Understanding the Model of Care - Community Health & Care Team Visits

Report of the Health & Adult Care Scrutiny Members

Please note that the following recommendations are subject to confirmation by the Committee before taking effect.

Recommendations:

that the Committee shares the learning from the visits to inform its future work programme.

Background

Following 22 March 2018 Health & Adult Care Scrutiny it was agreed that members would undertake a series of visits to community health and care settings across the County. Councillors wanted to get a first-hand account from staff of where the system is working well, how supported they feel and where there may be issues of concern. The visits were about members getting a better understanding of the way in which the new model of care in Devon is working operationally and the key issues affecting services from a frontline perspective.

Visits

The following councillors undertook visits to the community health and care teams in Exeter, Holsworthy and Teignmouth:

30 May 2018, Exeter Community Health & Care Team, Exeter Community Hospital

- Richard Scott
- Jeff Trail
- Carol Whitton
- Andrew Leadbetter (Cabinet Member)

6 June 2018, Holsworthy Community Health & Care Team, Holsworthy Community Hospital

- Sara Randall Johnson
- Brian Greenslade
- Sylvia Russell
- Andrew Saywell

21 June 2018, Teignmouth Community Health & Care Team, Teignmouth Community Hospital

- Sara Randall Johnson
- Sylvia Russell
- Andrew Saywell
- Carol Whitton

The Model of Care

The model of care in Devon is built upon the premise that people should be treated in their own homes wherever possible and that conditions that had previously required hospitalisation may no longer need it, or may not need it for as long. Staying any longer than necessary in hospital causes harm to patients – muscle function reduction, reduced independence & risk of infection. It particularly affects people who are frail and people who have dementia. The model also enables improved use of resource by transferring resource and workforce from the provision of community hospital beds to the provision of enhanced home-based care services more people can be supported.

- Comprehensive assessment to identify and support those most at risk of being admitted to hospital in an emergency
- Single point of access and rapid response service - front and back end of the pathway - admission avoidance and expedited discharge
- Building on what is already taking place; each intervention is an extension of work that is already happening in parts of Devon
- Changing how we think and act - changes in system & process only part of the change – 'doing the same, better'.
- Leading to changing the focus to prevention, population health & wellbeing. New focus & roles that span health, care and rehabilitation = 'doing things differently'.
- Trust, mutual understanding of risk and ability to share information are essential for successful integration.

Issues Identified by Members in discussion with Community Health & Care Teams

For the purpose of this brief report, and the candid nature of the discussions that were held with staff in each of the three settings, it was not felt to be helpful to attribute comments to either the individuals or the team's concerned but rather use the visits to highlight broad themes and issues.

Living Safely at Home

- There is a clear statutory responsibility under the Care Act to keep people living safely at home for as long as possible
- There is still something of a cultural shift for the community to get used to in terms of the independence / reablement approach, where people are not as dependent on the NHS.
- Work is being undertaken with partners on an electronic frailty scorecard to identify people most at risk and those who are becoming frail to facilitate earlier intervention.

Staff Recruitment / Retention

- Staff recruitment is both a major issue nationally as well as in Devon. Members were given an illustration of this issue, where a physiotherapist vacancy at one of the community teams had remained for 3 years.
- Market resilience in terms of care and the independent market is a challenge. A constant stumbling block is that there is not enough reablement available and there are difficulties getting packages of care.
- Officers work to try to carefully manage the domiciliary care market and not over commission services.

Communication with the Public

- The need to improve communication with the public about the model of care. Members felt it imperative to try to increase public understanding of why services are being aligned in this way and recognise that it is about so much more than bed spaces.
- There is also a need to promote and celebrate work staff are doing, and encourage patients and families to provide feedback. Self-promotion is important, as is learning for excellence and having a better understanding of good practice.

Families

- It can be difficult managing expectations with the family. With most complaints that are received the learning is usually around communication and staying in touch with people.
- Families tend to be risk averse and this is one of the areas where staff will receive the most complaints. An important issue is how to engage the public in conversations about their living arrangements as they get older. It is important that families encourage independence and forward plan.
- Money also tends to be a significant factor. Issues untangling what is happening with people's finances takes up a lot of time.

Case Study – Teignmouth Community Hospital: Volunteering in Health

Volunteering in Health is a charity based in Teignbridge which aims to improve the wellbeing of local people – patients, carers, and volunteers alike. Volunteering in Health offer a range of services for clients, including transport to and from hospital and other medical appointments, and a befriending service. Volunteering in Health operate from the Teignmouth Connection Hub at Teignmouth Community Hospital as a partner agency supporting local volunteers, and helping to signpost people to services. By getting people to access services it can help to overcome social isolation, and hopefully delay or even prevent their entering care.

Community Nursing

- The co-location of community and district nursing is extremely helpful.
- When comparing the visits for community nursing / community therapy for the year prior to bed closure and the year following, the number of visits have not increased significantly, however visits have become longer and use of multiple staff visits have increased due to complexity and acuity of patients.

Data Sharing

- Health and Adult Social Care have different IT systems, as do other agencies such as Devon Partnership Trust. Staff do not routinely have access to each other's IT systems, which is far from helpful in terms of integrated working.
- Co-location of staff may ease the problem of data sharing but it can be somewhat ad hoc depending on where certain individuals are on any given day.

Mental Health

- It is difficult to get mental health preventative support. Devon Partnership Trust in terms of adult mental health services have ever higher thresholds.
- It is also difficult to get Virgin Care to engage in terms of children's mental health.

Dementia

- It is difficult to get lower level support for people with dementia.

Residential Homes

- The use of residential homes for the step-down between hospital and a person's home and step up from home to care establishment is continuing to develop, with community teams working closely with care homes to promote independence and positive outcomes for service users.
- The County Council's Quality & Improvement Team makes a significant difference and is very effective in helping care homes, but not all providers engage. Some providers are struggling to keep up with CQC.

GPs

- GPs are much more tuned in now with looking at how to keep people at home. The closure of hospital beds has allowed more time for GPs to be actively involved in community care.

Case Study: Holsworthy Health & Social Care Team

Holsworthy Health & Social Care Team comprises Physiotherapists, Occupational Therapists, Assistant Practitioners, Rehab Support Workers, District Nurses, the Community Matron, Adult Social Care, Health Care Assistants and Admin Assistants. The Team covers about 18,000 people but over a huge geographical area.

There were 16 medical beds at Holsworthy Community Hospital, until their closure in March 2017**.** In April 2018 Northern, Eastern, Western Devon Clinical Commissioning Group (NEW Devon CCG) formally requested Northern Devon Healthcare Trust to formulate an implementation plan for the re-opening of the medical beds. Staff reported that if the beds re-open it is about using them effectively and appropriately with strict admission criteria and plans in place. The Day Unit Treatment Team has grown significantly since the temporary bed closure, along with extended outpatient clinics.

Out of Hours

- It can be difficult responding out of hours.
- There is a need for more placements available for night sits and also for rapid response (a spotlight review on this issue is currently being undertaken by the Committee and is expected to report to 22 November 2018 Health & Adult Care Scrutiny).

Outpatient Clinics

- Staff reported that the more outpatient clinics the hospital can offer the better, as the clinics tend to always be oversubscribed and people are saved lengthy journeys across the County. The concept of day treatment services linked into acute hospitals is an exciting opportunity and would also hopefully reduce waiting times in those settings.
- 3000 operations a year are undertaken at the Teignmouth Community Hospital theatre with a considerable number of these skin grafts from Torbay as they are specialists in plastics. Many operations no longer require overnight stays. There can be up to 5 outpatient clinics running at any time from audiology to podiatry.

Case Study - Patient

- Gentleman discharged from acute care following CVE
- Initial request to review manual handling at home – using full electric hoist – hospital bed
- Visits from the Community Rehab team = 69
- Journey and outcomes;
- Progressed from full hoist to electric stand aid
- Progressed then to manual transfer aid
- Reduction in care package from 2-1 carers
- Mobilising with gutter frame
- Use of exercise bike for further rehab
- Removal of hospital bed
- Rehabilitation continues

Conclusion

Members agreed that the site visits were highly illuminating, and provided invaluable insight into the way in which the new model of care is working from an operational perspective. The key objective is to keep people living safely at home, and promote their independence.

Resources should rightly be spent on prevention and keeping people well. Physical health is a key factor in having good mental health. Social prescribing or community referrals, need to be used as a means of enabling GPs, nurses and other primary care professionals to refer people to a range of local, non-clinical services which promote a healthy and active lifestyle. Schools also have a vital role in helping children and young people to find activities and sports that they like doing as part of a proactive approach to healthy lifestyles as they go through their lives.

The Committee should continue to consider further visits in line with the work programme to broaden members understanding on complex topics.

Councillor Sara Randall Johnson, Chair
Health & Adult Care Scrutiny Committee

Case Study - Exeter Community Health & Care Team: Illustration of Community Health & Care Team Activity

Overview of the Exeter Community Health & Care Team

- To provide Community Based Health and Social Care Support to Adults who have an Exeter GP
- To help people to remain independent as long as possible with a focus on 'What matters to me'
- Provide Community Nursing and Therapy
- Commission individualised packages of support

Community Nursing

- 76 whole time equivalent (wte) registered and skilled unregistered nursing staff (x7 matrons)
- 11 teams linked to the 17 GP practices
- Providing assessment and care into people's homes
- 924* number of people per week
- 1560* number of visits per week (*snapshot November 2017)

Therapy

- Community Rehabilitation Service
- 38wte registered & skilled non-registered Physiotherapy, Occupational Therapy & Rehab Nursing staff & a weekly consultant medical clinic
- Specialising in recovery & falls prevention in people's homes & group settings
- Specialist Neurological Rehab team
- 190* referrals per month
- 243* visits per week / 1077 per month (*approx. based on snapshot November 2017)

Pharmacy

- 5 people (1.8 wte Pharmacists 1.6 wte Tech)
- Visiting house bound people to support with medicines
- Providing advice, training and information to MDT
- 20 contacts per week

Urgent Community Response- Clinical Team

- 30 Registered and skilled unregistered professionals
- Therapy/Nursing/SW and Pharmacy tech
- Early supported discharge (x15-20 per week)
- Care of acutely unwell in community/admission avoidance (x15-20 per week)
- Multiple visits per day

Electoral Divisions: All
Local Government Act 1972

List of Background Papers

Contact for Enquiries: Dan Looker
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Background Paper	Date	File Ref
Nil		

There are no equality issues associated with this report