

QUARTERLY REPORT: OPERATIONS DIRECTORATE JANUARY 2008

1. INTRODUCTION

This report will update the PCT Board on a range of provider led activities undertaken across the directorate during the last quarter. Significantly this report will focus on cross directorate activities and a review of key challenges and work undertaken in each part of the directorate:-

- Children & Families
- Long Term Conditions
- Rehabilitation

2. CROSS DIRECTORATE ACTIVITIES

2.1 PROVIDER SERVICES DEVELOPMENT PROGRAMME

The Provider Services Development Programme was approved at the December PCT Board. Stephen Eaves (Head of Podiatry) has been seconded on a full time basis to the programme for the next six months. The directorate have asked Jackie Clark to lead the Podiatry Service in his place. Dedicated project office administrative support has been secured. Tracy Millar (Operations Business Support Manager) is also engaged on the programme. A programme working team has been meeting weekly since mid December to track progress. The first Provider Services Programme Board met on 8th January 2008, chaired by Susan Nixon. Key activities undertaken to date include:-

- Establishment of Programme Office and work programme
- PCT Board Sign off of the Programme Initiation Document (December 2007)
- Establishment of Programme Working Team (weekly) and Programme Board (monthly)
- Development of the Communications Plan including staff briefing
- Heads of service Clinical leads Event held on 10th December 2007 to launch Service review Programme, reporting mechanisms and timetable.
- Identification of resource to support service line reviews
- Establishment of risk register
- Securing involvement of PCT support services e.g. Finance and Information, Communications
- Timetabling dedicated gateway reviews with Commissioning, Public Health and Professional Services

It is important to emphasise that this programme is being run in parallel to **Business Continuity and major Commissioned Provider Developments** e.g. Intermediate Care, End of Life, Urgent Care, Pain Services. Whilst the Operations Directorate has seconded management staff to support, we still continue to recruit to vacancies in the management structure. It is therefore imperative that in order to deliver on all 3 aspects of activity, we secure the necessary PCT organisational support and do not agree to additional work streams between January and May 2008.

2.2 MANAGEMENT STRUCTURE RECRUITMENT

- **Intermediate Care Services**
Following the successful appointment of Sally Plant (ex-Head of Intermediate care services BENPCT) to the Service Director Rehabilitation position, we needed to recruit to the vacant Head of Intermediate Care Services post. Short listing and interviews occurred in December 2007 with colleagues in Adult Social Care, HEFT and user involvement. An appointment has been made and the successful candidate will join the PCT in February/March time.
- **Head of Children & Young People**
Paola Pedrelli took up post at the beginning of January, prior to this Paola joined a team development event with Health Visiting and School Nurse Managers.
- **Health Visiting Managers**
Following the promotion of Ann Doveston to the Public Health Nurse Manger post in Gloucestershire and the secondment of Sonia Gordon to Connecting for Health; we interviewed for a Health Visiting Manager position in December and Dorothy Wilson has been appointed to the vacancy.
- **Palliative Care, John Taylor Hospice**
In November Graham Nicholls joined as Business Support Manager following the retirement of Sue Brimmer. The internal John Taylor Hospice management restructuring has been completed and the Deputy Head of Palliative Care Clinical Lead Community vacancy has been advertised with a view to interviewing in late January.
- **Nutrition and Dietetics**
Two of the Team Leaders Paul McArdle and Sue Meredith have commenced acting up 3 days and 2 days per week respectively into the vacant Deputy Head of Service post for 12 months. This is providing additional management cover until Sarah Monk (job share Head of Service) returns from maternity leave in autumn 2008.

2.3 FINANCIAL POSITION

The Provider Arm has already achieved a 2.5 % cost efficiency target for the year in line with other Providers. The Provider arm was also requested to hold a 1% contingency. This sum is now able to be used rather than held as a contingency. In October it as agreed with the Director of Resources that we could commit up to £230,000 expenditure in the following:-

- Infection Control
- Health & Safety
- Wear and Tear
- Inter-dependency
- Privacy and Dignity

In line with overall BENPCT financial plans the Provider Arm is planning to be under spent by £2- 2.5 million at year end.

2.4 PERFORMANCE MANAGEMENT

A tripartite group between BEN performance, finance and commissioning teams and the provider arm has continued to meet and has received monthly performance

review reports from the Performance Management Group for example, review of Stroke Services, Long Term Conditions Nursing; Rheumatology, Cancer and COPD. The tripartite performance monitoring is supported by a Performance Management Group (PMG). Given the Provider Development Programme work schedule it was agreed to suspend the Performance management group as the entire service portfolio of the Provider Arm would be reviewed between January and April 2008. The Provider arm has continued to attend the PCT Business and Performance Management Group to report on those national and local targets where the Provider Arm has a lead e.g. Delayed Transfers of care, Community Equipment.

2.5 DIRECTORATE BUSINESS PLAN REVIEW PROCESS

Following the publication of the first directorates' operating business plan, a quarterly review process is in place administered by the Business Support Manager. Feedback on any aspect of the plan from other directorates is fed into this process.

2.6 HEALTH SERVICE JOURNAL (HSJ) AWARDS 2007

Following the presentation to a panel of HSJ award judges in the category of Cost Effective Partnership Working, the directorate were delighted that the submission was successful nationally at the HSJ awards ceremony in November 2007. The joint Intermediate Care Services has been contacted by a number of other PCTs, including an invitation in December to develop care pathway work by Sir Ian Philips and an invitation to present at the Health Care Conference in May 2008. A mayoral celebration has been planned later this month where staff on the ground can join in the celebration.

2.7 COMMISSIONING CONSULTATIONS- END OF LIFE CARE AND INTERMEDIATE CARE

Following agreement at the PCT Board the Director of Operations, Service Directors for Rehabilitation and Long Term Conditions have attended the Public Consultation meetings and local constituency partnership and health panel meetings. The directorate have also ensured that affected staff have been involved and updated.

2.8 BIRMINGHAM CITYWIDE SAFEGUARDING ADULTS ARRANGEMENTS

The Director of Operations has now attended all Safeguarding Boards monthly with representatives from the PCT nominated to participating in the following sub-groups:-

- Performance & Quality
- Serious Case Review
- Training and Development
- Policies and Procedures

Following the launch of the Memorandum of Agreement across the city, an impact assessment of introducing the new policies and procedures was undertaken and presented at the December Integrated Governance Committee. A Business Case is now being developed to increase capacity in the Professional Services directorate so that Safeguarding Children's arrangements can be mirrored.

An initial draft of the PCT's Safeguarding Adults Policy has been circulated for comment; this will be in line with the citywide new safeguarding arrangements.

2.9 COMMUNITY PAS (COMMUNITY ACTIVITY SYSTEM)

The implementation programme has now rolled out across all of the services with the exception of parts of intermediate care and the specialist nursing services in long term conditions where it has been agreed coming onto the PAS is the best option. These services should all be live by end of 2007.

As anticipated in the change management processes for the PAS implementation, particular issues are being addressed in District Nursing (due to the current double entry requirements from the Strategic Health Authority for ACM data), in Health Visiting / School Nursing (due to the bulk transfer of information every summer for 4 year olds commencing school) and in Physiotherapy and Dietetics (due to the amount and ranges of clinic work and speed of turnover of the caseload). 12 PAS input clerks are being recruited (initially for 12 months) to ensure there is no backload of data entry and any particular pressure points are addressed with targeted support to these services.

There have been difficulties with the interim reporting tool that was put in place because the Community PAS Reporting Tool had not been developed. The Directorate commenced use of the PAS tool "Health Data Miner" in August 2007. We are still working through establishing the full range of standard reports and summary reports required by the directorate. Progress has been slower than ideal because of the recruitment issues in Information Services but we are hoping to have the full reporting systems established by the end of 2007. A combination of manual data and the interim tool data was used to ensure there were no gaps in the 2006 / 2007 data returns.

Each service is working with Information Services and the Connecting for Health service in ICT on improving data quality, both in consistency of coding being used within and across services, on setting up the initial standard reports and on creating bespoke reports as per different service requirements.

A small number of services including the Urgent Care Centre and COPD are using the Vision 3 system rather than PAS as it is more suited to their clinical requirements and some services such as Children and Adult Food Nets in Dietetics and the Orthopaedic Triage are continuing to use bespoke stand alone data bases until the next generation software is available in Community PAS.

2.10 NHS PROFESSIONALS (NHSP)

The Director of Operations attended a dinner to ascertain the reasons for lack of take up of NHSP. The Provider Arm has agreed to undertake an audit of bank and agency arrangements with NHSP to review expenditure and HR arrangements with a view to improving efficiency and compliance. This may or may not include arrangements with other PCT's or NHSP.

3. CHILDREN AND FAMILIES

3. CHILDREN AND FAMILIES

3.1 Recruitment and Retention

Recruitment to vacancies within the clinical teams continues to be a challenge. We failed to recruit to the fixed term posts in both Health Visiting and School Nursing and are exploring options for supporting teams under pressure due to sickness absence. We have successfully recruited to the post of School Nurse Lead for Emotional Health and Wellbeing and the post holder commenced in December. The post is funded by the Child and Adolescent Mental Health grant and will support colleagues working at Tier 1 using prevention and early intervention tools in an effort to reduce the numbers of young people who require more specialist interventions. We are also exploring the role and function of CPTs in both Health Visiting and School Nursing Services, and the potential for a locality lead / team leader role in the future.

3.2 Brighter Futures for Children and Young People

The Be Healthy Outcome Group has begun to explore how we make the shift from output focused Performance Indicators to a genuine Outcome focused planning and delivery model. The operations directorate is also contributing to the Parenting and Engagement work streams.

Clinical managers have begun to review progress against the National Service Framework for Children, Young People and Maternity Services and this is supported by the NICE CG45 and 37 multi-agency working group which is developing a baseline audit tool for use early in 2008.

Partnership working is being strengthened and further developed, with Children's Centres and Extended School Clusters to help them achieve their core offer. Two Health Visiting Teams are now based in the Children's Centres, at Adderley Road and Waverly, and discussions are underway to see whether other teams could follow in due course. This is highly dependant on costs and accommodation space being available. Different models and approaches will need to be identified as some Children's Centres are "virtual" and may struggle to identify joint bases or venues for co-located service.

3.3 Additional Clerical Staff for the Community Patient Administration System (PAS)

Initial recruitment to the additional PAS input Clerks to relieve pressure on clinical and administration staff was completed and staff took up their new posts in September. They undertook intensive training on the Community PAS system and have begun working with clinical teams to address the backlog of work. The transfer of category A clients from Health Visiting to School Nursing services has been a priority and this is now largely completed. The registration of new to country families is also a time pressure which we hope to address with the new posts. Mary Savory will undertake an initial evaluation of the posts in January 08.

3.4 Risk Registers

All service areas have compiled risk registers which are reviewed quarterly and link to the Directorate Risk Register.

3.5 Health Visiting

The review of the Health Visiting service is being progressed but has been slowed down due to the provider service development programme as there is inevitable overlap. It is hoped to complete this piece of work within the next two months.

The Executive Nurse, Val Jones, has led three further Health Visiting Away Days to look at the development of a Balanced Score Card for services.

3.51.1 Immunisations

The Park Medical Centre childhood immunisation service which has been commissioned from the Operations Directorate commenced in November. This service will eventually be delivered by the Health Visiting service Community Staff Nurses and will be a key part of their public health role. Sickness absence, and difficulties in identifying a suitable venue led to a slow implementation phase but, with support from the Health Visitors at Waverley, we have managed to start the service with regular weekly catch up clinics and a successful additional clinic which was run at Partners in Health on Saturday the 15th of December. 150 children have now received overdue immunisations. However, there is still an inherited cohort of children who are overdue immunisations and who have a history of high DNA rates and the provider arm also needs to establish routine clinics for a second cohort of children reaching 8 weeks of age. Capacity for this work remains an issue and options are being considered.

There is a third cohort of children from across the PCT who have not received immunisations. These had previously been followed up by the Birmingham Immunisation Failsafe Unit. This work has also transferred to the operations directorate from 1st January 2008, but with no additional resource. The children in this cohort are hard to reach, persistent non attendees who will need to be offered domiciliary immunisations.

Future Priorities

- Maintain catch up clinics to address the backlog and reduce risk to the population in cohort 1.
- Establish routine immunisation clinics for children in cohort 2
- Establish a domiciliary service for children in cohort 3
- Ensure all HV service community staff nurses are competent and confident to immunise both in clinics and home settings
- Monitor uptake and embed effective communication strategies to increase uptake of clinic options

There is now a new model that sits within the Health Visiting Service, which will address poor uptake of the MMR vaccine across the PCT as well as providing the pre school immunisation service on behalf of the Park Medical Centre Practice.

The team has the skills, expertise and local knowledge of this client group and is best placed to provide this service in the future and address the historical and specific problem of the high "Did Not Attend" rates amongst this particular client group.

The operations directorate will be reimbursed retrospectively for this work and so it is a cost pressure for the directorate at the moment.

3.6 School Nursing

The Skill mix continues to be reviewed in teams as opportunities have arisen

A review of the school nursing service was commence in the autumn but, as in the Health Visiting service, this has not been completed as it will be effected by the Provider Services Development Programme. However, Barbara Terry, Tessa Norris and Val Jones have met to look at opportunities for modernising the service. This may reflect the locality model being developed for District Nursing and Health Visiting.

We currently have no CPT in the school nursing service due to sickness absence of the one CPT we employ. This has been discussed and we hope to fund a second CPT post from within existing resources in the New Year.

3.7 Children's Centres

A meeting has been arranged to discuss shared accommodation and future working practices within Children's Centres. There will be representatives from the Operations Directorate, PCT Commissioning and Birmingham City Council.

3.8 Urgent Care Centre (UCC)

The Round Table event was held in October to identify issues and explore ways of addressing them. This was a very useful exercise and helped develop stronger networks. Unfortunately none of the Medical staff invited were able to attend and so a further meeting will be held in March 08 to check actions have been implemented and been effective and to further strengthen the working relationships.

The revised clinical supervision format has continued and all staff attended two days in house training in November.

The Nurse Consultant for the UCC and her team contributed to the Healthcare Commission Emergency and Urgent Care Review.

Sir George Alberti visited the UCC at the end of November and met several members of staff plus Sophia Christie, 2 local GPs, a Reporting Radiographer from Good Hope Hospital and representatives from West Midlands Ambulance Service.

Two senior managers from Heart of England Foundation Trust met with the Nurse Consultant to increase understanding of the role and function of the UCC and how a similar service might help them address pressures on A and E at Heartlands Hospital.

Work has begun to establish a second UCC within the Washwood Heath locality. This is an exciting opportunity for the team and we are committed to supporting the commissioners who are leading the project. An initial meeting has been held with Waheed Saleem and following further discussions at director level we hope to progress this early in the New Year.

The Urgent Care Centre was closed on Christmas Day as last year they only saw one patient. However, Christmas Eve was busy with 80 patients being seen and Boxing Day saw 59

patients treated. This was busier than average Wednesdays through December. The Sundays either side of the Christmas break were busy with a 64% increase on average Sunday attendances in the month.

3.9 Support Services

BEN PCT inherited a Support Service function which is organised on different lines within different PCT areas which reflect its predecessor origins. In order to address these anomalies, differences and disparities, and to better address the needs of the new PCT, the Community Support Services have been reviewed with the aim of redesigning to achieve a single service providing efficient and effective support to the community clinicians.

The initial review report was presented to Louise Pritchard and Tessa Norris in October 2007.

The report recommended a new design structure for the service but one which carried with it an increased cost. Following debate and discussion the report is now under further review and development to seek ways of reducing the costs to an acceptable, affordable level while retaining the strengths of the design structure. In order to do this further options for structure design and role requirements are being considered.

The review report will feed into the Provider Service Development Programme initiative and the time table is now aligned to this programme for its completion in early February 2008.

3.10 Amaanah Practice – Evening Consultation Event

A letter was sent to all patients aged 16 years of age and over inviting them to a meeting to comment on the proposal for the Amaanah Practice to transfer from Primary Care Trust Medical Services to General Medical Services as from 1 January 2008. The meeting was held on Monday 3rd December at 7.00pm at Saltley Health Centre.

David Stenson welcomed those present and explained the purpose of the meeting. Louise Pritchard outlined the reasons for the establishment of the Amaanah Practice which had opened in May 2005 with the service being provided by salaried GPs within a PCTMS model. The audience was informed that the practice now had a list of 5,500 patients including those patients who had transferred from the list of Dr Latif. It was considered the time was right to now move to the GMS model of medical practice.

Dr Khalid outlined the rationale for changing to GMS status in that it would “enable the Practice to move more quickly” and be more responsive to the needs of patients. The Practice would also extend their hours of opening and would no longer close on a half day on a Wednesday.

There was a question and answer session during which several issues were raised and responses provided. In general, the feedback from the invited patients present was very positive and in response to a comment from the audience that the Practice was providing an “excellent” service, Mrs Pritchard said that it was “heartening” to hear that patients were satisfied with the service they were receiving.

After a healthy and constructive debate, there was a consensus of the patients present at the meeting that it was in the interests of patients and the Practice to move to a GMS Model. The plan for the practice to move to GMS independent status at 1st January 2008 is on course.

3.11 PCT employed Practice Nurses

A decision was made to terminate the S.L.A. from 31st December 2007 to allow time to explore options with 11 members of staff employed by the PCT.

.5 nurses have already transferred into GP Employment and 3 nurses are in the final stages of transferring to direct GP employment with a deadline for completion of paperwork and negotiations by the 31st January 2008.

1 nurse has been re-deployed back into a role within the PCT. 2 further nurses will be redeployed back into the PCT, 1 has already agreed to work at Warren Farm Urgent Care Centre to support the extra demand for wound care service, and for the other nurse we have commenced negotiations with the incontinence services for redeployment.

3.12 Phlebotomy Services

Primary Care Trust provision of Phlebotomy was terminated as from the 1st October 2007. 3 members of staff had been employed to provide the service but 1 person had already left PCT.

Of the 2 remaining staff one has been redeployed and the other is on long term sick leave and the issue of redeployment or leaving the service on health grounds has yet to be resolved, and will be a cost pressure in the interim..

4. REHABILITATION SERVICES

4.1 Rehabilitation Strategy

Following a multi- disciplinary and multi- agency workshop held on the June 14th 2007 to ratify the audacious goals for rehabilitation services in the area, 6 specific strategies were worked up by the group and action plans formulated. The strategy will be further developed and will be consulted on to a wider audience. Again there was commitment by representatives of all organisations that joint working is required to provide effective and efficient services.

4.2 Intermediate Care –Care Centre Development

At the present time the Intermediate Care bedded Units are on 4 sites with differing facilities, offering different levels of care. As part of the re-provision of the

Birmingham City Council residential homes, the opportunity to work in partnership with the LA to provide short term rehabilitation from the 2 Care Centre being built in BEN PCT area was offered. It is proposed that all IC beds will be re-provided from 2 Care Centres based in Perry Common & Sheldon. This does result in a reduction in 6 beds from 70 to 64 but with the redesign of the services(see below) it is felt that the beds can be used more efficiently which at present shows an occupancy level of 88% on average. The new Care Centres will provide single en-suite rooms along side purpose built rehabilitation facilities including a physiotherapy suite, activity of daily living kitchen and assessment flat. The centres also have clinic rooms available and further work on how these facilities can be used is ongoing and it is likely that the Pain Management Clinic is likely will be provided from Perry Common on a temporary basis. The Perry Common site (named as Perry Trees) is completed but full occupancy is not expected until April 08. Further negotiations are ongoing with BCC regarding the finance on the leasing the buildings but is not expected to preclude occupancy by the PCT services.

4.3 Redesign of Intermediate Care Service

With the Intermediate Care Bedded service being relocated into the Care Centres based at Perry Common and Sheldon, the opportunity became available to review the whole service in light of the loss of 6 beds. All referrals to Intermediate Care are considered for rehabilitation at home initially but if this is not possible, admission into one of the bedded units is considered. In the past year, it has become evident that there is not enough capacity within the community because a waiting list for rehabilitation at home has built up which at times has meant people waiting for the service for up to three weeks. Also a recent survey regarding the single point of access returned comments from General Practitioners in particular in that they are concerned about not being able to get the service due to capacity. It has been proposed in the business plan which is out for consultation, that a third team is funded which will service the constituency of Erdington. This will allow the three teams to be more responsive to local needs. In addition, the single point of access will be improved and duty officers appointed to take referrals and sign post appropriately. This will release more clinicians to assess and treat.

The Care Centre facilities will also give the opportunity to introduce a new service, where people can remain in their own home but attend for their rehabilitation on a daily basis if their environment or particular needs preclude the rehab at home service. This service will also facilitate earlier discharges from the beds as a more structured rehabilitation programme can be devised which can include them returning to the centre to continue their treatment. An additional small team has been included in the business plan to provide this service.

4.4 Intermediate Care involvement in LEAN

Intermediate Care staff have been working with both Good Hope & Heartlands on their LEAN programmes. Initially with the Fractured Neck of Femur pathway, the outcomes have identified a shortened length of Stay in the acute trust and an increase transfer into Intermediate Care or home from 64% to 90%. The LEAN methodology is now being applied to the stroke and frail elderly pathways and the IC team and stroke teams are involved in the Value Stream Investigations. The same methodology will be applied to the IC referral pathway later on in the year.

4.4 Intravenous Therapy (IV)

A joint rota for providing IV Therapy has been devised between ACMs & Intermediate Care (IC) and further work is ongoing to expand the service and develop additional

care pathways. An additional 2 nursing posts in IC have been agreed to support the IV Therapy service as it is time consuming to provide and is impacting on our ability to provide a responsive IC service. These additional two posts will form part of the proposed third Intermediate care Community team subject to consultation of the Intermediate Care Services. Further modelling needs to be conducted with options as to whether the service will be transferred mainly into the District Nursing service supported by IC or IC remains as the lead provider. An options paper will be considered by both services in the near future.

4.5 Stroke Services

The New Ambition for Stroke (DOH 2007) document challenges the local health economy to provide a modern and integrated approach to stroke care from the acute phase to community rehabilitation. The PCT in conjunction with the acute trust and Adults & Communities will be working together in a workshop planned for February to identify the stroke care pathway in particular around the interface between acute and community services. In addition, work will be completed on aligning the existing models of services provided in the East & North of the PCT. The workshop and ongoing work will be facilitated by the by the internal BENPCT OD facilitators.

4.6 Mainstreaming of Reimbursement Grant

The evidence on the effectiveness of the Nurse posts funded through the Reimbursement Grant (RIG) has led to the agreement that the PCT will mainstream the Intermediate Care Liaison Nurse and Registered Mental Health Nurse based on the Heartlands Site from 1.9.07. These two posts have now been recruited to. This model will be replicated on the Good Hope Site with both posts being mainstreamed from 1.4. 08 subject to HEFT mainstreaming the infrastructure costs which are being funded by the RIG

The benefits of the posts can be identified by reaching the set target of zero delays accountable to Intermediate Care on the weekly situation report. Through an education programme, the majority of wards across the Trust are aware of these roles and how to refer to Intermediate Care promoting effective partnership working. There has also been a reported drop of 75% referrals to the Community Mental Health teams as the RMN on site has been able to complete timely assessments and assist in planning appropriate discharges.

4.7 Physiotherapy

- The Orthopaedic Triage is now fully operational across the whole PCT area
- The Pain management service has passed the commissioning gateway requirements. Recruitment of staff has commenced and once in post there will be a phased roll out of the service across the PCT. Representatives from the Institute for Innovation and Improvement will be coming to review the service on 12th February 2008. A low back pain study day for Physiotherapists and GPs is also planned for March 11th 2008.
- The Community Physiotherapy service has now completed a review of their structure following integration including ensuring consistency of banding for comparable posts and a reorganisation of the administration and clerical services

- Work is commencing with the Commissioners and HEFT to relocate the existing community physiotherapy contract undertaken by Good Hope to the Community Service.
- The transfer of the private primary care contracts has all been absorbed and the extra staff required recruited.
- The service is experiencing significant estates issues in identifying enough community clinic space to meet all of the additional requirements. Some limited space has been taken up at Mere Green; Walmley clinic now provides both evening and Saturday clinics are planned for the future, evening appointments are being offered at Warren Farm and all spare capacity at Castle Vale has been taken up. There is still a shortfall in Sutton Coldfield resulting in extension of waiting lists although as yet not beyond 13 weeks. Significant additional space will become available at Capilano Road when the new Primary Care facility opens in early 2008 and some additional capacity at Stockland Green. An interim short-term solution is being explored at the Care Centre Perry Tree site in Perry Common but none of these are in Sutton Coldfield. Future options for Sutton Cottage Hospital are currently out to Public Consultation. However it is too early to know if this site could be considered for provision for some of the longer term solutions required for Community Physiotherapy.
- The neuro Physiotherapist attached to the Sutton Cottage team is at present on secondment to the Stroke team to cover maternity leave within that team.
- A Pulmonary Rehabilitation programme is being set up in the Kingstanding area with the Physiotherapy input being provided by secondary care

4.8 Integrated Community Equipment Stores (ICES)/ Equipment loans Stores (ELS)

- The Service are now comfortably meeting the 7 day equipment delivery requirement
- The additional lease has been taken out at Devon Street and detailed planning is underway to make best use of the additional capacity

5. LONG TERM CONDITIONS

5.3 Adult Community Nursing Services

5.31 District Nursing / Assertive Case Management

- The modernisation review was accepted by the PEC in June. The detailed workforce plan for reviewing and revising resource allocation has now commenced. The DN managers are working closely with HR to resolve any issues that have occurred throughout the process.
- The CPT role and Job description has been reviewed. A revised job description has been out to consultation and plans are underway within the current restructuring of the District Nursing teams to implement the new requirements with the job description.
- The service has been identified as taking the key worker co-ordination role for all patients at End of Life in the End of Life strategy now out to consultation. Preparatory work is commencing to confirm the care pathway and ensure resources are appropriately targeted to facilitate the broadening out of this role which is already undertaken by the service for some patients. District Nurses have been keen to act in the key worker role as defined within the

Gold Standards Framework and act as the coordinator of care for those patient at the End of Life.

- The District nursing service was approached by the commissioners to act as the alternative provider of the “wound care” LES for the 34 primary care practices that have opted out. The District Nursing service and the Urgent Care Centre agreed to acting as the alternative provider as of the 1st of October 2007 and are currently developing joint care pathways and referral criteria’s to support choice and easy access to the service. The District Nursing service have received an on average an additional 75 new referrals for wound care a month and the best approach to the delivery of wound care in the community is under review with the development of specific wound care clinics where the need is greatest.
- There has been marked progress in implementing the ACM service model across the whole PCT. The number of patients receiving the ACM service has steadily increased. The StHA targets for ACM numbers in post has been achieved.
- The 7 day A and E service is fully developed across both HEFT Hospitals and a Single Point of Access for ACM referrals has been established. The Acms and the District Nursing teams have been very proactive, flexible and responsive to the requests to support the acute bed pressures across the health economy by supporting patients in their own homes as an alternative to admission and facilitating early discharge from hospital.
- The Health Care Assistants Competencies, linked to Long Term Conditions management within the District Nursing service (another of the Institute for Innovation Improvement projects) have been established. Further HCA competencies have been developed, supported by the Professional Development Unit, and will be implemented in the New Year. Competency frameworks have also been developed and implemented for the ACM’s and the ANPs which have been shared with the StHA as examples of good practice.
- Three Away Days took place in October 2007 to consult with all staff groups regarding the contestability framework devised for District Nursing. The specific quality and outcome framework assures systems and processes are in place to demonstrate value for money and assure quality service provision. Eight programmes of care have been ratified and further work is underway in partnership with the Professional Services Directorate to quality assure and standardise another ten programmes. A balance scorecard for District Nursing services is also being developed and modified.
- District Nursing, ACMs and Advanced Nurse practitioners are working with IC services on delivering IV Therapy. Further joint work is being developed about expanding the IV Therapy pathway, to support the extension of the current referral criteria. A joint rota has been developed and a single access point has been identified. Ten more members of staff undertook IV Therapy training in December 2007 and require competency assessments.
- The service is fully involved in the further development of the Integrated Community Assistive Technology project and will be working to design how the telehealth pathway will work with for those patients known to the DN services. The Head of Adult Community Nursing recently attended a study tour to Copenhagen and Sweden to further explore alternative Long term condition management models

- Kingstanding / Oscott (Locality 5) are piloting the Virtual Ward concept with 2 primary care practices and the local District Nursing teams are actively engaged in preparatory stage of the pilot.
- District Nursing is working with the Specialist Tissue Viability Service Dr Ingham and Mr Dodds to establish the nurse led TV specialist clinics across the PCT. These will link to the expansion of telemedicine across the former East services to match those already rolled out in the North. . A business case was presented at gateway 1 and the PCT commissioners have agreed to support the further development of telemedicine and specialist TV clinics across the PCT.
- In Sutton PBC (Locality 6) the DN service is working closely with the cluster to improve the existing District Nursing model and current resource allocation and skill mix is being reviewed.
- Joint work is underway with CfH to integrate the PAS and Dudley database data collection systems as there is currently a double entry requirement for the District Nursing team which is impacting on productivity. Data inputters have been employed for twelve months to support District Nurses to input their data as increasingly we are at risk of not recording all activity performed. The implementation of PAS within the District Nursing service is being closely monitored.
- 64 out of the 84 (76%) of GP Practices in BENPCT have signed up to the Gold Standards Framework (GSF) for Palliative Care. One of the standards within the GSF is to provide quality care for patients in the dying phase. At present community nurses take to the patients' home a selection of nursing supplies to enable them to provide quality patient care. There is currently no standard container used to store these supplies in the patient's home. To enable proactive planning in line with GSF and enable standard access, in patient's homes, to nursing supplies for the provision of comfort care in the dying phase Comfort Boxes (plastic storage boxes) will be provided to all DN and Hospice at Home Teams. These will be proactively filled with the necessary supplies to support care for the dying patient at home. A laminated protocol for use and cleaning and a laminated stock list will be provided with each box. A monitoring form for documenting the distribution, stocking and cleaning of the box will also be provided. The Comfort care Boxes will be piloted within seven DN Teams and the Hospice at Home Team for a period of three months. The use of the Comfort care boxes will be reviewed monthly at the GSF Coordinator/Palliative care Key Worker meetings and a final audit completed at the end of the pilot period. This will inform the subsequent roll out of the Comfort care boxes across the PCT.

5.32 Continence

- An away day was organised for the specialist continence team to explore how they can support the development of triage clinics within existing resources. The team spent time reviewing their current workloads and current care pathways and have identified further actions required prior to implementing the triage clinics, which were originally piloted as part of the

Institute and Innovation projects. The team are working closely with partners from Commissioning and HEFT to progress this work.

5.33 Community Health Care Co-ordinators

- Two long standing vacancies have been filled
- All staff have undertaken training for the implementation of the revised National Continuing Health Care criteria and NHS Funded Nursing Care (commenced October 2007)
- A business case is being developed to manage the impact of the changes which is anticipated will lead to a significant increase in the workload of the team as more patients meet the criteria and receive on going care in their own homes and in the Nursing Home Sector
- The service is working with Commissioning to review the Nursing Home LES, and a strategy has been developed to roll out the LES via the PBC clusters from the current 9 to all 28 Nursing Homes. A letter has been circulated to all GPs within the PCT to invite expressions of interest.
- The service is also working very closely with Commissioning over meeting Safeguarding Adult requirements in the Nursing Homes. BEN is working to a citywide BHWP agreement to address these needs. A BEN PCT Monitoring Quality in Nursing Homes steering group has been established and is chaired by the Deputy Director of Redesign and Commissioning. The Continuing Care Manager in her capacity as Lead Nurse completes 6 monthly assessments of nursing care in all the units (working alongside CSCI and Adults and Communities Contract managers) to ensure the PCT's responsibilities under the Funded Nursing Care regulations are met. A risk stratification system for all homes is in place, for those homes where issues are identified, formal notification systems are in place with each home and action plans for improvement agreed.

5.4 Long Term Conditions Nursing Services

5.41 COPD

- COPD outreach services have commenced at the Good Hope hospital site and staff are completing a reorientation rotation programme.
- The service is working with commissioning to re-specify the current delivery in order to address the needs of the 'missing millions' and further develop services which are responsive to the needs of the population. Preliminary work with GP practices has generated partnership working opportunities to improve screening and access to services for COPD patients.
- A COPD pilot project has been launched in the Kingstanding locality. A COPD nurse post has been created to work with GP practices in the Kingstanding area to improve screening and further develop care pathways for patients.

5.42 CHD

Cardiac Rehabilitation

A Cardiac nurse facilitator post has been created from the MLE project to target patients who are currently not accessing phase 3 rehabilitation programmes and to offer patients a wider menu of choice in service delivery. Patients will be offered rehabilitation programmes in their own homes as part of the project.

5.43 Diabetes

A DAPHNE patient training programme has commenced for complex type 1 patients. The programme is an intense training programme which runs for 5 days and covers multiple aspects of self care. The initial outcomes are positive and demonstrate patients achieving improved blood glucose control. Type 2 patients are now able to access the expert patient programme which runs over a 6 week period. OGTT clinics have now been established following the 'accelerating the pace of change' work. The clinics are running at Partners in Health and 4 further locations have been identified for potential expansion of the service. These are: Saltley, Stockland Green, Kingstanding and Sutton Coldfield.

5.44 Cancer

The Macmillan Primary Care nursing team have launched a new service in December 2007. The service accepts referrals for patients with breast, prostate, gynaecological and colorectal cancers with a 12 month or longer prognosis. Referral rates to the service are well established. A full service evaluation will be undertaken in June 2008. The team have been invited to link with the national 'breast cancer care' charity based in Sheffield directly from patient involvement. The charity work closely with the Department of Health and are integral in representing patient views. The emphasis now is on targeting breast cancer patients with secondary spread of disease in primary care settings as this group of patients perceive heightened feelings of abandonment following initial diagnosis.

5.45 Lymphoedema

A new Lymphoedema service will commence in February 2008. The Lymphoedema team will be based at John Taylor Hospice and operate clinics at John Taylor Hospice, Partners in Health and the Marie Curie Hospice. .

5.46 Partners in Health

Partners in Health are expanding their administration and clerical team to support longer opening times. The centre will operate 6 days per week (Mon – Sat) and open from 8am until 6pm on Mondays, Tuesdays and Fridays. On Wednesdays the centre will operate from 8am – 7pm, Thursdays 8am – 9pm and Saturdays 8am – 4pm. The centre will be supporting an increase in service provision for obesity management, ENT and Continence. Demolition around the building is now well under way and there will be some changes to the car parking entrance during February/March.

5.5 Nutrition and Dietetics

Staffing continues to be a problem for the clinical dietetic teams. The combination of a complex recruitment process, lack of locum availability and the lengthy CRB process mean that vacancies are taking a long time to fill this has resulted in extra pressure on clinical waiting lists and some patients are waiting longer to be seen.

Within paediatrics, we are also seeing an increased referral rate and as this is a tiny service, waiting times are increasing.

Consultations are on-going with purchasers and bids are being made through the LDP processes for additional funding to meet demand. Bids have also been made to mainstream the successful elements of the Maternal Nutrition Initiative, funded until 31/3/08 through the Citywide perinatal mortality initiative.

Accommodation continues to be an issue at a number of our bases within the city and is impacting on the efficient running of the service. All options to improve the situation are being explored.

Collaboration with Birmingham City Council, initially through our nursing home nutrition education packs, has resulted in the advertisement for a BCC employed Dietitian who will work with BCC homes and on nutrition policy development. The nutrition support team, BEN PCT, will provide professional supervision.

5.6 Podiatry

- The service restructuring following the integration has been completed including the re-banding of diabetes specialists across the service because all undertake the same role.
- The service is compliant with the new decontamination standards by currently only using disposable instruments.
- Contract negotiations with B-Braun to provide a long term recyclable instrument solution are well advanced and are likely to cost less than originally anticipated. The start date for the new contract will be set shortly

5.7 John Taylor Hospice Services

Work in the Day Hospice to construct an atrium over the present courtyard has been delayed due to difficulties in the planning processes. The impact on opening additional supportive care beds is being modelled and the best way forward identified to ensure both are achieved in the first part of 2008.

The management restructuring has been completed with all staff affected relocated to new positions within existing JTH services or elsewhere in the Operations Directorate.

Work is underway to develop the Care Pathways required for the additional Supportive Care beds.

The Hospice at Home management post is being reviewed in readiness for the anticipated expansion of the service once the End of Life Care Strategy consultation has been completed.

A review of existing medical services has also been undertaken and planning is in hand to maintain the existing Consultant in Palliative Care input which has enabled the Hospice to be part of the network wide training scheme for registrars in palliative care.

The MITIE Domestic contract has commenced. The Business Support Manager is working with Shared Services Facilities manager to iron out some initial teething problems. The Hospice is benefiting from an increase in domestic cover across 7 days and into the evening, compared to what was available when the service was managed in house.

The Hospice is now hosting the new 'Bridges' support service for the HoBtPCT area. Again it is anticipated the service will expand into the BENPCT area subject to the outcome of the End of Life Consultation.

6. CONCLUSION

This report demonstrates the wide ranging activity being carried out across the service directorate and by each individual service area. Whilst the majority of activity is in line with the Operations Directorate Business Plan, this report demonstrates the need for a high level of flexibility for capacity in the directorate to respond to continual service re-design and commissioning requirements whilst assuring safe, accessible quality services and conducting the Provider Services Development Programme by April 2008.