Walsall Healthcare
For One & All

Walsall Healthcare NHS
NHS Trust

Community Health Services in Walsall: Next Steps

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Background

- Walsall's community health services combined with Walsall Hospitals NHS Trust to form Walsall Healthcare NHS Trust as part of the national Transforming Community Services programme in April 2011.
- The Scrutiny Committee received a community services briefing at its meeting in December. The briefing identified five future priorities:
    - Improved discharge and reduced readmissions;
    - Quality and safety;
    - Integration;
    - Increasing productivity;
    - Extending prevention.
- This paper sets out more detail on action to date and planned next steps in each of the five priority areas.

Community Services: Priorities

1. *Improving Support on Discharge from Hospital and Reducing Admissions* – increased hospital emergency demand reinforces a need for a step-change in community provision (supported by recent CCG investment).
2. *Quality and Safety* – continuing to improve on key measures (e.g. pressure ulcers) and developing a wider range of measures of effectiveness (e.g. reduced readmissions, reduced "frequent flyers").
3. *Integration* – working more closely with primary care and social care to shift care to the community.
4. *Increasing Productivity* – supporting teams with new technology to improve community productivity.
5. *Extending Prevention* – increasing the range and coverage of the preventative services delivered by the Lifestyles Team.

1. Improving Discharge and Reducing Admissions

- **Working with GPs.** We are changing the way community nurses work with general practices to introduce a weekly review of an agreed list of the most vulnerable patients. Currently being rolled out.
- **Community "wrap around" services.** We are adding capacity to our community nursing teams and providing additional community therapy support to these teams to enable them to help GPs keep more patients in their own home (part of CCG £1.5m investment). Recruitment is in progress.
- **Rapid Response.** We are increasing the capacity of the Rapid Response Team to increase the numbers of patients who can be supported at home as an alternative to admission (part of CCG £1.5m investment). Recruitment is in progress.
- **Community matrons** now liaise daily with the Manor's assessment unit to identify patients who can be managed in the community. Community matrons also review the patients on their caseload who are admitted to hospital to support rapid discharge.
- **IDT.** We are reviewing the way our Integrated Discharge Team operates to ensure discharge planning improves. This work will take place in the next 6 months.
- **FEP.** We will continue the work of our Frail Elderly Team based in A&E with the aim of preventing admission to hospital for an increased number of older people.

2. Improving Quality and Safety

- **Pressure Ulcers.** Community pressure ulcers have reduced from 286 in 2012/13 to 114 in 2013/14 to December. We will continue to prioritise improvement in pressure ulcer care.
- **Friends & Family Test.** We are one of the first trusts in the country to introduce the Friends & Family Test for community services. We will use this to track improvements in patient experience during 2014/15.
- **Cancelled DN Appointments.** At times of increased demand community nursing teams prioritise urgent patients leading to cancellation of some routine appointments. We will be working to reduce the occasions on which this occurs during 2014/15.
- **Reduced Readmissions and Frequent Admissions.** The work to invest in and remodel community nursing teams and the Rapid Response are part of work to reduce our hospital readmission rate (currently 16%) and to reduce the numbers of patients admitted more than 4 times a year as emergencies (currently c. 120 a month). We are introducing regular reviews and improved care plans for these groups of patients during 2014/15.
- **Wound Healing Rates.** Our community wound clinics have significantly improved the time it takes to heal leg ulcers in the community. We plan to continue this work in 2014/15.

3. Integration

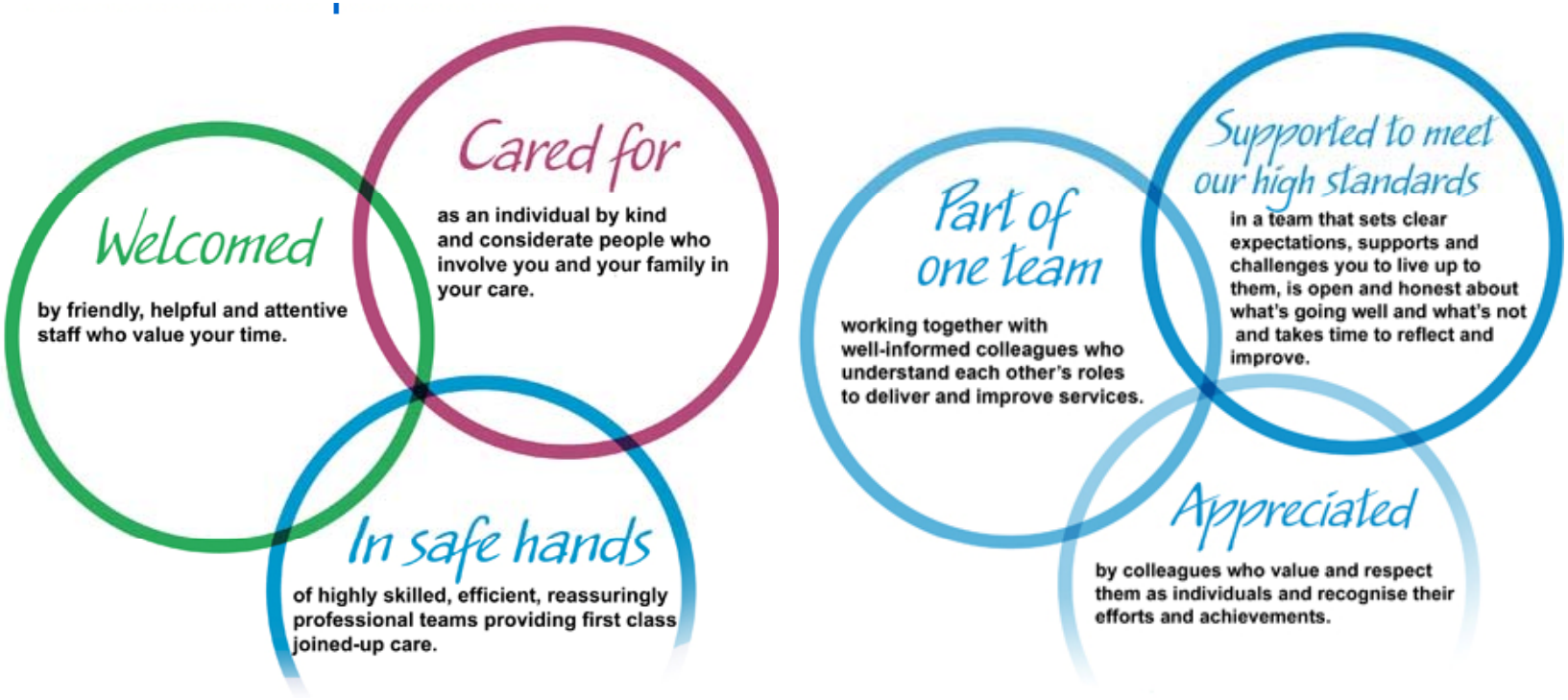
- **Integration.** We have agreed a programme of work with Social Care, the Clinical Commissioning Group and Dudley & Walsall Mental Health NHS Trust to deliver improvements in three areas:
  - Developing an integrated intermediate care for Walsall designed to support the swift and effective discharge from hospital and to provide an alternative to admission for older people needing short-term extra support;
  - Improving the way community nursing teams and social care teams work together including joint identification of vulnerable individuals and closer working together.
  - Improving joint support to residents of nursing homes to reduce admission to hospital in an emergency.
- **Better Care Fund**. We are working with the Council and the Clinical Commissioning Group to develop plans for the Better Care Fund. These have been shared with the Health & Well-Being Board.

4. Increasing Productivity

- **Single Patient Administration System.** From March 2014 we will have a new single integrated patient administration system for hospital and community services supporting shared information between hospital and community teams.
- **Mobile Working.** We are developing plans to make use of mobile technology in order to enable community teams to access information and update records from patients' homes. We intend to test this with health visiting teams.
- **Community Team Bases.** We have begun to review our community bases to ensure that we are making best use of the community premises that we occupy.
- **Productive Community Teams.** We plan to apply the nationally developed "productive community services" to our services where relevant to help us learn from best practice elsewhere.

5. Extending Lifestyle Services

- **Public Health Priorities.** The Lifestyles Team deliver a range of programmes that support public health priorities including health trainers and smoking cessation services.
- **Expert Patient Programme.** The team run and can extend further this programme that aims to give patients with long term conditions the skills to manage their own conditions. The programme uses volunteers alongside the Lifestyle Team to deliver advice and support.
- **Healthy Workplace.** The team operate a Healthy Workplace programme for employers to reduce sickness absence. This has been provided to a range of local organisations with significant impact. The team are also delivering this programme for key parts of the Trust workforce.


Welcomed
by friendly, helpful and attentive staff who value your time.
Cared for
as an individual by kind and considerate people who involve you and your family in your care.
In safe hands
of highly skilled, efficient, reassuringly professional teams providing first class joined-up care.
Part of one team
working together with well-informed colleagues who understand each other's roles to deliver and improve services.
Supported to meet our high standards
in a team that sets clear expectations, supports and challenges you to live up to them, is open and honest about what's going well and what's not and takes time to reflect and improve.
Appreciated
by colleagues who value and respect them as individuals and recognise their efforts and achievements.