional development and clinical governance arrangements. Staff are excited about the perceived benefits of moving to integrated teams. The nurses seemed clear on their role to avoid admissions of patient to hospital; additional work needs to be done to ask them to consider what else they can do through training and/or working with others (acute, social care, primary care, voluntary sector) to manage the patient’s journey through the system. District Nurses feel that their clinical skills are underutilised and that they could make a significant contribution to hospital avoidance and early discharge of patients if their scope of practice was extended.
COMMISSIONING

CONTRACTING

WCCCG recognise that a new approach to contracting is required to support the delivery of integrated patient centric care. It is clear that commissioning piecemeal services has, in part, led to the delivery of 'independent' services within CWP. Going forward commissioning should move from commissioning individual services to delivering a service to patients so that the provider can manage resource in the most appropriate manner to deliver the appropriate skills to that patient. As the majority of patients will need to access several pathways, they should be in a position to access the parts of the pathway that are most suitable for their situation. In the short term, the continued implementation of joint CQUINs will support this however CQUINS need more focus on providers working together to deliver service ensuring that only by working together can the CQUIN be achieved.

CONTRACT MANAGEMENT

We understand that the Quality and Performance meeting which take place monthly focusses predominantly on quality leaving limited time to discuss other aspects of the contract. We suggest that quality is reviewed on a quarterly basis as the systems in place in CWP should highlight any quality issues and flag them as exceptions to WCCCG. Another option is focus on quality and operational matters on alternative months. Commissioners should satisfy themselves as to the robustness of the clinical governance process in CWP.

CONTRACT NOTICE

In early 2013, WCCCG gave notice to CWP on their contracts including community services and as a result have caused some angst in the system. For example, Cheshire West and Chester (CWAC) local authority stopped the discussions re the integration of local authority teams into CWP causing delays to the implementation of Ageing Well. In addition, the new management team at CoCH have suggested that they are keen to manage some community services as they are of the opinion that having control over the resources will allow them to deploy them more appropriately. Indeed, examples have been reported to us of CWP staff being told by CoCH staff that they will soon be working for CoCH. This is proving very unsettling for CWP staff as they are of the opinion that CoCH do not understand community care and will focus staff on acute medicine particularly when experiencing emergency pressures.

WCCCG to decide whether they should embark on a procurement exercise taking into account:

- The length of time a procurement exercise can take: six to twelve months;
- The impact of uncertainty on staff; it has taken CWP two years to embed the team and it could take a similar length of time for the team to 'settle' in a new organisation;
- The planned local government and general election to be held in May 2015. Political change locally and/or nationally is likely to impact on the health and social care economy. In addition, local government will enter purdah from January 2015;
- The loss of momentum on Ageing Well which has built as a result of the commitment to date; and
• An understanding that patient centric care can be delivered using 'virtual' teams if all parties are committed to it and prepared to compromise.

THE WEST CHESHIRE WAY – VISION

The WCCCG commissioning plan for 2013/14 notes that there is a need for the health economy ‘to work together on developing a shared blueprint of how we see the local health economy transforming during the next 5 years and how it will feel different to patients, their carers and those working within it’. At the clinical senate on 25 April 2013, work began with clinicians across the economy to develop the ‘West Cheshire Way’. Commissioners with health and social care partners need to build on this and Ageing Well to develop the vision on which system changes can take place. We understand that work has started to develop this in advance of the next clinical senate in July. It is imperative that this builds upon the work already in progress and the lessons learned as a result of the work completed to date on the Altogether Better programme and takes into account the opinions of all. The vision should lead to:

• visible alignment of the leaders in the health and social care economy in order to deliver patient centric care;
• Collaboration by all;
• Ignoring organisational boundaries to focus on how services can be delivered in the community in a ‘virtual’ manner i.e. using the right skills regardless of organisation;
• The development of trust across organisations by understanding the services offered by each perhaps agreeing how staff could ‘shadow’ in other organisations;
• A recognition that care will be delivered in different settings perhaps requiring outreach or inreach services; and
• Agreement on funding models, incentives and contracting.

As stated previously, the planned general and council elections in 2015 possibly limit the time to deliver system wide changes to less than two years. To deliver a sustainable change within this time frame will require:

• WCCCG to take a lead role in driving the change and supporting other organisations through the change using new approaches to contracting to support; (see CSU Bulletin for contracting approaches);
• Strong programme and change management ensuring that scope and outcomes are clearly defined, risks are understood, schedule is predictable, priorities are clear and front line staff are actively engaged; and
• Visible alignment of the leaders in the health and social care economy in order to deliver a patient centric care.
INTRODUCTION

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CONTEXT

In common with many health economies in the country, Western Cheshire has experienced unprecedented amounts of change over the last two years:

- Transforming Community Services led to integration of community services into CWP in April 2011;
- CWP reorganisation to focus on their key localities – West Cheshire, East Cheshire and Wirral;
- The Health and Social Care Act 2012 mandated the development of Clinical Commissioning Groups which were formally authorised in April 2013 although operated in shadow form prior to this;

\(^2\) Benchmarking community services benchmarking report – Validated July 2012
- A Local Authority under severe financial pressure causing it to re-organise several times; and
- A new Chairman (Nov 2012), Chief Executive (Dec 2012), Director of Nursing (March 2013) and Director of Planning, Partnerships and Development (May 2013) of the local acute Foundation Trust – Countess of Chester Hospital (CoCH).

In addition, the Local Authority, Cheshire West and Chester (CWAC) has led the development of ‘Altogether Better’, a programme to integrate organisations around the citizen to improve outcomes and increase efficiency. ‘Ageing Well’ is a key component of the Altogether Better programme which is focused on older people and seen as pivotal to Western Cheshire becoming one of the select group of 10 ‘pioneers’ for the government’s health and social care integration programme to spearhead more innovative approaches to integration. Altogether Better is discussed in further detail in the section Delivering tomorrow. It is clear that both the Commissioner and CWP see Ageing Well as key to delivering their integration ambitions.

In parallel with the organisational changes within the area, A&E admissions are increasing particularly for the frail elderly. Community services report an increase in the complexity of patients in the community as patients are discharged earlier and people live longer with more complex conditions; these patients often require the attendance of two nurses to tend to patient needs and the duration of visits has also increased.

TRANSFORMING COMMUNITY SERVICES (TCS)

As part of the government’s Transforming Community Services programme (TCS) to separate, providers and commissioners of health services, Western Cheshire Primary Care Trust (PCT) initially examined the option of integrating community services with the Local Authority in order to deliver integrated health and social care services. This was not feasible as the PCT would not be able to provide the majority of services through a Section 75 agreement with the Local Authority as it could not retain employment of the staff. As a result a working party was formed to examine other options, these included:

- Acute NHS Foundation Trust
- Mental Health Foundation Trust
- Community Foundation Trust (NHS Trust)
- NHS Body
- Social Enterprise

These were subject of a rigorous stakeholder engagement exercise which included asking GPs, staff and others in the community about their views on where community services should reside. A board paper from September 2010 summarises the decision, “At the GP Consortium Board in August, the Board were briefed regarding the concerns associated with the establishment of the Social Enterprise option. Of the available contingencies, the Board reiterated their view that services should not transfer to an acute trust and indicated their strong support for a solution that would protect the community identity and focus of the services and which would enable GPs to be involved in the oversight of the design, development and delivery of services. They confirmed that they felt Cheshire & Wirral Partnership (CWP) NHS Foundation Trust would offer this and supported the transfer of services.”
CWP provides inpatient and community mental health services for children, adults and older people as well as learning disability services and drug and alcohol services across Cheshire and Wirral. The Trust also provides specialist services within Liverpool, Bolton, Warrington, Halton and Trafford.

From April 2011 CWP took over the provision of community physical care services in Western Cheshire with the transfer of over 800 staff from Community Care Western Cheshire (CCWC).

COMMUNITY SERVICES AT THE TIME OF TCS

At the time of the transfer the organisation was seen as a ‘basket case’ by some. In line with community services throughout the country, they received minimal investment. Several areas have suffered from disinvestment as a result of Cost Improvement Programmes (CIPS); the board paper 2010/11 Financial Budget states, "A fundamental strand of the 2009/10 financial balance was the delay in appointing vacancies. As part of the budget setting process a detailed review of all vacancies has been undertaken. Following this review and conversations with service heads, vacancies in the amount of £456,000 have been taken out of the budget on a recurrent basic."

An internal comprehensive review of the District Nursing was undertaken at the time of transfer of the service into CWP. This review was set up to:

- Review the existing arrangements for service delivery, eligibility criteria and equitable District Nursing Service across the whole of NHS Western Cheshire
- Develop and implement case management model within District Nursing to reduce unnecessary waste and increase time spent on direct patient care
- Undertake a Skill Mix review and mapping of existing demand and supply of District Nurses and to propose plans to manage the service more efficiently and effectively

The findings and action taken are presented in section Transfer of CCWH District Nursing Service into CWP and changes introduced

COMMUNITY SERVICES IN CWP SINCE 2011

Only after the transfer of Community Care Western Cheshire to CWP, was the full extent of lack of investment in staff development and technology realised e.g. District Nurses did not have mobile phones.

Community services represent approximately 16% of the income of CWP and report to the Director of Operations who is an Executive Director of the Board. At the point of transfer there were three managers involved in the service. A management of change programme has led to a restructuring and an increase in the responsibilities of the appointed Service director for West Cheshire; she now has responsibility for both mental and physical health. The chart below represents the directorate structure as at April 2013. By the end of 2013, the aim is to revise the organisational structure further to reflect the health aspects of the Altogether Better Programme (see section Delivering Tomorrow). To that end two general managers were appointed at the end of April; their responsibilities will include both physical and mental health. The appointment of team leaders to support integrated locality teams is currently in progress.
In 2012 CWP appointed a Deputy to the Director of Nursing and an additional nurse to provide professional development support to the Service Director for West Cheshire and her team through staff development and clinical audit. Feedback from clinical staff indicated that this was an area that had received little investment prior to TCS. The Deputy Director of Nursing and the Service Director for West Cheshire are very clear about their respective roles and responsibilities and they work very closely together.

A GP Advisor was also appointed in Dec 2012; the aim of this post was to provide some strategic leadership to community services and support in their discussion with primary care. The postholder is working hard to understand operational issues and is providing detailed and helpful support in improving processes within the Trust and with GPs.

The implementation of the recommendations from the DN nursing review mentioned previously have been ongoing since 2011 and have led to some movement of staff as a result of new recruits, retirements and leavers; a précis of the DN review is included below

We understand that there were serious issues with a particular nursing team in Ellesmere Port prior to transfer which led to disciplinary action during 2011. This resulted in some reconfiguration of the local teams in order to provide service to patients. This in combination with implementation of the recommendations of the DN staffing review may have led to some GP concerns that ‘they were losing their community nurse’.

Feedback from the staff indicates that they are generally comfortable with the new organisation and have seen benefits as a result of the investment in professional development for the clinical teams, a more robust audit and assurance process and the investment in technology.

There is a mixed picture from other stakeholders (see section Stakeholder Feedback), many perceive improvements in service since the transfer took place, some commissioners are disappointed in the lack of visibility of the changes that have taken place since TCS and GPs have
mixed views – many are very happy with the service provided by CWP but unhappy with CWP management for moving ‘their’ nurses around.

CWP are clear in their view that their organisation has changed immeasurably and positively as a result of the integration of community services; they now take a more holistic view of the patient looking at both physical and mental health and wellbeing. Their strategy clearly states that they are committed to the integration of health and social care and other partnership working to deliver patient-focused, high quality services that deliver improved outcomes including reduced health inequalities.

TRANSFER OF CCWC DISTRICT NURSING SERVICE INTO CWP AND CHANGES INTRODUCED

The findings of the comprehensive review of District Nursing Services undertaken at the time of TCS and action taken are presented below. This review was also a key input into the development of integrated teams for the Ageing Well programme.

SERVICE DEFINITION AND REFERRAL CRITERIA

A revised service specification was developed as a consequence of the review which reiterated the delivery of a professional, high quality service, without discrimination of place or individual for people who are referred with a specific nursing need, who are housebound or meet one or more of the following criteria:

- post-operative patients who are unable to travel;
- patients who are undergoing treatment whose health condition would be compromised by having to travel;
- patients who require treatment, which cannot be appropriately carried out in a clinic setting; and
- Patients who require short term education and support at home in order to manage their own health needs.

EFFECTIVE AND EFFICIENT CARE DELIVERY

At the time of the review, District Nursing teams worked from 20 bases and each team tended to work quite separately from each other, with different systems and processes leading to a variation in service offer and delivery. Therefore, in order to ensure equity and consistency of practice, 19 Care Packages (Care Pathways/Plans) were developed with the support of Skills for Health. The Care Packages are competency based and reflect themes rather than specific tasks which facilitate transfer across health and social care thereby supporting the integration agenda. The Care Packages were also designed to support a case management approach with senior staff taking a role in both delivery and coordination of care. In addition, the Care Packages recommend the minimum grade of staff required to carry out care required average time frames have been identified for completion of elements of care to encourage greater standardisation.

DEMAND AND SUPPLY OF DISTRICT NURSES
An analysis of District Nursing referrals undertaken as part of the internal review demonstrated that 84% of all referrals and subsequent patient contacts were with patients aged 65 years and over (range 72% - 91%). As a consequence it was imperative that the age profile of practice populations was taken into account when reviewing staffing distribution. The following figure demonstrates the mismatch between staff availability and potential demand for the service.

In addition, many of the District Nursing Teams were very small with insufficient staff to cover for holidays and sickness absence.

### ANALYSIS OF DISTRICT NURSE WORKLOAD

Analysis of work undertaken by the District Nursing service demonstrated that 30% of the nursing activity undertaken could be carried out by a Band 3 staff grade. At the time of the review only 20% of the District Nurse workforce comprised Band 3 staff grades and in addition, they worked Monday to Friday only.

It was also noted that an additional 18% of work undertaken by District Nurses at Bands 5, 6, and 7 could be carried out by a Band 4 if such a post existed.

Inappropriate use of skilled nursing time was further compounded by the lack of any administrative support.

### DEVELOPMENT OF DISTRICT NURSING CLUSTERS
District Nursing Teams were to be redesigned to form larger teams which were geographically based within localities:

- Ellesmere Port and Neston
- Chester North
- Chester South
- Vale Royal
- Tarporley (to include Audlem and Wrenbury)
- Broxton (Tattenhall, Farndon, Malpas);

These larger teams were designed to ensure greater equity of access and continuity of care, in addition to enhancing efficiencies within the service. In particular, better provision for sickness, holiday and training cover. It was anticipated that the proposed restructuring of the District nursing service would result in an 11% reduction in salary costs before costs of administrative support costs are accounted for.

REVISED SKILL MIX

The workforce profile within the District Nursing clusters and teams is being revised to support more efficient and effective service delivery and to ensure equity of service provision. The review suggested:

- A new Team Manager role and job description was developed to reflect the new management responsibilities of each cluster. This should result in a reduction from 19.68 wte Band 7 positions to 6 wte to reflect the proposed Cluster structures. In addition the Team Managers were to be supported by a number of Band 6 Deputy Team Leaders whose role was being operational day to day management of the team within each zone.

- The Band 6 posts were to be increased from 9.00 wte to 16.60 wte to reflect zonal working within the clusters but could change as the structure of the teams are further defined in terms of needs of practice populations, areas of deprivation and activity analysis.

- Work was undertaken to develop a Band 4 Assistant Practitioner role, supported by appropriate training. Initially, each District Nursing Team was to be assigned 1 Band 4 (5% of workforce, to increase over time to reach 18% workforce, as identified by activity analysis) with a potential reduction in Band 5 and 6 staff to better reflect activity.

- A 10% increase in Band 3’s, taking into account the potential for some of increased capacity to occur through integration with the Local Authority.

- Provision of Band 2 administrative support for each team.

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MANAGING THE CHANGE IN WORKFORCE PROFILE

Re-profiling the workforce takes time if patient care, staff stability and positive industrial relations are to be maintained. CWP has approached this exercise as a continuous service improvement and has used the opportunity of natural wastage to make changes as the work towards integration of services with the Local Authority has progressed. The following figure demonstrates the size of the re-profiling work being undertaken.

CWP proposed that the Band 7 posts displaced by the restructuring might be used to develop Advanced Practice roles in support of Admission Avoidance and Planned Early Discharge from hospital working in conjunction with the Hospital at Home service. A further proposal is the development of a Community Diabetic Nurse Service to work in partnership with the Diabetic Nurse specialist at the Countess of Chester Hospital. Outcomes of the review

As will become clear from the commentary in the District Nursing section, some aspects of this review have been implemented to date, for example, DN services are now delivered from 16 sites as opposed to 20. The commitment to the Ageing Well programme has meant that the recommendations have been adapted to reflect the needs of the programme and implementation will be achieved through the delivery of Ageing Well.

COMMISSIONING OF COMMUNITY SERVICES

In line with other health economies, community services is commissioned on a block contract basis supported by a series of services specifications which have been developed over time. The contract contains no activity targets as the aim is to move towards a more outcomes based contract in years to come.

Although the contract is block, the services have been commissioned in a piecemeal fashion and in some case funded from different sources.

WCCCG CONTRACT MANAGEMENT OF CWP COMMUNITY SERVICES

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Several of the commissioner's staff and management are involved in the negotiating and management of the community services contract - the head of Contract and Performance, a part
time WCCCG role, and the head of Quality supported by a Quality Improvement Manager. Until recently the Ageing Well programme manager has also been involved in contract management as she had some responsibility for the community services contract historically.

A Quality and Performance meeting takes place monthly; this reviews progress against metrics for CWP both mental and physical health. It is chaired by Dr Steve Pomfret and attended by the CWP Service Director for West Cheshire, the CWP associate director of compliance and quality audit, a CWP medical director, plus the commissioners listed above. Significant amounts of quality metrics are provided by CWP to that meeting for review. It is reported that such extensive review of quality data leaves little or no time for discussion of contractual issues or service developments.

WCCG and CWP report that there are no agreed Key Performance Indicators (KPIs) for the service and that work progresses to establish a set of meaningful indicators by which the contract can be monitored. No time frame has been agreed by which the KPIs will be agreed and implemented. CWP clinical service managers have a Management Dashboard and Safety Thermometer through which they monitor and manage activity, clinical quality and financial performance. This is being refined further as EMIS is rolled out.

CQUIN are being used across the economy to incentivise integrated working. Each Provider will be given responsibility for the achievement of a CQUIN which will involve working with other providers to deliver it. A review of the CWP CQUINs demonstrates that much of the data being collected is related to activity as opposed to tracking the outcomes from a patient’s point of view perhaps through a reduction in handoffs and the number of times the same information is requested. It is recognised that further work is to be done on defining integrated CQUINS and this will be discussed with providers in advance of 2014/15 contracting round.
The chart above summarises the base contract value excluding CQUIN and including CIPS targets. It demonstrates that there has been a small but steady reduction in the total value of the community contract reflecting the delivery of CIPS over the years.

As previously mentioned the contract is a block contract hence any increase in referrals is met within current resource. In addition, the investment in Ageing Well is met from within the currently available resource although successful achievement of CQUIN will go some way to funding the changes required to deliver Ageing Well. We understand that CWP are very focussed on delivery of CQUIN and usually achieve it.
SERVICES DELIVERED TODAY - FINDINGS

Each of the community services within the remit of the review are described and where data is available, performance has been benchmarked against the findings presented in, Benchmarking Community Services Benchmarking Report, July 2012.

DISTRICT NURSING

Cheshire and Wirral Partnership NHS Trust (CWP) provide a range of services for people who are housebound, including:

- Acute and chronic wound care, including leg ulcer care;
- Elimination and continence care;
- Enabling and education in the management of chronic disease;
- Support and nursing care for end of life care needs; and
- NHS Continuing Care.

These services are provided by the District Nursing (DN) service which is offered 7 days a week and includes an evening and night service. The service is provided by District Nursing teams which comprise:

- Team leaders;
- Community staff nurses and assistant practitioners who participate in the delivery and evaluation of care provided under the indirect supervision of a registered nurse;
- Trainee assistant practitioners; and
- Health care assistants (HCA).

In addition, the DN Teams are supported by a Phlebotomy Service and clerical staff.

The DN Service aims to achieve a high quality service through a process of managed care, which includes:

- Holistic nursing assessment;
- Individualised care planning;
- The delivery of needs-led clinical care;
- Health promotion and health education; and
- Teaching of individual patients, their carers and other care agencies.

SERVICE MODEL

Currently, 16 DN Teams operate out of 16 clinics and GP Practices with a planned move to 9 Clusters as the Integrated Teams are implemented. Provision is centred round partnership with social care services and mental health services and is based on a timely needs assessment of all patients. The services report that they work closely with primary care and secondary care services to provide a seamless transfer of patients between case managers, enabling them to move smoothly between local health care services with an emphasis on care closer to home.
All patient referred to the DN Service receive a comprehensive assessment of their care needs using the Universal Assessment Document which is valid for up to 6 months. A shortened version of the assessment document is available for use with patients who have been discharged and re-admitted to the case-load after a short space of time and for ‘1 off visits’. The assessment of care needs underpins the patient’s plan of care. District Nurses employ a range of standardised Care Packages (Care Pathways/Plans) which have been developed to ensure equity and consistency of practice. The Care Packages are competency based and reflect themes rather than specific tasks which facilitate transfer across health and social care thereby supporting the integration agenda. In addition, the Care Packages recommend the minimum grade of staff required to carry out the care required.

**NURSE PRESCRIBING**

All Band 7 DNs hold V300 Independent Nurse Prescribing and the need for Band 6 prescribers, is being looked at.

CWP is taking on the total purchase of dressings and that will make it much easier to obtain expensive dressings and will not require GPs to prescribe them.

**DOCUMENTATION**

Patient care is documented in patient held notes which are available for reference by other health and social care staff who may also be attending the patient. In addition, DN staff complete administrative records on EMIS web at their base. District Nurses do not, as yet, have access to the clinical record functionality of EMIS web.

**REFERRALS**

District Nurses receive referrals from GPs, patients, relatives, Community Matrons and Specialist Nurses. These are directed via e-mail, telephone, single point of access (SPA), written notes and books held in GP practices. All referrals are triaged according to priority. Palliative Care, especially pain control has high priority, problems with urinary catheters are seen within 4 hours of referral and IV antibiotics and insulin administration are key priorities. All patients are seen on the day of referral.

**COMMUNICATION WITH GPS**

GPs are informed of District Nurses initial visit to patients referred to them by e-mail; entry into a message book, face to face or by fax. In addition, additional notes are completed on a ‘Pink Form’ which is left at the Surgery and is scanned into GP EMIS web.

DN staff also meet with GPs at their Surgery, or have telephone meetings to discuss patients giving rise to concern.

**CASE-LOAD MANAGEMENT/DEPLOYMENT**
Management of team case load is planned the evening before using the EMIS administration system. The work is delegated according to skill mix, geography and workload and knowledge of the patient. Urgent calls on the day are allocated in a similar manner. HCAs are very experienced and undertake follow-up simple wound dressings, reporting back seeking DN assistance if required.

### Referrals to the District Nursing Service

The number of referrals into the service for 2012 – 2013 has increased by 78.5% compared to the previous year. This increase may be accounted for by the cessation of DN ‘dormant lists’ with subsequent capture of referrals of ‘known patients’ as new referrals. It also demonstrates the extent of patient/family self-referrals and possible avoidance of attendance by GPs.

![District Nursing Team Referrals](chart.png)

<table>
<thead>
<tr>
<th>Year</th>
<th>District Nurses</th>
</tr>
</thead>
<tbody>
<tr>
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<td>6712</td>
</tr>
<tr>
<td>2011/12</td>
<td>6581</td>
</tr>
<tr>
<td>2012/13</td>
<td>11008</td>
</tr>
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</table>

### Change in Discharge/Referral Policy

It has been common practice throughout the country for District Nurses to maintain a ‘dormant list’ of patients. These were patients who had completed treatment but who were considered ‘at risk’ of requiring further DN support within a short time frame. Patients and/or carers were advised to call the DN if they were in need of support and the patient’s care was re-activated without a record of a referral. With the introduction of EMIS, CWP has stopped the practice of ‘dormant lists’ and DN now formally discharge patients on completion of treatment. Similarly, when patients self-refer or other referrals of known patients are made, they are now captured as new referrals. Therefore the 78.5% increase in referrals is likely to be primarily a distortion arising from changes in discharge policy and recording practice.

### Assessment Against Benchmarks

Benchmarking community services is notoriously difficult due to the diversity and complexity of service provision and delivery. However, a recent exercise undertaken by the NHS Benchmarking Network[^3] has attempted to map community health services in some detail with submissions from some 66 community service providers.

[^3]: Benchmarking community services benchmarking report – Validated July 2012
With respect to community nursing services, the most applicable benchmarks relate to DN as NHS Benchmarking states that this is the one area with the most comprehensive and consistent data submissions. CWP are not members of the club currently; we suggest that this may be a useful tool for comparison purposes in the future.

The data about local services made available to us enables us to make some specific comparisons against the range of benchmarks published in the NHS Benchmarking report. These are noted below.

### DN WTE PER 100K OF REGISTERED POPULATION

The NHS Benchmarking report based on 65 submissions indicates that the average WTE DN per 100k of registered population is 42.23; the inter-quartile range being between 30 and 50 WTE per 100k of registered population. By comparison, the outturn 2011/12 for CWP is 48.61 placing CWP at the upper end of the inter-quartile range.

### THE AVERAGE CONTACTS PER DN WTE

NHS Benchmark data demonstrates an average of 1,319 contacts per WTE District Nurse with an inter-quartile range of 1,100 to 1,450 contacts per WTE. For CWP, the average contacts per WTE District Nurse are 1,087 which just fall into...
the lower quartile range.

Actual contacts in 2012/13 fell by 1.7% against 2011/12 performance and this is also reflected below.

### THE AVERAGE CONTACTS PER 100K OF REGISTERED POPULATION

The NHS Benchmarking sample of 59 Trusts demonstrates a benchmark average of 56,658 contacts per 100k of registered population with an inter-quartile range of 40,000 to 72,000 contacts per 100k of population. CWP DN contacts per 100k registered population for the same time frame was 53,395 which is below the average but well within the inter-quartile range.

### SKILL MIX CHANGE

Skill-mix is difficult to determine from grade mix but it is indicative. Band 5 DNs are the exception as this is the Staff Nurse grade and comprises staff that have completed Specialist Community Public Health Nursing (SCPHN): District Nurse training and those who are Registered Nurses but do not hold the DN qualification.

The figure demonstrates some movement in skill mix in accordance with the staffing plan agreed in 2011. The number of Band 7 staff has reduced from 17.28 to 13.11 with a subsequent increase in Band 6 from 12.38wte to 16.38wte. Band 3 staff also increased from 23.15wte to 26.3wte and at Band 4, 7wte Assistant Practitioners have been introduced.
Based on 45 submissions, NHS Benchmarking calculates the average sickness rate for DN services as 5.5% marked by the dashed amber line in the graph above with an inter-quartile range of between 4.2% and 6.2%.

The sickness absence rate for CWP was 6.6% in 2011/12 which is above the average and in the lower part of the upper quartile.

The chart below demonstrates the differential sickness absence rates.

The graph demonstrates reducing sickness absence by each DN service. The evening services are provided by a small team so sickness rates are impacted by individual sickness. The spike is for evening service in 2011-12.
TOTAL STAFF COST PER DISTRICT NURSING WTE

The NHS Benchmarking average for total staff cost per WTE is based on 59 submissions. The average is £34,677 with an inter-quartile range between £31,000 and £36,000 and a range of £20,000 to £54,000.

The figure for CWP is £51,248 which is above the average and at the top of the upper quartile range.

TOTAL COST OF DNS PER 100K OF REGISTERED POPULATION

The NHS Benchmarking demonstrates that DN investment levels range between £1.66m- £3.6m per 100,000 registered population with average investment levels at approximately £1.66m and an inter-quartile range between £1,350,000 and £1,850,000 based on 65 submissions. This variation illustrates the differing service models used by health economies and the variation in historic investment patterns.

The figures for CWP are £249m per 100k population which is higher than the average benchmark and in the middle of the upper quartile.

CHANGE IN SPEND ON DISTRICT NURSING SERVICES

This chart highlights a steady reduction in DN (day service) spend.
PATIENT SATISFACTION

A Patient Satisfaction survey was conducted in 2011/12.

Patients reported very high levels of satisfaction with the service with 99% reporting they were satisfied or extremely satisfied with the service. Areas for improvement include Patients’ family/carers/representatives involvement in decision making; only 77% reported that they were as involved as they would wish to be.

COMMENTARY ON DISTRICT NURSING SERVICE

The DN Service appears to be comparatively well resourced, being placed at the upper end of the benchmark inter-quartile range. However, whilst contacts are below the average, they are well within the inter-quartile range. Work has been undertaken to re-profile the DN Workforce but this has been slow because of high levels of staff retention and low turnover. Changes have only occurred through natural wastage.

DN activity is within the benchmark inter-quartile range. The fall in performance in 2012/13 is attributed to increased complexity of patients. It is reported that more complex patients frequently require more than one member of staff in attendance and that each visit is of longer in duration. However, when more than one staff member is required, this is only recorded as one contact. With the introduction of EMIS, District Nurses are now recording the length of time of each visit as a measure of complexity but this data is not yet available.

It is also of note that the reduction in District Nurse contacts occurred in the same year that the Community Matron Service changed its service model to include the provision of direct patient care. It is also reported that the Rapid Response Team has taken up referrals which previously would have resulted in District Nurse contacts.

Since the transfer of community services to CWP, there has been planned movement of staff between teams. Initially, this was undertaken to match availability of District Nurses with the
population aged 65 years and over. As a consequence, where there were mismatches, staff were moved from better provided teams to those who were less well provided for. In addition, subsequent movement has taken place as the DN teams have enlarged to create larger teams serving a number of practices as part of the journey towards the establishment of the 9 clusters of integrated teams.

Sickness absence levels are being controlled and do not contribute significantly to impaired service delivery.

Patients report very high levels of satisfaction with the service with 99% reporting they were satisfied or extremely satisfied with the service.

The high level of expenditure on DN cannot be accounted for solely in terms of higher than average staffing levels. It also reflects the high staff stability and consequently the high numbers of staff who are at the higher end of pay bands.

**COMMUNITY MATRONS**

The Community Matron as a role is a relatively recent development in the wider context of the NHS and the professional groups that work within it.

The role is a combination of experienced, skilled healthcare professionals with case management to care for adults with long-term conditions who are intensive users of acute healthcare services. It came into being as a result of the 2004 NHS Improvement Plan and is based on the Evercare Care Model. Evercare, part of the United Health Group (USA), developed and successfully implemented a model of community-based care for adults with long-term conditions that provided intensive primary care interventions to keep patients stable and prevent hospitalisation.

The role of the Community Matron is to:

- Prevent unnecessary hospitals admissions;
- Enable patients to remain in their homes;
- Improve self-care, ability to function and thereby maintain quality of life;
- Increase patient choice, care options and enable future planning; and
- Improve outcomes

**SERVICE MODEL**

The Community Matron/Clinical Case Manager (CM/CCM) service operates over a seven day period with reduced service levels at week-ends but excluding Bank Holidays.

CM/CCM will carry a case-load of patients identified by GPs as high users of GP and hospital services. The CCG is working with GPs to agree a risk stratification predictive model and in future, this will be the primary mechanism to case find patients, based on their risk of hospital admission or utilisation of health care resources. Some of these patients will be very high dependency; others will be of a lower dependency according to their particular Long Term Condition management. Patients will move along the continuum from high to low dependency and vice versa and it is expected that non active, low dependency or ‘dormant’ patients are discharged from the CM/CCM caseloads when appropriate to do so.
CM/CCMs case manage their caseload population and in addition respond in a timely manner to the management and care of patients who suffer an acute exacerbation if this is clinically appropriate or arrange appropriate care in order to avoid hospital admissions.

The EMIS Single Assessment Template is used to obtain a holistic patient assessment which allows for the development of a personalised Care Plan to meet individual requirements. Consent is requested from each patient to enable the Care Plan to be shared with other professionals to assure delivery of the agreed care plan.

REFERRAL CRITERIA

The CM/CCM service is available to patients registered with General Practices within Western Cheshire Primary Care Trust.

Patients must be over 18 years of age and have two or more recognised long term conditions which are complex in nature, precipitating frequent admission to hospital. These patients may not be managing their long term condition and may require significant additional input from other health and social care professionals.

Sources of referral include:

- Case finding from GP registers (e.g. CHD, COPD, Diabetes);
- GPs or specialist clinicians who feel a patient is at imminent risk of an unplanned hospital admission;
- Single Point of Access and GP Out of Hours (to support admission avoidance alternative); and
- Health, social and voluntary agencies as well as family and carers.

ASSESSMENT AGAINST BENCHMARKS

COMMUNITY MATRON/CLINICAL CASE MANAGER STAFFING

Based on 48 submissions the NHS Benchmarking report states that the average WTE Community Matrons/Clinical Case Managers per 100k of registered population is 4.87; the inter-quartile range being between 2.5 and 6 WTE per 100k of registered population. By comparison, the outturn 2011/12 for CWP is 5.25 placing CWP above the average but towards the middle of the inter-quartile range.
As is demonstrated above, the number of CM/CCM staff per 100k population is above the benchmark average and the budgeted establishment has increased further in 2013/14. However, the service delivery model provided by CWP is different from that provided by the majority of service providers. The usual service model is one of case management with referral to the DN Service in the event of patients requiring direct nursing care but CWP Community Matrons/Case Managers continue to actively support patients on their caseload during exacerbations of illness, thus providing greater continuity of care for patients and their families. This has resulted in changes in skill mix as presented below.

Following a review of work undertaken by Community Matrons/Clinical Case Managers in 2012/13, a Band 5 Registered Nurse (1.0 WTE) and a Band 3 Community Support Worker (1.0 WTE) were introduced on a trial basis to provide a ‘step down’ option for patients who have been actively case managed but remain at risk of potential admission. Duties include; basic clinical observations, liaison with family and carers, phlebotomy, continence promotion, wound dressings,
promoting healthy lifestyle, medication monitoring, social inclusion and raising any concerns with the patient’s CM/CCM.

In addition, in 2012/13 a Band 5 Registered Mental Health Nurse (0.8 WTE) was seconded to meet the mental health needs of patients on the CM/CCM caseload. The Registered Mental Health Nurse is responsible for assessing patients identified by the CM/CCM as potentially having mental health issues that may be impacting on their physical health. Duties include providing a mental health assessment, working in partnership with health care professionals to provided interventions and treatments for anxiety and depression, referring directly to the appropriate specialist mental health services and providing advice and support to the Community Matron Team and the wider Health and Social Care Team involved in a patients care including family and carers.

This change in skill mix added considerably to the capacity of CM/CCMs to continue their primary role of surveillance. As a consequence, in 2013/14 the Band 3 Community Support Worker role was extended and increased to 2 WTE.

The Band 5 (1 WTE) Registered General Nurse post was not found to provide added value and was not continued.

On completion of the secondment the Band 5 Registered Mental Health Nurse (0.8 WTE) returned to the Community Mental Health Team but will continue to provide a link and works closely with the Community Matron Team.

COMMUNITY MATRON/CLINICAL CASE MANAGER ACTIVITY

The NHS Benchmarking report based on 29 submissions indicates that the average contacts per WTE is 967; the inter-quartile range being between 450 and 1,300. By comparison, the outturn 2011/12 for CWP is 1060 placing CWP above the average but in the middle of the inter-quartile range.
The higher level of contacts is accounted for by the service model which includes provision of direct patient care.

**COMMUNITY MATRON/CLINICAL CASE MANAGER COSTS**

Based on 48 submissions, NHS Benchmarking demonstrates that CM/CCM investment levels range between £4,589 and £14,507 per 100,000 registered population, with average investment levels at approximately £210,859 and an inter-quartile range between £125,000 and £250,000. This variation illustrates the differing service models used by health economies and the variation in historic investment patterns.

The figures for CWP are £387,190 per 100k population which is higher than the average benchmark and exceeds the upper quartile range.

**COMMENTARY ON COMMUNITY MATRON/CLINICAL CASE MANAGER SERVICE**

The CM/CCM service appears to be comparatively well resourced which reflects the changed service model of providing direct patient care. This is confirmed when reviewing contacts per WTE which shows similarly above average activity. However, questions are raised regarding the rationale for this change in service model when there is already a fully resourced DN Service. The increase in CM/CCM activity may in part account for the lower than average DN activity. Furthermore, the provision of direct patient care may conflict with the proposal that with the introduction of the use of a Risk Stratification Tool, CM/CCM activity should be directed towards moderate risk patients to prevent them from becoming high risk patients. It should also be noted that Community Matrons are also the first point of call by SPA to avoid hospital admission.

The very high level of expenditure on Community Matrons/Clinical Case Managers Nursing cannot be accounted for solely in terms of higher than average staffing levels. It also reflects a very different service model, high staff stability and consequently high numbers of staff who are at the higher end of pay bands.
Another significant contributor to the high cost of the service is the commissioned caseload of CM/CCMs. It is reported that the service was commissioned with the expectation that Community Matrons would carry an average caseload of between 30-50 cases. CWP data on caseload is incomplete but a commissioned case load of 50 compares very differently from the benchmark average of 151.

SERVICES PROVIDED BY SPECIALIST TEAMS

CHRONIC OBSTRUCTIVE PULMONARY DISEASE SERVICE

The Chronic Obstructive Pulmonary Disease (COPD) Service provides support for people with diagnosed Chronic Obstructive Pulmonary Disease who are registered with a GP in West Cheshire. The aim of the service is to help patients to manage their condition by providing advice and support to prevent an exacerbation of their condition and admission to hospital.

SERVICE MODEL

The COPD services are based at the Countess of Chester Health Park and delivered in local clinics. The service is available on week days only, excluding bank holidays and is provided by 2.5wte Specialist Nurses and 1wte Oxygen Nurse. The Nurse Specialists have specific clinical experience and specialist respiratory nursing qualifications to enable them to diagnose health problems and to prescribe independently. Patients referred to the service receive a comprehensive assessment and plan of care/training.

Care is provided in accordance with standardised evidence based Care Pathways and Clinical Guidelines.

REFERRAL CRITERIA

The Service accepts referrals for patients registered with GPs within West Cheshire with diagnosed Chronic Obstructive Pulmonary. The majority of referrals are from secondary care. Referrals from GPs are very much determined by their knowledge and experience of the service.

ASSESSMENT AGAINST BENCHMARKS
CAUTIONARY NOTE: The benchmark is for Respiratory Nurses not just COPD

The NHS Benchmarking report (39 submissions) states that the average WTE Respiratory Nurses per 100K population is 2.12 with a range of 0.04 to 5.36 and an inter-quartile range of 0.9 to 3.2 WTE. By comparison, the 2011/12 outturn for CWP is 0.5 WTE per 100K population which is at the lowest end of the range.

The number of Respiratory Nurses has increased to 1 WTE in 2013/14 but remains at the lowest end of the inter-quartile range.

PARKINSON’S DISEASE SERVICE

The Parkinson’s disease Service provides support for people with diagnosed Parkinson’s disease and their carers, who are registered with a GP in West Cheshire. The aim of the service is to help patients to manage their condition by providing advice and support to prevent relapse and admission to hospital.

The service is available on week days only, excluding bank holidays and is provided by 1 WTE Nurse Specialist with specialist education and experience to enable her to diagnose health problems and to prescribe independently.

SERVICE MODEL

The Parkinson’s disease service is based at the Countess of Chester Health Park and the service is delivered in local clinics and in patients’ homes. In addition, the service supports hospital staff and patients undergoing elective surgery or an emergency admission with regard to Parkinson’s medication regimes and communication issues.

Patients referred to the service receive a comprehensive assessment and plan of care including the provision of information on a range of care and treatment interventions. In particular, advice is given regarding medicines management from diagnosis to end of life.
The service accepts referrals for patients registered with GPs within West Cheshire with diagnosed Parkinson’s disease. Referrals are made by consultant physicians, GPs, Allied Health Professionals, Community Matrons, District Nurses, Nursing/Residential Homes and by patients (self-referral).

### ASSESSMENT AGAINST BENCHMARKS

*Cautionary note, this benchmark includes dementia care which is not included in the CWP Service Model.*

The NHS Benchmarking report (22 submissions) states that the average WTE Parkinson’s/Dementia Nurses per 100k population is 0.82 with a range of 0.15 to 3.3 and an inter-quartile range of 0.3 to 1.05 WTE. By comparison, the outturn 2011/12 for CWP is 0.31 WTE per 100K population which is below the average and at the lowest end of the inter-quartile range.

### TISSUE VIABILITY SERVICE

The Tissue Viability Service provides expert advice, treatment and support in the management of complex wounds or conditions where multiple factors affect skin integrity. The service is offered to CWP staff and patients registered with GPs in West Cheshire. The service is provided in all community settings which include:

- Patients’ homes;
- Nursing Homes within West Cheshire; and
- Mental Health Services at Bowmere Hospital and Pine Lodge.

Advice and support may be given via telephone or personal assessment and joint working with DN services, nursing homes and primary care staff. The team also provides education to all CWP West Cheshire Physical Health Services clinical staff and facilitates the provision of appropriate pressure relieving equipment to identified high risk patients.

A leg ulcer management course is provided annually offering 12 places to staff to ensure all DN teams have access to staff who have undertaken and completed the leg ulcer management training.
Health Care Assistant training is also provided which covers a range of topics relevant to tissue viability on a 6 monthly basis.

The team also provides a Tissue Viability Link Nurse system to enhance tissue viability knowledge and skills within DN Teams, Nursing Home staff and Practice Nurses.

The service is available on week days only, excluding bank holidays and is provided by any of 3 part-time Registered Nurses (1.8wte), with further training and qualifications in Tissue Viability and leg ulcer management.

### SERVICE MODEL

The Tissue Viability Specialist Nurse is responsible for the development, provision and management of a comprehensive evidence based clinical service, incorporating the clinical, advisory, educational, and leadership role within this specialty. In addition, the role includes the provision of expert advice at operational and strategic levels, promoting safe practice for all patients and staff.

The Tissue Viability Team and Vascular Nurse specialists at the Countess of Chester Hospital work together to facilitate comprehensive management of patients referred into the service.

The team provides a Doppler/Stocking Assessment Clinic twice weekly at Stanney Lane Clinic, Ellesmere Port, which takes referrals from Ellesmere Port GPs. District Nurses in the Ellesmere Port locality; they also use this clinic for management of their patients.

The team also supports CWP staff to ensure competence in the delivery of Topical Negative Pressure treatment. This includes liaison with WCCCG to ensure timely approval of funding for this treatment. The use of Topical Negative Pressure Systems facilitates early discharge of patients and reduces the number of visits required.

The team works closely with CCG Pharmacists to develop and manage the local Wound Management Formulary and Wound Guideline, (last published in March 2009). The new Wound Care Formulary is to be launched in July 2013.

A comprehensive Wound Resource Pack is managed by the Tissue Viability Team and was issued to all staff in May 2009. This is currently being updated and will be held in an electronic version only, ensuring that the evidence is current.

The Team is also in the process of trialling the total purchase system for wound dressings and delivery to patients. This will take away the need for prescriptions for each patient requiring dressing to give a better service and at the same time reducing cost.

The Tissue Viability Team is informed of all new Stage 3 or 4 pressure ulcers and each new incidence is reviewed by a team member. If a pressure ulcer deteriorates within the community, a peer review is undertaken and action taken as appropriate in conjunction with governance arrangements.
Referrals are received from all user groups via fax. Following initial referral telephone advice may be given, or joint visits arranged with the referrer.

ASSESSMENT AGAINST BENCHMARKS

The NHS Benchmarking report (46 submissions) states that the average WTE Tissue Viability Nurse per 100k population is 0.97 with a range of 0.18 to 3.36 and an inter-quartile range of 0.4 to 1.2 WTE. By comparison, the 2011/12 outturn for CWP is 0.78 WTE per 100K population which is below the average and within the inter-quartile range.

However, it should be noted that the Tissue Viability Service provides a service to the Mental Health services within CWP and therefore direct comparison is not possible. In 2013/14 to date actual Tissue Viability staffing has increased to the benchmark average of 2011/12.

COMMENTARY ON SPECIALIST NURSE SERVICES

These services are difficult to benchmark because of the varied service configurations within trusts providing community services. However, generally the Specialist Nursing services are poorly resourced and are not well understood by GPs. As a consequence, these services tend to receive low levels of referrals from GPs. It appears that the majority of referrals are made by Community Matrons, District Nurses and Residential and Nursing Homes.

These services have tended to be commissioned to fill identified service gaps and do not appear to have been reviewed in the light of other service developments. As a consequence there appears that there is overlap in the provision of Chronic Disease Management. It is recommended that these services should be reviewed in the context of the Patient Journey with clear lines of responsibility, referral criteria and ‘hand back’ arrangements.

COMMUNITY THERAPY

The General Therapy services are based at The Countess of Chester Health Park and operate as 3 teams of Physiotherapists and Occupational therapists to enable people to live safely at home by maximising their independence following a period of ill health. The team are led by a Head of
Therapy services and two Therapy Team Leaders who are supported by a Physiotherapy Professional Lead.

The service provides rehabilitation to support people to optimise their independence and safety, facilitate discharge and prevent admission to hospital or long term care. There are also clinical specialists within the service who provide assessment and treatment for patients with falls, neurological, respiratory, and palliative conditions.

**SERVICE MODEL**

The Community Rehabilitation service is available to all patients registered with GPs in West Cheshire and operates on week days only, excluding bank holidays. The service is provided within patients’ own homes (or preferred residence) and is also provided to inpatients at Ellesmere Port Hospital, Tarporley and Bowermore Hospitals, Sutton Beeches intermediate care unit and the Hospice of the Good Shepherd. Other community locations within West Cheshire are used to deliver treatment, as appropriate.

GP referrals to the Community Therapy service are made through ‘Choose and Book’ and community nursing and other staff refer directly to the team by telephone or fax. Patients can also self-refer.

Patients are initially triaged into one of four categories:

- Red Flag patients - will be sent to secondary care within 1 working day of receipt of referral;
- Urgent Patients - will be treated within 2 working days from receipt of referral; and
- Routine Patients - will be treated within 20 working days of receipt of referral.

Triage criteria have been agreed to provide guidance in triage.

All patients referred to the service are assigned a rehabilitation coordinator. A comprehensive assessment is undertaken and rehabilitation programme is developed in collaboration with the patient; this is delivered at the patient’s place of residence. Care Pathways, contained within Map of Medicine are used as are local notes to aid referral of all patients with orthopaedic conditions.

**REFERRAL CRITERIA**

The service accepts referrals for patients registered with GPs within West Cheshire who have identifiable rehabilitation needs.

Patients referred to the service must comply with the following criteria:

- Aged 18 or over;
- Registered with a West Cheshire GP (except Military personnel);
- Have a predominantly physical diagnosis with identifiable rehabilitation need;
- Are unable to attend/ inappropriate for musculoskeletal out-patient physiotherapy; and
- Need therapy to enable themselves and carers to function safely in their own environment.

**ASSESSMENT AGAINST BENCHMARKS**
COMMUNITY THERAPY STAFFING

The NHS Benchmarking report based on 30 submissions indicates that the average WTE Therapists per 100k of registered population is 17.02; the inter-quartile range being between 5 and 25 WTE per 100k of registered population. By comparison, the 2011/12 outturn for CWP is 14.2, which although below the average, places CWP at the upper end of the inter-quartile range.

COMMUNITY THERAPY ACTIVITY

Based on 23 submissions, the NHS Benchmark data demonstrates an average of 6,496 contacts per 100,000 population, with a range of approximately 1,500 to 24,500 and an inter-quartile range of approximately 3,000 to 7,000 contacts per 100,000 population.
For CWP, the average contacts are 11,303 per 100,000 population which is above average and in the middle of the upper quartile.

Based on 23 submissions, the NHS Benchmark data demonstrates an average of 538 contacts per WTE, with a range of approximately 500 to 1,300 and an inter-quartile range of approximately 250 to 720 contacts per WTE.

For CWP, the average contacts per WTE are 885 which is above average and in the upper quartile.

**COMMUNITY THERAPY COSTS**

Benchmarking demonstrates that Community Therapy investment levels range between £50,000 and £2.3 million per 100,000 registered population, with average investment at approximately £0.66m and an inter-quartile range between £200,000 and £900,000 based on 30 submissions. This variation illustrates the differing service models used by health economies and the variation in historic investment patterns.
The figures for CWP are £938,836 per 100k population which is higher than the average benchmark and just in the upper quartile.

The benchmarking average for total staff cost per WTE is based on 30 submission. The average is £33,497 with an inter-quartile range between £31,000 and £36,000 and a range of £20,000 to £54,000.

The figure for CWP is £58,943 which is above the average and exceeds the upper quartile range.

**COMMENTARY ON COMMUNITY THERAPY SERVICE**

The Community Therapy Service appears to be comparatively well resourced, being placed at the upper end of the benchmark inter-quartile range. Whilst Community Therapy contacts are below the average, they are towards the middle of the inter-quartile range. However, it should be noted that the CWP Community Therapy service is not directly comparable with the benchmark services as it includes Therapy services delivered to Ellesmere Port Hospital.

Review of a sample of Therapy case notes indicates that the usual time period between referral of patients on discharge from hospital to initial assessment is 20 days. Whilst this is just within the standard wait-time for patients discharged from hospital, it appears that the maximum wait time has become the usual wait-time. Meanwhile, patients are referred to rapid response and receive a 2 week package of care. Similarly, wait times for other triage categories appear unduly long. It is recommended that CWP undertake a review of current working practices and seek to provide a more responsive Community Therapy service. It is also recommended that GPs be informed of Therapists’ initial assessments and treatment plan in a timely manner and not to rely solely on the discharge summary.

Patients report very high levels of satisfaction with the service with 99% reporting they were satisfied or extremely satisfied with the service.
The high level of expenditure on Community Therapy cannot be accounted for solely in terms of higher than average staffing levels. It also reflects the high staff stability and consequently the high numbers of staff who are at the higher end of pay bands.

MULTIDISCIPLINARY COMMUNITY SERVICES

REHAB LINK SERVICE

The Community Rehab Link service is based at the Countess of Chester Health Park with satellite offices at Lightfoot Lodge Chester, Sutton Beeches Ellesmere Port and Ellesmere Port Hospital and operates on week days only, excluding bank holidays. The service:

- provides an interdisciplinary care management approach to patients who have complex needs in order to avoid unnecessary acute hospital admission or long term care placement;
- reduce the level and requirement for care packages;
- facilitate discharge from acute services; and
- enable people to remain safe at home, maximising their independence.

The service operates as a patient centred, multidisciplinary team with strong working relationships with Community Nursing and Therapy services, GPs, CWAC, CoCH, the District Housing Trust and the Voluntary Sector to ensure that patients’ needs are efficiently and effectively met.

SERVICE MODEL

A 6 week care and rehabilitation package of care is provided in a variety of community settings depending on patients’ needs. All patients referred to the service are assigned a rehabilitation coordinator; a comprehensive assessment is undertaken and rehabilitation programme is developed in collaboration with the patient which is delivered at the patient’s place of residence.

A care managed rehabilitation model is followed which may require an initial placement in a Residential Rehabilitation Unit, a rehabilitation nursing bed in the private sector or in a sheltered housing flat. Alternatively, patients may be managed in the usual place of residence. Patient assessment is undertaken using ‘The Single Assessment Process’ and documentation of treatment is recorded using the EMIS web single patient record.

Care Pathways, contained within Map of Medicine are used as are local notes to aid referral of all patients with orthopaedic conditions.

Patients are initially triaged into one of 3 categories:

PRIORITY 1

- Initial contact within 3 working days of receipt of referral;
- Referrals for hospital in-patient;
- Carer breakdown; and
- Admission to care/hospital likely without rehab intervention.

**PRIORITY 2**

- Screen within 5 working days of receipt of referral;
- Gradual deterioration at home; and
- Social Services package could be temporarily increased to maintain client at home.

**PRIORITY 3**

- Screen within 7 working days of receipt of referral;
- Safe at home but have rehab potential; and
- Has a package of ‘care in place meeting needs at present but has potential for further independence.

Patients are discharged or transferred to the support of General Therapy services when the initial agreed rehabilitation goals are achieved. Discharge planning is proactively managed with the identification of a predicted discharge date within one week of admission to the scheme.

**REFERRAL CRITERIA**

Referrals to the service from GPs Community nurses/therapists and Secondary Care is made through Single Point of Access (SPA). The Service accepts referrals for patients who

- Are aged over 18 years and registered with GPs in West Cheshire;
- Have complex or varied social/medical/psychological needs which would benefit from a care management approach; and
- Have potential to regain independence through inter-disciplinary assessment and rehabilitation.

**PERFORMANCE**

All performance data is maintained on the local authority (CWAC) electronic information system (Liquid Logic) and is not currently available.

**PATIENT SATISFACTION**

A Patient satisfaction Survey conducted in May 2012 demonstrated very high levels of satisfaction:

- 95% patients rated the service as either satisfied (32%) or very satisfied (63%);
- 100% patients received the support they expected from the service;
- 90% patients were provided with sufficient information about the Rehabilitation Link Service;
- 100% patients felt involved in decisions made about their rehabilitation goals and treatment;
- 100% patients reported that they were treated with respect; and
60% patients were informed about how the NHS uses their personal information.

RAPID RESPONSE TEAM

The Rapid Response service is based at the Countess of Chester Health Park with an office in the A&E Department at COCH. The service offers co-ordinator and therapy services on week days from 8.30 to 18.00 and at week-ends from 8.30 to 16.30. The service provides early crisis intervention to avoid unnecessary acute hospital admission, including urgent assessment and facilitated discharge in A&E / MAU. It also provides urgent support for timely discharge from hospital of patients who wish to receive End of Life care at home. The service is provided by a multidisciplinary team comprising Nursing, Therapies, Social Care and rehabilitative support for up to 2 weeks.

SERVICE MODEL

Following an initial assessment, a plan of care is agreed and reviewed within 4 days to determine the need for ongoing support. Patients are discharged when the patient is sufficiently stable for transfer to mainstream services; has returned to pre-crisis level of function.

REFERRAL CRITERIA

The Service accepts referrals for patients registered with GPs within West Cheshire who are aged 18 years and above who are experiencing a health crisis that impacts their normal functioning but do not require an acute admission. Patients must also have complex and immediate needs that cannot be met by mainstream services.

Community Nurses and Therapists refer patients to the service by direct telephone access and GPs and Social care staff access the service through SPA. Response times to referrals are from 1 to 2 hours depending on the capacity of the service.

STROKE EARLY SUPPORTED DISCHARGE SERVICE

The Stroke Early Supported Discharge (ESD) is managed jointly by CWP and CoCH and has been operational since September 2012. Its purpose is to enable accelerated discharge of stroke patients to their home (or place of residence) by providing specialist intensive rehabilitation and social support in the community comparable to that of an in-patient stroke unit.

The service is operational hours are 7 days a week during day time hours but no patients are accepted into the service at weekends.

SERVICE PROFILE

The Service is provided by a multidisciplinary team comprising Physiotherapy, Occupational Therapy, Speech and Language Therapy and Nursing/support workers. The service provides for up to 8 weeks of therapy post-discharge and is focused around time-specific patient goals which also embrace the needs and ability of carers and follows an agreed Care Pathway/Plan.
Key Performance Indicators have been agreed and are reported which include:

- Reduction in average length of stay of Stroke patients;
- 100% of patients having contact with the ESD team within 24 hours of discharge;
- Activity target of 40% of total stroke admissions per annum;
- Reduction in re-admissions for Stroke patients (from baseline);
- 90% of patients to complete therapy within 8 weeks; and
- Reduction in the number of calls and carers required for packages of care.

Number of Stroke patients referred directly to long-term care and the percentage of those remaining in long-term care after 12 weeks.

REFERRALS

The service accepts referrals for patients registered with GPs within West Cheshire who have suffered a Stroke. Referrals are received from secondary care: Countess of Chester Hospital Acute Stroke Unit and Stroke Rehabilitation Unit and out of area hospitals, Arrowe Park and Clatterbridge Hospitals.

PERFORMANCE

In the first 13 weeks of the start of the programme, the service met all but one performance standard; the activity target of 40% of total stroke admissions was narrowly missed at 36.6%. Reduction in length of stay was achieved with a saving of 680 bed days and no patients were referred to long-term care.

CARDIAC REHABILITATION SERVICE

Approximately 9,650 patients in West Cheshire have been diagnosed with Coronary Heart Disease and 2,100 patients are listed on GP Heart Disease Registers.

Cardiac Rehabilitation forms part of the National Service Framework (NSF) for Cardiac Rehabilitation which includes exercise, education and psychological support. The service is provided by a multidisciplinary team comprising a specialist nurse, exercise specialists, physiotherapy, and occupational therapy with sessional input from dietetics, psychiatry liaison and a mental health nurse. Other services such as Community Matron, Specialist Nursing teams and smoking cessation services can also be accessed.

The service is provided in 4 phases at:

- Countess of Chester Hospital (Phase 1, 2 and 3)
- University College Chester (Phase 3)
- Ellesmere Port Hospital (Phase 3)
- Ellesmere Port Fire station (Phase 3 and 4)
The Cardiac Rehabilitation service follows BACPR, SIGN Guidelines and NICE (British Association of Cardiac and Pulmonary Rehabilitation Guidelines, Scottish Intercollegiate National Guidelines, National Institute of Clinical Excellence), in delivering a phased approach to cardiac rehabilitation.

**Phase 1** of the rehabilitation programme comprises medical and/or surgical stabilisation.

**Phase 2** is initiated following planned early discharge. A comprehensive clinical assessment is undertaken which includes sub maximal exercise capacity and advice is provided on medication, misconceptions, symptom review, risk factor modification, and advice on diet, smoking, physical activity, anxiety and depression. A care plan is formulated as appropriate with specified patient goals and ongoing follow up with patient consent. Cardiology advice is also available if required.

**Phase 3** comprises a 12 week programme of structured exercise, education and psychological counselling which is provided at the University of Chester, Countess of Chester Hospital and Ellesmere Port Fire Station.

**Phase 4** signifies long-term maintenance of physical activity and lifestyle changes and is supported by local charity groups who fund exercise schemes and leisure services.

### Referral Criteria

Referrals are accepted from secondary care for patients registered with a GP in West Cheshire who meet the eligibility criteria which are:

- Chronic heart failure of new diagnosis or chronic heart failure with a step change in clinical presentation including complex devices (CRT-P, CRT-D);
- Troponin > 0.5 with diagnosis in medical case notes of Myocardial Infarction;
- Referral by a cardiologist/Medical team - definitive diagnosis of Myocardial Infarction;
- Post revascularisation surgery (CABG, PCI, PTCA) patients referred from the main Regional Cardiothoracic Centre which may include valvular heart surgery such an MVR TVR and AVR; and
- Any of the above with defibrillator including CRT-P and CRT-D.

The following conditions are excluded from the service:

- Congenital heart disease;
- Patients diagnosed with angina;
- Newly diagnosed angina patients; and
- High risk Coronary Heart Disease (high blood pressure, high cholesterol, primary prevention CHD patients).

Referrals to the service are primarily from consultant medical staff.

### Continence Service

The Continence Service is a multidisciplinary service which serves a population of around 260,000 across West Cheshire. It is estimated that 17% of elderly people living at home suffer from faecal incontinence and this rises to 25% in care settings. Failure to manage faecal and urinary incontinence can lead to social embarrassment and exclusion and can cause conflict between an
individual and their carer. Incontinence is second only to dementia as an initiating factor in moving people to residential or nursing homes.

In addition, the Continence Service also provides a service to people with learning disabilities to enable them to take as much control as possible over their lives and the services they receive.

The aim of the continence advisory service is to:

- Provide a high quality, comprehensive service for both adults and children.; and
- Encourage pro-active individualised programmes of care with a high emphasis on improvement and cure rather than containment.

**SERVICE MODEL**

The continence service operates as a needs-based service delivery model for adults. Children with continence problems are managed in secondary care; however, an innovative programme for pre-school age children with special needs has been introduced.

Referrals to the continence service are made directly to the service and are triaged according to priority:

- **High Priority**: In-patients at Ellesmere Port Hospital - Response time 5 working days;
- **Medium non-urgent**: Community based patients not currently receiving other nursing services - Response time 10 working days; and
- **Routine**: Response time 20 working days.

The Continence Advisory service is provided by a team of Continence Nurse Specialists, Specialist Physiotherapist, Healthcare support Workers and Nursery Nurses and is delivered in nurse led clinics in Ellesmere Port Hospital, Hope Farm Clinic, Ellesmere Port, St Martin's Clinic, Chester, Frodsham and Tarporley Health Centre. If patients are housebound they receive services in their usual place of residence including those residing in residential care homes. The service is available on weekdays only between 8.30am and 4.30pm and an answer machine is available for messages out of hours.

Standardised evidence based Care Pathways and Clinical Guidelines have been developed in conjunction with medical and nursing colleagues at CoCH to ensure that the service is effective, consistent, sustainable and cost effective. All patients receive a comprehensive assessment and care/training plan with referral to secondary care if appropriate. Patients with intractable incontinence may be provided with containment products and their requirements are reviewed six monthly.

GPs are informed of the Continence Nurse’s/ District Nurses initial assessment and the plan of treatment/training and of any referral to secondary care if required.

**REFERRAL CRITERIA**

The Continence Service offers an open referral system from health professionals, Social Services, individuals and families and statutory and non-statutory organisations across all health and social care boundaries. The Service accepts referrals for patients registered with GPs in West Cheshire who have with identified continence problems.
Patients referred to the service must comply with the following criteria:

- The patient and carer must be aware of the referral; and
- The patient must have a continence problem.

**SINGLE POINT OF ACCESS (SPA)**

SPA works closely with the GP Out of Hours service and by working together, offers a seamless 24/7 one stop single point of access for the allocation of urgent care community resources within agreed timeframes. SPA is based at the Countess of Chester Health Park; it is co-located with the GP OOH service and is managed by the same person.

SPA provides telephone support to GPs, health, allied health and community service providers in facilitating and co-ordinating the urgent unplanned care of adults. This includes the allocation of community resources to avoid admission to hospital where care can be more appropriately provided in the community, as well as providing resources to enable early supported discharge from hospital. In addition, the service promotes active liaison with CWP and CWAC Rapid Response Team.

SPA serves all patients registered with a GP in West Cheshire and includes all appropriate cross border arrangements with services required by patients. SPA operates between 8am and 8pm, Monday to Friday but also offers a seamless provision 24/7 by working in partnership with GP Out of Hours which provides complimentary call handling for unplanned appointments from 8pm to 8am, and at weekends and Bank Holidays.

**SERVICE MODEL**

SPA provides a co-ordinating service for GP to access hospital through liaison with the Bed Bureau. In addition, SPA seeks alternative referral to Hospital at Home, Rapid Response, Community Matrons and District Nurses and intermediate care services. Triaging is undertaken by a Senior Nurses. In addition, SPA is the single point of access for secondary care referral to the DN service. SPA also provides advice and support to Care Home staff.

Immediate response is available for the majority of calls but at peak activity times there may be a short delay in answering the phones. Action time from referral varies according to complexity of the case referred. Response action times are prioritised as:

- Immediate and necessary - for immediate life threatening referrals - (these should not normally be referred via SPA but as 999 (blue light) calls);
- Urgent – within 2 hours;
- Soon – within 4 hours; and
- Routine – within same working day or within planned care pathway.

All calls are closed with a communicated management plan by the end of the working day.
SPA operates agreed pathways of care for each service as detailed within the Directory of Community Services Operating Manual and also incorporates ongoing developments for Ambulatory Care Sensitive Conditions clinical pathways.

GPs are informed by e-mail within 24 hours, outlining actions and SPA outcome for each patient referred.

**REFERRAL CRITERIA**

All adults with urgent unplanned care needs not requiring emergency (999 call) admission to hospital.

Referrals are received from GPs, health and social care professionals using a direct telephone number.

Referrals from Hospital Wards and Discharge Liaison teams are received by fax and telephone.

**PERFORMANCE - MONTHLY ACTIVITY 2012/13 BY MONTH**

SPA receives between 524 and 755 calls a month of which between 317 and 472 calls result in an admission to hospital. The remaining requests are directed to alternative services to avoid hospitalisation. Diversions for 2012/13 were 30% and exceeded the target of 25%.

It is also of interest to note the variation in activity by day of the week. The chart presents this very clearly with activity dipping mid-week and at week-ends.
COMMENTARY ON MULTIDISCIPLINARY SERVICES

Many of the specialist/multidisciplinary services commissioned and provided have arisen because of identified service gaps. As a result they continue to operate independently of the underlying core services.

Rapid response: The CWP Rehab Link Team and the Crisis and Re-ablement Team (CART) were created to ensure timely access to therapy services and social care packages. Until recently, these teams operated independently.

In December 2012, the CWP Rehab Link, CART and the CoCH Discharge Liaison Team joined together to become a new Rapid Response Team.

It appears that these teams have been working together but in parallel and need to establish a common vision of the service they are to provide and to agree changes in working practices by each former team which will be required to deliver the agreed vision of patient centric care. In addition, the service is not provided after 6 pm yet it is felt that many elderly people presenting in A&E could avoid hospital admission if this service was available until later into the evening. It is understood that a business case for the extension of SPA services is currently under consideration and might be enhanced further with the inclusion of Therapy and Social Care services to support an extension of the newly formed Rapid Response Team. However, it appears that initially, a service was available from 6pm to 10 pm but no referrals were received and it was therefore cancelled. It is recommended that CoCH should undertake an audit of patients presenting in A&E after 4.30pm who could be diverted from admission to hospital, in order to determine the resources required to extend the service. Attention should also be paid to daily variations.

SPA: This service is making a considerable contribution to the avoidance of hospital admission and at a performance of 30%, is exceeding its target of 25%. However, staff within CoCH appear unaware of this activity and the consequent contribution that CWP is making in measured hospital avoidance. It is recommended that this information is shared regularly with CoCH so that all parties recognise the contribution that each is making to alleviate a shared problem. It is recommended that SPA should be included in any future work regarding possible extension of the Rapid Response service and that any proposed increase in service provision should be included in the Full Business Case currently being developed for the extension of SPA services.
STAKEHOLDER EXPERIENCE

GP EXPERIENCE OF COMMUNITY SERVICES

GP experience of Community Services was obtained by discussions held at the 3 GP Network meetings, a Practice Manager’s meeting and review of minutes of previous network meetings. The findings are presented below.

GENERAL THERAPY SERVICES

The therapy services are reported as good when the patient receives therapy but GPs frequently do not receive feedback until a discharge letter is received, which may be several months after referral. Patients are referred to the therapy services by GPs through Choose and Book and GPs are required to make separate referrals if more than one joint requires treatment. Whilst there are agreed ‘wait times’ by urgency of referral, these are not reported back to GPs as had been done previously. Similarly, GPs are not informed of when the patient has been seen or of the patient’s initial assessment and treatment plan.

COMMUNITY MATRONS

Concerns were raised that not all GP practices were assigned a Community Matron but shared them with other practices. In addition, there was a perception that not all Community Matrons were of the same level of experience, particularly in respect of non-medical prescribing. In addition it was felt that the numbers of Community Matrons were insufficient to meet current and future demand. The initial Community Matron Service was commissioned on the basis of the numbers of patients with complex care needs who were identified in each practice as being frequent hospital attenders. Referrals to the Community Matron Service are increasing and will increase further with the implementation of a Patient Risk Stratification Tool with emphasis placed on the needs of lower risk patients to prevent them from becoming high risk patients. Further to this, a belief was expressed that Community Matrons preferred to care for complex patients and were reluctant to take on the more preventative role of supporting medium risk patients.

DISTRICT NURSING

COMMUNICATION AND CONTINUITY OF CARE

GPs in all networks reported that when the District Nurses were based in GP practices, that communication was improved. Concerns were raised regarding the need for stability of DN Teams. It was recognised that staff were required to cover absences in other teams but when this happened frequently, it destabilised the team, created opportunities for communication breakdown and introduced nursing staff with different levels of skill resulting in a perceived lack of continuity of care for patients. Some GPs expressed anticipatory concern regarding the implementation of larger teams and the potential for this resulting in less continuity of care if patients are visited by different nurses who are not familiar with the patient.
Communication with District Nurses was generally reported to be satisfactory. DNs are accessible and referrals are made via a range of electronic and paper-based methods, in addition to telephone calls and face to face contact. GPs reported no experience with the new telephone referral service which had just been launched immediately prior to the meetings with them. Feedback to GPs regarding DN patient care is currently provided as a print-off of the District nurse documentation which is left at the Surgery and is then input into the GP system. GPs expressed a universal desire that DNs should not enter data directly into the GP system but felt that mutual read only access to the respective electronic GP and Community Nursing records would have the potential of improving clinical communication. However, the need for verbal clinical dialogue was felt to be very important and should not be replaced by electronic record keeping.

Concerns were also expressed regarding the scope of DN Practice. GPs felt that there was lack of clarity regarding clinical procedures that they might expect District Nurses to undertake. Examples provided included the need for a GP to undertake an initial rectal examination prior to the administration of enemas and the need for GPs to authorise prescriptions of Heparin which had been prescribed and provided by hospitals when patients were discharged. It was felt that it would be helpful if GPs were included in determining the scope of practice and in the development of clinical procedures and pathways.

GPs also raised the level of complexity of care required by patients in the community and the need to extend the levels of skills held by District Nurses. It was felt that the numbers of care pathways should be extended to enable DNs to provide a wider range of intravenous drugs which would contribute further to the prevention of admission to hospital and to the early discharge of patients from hospital.

All GPs expressed high levels of satisfaction regarding the excellent ‘End of Life’ care provided by the community nursing service. However, concern was expressed about the 1.8% planned cut in funding of community services which ran counter to the policy shift of transferring services to the community. They felt that there should be an investment in the DN Service as there was a need for high quality District Nurses to support more cancer patients to die at home.

**DN STAFFING LEVELS AND SKILL-MIX**

Concerns were expressed in one GP network regarding high levels of District Nurse staff turnover as a result of staff retirements and staff movement following disciplinary action being taken. However, the staff movement relating to disciplinary action was found to relate to incidents that had occurred 3 years previously. Currently, the DN services are experiencing long-term sickness among 2 senior staff members and this has necessitated some movement of staff and increased use of bank staff. CWP enjoys high levels of staff retention. Overall, GPs felt that that staffing levels were sufficient to meet locality needs, providing there was no staff movement. However, increased staffing would enable additional work to be transferred from secondary care, especially in respect of ‘End of life’ care.

Of wider concern is a perception amongst GPs that the current restructuring of Community Services into 9 Locality Clusters will result in a reduction in the grade mix of staff and in particular the planned introduction Band 4 staff in addition to Health Care Assistants.

**SPECIALIST COMMUNITY NURSES**
Generally, GPs did not seem aware of the services provided by Specialist Nurses. Reference was made to the Respiratory Specialist Nurses and the lack of clarity regarding referral criteria and how to refer to them. It was felt that the wide variation in the number of GP referrals to the service is dependent on the experience of GPs with the service. Most referrals to this service and Community Heart Failure Specialist Nurses are initiated by hospital consultants. No reference was made to Continence, Parkinson’s and Tissue Viability Community Specialist Nursing services.

**CWP Management**

Whilst GPs expressed satisfaction with the quality of Community Services, there was a general level of dissatisfaction with CWP management of the service. This was expressed in terms of ‘constant reorganisation’ and staff movement, lack of contact with CWP managers and ‘GPs being constantly asked what was wanted’.

**Commentary on GP Experience**

**District Nursing:** The concerns raised by GPs regarding continuity of care provision, changes in skill mix and consistency in expectation of procedures undertaken, is common to many Community Nursing Services as workload increases and the need to demonstrate ‘value for money’ is pursued. CWP has introduced Healthcare Support Workers and Assistant Practitioners following a skill mix review which analysed the levels of skill required to meet the care needs of patients. In addition, as part of the management restructuring, GPs see the number of Team Leaders reducing from 16 to 9. CWP have informed GPs that the new Integrated Team Leader posts will be full-time management posts and that the 7 unplaced Band 7 post-holders will become full-time clinical practitioners, thereby enhancing the skill levels within the clusters.

It is also clear from discussion with District Nurses and GPs that some District Nurses are demonstrating ‘risk averse behaviour’ in referring some patients back to GPs when CWP clinical policies and procedures do not require this. However, it appears that this may be as a result of two serious incidents which occurred in the past.

**Community Therapy:** The concerns raised by GPs regarding Community Therapy relate primarily to wait times and lack of timely communication regarding assessment and treatment plan. It is clear that standard wait times are unduly long which may reflect the level of investment in the general therapy services. It is also clear from discussion with Community Therapists, in addition to GPs, that Therapists do not inform GPs in a timely manner of their initial assessment and treatment plan, communicating only by the Discharge Letter which may be several months after initial referral.

**Engagement with CWP:** The majority of issues raised regarding CWP engagement with GPs relate to constant re-organisation and in particular, the lack of contact with service managers when concerns could be raised face to face.

GP perception of constant re-organisation reflects the reality of changes made within CWP since TCS in April 2011. These organisational changes were made to support the integration of the service into CWP and more recently to support the restructuring of services for development and implementation of Integrated Teams within the Ageing Well programme.

Prior to the transfer of Community Services to CWP, Community managers met Quarterly with GPs at the GP Network meetings. This provided an opportunity for GPs to raise issues and for the
Community Managers to report on actions taken and developments/changes planned. However, since the transfer of services in 2011, the PCT has become the CCG and the network meetings have become GP commissioning forums. As a consequence, the opportunity for discussion of community operational issues has been lost and no alternative forum has been created.

Considerable effort has been made by the senior community services manager to inform GPs of changes and developments planned but this has taken place within the context of the GP Commissioning networks which may not be the most appropriate forum. CWP is attempting to address this communication gap in the current re-structuring where Integrated Team Managers will be full-time service managers with the time to meet regularly with GPs in their practices to discuss operational issues and to engage more constructively with GPs.

GPs work closely with District Nurses and are therefore very operationally aware of changes that may take place. It is clear that staff movement has taken place but this has mainly been planned movement to support safe service delivery.

When Community Services were transferred in 2011 they were, as previously discussed, recognised to be in a poor state. Immediately following transfer it was necessary to make changes to a DN Team when it was found necessary to take disciplinary action. Consequently, staff were moved as new teams were re-constituted. Since that time, there has also been a resource redistribution to balance District Nurse availability with the distribution of the population over the age of 65 years. This has resulted in some GP Practices losing DN staff, whilst others have gained. A further contributor to the movement of staff has been the journey towards integrated teams which will result in the establishment of larger teams in 9 clusters based on GP practices. Senior managers have attended GP networks to inform them of the changes as they are planned but there remains a feeling that the changes have been forced upon them and that they have not been consulted. However, these changes have taken place to support the agreed Ageing Well programme which has the support of GPs.

DISTRICT NURSES' EXPERIENCE

Meetings were held with DN to elicit their experiences. The findings are presented below.

TRANSFER TO CWP

DN staff identify very strongly with CWP. They report significant improvement in working practices since the transfer from the previous organisation. They refer specifically to the development of robust nursing policies and procedures; effective clinical governance arrangements and ready access to training. They believe that being part of a larger clinical Trust with a strong community ethos has resulted in managers being much more organised and supportive. They also recognise and welcome the Trust's willingness to deal with 'problem areas'. DN staff also appreciates the access to Occupational Health support and the Trust's positive approach to the reduction of sickness absence which has resulted in greater stability of teams over the past year.

COMMUNICATION WITH GPs

District Nurses also report that they work well with GP colleagues. However, they do report some problems in communicating with GPs. The majority of communication is via e-mail and paper
reports left with Surgery receptionists for later scanning into patients’ records. However, District Nurses report that there are occasions when the District Nurse needs direct professional dialogue concerning a patient’s condition and this can at times prove difficult. There are times when District Nurses attempt to speak with GPs but receptionists present a considerable protective barrier and that they do not appear to understand that if a District Nurse calls to talk with a GP, that this must be accorded priority. On other occasions, District Nurses report that they visit Practices and wait for considerable periods of time to speak with a GP between GP appointments. Generally, District Nurses felt that GPs are not aware of the care that they are providing for patients and examples were provided of GPs being extremely rude and disrespectful towards District Nurse colleagues. These incidents are invariably not fed back to service managers, GPs or commissioners and are simply accepted because of the need to deliver service to patients.

District Nurses also report that triaging referrals is frequently challenging as they are usually given very little information about the patient. However, it is felt that the move to EMIS with access to GP patient notes will alleviate this problem in the future.

NURSING SKILL UTILISATION

Many District Nurses felt that they were not used to their full potential. The majority of District Nurses were experienced medical/surgical/A&E staff nurses prior to working in the community setting. In their previous roles they had undertaken a wide range of technical nursing skills but with exception of administration of IV antibiotics for patients on the Cellulitis Pathway, were unable to use the skills they had acquired. They felt strongly that they could have a wider technical remit which would contribute greatly to hospital avoidance and planned early discharge of patients.

INTEGRATED TEAMS

District Nurses were very well informed about the planned move to Integrated Teams. They expressed excitement about the improved access to Social Work and Mental Health expertise. Some District Nurses reported that multi-disciplinary teams were already being brought together but there was some uncertainty expressed as to the appointment of Integrated Team Leaders which were yet to take place. However, District Nurses reported that despite this uncertainty, they would work together to ensure that the full benefits of integration were realised.

COMMUNITY MATRONS/CLINICAL CASE MANAGERS’ EXPERIENCE

Discussions were held with all of the Community Matrons. The findings are presented below.

TRANSFER TO CWP

Community Matrons identify very strongly with CWP. They report significant improvement in working practices since the transfer from the previous organisation. They refer specifically to the development of robust nursing policies and procedures; effective clinical governance arrangements and ready access to training. They also value strongly the access to Mental Health support in the management of the care of patients with Dementia. Community Matrons also expressed the need to move forward following the organisational changes they have experienced.
**RELATIONSHIPS WITH PRIMARY CARE**

Community Matrons report that they work well with GP colleagues but communication can be difficult. As GPs schedule their work in different ways, it can be difficult to know when to contact them. Community Matrons also report that if can frequently be difficult to obtaining GP input to Multidisciplinary Case Conferences with the patient and family because of the different work schedules. As a result, case conferences proceed without the presence/input of GPs. Community Matrons felt strongly that the use of SKYPE would improve access to GP input and could also be used for discussion with consultant and or other staff within Secondary Care and for contacts with patients.

Community Matrons also report that, the lack of electronic access to the GP patient record and GP access to Community Matron records has considerable impact on the achievement of effective communication. Community Matrons also reported that some Practice Managers hindered effective communication with GPs as they do not appear to understand the role of the Community Matron.

**RELATIONSHIPS WITH SECONDARY CARE, SOCIAL SERVICES AND HOSPITAL AT HOME**

Community Matrons report very good relationships with Secondary Care, Social Services and Hospital at Home. There are clearly defined communication and referral channels which work well.

**DOCUMENTATION OF CARE AND INFORMATION TECHNOLOGY**

Community Matrons record patient care in EMIS, the electronic patient record. However, they do not have remote access to the network and therefore have to return to base to complete patient documentation. It is reported that there are a small number of ‘tough books’ in use but the network coverage is poor. In addition, use of EMIS web from alternative access sites is very poor, with the system taking up to 30 minutes to load. Despite this, Community matrons value the access to information that EMIS web provides.

**SPECIALIST NURSES’ EXPERIENCE**

A meeting was held with Specialist Nurses from 4 Specialist services. The findings are presented below.

**TRANSFER TO CWP**

Specialist Nurses reported that the transfer to CWP had been very beneficial. When the transfer was initially announced there was a lot of worry but this proved to be unnecessary. They reported that the change had been very positive. Previously, they had felt very isolated but they found the CWP inclusive management style very empowering. They feel very much involved in the Trust, they are well-informed, they feel ‘listened to’, are involved in change processes. However, the experience of one Nurse Specialist was different who felt that her small team felt over-looked within all the change that has taken place.
RESPONSE TO COUNTESS OF CHESTER ASPIRATIONS TO TAKE OVER COMMUNITY SPECIALIST NURSES

Heart Failure and Cardiac Rehab Nurses understood the rationale for this in respect of the services they provide but expressed concern that the services were almost certainly to be drawn into the hospital. They also expressed concern that the management style of secondary care would not afford them the respect and autonomy that they receive from CWP.

RELATIONSHIPS WITH GPS

Heart Failure Nurses and Cardiac Rehab report that GPs are still confused about the service they provide. Almost all referrals are from Consultant Cardiologists and they receive very few, if any, referrals from GPs. They feel strongly that if GPs referred patients to the Heart Failure Nurses, there would be fewer referrals to secondary care.

The respective teams stated that they would like to take clinics into GP Practices when they could also work with Practice Nurses and GPs to help them get their Heart Failure Registers up to date. Nationally (and Cheshire is the same picture) there is only a 50% capture and listing of patients on the Heart Failure Register. If GPs do not keep their register up to date, patients will not get the services available which would improve their quality of life. The team reported that they could make a substantial contribution to relieving GP work-load and improvement of the management. Patients having medications re-titrated will make 8 visits to a GP, work which could be done by the Heart Failure Nurse Specialist.

COPD Nurses expressed similar experience in that they do not receive any referrals from GPs for early stage COPD where their input could really make a difference in disease management to prevent progression. As a result the work of the COPD team is primarily palliative. Referral of patients 2 years earlier could have improved their quality of life. The COPD team report that only 6 GPs make referrals to the COPD Nurses.

The COPD team also reported that recent work to administer Flu Vaccines in one GP Network revealed that of the 400 patients with COPD only 1 was known to the COPD nursing team. The COPD nurses feel that they need a far greater presence in GP Practices and much greater contact with Practice Nurses in the support of Long-term Disease Management but currently there isn’t sufficient staffing resource to meet the service requirement if all cases were identified. The team also reported that the COPD GP Lead has established a COPD Forum and has set up work to develop a COPD Care Pathway and Self Care Management Plans.

Continence Nurse Specialists report a mixed experience with some GPs using the service very effectively whilst others make inappropriate referrals to the Urology service or just prescribe incontinence pads. The Team reported that they do not have sufficient contact with GPs; closer working would enable the 2000 patients receiving continence products at a cost of £350,000 to receive more effective support.

DOCUMENTATION OF CARE OF CARE AND INFORMATION TECHNOLOGY

All Nurse Specialist teams use the full functionality of EMIS but they also experience the challenges of remote access and the need to return to base to complete documentation.
COMMUNITY THERAPISTS EXPERIENCE

A meeting was held with the majority of Community Therapists, including Rehab Link and Rapid response... The findings are presented below.

TRANSFER TO CWP

Community Therapists identify very strongly as a team and with a community based service. Therapists reported that the period of (TCS) was a very unsettling time, particularly as they were not made aware of the host organisation until immediately before the transfer. They also report that they are less well integrated within CWP than other community services and still refer to themselves as Community Care Western Cheshire (CCWC). In the current absence of the Head of Therapies, many Therapists feel that they have no access to senior managers, only to their respective Team Leaders. Other Therapists referred to the Allied Health Professions Group (AHP) as a conduit to Senior Managers and to the Professional Forum which provided an opportunity to contribute to strategic and professional developments.

INTEGRATED TEAMS

Therapists are aware and excited about the planned changes for integrated working. Whilst they understand the Integrated Team arrangements and the opportunities for interdisciplinary working, they have not yet been informed as to which team they will be assigned to. Some concerns were also expressed regarding the ability to provide sickness absence cover when spread across 9 teams rather than the current 3.

COMMUNICATION WITH GPS

General Therapists do not appear to have regular direct contact with GPs. Referral of patients is made through ‘Choose and Book’ and Discharge letters are sent on completion of therapy. Therapists tend not to have any clinical dialogue with GPs; neither do they inform GPs of their initial patient assessment and plan of treatment.

CASE-LOAD MANAGEMENT

General Therapists carry a caseload of between 30 and 40 patients, depending on case-mix. They are supported by Therapy Assistants who prompt and supervise patients undertaking exercises. The caseload is managed by adjusting the wait times of non-urgent cases. Wait times for each priority category are monitored and breaches reported to the Senior Management Team.

DOCUMENTATION OF CARE AND INFORMATION TECHNOLOGY

Therapists record patient assessments, treatment plans and progress notes on EMIS web, the electronic patient record. Tough Books are currently being trialled in the Rural Network but the network coverage is insufficient resulting in Therapists having to return to base to complete documentation.
**ACCESS TO EQUIPMENT**

**The Rehab Link Team** reports problems in obtaining equipment for patients in Nursing Homes as they are not permitted to prescribe equipment for residents. Patients or the Nursing Home are required to purchase equipment. Frequently, the appropriate equipment is not purchased and patients lose their independence and/or fall, resulting in admission to hospital.

**General Therapists** report problems in getting equipment for patients referred from ‘Out of Area hospitals’ when they are discharged without the necessary equipment. Again, patients are informed that they have to buy their own equipment.

General Therapists also report that since the introduction of the out-sourced equipment provider, used equipment can no longer be returned, with the exception of hoists and other expensive items of equipment. They also report that the Equipment Loan Service ceased in 2009 and this is reported as exacerbating the difficulties in obtaining appropriate equipment when patients are unable or unwilling to purchase new equipment.

**COMMENTARY ON COMMUNITY STAFF’S EXPERIENCE**

The vast majority of staff have settled well into CWP with the realisation of many benefits including robust nursing policies and procedures; effective clinical governance arrangements and ready access to training. Considerable work has been undertaken by CWP to develop what was repressed community workforce to one which is now ready to take forward the concept of integrated working and to fully utilise their clinical skill in expanding the range of clinical services offered.

**District Nurses** work well with GP colleagues but they do experience problems in communicating with some GPs. Time is spent circumventing communication barriers and waiting to talk with GPs between patient appointments. Some of these obstacles could and should be overcome with mutual access to EMIS.

Many District Nurses feel that they were not being used to their full potential. As experienced medical/surgical/A&E staff nurses prior to working in the community setting, they feel that they could undertake a wide range of technical nursing skills which would contribute further to Hospital avoidance and Early Discharge. Given the current level of resourcing in DN, there appears to be capacity to extend the work of District Nurses within current budgets.

**Community Matrons** identify very strongly with CWP and report significant improvement in working practices since the transfer from the previous organisation. They also value strongly the access to Mental Health support in the management of the care of patients with Dementia.

Community Matrons report that they work well with GPs but contacting them can be difficult when they all schedule their work in different ways. The use of SKYPE and/or teleconferencing should be considered as an alternative way of obtaining GP input. In addition, the lack of mutual electronic access to patient record has considerable impact on the achievement of effective communication.

**Specialist Nurses** have also found the transfer to CWP to be very beneficial. Previously, they had felt very isolated but have found the CWP inclusive management style very empowering.
The majority of Nurse Specialists feel that their role is poorly understood by GPs. Those GPs who do have a good understanding of their role do make good use of the services but these are small in number. Many of the Nurse Specialists would like to work more closely with GPs and Practice Nurses to identify those patients which would benefit from their expertise. However, current staffing levels which are significantly below the Benchmark preclude this at present.

There appears to be some lack of clarity between the role and responsibilities of Community Matrons, Practice Nurses and the COPD and Heart Failure teams regarding referrals and 'hand-off', which needs to be addressed.

**Community Therapists** identify very strongly as a team and with a community based service. However, they feel less well integrated within CWP than other community services. Therapists are aware and excited about the planned changes for integrated working and the benefits that this will bring for patient care but they do have concerns about being spread thinly across 9 teams rather than the current 3 teams. It appears that the Multidisciplinary Rehabilitation Teams have been developed by withdrawing resources from the General Therapy Team and this has resulted in Community Therapy staffing levels which are well below the Benchmark Average.

General Therapists do not appear to have regular direct contact with GPs. Referral of patients is made through ‘Choose and Book’ and Discharge letters are sent on completion of therapy. Therapists tend not to have any clinical dialogue with GPs; neither do they inform GPs of their initial patient assessment and plan of treatment. It is suggested that Community Therapists should inform GPs of their initial assessment and treatment plan in a timely manner. However, it is noted that mutual access to respective EMIS patient records should alleviate this problem.

Access to equipment is a very real concern for all of the Therapists, particularly for patients in Nursing Homes. They also report that since the introduction of the out-sourced equipment provider, used equipment can no longer be returned, with the exception of hoists and other expensive items of equipment and they believe that this has exacerbated the difficulties in obtaining appropriate equipment when patients are unable or unwilling to purchase new equipment. It is understood that WCCCG is currently reviewing the Equipment contract and it is recommended that the opinion of front-line Therapists should be sought as part of this review.
In December 2011, West Cheshire was selected by the government to be one of four pilot areas to deliver a whole place community budget. The bid submitted by CWAC on behalf of public, private and voluntary sector partners from across West Cheshire outlined how they would work together for the benefit of the West Cheshire community to fundamentally change and improve local public services. The Altogether Better vision is to deliver the highest quality of life in the UK to West Cheshire residents, creating more outcome-focused services for customers and delivering the right services, in the right place at the right time. The aim of the programme is to deliver:

- joined-up service planning and delivery;
- services that are responsive to local needs;
- services that are proactive (not reactive);
- services that focus on better outcomes for residents;
- greater sharing of resources, including buildings and staff;
- simpler, more transparent funding models; and
- much more effective structures to support partnership working.

The programmes of work have been grouped together to represent a typical life cycle. Although all of the programmes are multi agency in nature, all are led by council officers with the exception of Ageing well which is health led.

Ageing well has been designed to address the:

- Financially unsustainable model of care for older people within health and social care in Cheshire West. Locally:
  - £133.557m (2011/12) was spent on NHS acute and community care and social care on the over 65s;
  - Local Government making budget reductions of 25+% and the NHS on ‘flat cash’. Given the current economic climate this is more likely to come under further financial pressure rather than continue; and
  - The increasing demand for acute care for older people, particularly those >85. Current population forecast that the population >65 will increase by 26% by 2020 and those >85 by 44% by 2020.
- In addition, a local analysis demonstrates at least 25% of older people in an emergency hospital bed would not be there if alternatives care models were in place and that there would be 15% fewer placements to long-term care if adequate alternative provision and a ‘whole system’ approach was in place.
AGEING WELL TO DATE

The Ageing well programme is jointly sponsored by Sheena Cumiskey, Chief Executive of CWP and Alison Lee, the Chief Officer of WCCCG.

In parallel with this review, work has been completed to refine the governance and programme management structure of Ageing Well. The diagram shows the current structure highlighting in green those groups that we understand to be decision making groups and those that the programme reports to for information.

As highlighted in the diagram, further work is required to streamline reporting lines for the programme to minimise the time spent preparing and delivering updates rather than delivering the outcomes of the programme.

Although all organisations involved to date, (CWP, WCCCG and CWAC) remain committed to the programme and its aims, post the development of the business case in late 2012, there was minimal commissioner involvement in the programme from a managerial and clinical perspective until recently. Dr Claire Baker took on the role of clinical sponsor in Dec 2012; this was in addition to her other CCG roles that are completed in her allocated 1 day per week. From April 2013, Dr Baker was supported by Amanda Lonsdale as part time programme lead; since May this has been changed to a full time role. The addition of these two people has provided pace, passion and structure to the programme.

The Operational Transformation lead for CWP worked with the CCG and an interim provided by the CCG to develop the business case. Post the production of the business case, the operational transformation lead has been working within CWP to design and implement the re-structuring that is required in order to move to Integrated Team working.

The table below highlights the amount of resource involved in the programme from across the health economy which given the perceived priority and delivery deadlines of this programme appear small with many of the roles being part time. An exercise to review resource required to deliver priority workstreams is required. In addition, further clinical sponsorship is required to support Dr Baker with engagement of primary care colleagues.
Also, the table highlights the lack of CoCH involvement in the work streams to deliver the programme which should be rectified if the health economy is to deliver a seamless patient journey across organisations.

Although the new management team at CoCH are more outward focussed than previous incumbents, anecdotally it appears to be difficult to engage them in development of integrated processes. There is a view that CoCH do not wish to build on the good work already completed by other organisations within the health and social care community. As noted earlier, CoCH have changed a significant number of key management posts since last November and need the opportunity to demonstrate their ability to deliver in an integrated manner.

Rapid Response is an integrated service involving staff from CoCH, CWAC and CWP. We have been informed that setting up this service was difficult given the cross organisational boundaries, distrust and lack of understanding of services offered. Although service delivery has improved, further work is required to involve staff to define a patient centric process that they would be happy for their loved ones to benefit from. Barriers to delivery need to be identified and addressed by the participating organisations both individually and collectively. We respectfully suggest that cross economy working to improve this service both in hours and out of hours with visible leadership input from all of the participating organisations could provide valuable insight into the implementation issues to be addressed as a result of integrating care to deliver a patient centric service. The resulting process should reduce admissions and provide a better service to patients and allow CoCH to participate and contribute to the delivery of a truly integrated service delivered by a team drawn from several organisations.
PROCEEDING WITH AGEING WELL

The programme manager is in the process of developing the programme infrastructure including developing high level plans. Further work is required to support the development and delivery of such a broad programme of change:

- Work with the executive and clinical sponsor to agree how this programme delivers the West Cheshire Way;
- Agree how the executive and clinical sponsor will support the programme and what they require from the programme team;
- Include a stakeholder engagement plan highlighting how each of the skills groups regardless of organisation will be communicated with;
- Consider the cultural changes required for all skill groups e.g. the need to think patient journey as well as patient care, the need to forget about organisational boundaries and work in the ‘virtual’ team of the moment to deliver patient and citizen care and support;
- Many of the projects need a cross health economy operational team to support. Ensure roles and responsibilities are clearly defined and agreed;
- In addition to the operational changes, enabling work streams are required with named individuals to deliver e.g. technology and workforce
- Ensure that staff are involved in designing, testing and implementing changes to working practices to facilitate the change process;
- Add a programme management office to facilitate planning, reporting across the health economy and provide visibility of progress – v- plan, benefits management, resource, risk and dependency management. Ensure that the appropriate planning tools are in place;
- Prioritise the projects within the programme highlighting the expected resource to deliver – major change projects have a cost to deliver; and
- Ensure that each project has benefits and associated baselines clearly defined.

PATIENT ENGAGEMENT

A patient consultation exercise needs to be included as we have seen no evidence of patient involvement.

The diagram opposite summarises the feedback from service users gathered as a result of the recent national voices campaign. This highlights the requirements from a patient perspective.
GOING FORWARD

CONTRACT NOTICE

In early 2013, WCCCG gave notice to CWP on their contracts including community services and as a result have caused some angst in the system. For example, CWAC stopped the discussions re the integration of their teams into CWP causing delays to the implementation of Ageing Well. In addition, the new management team at CoCH have suggested that they are keen to manage some community services as they are of the opinion that having control over the resources will allow them to deploy them more appropriately. Indeed, examples have been reported to us of CWP staff being told by CoCH staff that they will soon be working for CoCH. This is proving very unsettling for CWP staff as they are of the opinion that CoCH do not understand community care and will focus staff on acute medicine particularly when experiencing emergency pressures.

WCCCG to decide whether they should embark on a procurement exercise taking into account:

- The length of time a procurement exercise can take: six to twelve months;
- The impact of uncertainty on staff; it has taken CWP two years to embed the team and it could take a similar length of time for the team to ‘settle’ in a new organisation;
- The planned local government and general election to be held in May 2015. Political change locally and/or nationally is likely to impact on the health and social care economy. In addition, local government will enter purdah from January 2015;
- The loss of momentum on Ageing Well which has built as a result of the commitment to date; and
- An understanding that patient centric care can be delivered using ‘virtual’ teams if all parties are committed to it and prepared to compromise.

THE WEST CHESHIRE WAY – VISION

The WCCCG commissioning plan for 2013/14 notes that there is a need for the health economy’ to work together on developing a shared blueprint of how we see the local health economy transforming during the next 5 years and how it will feel different to patients, their carers and those working within it’. In addition to the commitment to Altogether Better, at the clinical senate on 25 April 2013, work began with clinicians across the economy to develop the ’West Cheshire Way’. Commissioners with health and social care partners need to build on this and Ageing Well to develop the vision on which system changes can take place. We understand that work has started to develop this in advance of the next clinical senate in July. It is imperative that this builds upon the work already in progress and the lessons learned as a result of the work completed to date and takes into account the opinions of all. The vision should lead to:

- visible alignment of the leaders in the health and social care economy in order to deliver patient centric care:
- Collaboration by all;
- Ignoring organisational boundaries to focus on how services can be delivered in the community in a ‘virtual’ manner i.e. using the right skills regardless of organisation;
- The development of trust across organisations by understanding the services offered by each perhaps agreeing how staff could ‘shadow’ in other organisations;
• A recognition that care will be delivered in different settings perhaps requiring outreach or inreach services; and
• Agreement on funding models, incentives and contracting.

As stated previously, the planned general and council elections in 2015 possibly limit the time to deliver system wide changes to less than two years. To deliver a sustainable change within this time frame will require:

• WCCCG to take a lead role in driving the change and supporting other organisations through the change using new approaches to contracting to support; (see CSU Bulletin for contracting approaches);

• Strong programme and change management ensuring that scope and outcomes are clearly defined, risks are understood, schedule is predictable, priorities are clear and front line staff are actively engaged; and

• Visible alignment of the leaders in the health and social care economy in order to deliver a patient centric care.

Kotter’s model of change has been included to remind readers of the steps required to implement change. This is expanded on in Appendix A

CONTRACTING

WCCCG recognise that a new approach to contracting is required to support the delivery of integrated patient centric care. It is clear that commissioning piecemeal services has, in part, led to the delivery of ‘independent’ services within CWP. Going forward commissioning should move from commissioning services to delivering a service to patients so that the provider can manage resource in the most appropriate manner to deliver the appropriate skills to that patient. As the majority of patients will need to access several pathways, they should be in a position to access the parts of the pathway that are most suitable for their situation. In the short term, the continued implementation of joint CQUINs will support this however CQUINS need more focus on providers working together to deliver service ensuring that only by working together can the CQUIN be achieved.
We understand that the Quality and Performance meeting which take place monthly focusses predominantly on quality leaving limited time to discuss other aspects of the contract. We suggest that quality is reviewed on a quarterly basis as the systems in place in CWP should catch any quality issues and flag them as exception with WCCCG. Another option is focus on quality and operational matters on alternative months. WCCCG need to satisfy themselves as to the robustness of the clinical governance process in CWP.

COMMUNITY SERVICES SUMMARY

The District Nursing Service appears to be comparatively well resourced, being placed at the upper end of the Benchmark inter-quartile range. However, whilst contacts are below the average, they are well within the inter-quartile range. The fall in performance in 2012/13 is attributed to increased complexity of patients with the requirement for more than one staff to attend still recorded as one contact. Duration of visits has also increased and is now being recorded. It is also of note that the reduction in District Nurse contacts occurred in the same year that the Community Matron Service changed its service model to include the provision of direct patient care.

The CM/CCM Service is very well resourced, exceeding the upper range of the benchmark group and reflects the low commissioned caseload per WTE. It appears that there is considerable available capacity within the service to accommodate the introduction of lower risk patients if direct patient care were referred to the DN Service. Community Matrons are also the first point of call by SPA to visit patients and avoid hospital admission.

Specialist Nurse Services receive low levels of resource and have generally been commissioned to fill identified service gaps and do not appear to have been reviewed in the light of other service developments. As a consequence there appears that there is a deal of overlap in the provision of Chronic Disease Management. It is recommended that these services should be reviewed in the context of the Patient Journey with clear lines of responsibility, referral criteria and ‘hand back’ arrangements.

The Community Therapy Service appears to be comparatively well resourced, being placed at the upper end of the benchmark inter-quartile range. Community Therapy contacts are below the average but towards the middle of the inter-quartile range. However, it should be noted that the CWP Community Therapy service also provides services to Ellesmere Port Hospital. Wait times for Therapy services appear unduly long; work practices need to be reviewed to produce a more responsive service. It is also recommended that GPs be informed of Therapists’ initial assessments and treatment plan in a timely manner and not to rely solely on the Discharge summary.

Many of the specialist/multidisciplinary services have been commissioned and provided to fill identified service gaps. As a result they continue to operate independently of the underlying core services.

The new Rapid Response Team has been created from the merger of the CWP Rehab Link Team, the CWAC Crisis and Re-ablement Team and CoCH Discharge Liaison Team to enable timely access to therapy services and social care packages. However, these teams continue to work in parallel and work is required to establish a common vision for the service and to agree changes in working practices by each former team to deliver the new vision. Currently, the service is not provided after 6pm yet many elderly people presenting in A&E could avoid hospital admission if this service was available until later into the evening. It is recommended that the business case for the extension of
SPA services might be enhanced further with the inclusion of Therapy and Social Care services to support an extension of the newly formed Joint Rapid Response Team.

SPA is making a considerable contribution to the avoidance of hospital admission and is exceeding its target of 25% admission avoidance. However, CoCH staff appear unaware of the contribution that CWP is making in measured hospital avoidance. It is recommended that this information is shared regularly with the Countess of Chester Hospital so that all parties recognise the contribution that each is making to alleviate a shared problem.

In summary, Community Services in Western Cheshire compare favourably to other services in the Benchmarking club in terms of numbers of staff and contacts achieved:

- Further work is required to assess the DN contacts and if work is being completed by other services;
- Policies and procedures need to be consistently applied. GPs to be made aware of the policies and procedures;
- Issues have been highlighted with Therapies which the general manager is continuing to address. In addition, access times to therapies should be reviewed.
- A review of Rapid Response indicates that the nurses are not delivering nursing care but passing that onto the District Nurses to complete. A review of the Rapid Response process should take place to map out the process highlighting barriers and agreeing action plans to address.

Communication with GPs is key and improvements should be seen as integrated teams are implemented as this will lead to:

- The identification of named community nurses and team leaders for each practice; and
- Provide a communication route for GPs to raise concerns with CWP and vice versa.

The addition of a board level GP will support communication and marketing of CWP services to the primary care community.

The organisation needs to develop a more commercial approach to dealing with the commissioner considering how to ‘account manage’ the commissioning team in the first instance.

In common with other Community Services organisation there had been little investment in technology which in turn reduced the information available to commissioners, management and operational teams. This is being addressed in CWP through the implementation of EMIS however further work is required to resolve remote access issues amongst other things.

The majority of community staff have integrated well into CWP with considerable benefit from effective professional development and clinical governance arrangements. Staff are excited about the perceived benefits of moving to integrated teams. The nurses seemed clear on their role to avoid admissions of patient to hospital; additional work needs to be done to ask them to consider what else they can do through training and/or working with others (acute, social care, primary care, voluntary sector) to manage the patient’s journey through the system District Nurses feel that their clinical skills are underutilised and that they could make a significant contribution to hospital avoidance and early discharge of patients if their scope of practice was extended.
It has taken two years for the physical team to be embedded into CWP and should the service be tendered in the near future, a further one to two years will be lost as staff worry about changing organisations and the impact on their livelihood. This combined with a general election in two years suggests that disruption of this level will take the focus away from delivering an integrated solution for patients.

A table of recommendations is included in Appendix C.
APPENDICES

APPENDIX A - KOTTER’S THEORY OF CHANGE


STEP ONE: INCREASE URGENCY

In order to change, we need to understand the need to do it. Time is required at this stage to ensure support for the change. The reasons need to be human, not business.

STEP TWO: BUILD GUIDING TEAMS

Change needs leadership. This comes from influential people throughout the organisation, not necessarily the senior people. They need to work together as a team to build momentum around the change. All relevant points of view should be included.

STEP THREE: GET THE VISION RIGHT

We need to understand and remember why we are doing the change. A vision helps us to understand what we are trying to achieve. The vision must be inspirational and achievable.

STEP FOUR: COMMUNICATE THE VISION

The vision needs to be shared frequently and powerfully. It should be part of all communication. We need to see that leaders are practising what the vision says. Behaviour is more powerful than words.

STEP FIVE: ENABLE ACTION

There will be some processes and structures that get in the way of change. Some people will also resist it. We need to be rewarded and recognised for change, and supported to overcome barriers. Where there is resistance, honest discussion is needed.
STEP SIX: CREATE SHORT-TERM WINS

Look for things that you can achieve as you go along, set goals that can be met in the short-term so that everyone is motivated by the early successes and is rewarded for their effort. This makes everyone more positive and optimistic.

STEP SEVEN: DON’T LET UP

Evaluate as you go along to see what is working and what needs to improve. Keep on building on the successes. Keep sharing the vision and get more and more people involved.

Step Eight: Make it stick

The change needs to be based on values that can be seen in day-to-day work. The change should be visible in all that you do. Culture change comes last, not first and happens because people can see the new way is better than the old.

Remember what people have achieved.

## APPENDIX B – BIBLIOGRAPHY

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APPENDIX C – TABLE OF RECOMMENDATIONS

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<tr>
<td>Agree/confirm role of DNs in support of patients living in residential care homes or nursing homes</td>
<td></td>
<td>Review/revise commissioning of District nursing support to residential care homes and nursing homes.</td>
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<tr>
<td>Review the requirements for District Nurse independent prescribers (V300) and commission training as appropriate</td>
<td></td>
<td></td>
<td>Support the development of Independent Nurse prescribers by providing clinical support and mentorship during their training as designated medical prescribers</td>
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<tr>
<td>Extended District Nurse roles</td>
<td>Explore how to leverage the latent clinical skills of experienced DNs in supporting admissions avoidance and early discharge e.g. expansion of clinical procedures delivered.</td>
<td>Explore with CWP how to leverage the latent clinical skills of experienced DNs in supporting admissions avoidance and early discharge e.g. expansion of clinical procedures</td>
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## Focus of Recommendation

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<tr>
<th>Focus of Recommendation</th>
<th>CWP</th>
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<td>delivered.</td>
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### COMMUNITY MATRONS/ CLINICAL CASE MANAGERS

#### Service Model

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<tr>
<th>Service Model</th>
<th>CWP</th>
<th>WCCC</th>
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<tbody>
<tr>
<td>Work with GPs and CCG to agree service model for Community Matrons / Clinical case Managers.</td>
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<tr>
<td>Review Commissioning plan for Community Matron service with regard to commissioned case load and surveillance of lower risk patients</td>
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<tr>
<td>Agree ‘hand-off’ protocols with the District Nursing Service, Specialist Nurses and CoCH</td>
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<tr>
<td>Work with CCG and CWP to agree service model for Community Matrons / Clinical case Managers</td>
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<tr>
<td>Agree ‘hand-off’ protocols with CWP</td>
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<tr>
<td>Workforce</td>
<td>Undertake work to better understand Community Matron contacts and review/quantify use of Community Matron as SPA first point of Contact</td>
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<td></td>
<td>Re-profile Community Matron workforce to reflect agreed service model</td>
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<tr>
<td>Clinical Practice</td>
<td>Review the use of Telehealth to ensure it is used with appropriate patients and that implementation targets are met.</td>
<td>Revise the commissioning specification for Telehealth to include appropriateness of use as well as target numbers to be implemented.</td>
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**SPECIALIST NURSES**
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<tr>
<th>Focus of Recommendation</th>
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<th>CWAC</th>
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</thead>
<tbody>
<tr>
<td><strong>Role and Function</strong></td>
<td>Work with GPs to inform them of Specialist Nursing Services, to develop new service models and referral criteria.</td>
<td>Determine the contribution of Specialist Nursing Services to commissioned Patient Pathways and resource accordingly.</td>
<td>Work with CWP to better understand the contribution that Specialist Nurses can make to direct patient care and in providing specialist advice to GPs and Practice Nurses.</td>
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<td></td>
<td>Work with CoCH and GPs to develop care pathways which cross primary, secondary and community care.</td>
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<td></td>
<td>Identify and clarify the complimentary roles of Specialist Nurses, Community Matrons and District Nurses in meeting the needs of patients at differing stages of their chronic disease.</td>
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</tbody>
</table>
Focus of Recommendation | CWP | WCCCG | GPs | CoCH | CWAC
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management journey. |  |  |  |  |  
Develop further the specialist advisory role of Specialist Nurses to community nursing colleagues and primary care. |  |  |  |  |  
**COMMUNITY THERAPIES**

**Professional Leadership** | Explore with CoCH, the provision of professional leadership for the Therapy Services to ensure consistency of practice and cross boundary working. |  |  |  |  
Explore with CWP how CoCH might provide professional leadership for the Therapy Services to ensure consistency of practice and cross boundary working. |  |  |  |  |  
<table>
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<tbody>
<tr>
<td><strong>Wait times for treatment</strong></td>
<td>Review current practice and wait-times to ensure a more responsive service.</td>
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<td></td>
<td>Wait-times should be monitored, reported upon and shared with GPs</td>
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<tr>
<td><strong>Communication with GPs</strong></td>
<td>GPs should be informed in a timely manner of Therapists’ initial assessment findings and the proposed treatment plan. GPs should also be informed of any change to the treatment plan.</td>
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<tr>
<td><strong>Clinical Practice</strong></td>
<td>Further develop the work commenced to standardise therapy practice and expected duration of treatments.</td>
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<tr>
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<tr>
<td>Access to mobility aides</td>
<td>CWP should work with the CCG Equipment Project Lead to inform her of the difficulties they face in obtaining appropriate equipment to support patients in their usual place of residence.</td>
<td>WCCCG Project Lead to meet with CWP therapists to understand equipment access issues to support patients in their usual place of residence.</td>
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<td></td>
<td></td>
<td>The CCG Equipment project should be completed in a timely manner.</td>
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</tbody>
</table>

**RAPID RESPONSE TEAM**

<p>| Establishment of a common vision for the new service and different ways of working | CWP should work closely with CoCH and CWAC to establish a common vision of the new service and to agree changes in working practices to deliver the new | | | | |
| | CoCH should work closely with CWP and CWAC to establish a common vision of the new service and to agree changes in working practices to deliver the | | | | |
| | CWAC should work closely with CWP and CoCH to establish a common vision of the new service and to agree changes in working | | | | |</p>
<table>
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<tbody>
<tr>
<td></td>
<td>vision.</td>
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<td></td>
<td>new vision.</td>
<td>practices to deliver the new vision.</td>
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<tr>
<td></td>
<td>Review team structure to ensure sufficient range and number of skills are available to support patients’ needs</td>
<td></td>
<td></td>
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<td>Review team structure to ensure sufficient range and number of skills are available to support patients’ needs</td>
</tr>
<tr>
<td>Extension of service offered</td>
<td>Work with CoCH and CWAC to consider the extension of the service into the later evening.</td>
<td></td>
<td></td>
<td>Work with CWP and CWAC to consider the extension of the service into the later evening.</td>
<td>Work with CWP to consider the extension of therapy and/or social care service to work into the later evening.</td>
</tr>
<tr>
<td></td>
<td>Any proposed extension of service and consequent resources should be added to the Full Business Case for the extension of SPA services which is currently be developed.</td>
<td></td>
<td></td>
<td>CoCH should undertake an audit of patients presenting in A&amp;E after 6:00pm, who could be diverted from admission to hospital, in order to determine the resources required to extend the</td>
<td></td>
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</table>
### Focus of Recommendation

<table>
<thead>
<tr>
<th>CWP</th>
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<th>GPs</th>
<th>CoCH</th>
<th>CWAC</th>
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</thead>
<tbody>
<tr>
<td><strong>Case Study of partnership working and shared learning</strong>&lt;br&gt;Develop this work as a case study of integrated services and share learning amongst other teams</td>
<td>Develop this work as a case study of integrated services and share learning amongst other teams</td>
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<td>Develop this work as a case study of integrated services and share learning amongst other teams</td>
<td>Develop this work as a case study of integrated services and share learning amongst other teams</td>
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### SINGLE POINT OF ACCESS

<table>
<thead>
<tr>
<th>Commissioning</th>
<th>Rapid Response Team</th>
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</thead>
<tbody>
<tr>
<td>Work with CoCH to update the service specification to reflect the model of care required by CCG.</td>
<td>Work with CoCH to determine how SPA might further contribute to the Rapid response Service.</td>
</tr>
<tr>
<td>Update commissioning requirements to reflect the developing model of service.</td>
<td>Work CWP to determine how SPA might further contribute to the Rapid response Service.</td>
</tr>
<tr>
<td>Focus of Recommendation</td>
<td>CWP</td>
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<tr>
<td>Hospital avoidance</td>
<td>CWP should share SPA’s monthly hospital avoidance data with CoCH, GPs and the community nursing and therapy services, to demonstrate its contribution to the alleviation of emergency admission pressures.</td>
</tr>
</tbody>
</table>

**EMIS WEB/IT**

<p>| Network Accessibility | Resolve current network technical issues affecting speed and access. | | | | |
|------------------------|---------------------------------------------------------------|-----|-----|-----|
|                        | Expedite implementation of full EMIS functionality to all community staff. | | | |
|                        | Access to all community | | | |</p>
<table>
<thead>
<tr>
<th>Focus of Recommendation</th>
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</thead>
<tbody>
<tr>
<td><strong>Shared Patient Records</strong></td>
<td>Work with WCCCG to agree a way forward in providing mutual access to GP and community services patient records and operational policies.</td>
<td>Establish a short-life working group to agree a way forward in providing mutual access to GP and community services patient records and operational policies.</td>
<td>Work with WCCCG to agree a way forward in providing mutual access to GP and community services patient records and operational policies.</td>
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</table>

**CWP MANAGEMENT OF COMMUNITY SERVICES**

<p>| Strategic development | Recruit a GP at board level to provide clinical leadership and to lead community service development across community, primary and secondary care | Work with WCCCG to promote and deliver community services across community primary and secondary care | Work with GPs to promote and deliver community services across community primary and secondary care | Work with CoCH to promote and deliver community services across community primary and secondary care |  |
| Communication | Need to shout about success more |  |  |  |  |</p>
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<td></td>
<td>Develop a DoS outlining what the services are, where they are and how provided</td>
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**COMMISSIONING/CONTRACT MANAGEMENT**

<table>
<thead>
<tr>
<th>Patient Pathways</th>
<th>Work is required to further develop patient pathways and to clearly identify the services required to support the patient journey</th>
<th>Work is required to further develop patient pathways and to clearly identify the services required to support the patient journey</th>
<th>Work is required to further develop patient pathways and to clearly identify the services required to support the patient journey</th>
<th>Work is required to further develop patient pathways and to clearly identify the services required to support the patient journey</th>
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<tbody>
<tr>
<td>Service Specifications</td>
<td>Specifications should be updated to reflect the model of care required to support the patient journey.</td>
<td>Specifications should be updated to reflect the model of care required to support the patient journey.</td>
<td>Specifications should be updated to reflect the model of care required to support the patient journey.</td>
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<tr>
<td>Performance management</td>
<td>New structure/process and process/outcome KPIs to be developed in partnership with WCCCG, focussed on agreed priorities.</td>
<td>New structure/process and process/outcome KPIs to be developed in partnership with CWP, focussed on agreed priorities.</td>
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<tr>
<td></td>
<td>Work with WCCCG to support Quality and Contract Monitoring processes to permit evidence of trend data and management action and to enable capacity to discuss service performance and development.</td>
<td>Review frequency of current Quality and Contract Monitoring processes to permit evidence of trend data and management action and to enable capacity to discuss service performance and development.</td>
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<td></td>
<td>Join the NHS benchmark club to assess performance and progress</td>
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<tr>
<td>Focus of Recommendation</td>
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<tr>
<td><strong>Partnership and Communication</strong></td>
<td>Work with WCCCG to identify key contacts and participate in ‘Person Marking’ to assure effective communication channels out-with formal meetings.</td>
<td>Identify key CWP contacts and establish ‘Person Marking’ to assure effective communication channels out-with formal meetings.</td>
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<tr>
<td><strong>Primary Care</strong></td>
<td></td>
<td>Changes in ways of working are required in primary care in order to deliver patient centric care closer to their place of residence</td>
<td>To deliver continuity of care, primary care also need to change ways of working in order to deliver patient centric care closer to their place of residence</td>
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<td></td>
<td>Specialist nurses to work with GPs and practice nurses to assess completeness of registers</td>
<td>Work with specialist nurses assess completeness of registers e.g. heart failure</td>
<td>Work with specialist nurses assess completeness of registers e.g. heart failure</td>
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<tr>
<td>Focus of Recommendation</td>
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<tr>
<td>Ellesmere Port Hospital</td>
<td></td>
<td>Consider the future of Ellesmere Port hospital - could it be used as a community step up /step down facility and/or provide some access to diagnostics for those living close by</td>
<td></td>
<td>Consider using it as a community step up /step down facility? Access to diagnostics?</td>
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<tr>
<td>Contract Notice/tendering</td>
<td></td>
<td>Decide whether to tender contracts at this stage in the cycle</td>
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<tr>
<td>Focus of Recommendation</td>
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<tr>
<td><strong>AGEING WELL</strong></td>
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<tr>
<td><strong>Vision</strong></td>
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<tr>
<td>Contribute to WCCCG vision development</td>
<td>Engage all parts of the Health and Social care economy to build on the vision from Ageing Well to agree the West Cheshire Way</td>
<td>Contribute to WCCCG vision development</td>
<td>Contribute to WCCCG vision development</td>
<td>Contribute to WCCCG vision development</td>
</tr>
<tr>
<td><strong>Communication of vision to staff of key stakeholders</strong></td>
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<tr>
<td>Agree on the key messages for staff to encourage working in partnership on the front line. Leaders to demonstrate commitment to partnership working through words and actions</td>
<td>Commissioner to take the lead on agreeing the key messages for staff to encourage working in partnership on the front line. Leaders to demonstrate commitment to partnership working through words and actions</td>
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<tr>
<td><strong>Programme Governance</strong></td>
<td>Confirm the governance of the programme and determine if it can be further streamlined to reduce the number of meetings it reports to.</td>
<td>Review the objectives of CCG meetings to determine if any can be combined e.g. PDG and Clinical leads.</td>
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<tr>
<td><strong>Resourcing</strong></td>
<td>Continue to provide resource as required</td>
<td>Focus substantive resource on Ageing Well to deliver it - clearly articulating the value to be achieved. Invest additional focused GP resource to drive this forward</td>
<td>GPs to participate in Ageing at strategic and operational levels</td>
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<td>Ensure that there is appropriate PMO resource to support project processes and reporting</td>
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<tr>
<td>Project plans and management</td>
<td>Review plans and use appropriate tools to track progress and achievement of milestones</td>
<td>Review plans and use appropriate tools to track progress and achievement of milestones</td>
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<td></td>
<td>Refocus reporting on progress against plan, risks, barriers to implementation</td>
<td>Refocus reporting on progress against plan, risks, barriers to implementation</td>
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<tr>
<td></td>
<td>Work with WCCCG to expedite the implementation plan for Integrated teams to ensure the full implementation by September 2014</td>
<td>Expedite the implementation of Integrated teams to ensure the full implementation across all clusters by September 2014</td>
<td>Work with WCCCG to expedite the implementation plan for Integrated teams to ensure the full implementation by September 2014</td>
<td>Work with WCCCG to expedite the implementation plan for Integrated teams to ensure the full implementation by September 2014</td>
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<td>Focus of Recommendation</td>
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<tr>
<td>CoCH engagement</td>
<td>Continue to encourage CoCH to support the development of Integrated Teams</td>
<td>WCCCG to engage CoCH possibly in the development of Ageing Well considering development of outreach services, and step up/down services at Ellesmere Port Hospital.</td>
<td></td>
<td>CoCH to engage in the development of Ageing Well considering development of outreach services, and step up/down services at Ellesmere Port Hospital.</td>
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</tbody>
</table>

Provide leadership through the development of integrated CQUINs and other contractual measures.

<table>
<thead>
<tr>
<th>Patient and public engagement.</th>
<th>Implement agreed Ageing Well patient involvement plan</th>
<th>Develop and agree a patient involvement plan</th>
<th>Develop and agree a patient involvement plan</th>
<th>Develop and agree a patient involvement plan</th>
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</thead>
</table>

| Staff involvement | Continue to involve staff in the development of new ways of working | Involve staff from all partner organisations in the development of new ways of working | Partake in the development of new ways of working | Partake in the development of new ways of working | Partake in the development of new ways of working |
**Focus of Recommendation** | **CWP** | **WCCCG** | **GPs** | **CoCH** | **CWAC** |
--- | --- | --- | --- | --- | --- |
**IT support to Ageing Well** | Work with WCCCG to identify the IT requirements to support the delivery of the respective work-streams and any additional support tools e.g. intranet for policies and procedures, tools to support communication with GPs. | The Ageing Well Programme should identify the IT requirements to support the delivery of the respective work-streams and any additional support tools e.g. intranet for policies and procedures, tools to support communication with GPs. | Work with WCCCG to identify the IT requirements to support the delivery of the respective work-streams and any additional support tools e.g. intranet for policies and procedures, tools to support communication with GPs. | Work with WCCCG to identify the IT requirements to support the delivery of the respective work-streams and any additional support tools e.g. intranet for policies and procedures, tools to support communication with GPs. | Work with WCCCG to identify the IT requirements to support the delivery of the respective work-streams and any additional support tools e.g. intranet for policies and procedures, tools to support communication with GPs. |

Identify an Ageing Well Project lead for IT as it is an enabling workstream.