Appendix 2 (A)

THE RECONFIGURATION OF COMMUNITY TEAMS
HOSC 21 MARCH 2012

1.Background on the proposed model for the reconfiguration of existing community teams

Previously there were many different teams, supporting patients within the community. These teams commissioned at various times and had not developed in an overall coherent way.
The teams included within the reconfiguration are

- District Nurses;
- Community Matrons;
- Care Home Support Team;
- Medical Review Pharmacist;
- Community Phlebotomy (Phase 2 of the development)
- Community Physiotherapy

The aim of the reconfiguration is to deliver efficiencies alongside improvements to patients and carer outcomes and experience and the support to primary care to manage this cohort of patients

2. Service Model

These teams have been reconfigured into new multidisciplinary teams each with dedicated carers support aligned to small clusters of GP practices (Integrated Primary Care Teams) which are able to manage the full spectrum of needs patients with long term conditions have. The overall objective of the teams is to provide flexible, appropriate and tailored levels of support to patients and their carers, in conjunction with primary care to enable the patient to develop, establish and achieve their own goals

Key features of the new model

- There are eleven practice clusters in total, informed by a public health needs analysis which clustered practices of similar age profile, deprivation indices and factors such as registered Nursing and Care Home populations . These proposed clusters have been supported by localities.

- The teams will operate 7 days a week, providing care between 8am and 8pm.Out of these hours care will transfer to South East Health Ltd.

- The practice remains the hub of care and effective working between practices and the dedicated teams will enable a more integrated and flexible approach to delivery of care on a day to day basis.

- The patient level data (real time information about those accessing urgent care services and risk of future admission to hospital score for patients within the practice) held within the Urgent Care Clinical Dashboard which is now embedded in each practice will enable the teams and practices to identify and direct resources appropriately and collectively agree the management plan for patients proactively.

- Patients with complex needs will have a dedicated care co ordinator and care plan reflecting their needs in order to support self care and identify anticipatory care requirements. This information will be shared with consent of the patient with all relevant parties involved in the patients care

- This care co-ordination also facilitates streamlined referral into and discharge from specialist services when required,(instead of patients remaining on a number of different caseloads for long periods of times) and planned alignment of Adult Social Care Teams to localities will improve joint working between health and social care, reducing duplication.

- The teams provide support to the registered population regardless of setting of care, therefore providing housebound and those in care home, meeting with an equitable service.

- Dedicated wound care and continence service, (which visits people at home) developed to support a key proportion of the existing district nursing activity where the intervention is short term or the only intervention being received by the nurse.

Integrated Primary Care Teams

The skill set of each of the 11 teams includes the following core competencies to ensure the effective management of the full range of patient needs is met

- Advanced Physical Assessment skills
- Independent prescribing and case management
- Care co-ordination
- Nursing staff
- Allied Health Professionals
- Community medication review pharmacist
- Generic support workforce
- Administrative support

Each team has a clinical lead and will be overall managed by one of 3 Clinical Service Managers covering the 3 localities across the city. City wide leadership comes from the newly appointed Head of Service for Brighton and Hove. Staff within the team receive line management and clinical supervision from the grade above.

Ongoing training requirements will be identified through the appraisal, personal development planning process, wider organisational development plan and feedback via the ongoing performance and quality monitoring of the new teams which includes feedback directly from Primary Care.

Transitional Year 2012/13
The new model begun to be implemented in an incremental fashion from January 2012 onwards. 2012-13 is be a transitional year and will be subject to full evaluation to inform future commissioning intentions.
A service specification has been developed and performance against this specification will form part of the evaluation for future service delivery.

The evaluation framework is based on the agreed KPIs and quality outcomes for the new service. This outcome based evaluation is based on the NHS Quality Outcomes Framework and key outcome indicators are reflected additionally in CQUINS and the

Annual Operating Plan. Performance of the service will be monitored by commissioners in conjunction with the Commissioning Support Unit (through regular contract performance meetings) and include staff, primary care, patient and carer feedback. Key aspects of this evaluation will include

- Performance against service specification
- KPIs and outcomes achieved
- Patient/carer and staff satisfaction
- Delivery of agreed efficiencies
- Effective working with specialist services

This evaluation will be led by clinicians and commissioners and be carried out by the third quarter of transitional year 2012-13. The outcomes of this evaluation will inform future commissioning intentions and determine the final service specification.

3. Current Progress

A multidisciplinary clinically led project board has overseen the development of the new model and the service specification. This group has now evolved into a project board which is responsible for overseeing the full implementation and successful delivery of the new service.

To maximise effectiveness of the new model, a number of underpinning processes and systems have been developed. These include:

- Proactive patient identification through a predictive risk tool and real time information about patients accessing urgent care services brought together in one place through the Urgent Care Clinical Dashboard.

- Care planning and coordination; basic care plan developed in template form compatible with a range of GP systems now being trialed within practices across the city.

- Clear and effective pathways between the MDT team and the existing specialist services to ensure duplication of care is minimised and patients receive care from the right person and the right time. These have covered four main areas Urgent care, End of Life Care, Disease specific and Adult Social Care

- Further work is underway to explore the opportunity of future community mental health teams being clustered to align to the new teams.

- Alignment of Dementia programmes, particularly Dementia Care Home Support team development again to minimise duplication and ensure one clear service model.

- Funding and model for dedicated carers support agreed and service now being developed

- Health promotion and prevention; clear pathways to effective health promotion and prevention services to support effective self care and maximise patient outcomes, including alignment with services provided by the community and voluntary sector.

4. Impact on Primary Care

The redesign of existing community teams not only has a positive impact on the outcomes for patients within the city but also within primary care establishing stronger working relationships between practices and their linked community teams,

reducing crisis episodes for patients and the subsequent draw on already stretched primary care resources.

The new model is being implemented in an incremental fashion throughout the transitional year and the redesign of these teams means a significant amount of change, not only in structure but ways of working for existing community staff but also primary care.

Key to all of this will be the success of practices and community teams working together effectively. Team meetings are currently taking place to establish relationships and effective systems and processes to support coordinated working.

As part of the evaluation process , practices will be asked through satisfaction surveys to feedback on progress of the new model, issues and areas where best practice have been identified and could be shared. Lessons learnt will also be captured to inform the final service specification in addition to applying these to the way in which future services are developed across the city.