Manchester City Council
Report for Information

Report to: Health Scrutiny Committee – 25 June 2015

Subject: Community Nursing in South Manchester

Report of: Chief Nurse, University Hospital South Manchester and the Deputy Chief Officer, South Manchester CCG

Summary

This report is to provide Health Scrutiny Committee with an overview of Community Nursing Services in South Manchester.

Recommendation

The Health Scrutiny Committee is asked to note the contents of this report.

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Background documents (available for public inspection):

The following documents disclose important facts on which the report is based and have been relied upon in preparing the report. Copies of the background documents are available up to 4 years after the date of the meeting. If you would like a copy please contact one of the contact officers above.

None

South Manchester
Clinical Commissioning Group

Community Nursing in South Manchester

Introduction

This report is to provide Health Overview and Scrutiny Committee with an overview of Community Nursing Services in South Manchester.

Background and Context

Transforming Community Services (TCS) saw the transfer of the District Nursing (Days and Nights) and the Active Case Management (ACM) Service to University Hospital of South Manchester (UHSM) in 2011, and specialist nursing services for Diabetes, Cardiovascular Disease and Respiratory. The establishment for nursing services transferred equated to 187 wte (inclusive of specialist nursing as detailed within the Business Transfer Agreement in 2011). Since the community services transferred to UHSM in 2011, SMCCG has applied the appropriate contractual/financial amendments in line with NHS England guidance, this equated to an average of 2.8% deflation along with the requirement that all providers show year on year efficiencies.

During 2013/14 SMCCG embarked on a review of 22 of the 32 community services transferred to UHSM, which included the nursing services described above. The findings from the review concluded that there were some excellent examples of good practice showing effective and responsive services. However for some services (including the nursing services detailed above) the following issues were highlighted:

- Fragmentation and lack of coordination between services
- Duplication of service effort
- Measurement of patient experience
- Generalist vs. Specials provision
- Activity and outcome based recording
- Value for Money

In parallel to the community services review SMCCG invested funding as part of the South systems response to the City's Living Longer Living Better integrated Care Programme. The investment resulted in an increased of 17wte community nursing staff who formed the Neighbourhood Team model of delivery. The investment was time limited, with a clear focus on testing the concept of integrated care delivery, with health, social care staff and GP practices working together to support patients and their carers. Providing a coordinated approach centred on the needs of individuals.

The pilot was also instigated to facilitate new ways of working that would then be embedded within mainstream services as business as usual.

The pilot was phased, in the first instance covering 2 of the 4 patches in South Manchester, following successful evaluation of Phase I in April 2014, SMCCG confirmed that the pilot should be extended, so that the benefits realised from phase 1 would be extended to covering the remaining 2 patches in South. There were difficulties in recruiting and retaining staff due to fixed term contracts being offered in line with funding for the duration of the pilot. UHSM and SMCCG entered a risk sharing agreement to enable staff to be recruited on permanent contracts. In October 2014, SMCCG gave notice that funding for the Neighbourhood Teams would be deferred and subsequently was withdrawn from 31 March 2015. The funding equated to 17 whole time equivalents (WTE). As this was a time limited project SMCCG informed the Trust that the learning and benefits realised from the pilot should be mainstreamed and become business as usual. This was in line with outcomes of SMCCGs review of the 22 community services and the introduction of the revised service specifications requiring full implementation by April 2015.

UHSM Community Nursing Consultation

In August 2014, UHSM received the outcome from the Greater Manchester Benchmarking project relating to District Nursing Services. This identified that UHSM had a higher proportion of senior nursing staff compared to peers. In addition, it highlighted that the UHSM service had fewer patient contacts per WTE.

A consultation has taken place in January to March 2015 to integrate the three elements of the Community Nursing Service (Active Case Management, District Nursing and Neighbourhood Teams). A review was necessary as practices and shift patterns did not support the future model of integrated community care services and the aim of the consultation was to transform the community nursing service to prepare the service for future delivery with an appropriate skill mix and to align with:

- Living Longer Living Better (LLLB), which is Manchester's Integrated Care Programme
- "One Team" (Place Based Care) and therefore preparing the service for future delivery
- Five Year Forward View – "integration at the heart of removing barriers to how care is provided".

This aligns with UHSM strategy and, along with the formation of the Community Services directorate, provides the foundation to integrate adult social care with community health and supports the wider integration initiatives of LLLB and GM Devolution.

Outcome of the Consultation

The consultation outcome was to integrate the three service elements (ACM, Neighbourhood Teams and District Nurses). This also included a skill mix review to ensure the right staff undertook the right care resulting in a reduction of 6.93wte from the overall establishment of the services previously delivered in isolation. The

revised establishment going forward is appropriate for the activity levels and complexity of the current patients seen within the Integrated Community Nursing Service.

Ways of utilising technology to increase patient facing time were explored but from feedback from colleagues it was recognised that the efficiencies wouldn't be realised quickly and that further piloting of technology is required. UHSM was successful in bidding for NHS Nursing Technology Fund Support to provide 170 mobile devices for its community workforce.

To ensure the volume of patient activity could be met with this reduction in establishment an activity analysis was completed. The activity analysis confirmed that to meet the current work load and with the changing work patterns, to cover the service 7/7, the establishment that is being implemented of 115 wte was sufficient to care for our patients across all patches based on activity and population.

UHSM have committed inline with practice in the hospital services, to review the activity and acuity of the patients every 6 months. In addition, any changes to national guidance will be reflected in future reviews of the service and any changes to the staffing establishment will be made as necessary. A review of the establishment will be undertaken in March 2016 6 months following implementation. The service currently has vacancies and a number of colleagues have requested MARS, which means there are no expected redundancies. In addition a number of posts have been held as suitable alternative employment, should they be required.

Below are some of the excellent patient stories about Community Nursing Services.

Case Study 1

JM is a 64 year old lady who lives alone and has schizophrenia, which is generally controlled with medication. I was keyworker for 5 months and when I first met her, she was quite a recluse. She was afraid to go out alone, especially to appointments and her anxiety was increasing. Debbie spent time with her supporting her on hospital appointments, arranging ring and ride and encouraging her to go out, promoting independence. Her main physical problem was faecal incontinence, which has now been investigated and resolved thanks to Debbie's support with the appointments, which she would not have attended otherwise. Her confidence has increased, with referrals to good neighbours, which she attends twice weekly and she has made new friends. I stepped her forward once I knew she had the confidence to continue independently.

Case Study 2

Patient referred from A&E following 2 consecutive visits with episodes of breathlessness.
Assessed initially, pt. had attended A&E on 2 occasions with increased Breathlessness and episodes of panic. Initial assessment identified

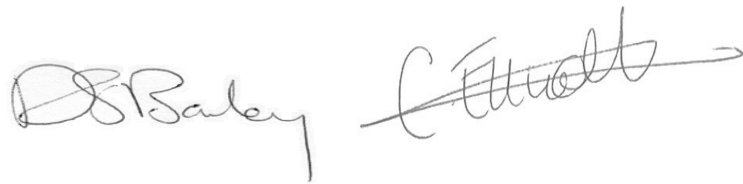
unintentional non compliance with medications and patient had also lost antibiotics prescribed to him in A&E a couple of days before.
Patient had suffered from an MI 3 weeks ago in Wales and had a diagnosis of Lung cancer with metastasis for which he had received chemotherapy and radiotherapy.
Pt. became tearful during assessment and had an episode of panic increasing SOB, reassurance and advice given which settled him.

Interventions included provision of raised toilet seat ,request for outdoor 4 wheeled walker ,support monitoring and advice with current symptoms over the next 4 days .Prompting of prescribed medications not in blister pack including changes made in A&E which had been added to blister pack by mistake .
Liaison with GP to arrange for antibiotics, blister pack and informed him of recent A&E attendances and episodes of panic, GP went on to prescribe accordingly.
Patient and his wife expressed their appreciation of such an efficient and supportive team at that time.
Discharged back to Macmillan Team for on-going symptom control and support

Patient referred to rapid response for support at home. Patient came on with an acute chest infection but also long term complex health conditions. Joint assessment completed by nurse and OT within a couple of hours of referral.
On initial assessment the following were put in place:

- ***Package of care arranged four times daily.***
- ***Review of mobility and transfer needs completed.***
- ***Specialist equipment i.e.: glide about commode and hospital bed ordered and in place within 48 hours.***
- ***The patient then had Daily nursing input over a few days re: bloods, pressure care, observations, monitoring of fluids and diet.***
- ***Pharmacist review: re urgent changes to medication.***

This example highlights the importance of working in a close integrated team. For example without this service the patient would have needed to be referred to all professions separately. This would likely lead to duplication of work and frustration for the patient. It is likely the specialist equipment would not have been in place so quickly. Working in a close integrated team also leads to great communication skills and understanding of each other's roles. In the case of this example this was crucial as the patient had very complex health and social needs. Good inter-professional working was required to achieve the best outcome for the patient, pulling on all professional's different skills and working holistically.



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