Community Nursing Strategy: Supporting the delivery of Integrated Care 2014-2017

12 March 2013 v1.1
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1. The Community Nursing services within Waltham Forest are currently provided via an NHS block contract through North East London Foundation Trust (NELFT). The current contract expires in March 2014 and is due to be extended by one year to March 2015. This project is to recommend a strategic approach for the re-procurement of these services.

2. Overall Waltham Forest CCG (WFCCG) spends significantly less - around a third - on Community Nursing than the average or the peer group. The precise number is not available due to lack of data, but the general scale of the difference is clear.

3. This results in more people being admitted for secondary care than would be expected and for acute and A&E patients to remain in hospital longer than necessary.

4. The current balance of spending is not sustainable and, unless it is addressed, WFCCG will face a vicious circle where community services are under resourced and acute care costs continue to rise disproportionately, putting further pressure on community services.

5. The plans for Integrated Care are vital to break into the vicious circle. In turn, developing Integrated Care at scale depends on reshaping the Community Nursing service.

6. Community Nursing is delivered by NELFT. There are many good features, notably the commitment of the staff and the desire to improve the services. There is however confusion about some roles and responsibilities. There is scope to improve efficiency through e.g. standardising processes. The biggest improvements in value for money though, will come through increasing the scale of the service and investing more in integrated teams and specific initiatives on e.g. falls.

7. The service needs to be built around the localities, strengthening the relationship with GP practices and developing the links with Waltham Forest Council (in social services and housing) and supporting local solutions to the required expansion in community support. Closer links are also needed with acute providers, primarily Barts Health NHS Trust.

8. Besides the locality structure, key features of the service include: single point of access; supporting integrated care through standard processes, co-location, joint training as well as formal projects; better out of hours services; increasing support to self management at all stages of need.

9. A reshaped service needs stability to grow and develop. Many of the improvements need investment in training and IT. These factors tend to argue against a standard procurement path with the risk of disruption. They argue for a stable, longer-term commitment.

10. A rebalancing of spending towards community nursing will be difficult because it is not aligned with the financial incentives of the providers. It will also be taking place while there is increasing pressure on related London Borough of Waltham Forest Council (LBWF) budgets.

11. The procurement approach needs to allow for the possibility of competition, but ideally the commissioning would build from the Waltham Forest, East London and City WELC integrated care strategy. A specific integration role needs to be included in the specification. This role may be undertaken by an existing provider.

Waltham Forest Clinical Commissioning Group is committed to putting patients at the heart of everything we do and use our joint experience to improve the delivery of local health care and ensure value for money.

This three year strategy outlines how we aim to give the population of Waltham Forest the transformational, affordable and sustainable community nursing model that they need to improve local health outcomes. Some of the key messages are set out below:
Introduction – The national context

Everyone Counts: Planning for Patients 2014/15 - 2018/19 sets out the outcomes and ambitions that will deliver the vision of ‘high quality care for all, now and for future generations’; as well as the approach to strategy and planning for health and integrated care services over the next five years. “Care in local communities, a vision and model for District Nursing” demonstrates how the “6C’s” care, compassion, competence, communication, courage and commitment support delivery of a call to action.

As part of the “Call to Action”, NHS England has identified six transformational service models that will define the characteristics of the NHS in five years:

- A completely new approach to ensuring that citizens are fully included in all aspects of service design and change and that patients are fully empowered in their own care
- Wider primary care, provided at scale
- A modern model of integrated care
- Access to the highest quality urgent and emergency care
- A step-change in the productivity of elective care
- Specialised services concentrated in centres of excellence

Our community nursing strategy aims to give the population of Waltham Forest the transformational, affordable and sustainable community service model that they need to improve local health outcomes. Our community nursing services will play an important role in supporting the delivery of integrated care.
There are a number of reasons why we need to find a new way of delivering services, including community nursing, in Waltham Forest:

- To shift more health care from hospital to settings closer to people’s homes. This will have a number of benefits:
  - Improving quality and experience for patients by providing care closer to home
  - Enabling the local hospital to focus on the most acute care
- To move from reactive care to prevention and early intervention, reducing the likelihood of people developing long term illnesses with complex needs
- Multi-disciplinary teams for people with complex needs, including social care, mental health and other services
- To improve quality care in the face of increasing demand and limited resources
- To wrap services around primary care and locality boundaries, offering 24/7 services as standard complemented by highly flexible and responsive community and social care services
- To ensure service delivery is aligned with the commitment to patients via the 6c’s.
- Build an infrastructure to support a model that includes better ways to measure and pay for services
- Reduces the complexity of services, leading to improved understanding of services and experience by patients

The Community Nursing services within Waltham Forest are currently provided via an NHS block contract through North East London Foundation Trust (NELFT). The current contract expires in March 2014 and is due to be extended by one year to March 2015.

The Clinical Commissioning Group (CCG) wants to be the best commissioner it can be and we want to ensure we have the most effective and sustainable services available within the constraints of the current financial environment.

The CCG has identified community nursing services for opportunities to improve quality, innovation, efficiency and investment.

As part of the process, the CCG clinical leadership team has canvassed views from the membership on their perception of current community nursing services. The CCG also engaged with local clinicians and service providers both health and social care to seek their views about current services but also about the changes required to be able to delivery community nursing to support the delivery of integrated care.

Feedback from GP members on the quality and quality of community nursing services:

- Waltham Forest’s historic funding levels have led to lower levels of investment in community services Recognise the commitment and contribution of the current community nursing teams.
- General sense that some expected core tasks are not being delivered. It was suggested this may:
  - Reflect poor definition of core tasks and poor delivery of practice based support...
  - Reflect shortfalls in staff numbers because of the challenges in recruiting and retaining staff
- Aware that there are several specialist teams (Rapid Response, palliative care, specialist nurses, nurses in residential care, Community Matrons, District Nursing teams), but less clear on who does what
- Would like to see a better connection between community nursing and practice nursing
- Would like to see community nursing helping to to deliver 365 – 7 day care in a more joined up way with GPs and A&E
- Keen to have better data sharing between providers
- Need a shared understanding of how the current system works and delivers outcomes for patients, within the context of a better defined contract and the commissioners’ priorities
Through engagement with local clinicians and local providers both health and social care we received a feedback on what’s working well, key challenges and opportunities. This is not an exhaustive list of feedback but illustrative of the key themes.

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<thead>
<tr>
<th>Case For Change - Challenges and opportunities identified from the local engagement</th>
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<tr>
<td>Improve access through single point of access and standardised assessment</td>
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<td>Improve Self-Management</td>
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<td>Improve Case Management &amp; Care co-ordination</td>
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<td>Integration with other services e.g. occupational therapy, physiotherapy, mental health and local authority</td>
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<td>Improved communication/Telecare/Telemedicine for people with long term conditions</td>
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<td>Address resource issues, particularly workforce</td>
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<td>Ensure clarity of Roles &amp; Responsibilities</td>
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<td>Provide care 24/7</td>
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<td>Reduce duplication of effort</td>
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<td>Address challenges of geography</td>
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<td>Ensure the right, quality and effective services are being commissioned</td>
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We are committed to our commissioning having a clear evidence base. Critical to this is our Joint Strategic Health Needs Assessment (JSNA).

We have considered the available needs evidence from the JSNA and evidence from a number of other sources such as quality and performance issues in current service delivery and the Department of Health Operating Frameworks requirements as well as the new NHS Mandate. This has informed our priorities for our community nursing strategy on the evidence and conclusions from these varied sources.

Key findings and Conclusions
There are 258,000 people living in Waltham Forest. It is a relatively young population, 26% are under 20 years old. It is also a growing population with high birth rates and the number of adults aged 50-62 is expected to increase rapidly with significant increases in those aged over 80 years. 48% of the population are from minority ethnic groups.

There are a number of areas where the data available shows indicators showing clear deteriorating trend:
• Under 75 cardiovascular mortality
• Under 75 respiratory mortality
• Under 75 liver disease mortality
• Emergency admissions due to liver disease
• Cancer mortality (male)

Or are significantly worse than the England value:
• (female) Potential years of life lost from causes amenable to healthcare
• Unplanned hospitalisation: chronic ambulatory care sensitive conditions
• Unplanned hospitalisation: asthma, diabetes and epilepsy in under 19s
• Emergency admissions that should not require hospital admission
• Patient experience of GP services
• Patient experience of GP out of hours services

Although no major change in trends there are issues with:
• People feeling supported to manage their long term condition
• Unplanned emergency admissions for ambulatory care conditions

Specific Health Issues in Waltham Forest
Our JSNA has highlighted some specific health issues:
• **Increasing deprivation:** Waltham Forest is the 15th most deprived Local Authority in England. Waltham Forest has experienced an increase in absolute deprivation too, based on increased numbers claiming benefits and increased applications for social housing

• **A growing child population** and a **growing elderly population**

• **Continuing poor outcomes** and higher than national death rates in under 75 year olds for heart disease and cancer

• **Smoking and obesity** are serious problems that impact on the health outcomes of the population. Smoking rates are reducing but obesity is increasing, particularly amongst children

• The main **causes of death** are cancer, cardiovascular disease and lung disease with higher than average death rates for heart disease and cancer

• Almost 50% of the estimated numbers of **cases of diabetes are undiagnosed**

• High **prevalence of mental health** disorders.

• High rates of **unplanned hospitalisations** for asthma for people under 18 years

• **High emergency admissions** for chronic conditions
Performance data shows scope for improvement in areas that are associated with underinvestment in community nursing.

The NHC Commissioning Board (NHSCB) benchmarking support pack shows that the unplanned and emergency admissions, as well as emergency readmissions within 30 days, where Waltham Forest scores are markedly worse than the peer group average.

For instance, the NHSCB data show emergency readmissions with 30 days of discharge from hospital to be about 500 a year or 20% higher than expected.

Delays in transfers of care in 2013

The delays in transfer of care statistics for Waltham Forest suggest that there will be over 3,900 excess bed days required in 2013/14 because of delays in the transfer of care. Of that total, around 800 excess bed days are likely to be required because of delayed assessments and over 1400 excess bed days are likely to be required because of waiting for NHS non-acute care. Investment in community nursing could and should have an impact on these excess bed days.

Some of these may not be directly addressed by increased community care resources and WFCCG have other initiatives in train. However there is a case to explore that investing in community nursing could address say a significant % of these delivering high quality of care and improved patient experience.
Our Vision, Values and Commitments

Waltham Forest CCG vision: “We will put patients at the heart of everything we do and use our joint experience to improve the delivery of local health care and ensure value for money”

Our Vision for Community Nursing supporting the delivery of Integrated Care:

Our community nursing strategy aims to give the population of Waltham Forest the transformational, affordable and sustainable community nursing model that they need to improve local health outcomes. Our community nursing services will play an important role in supporting the delivery of integrated care and putting patients at the heart of service delivery. Through placing an emphasis on prevention, early identification, early intervention, supporting self-management as well as supporting those with complex needs we will build resilience in our community.

More people are living into older age and many more people are living with co-morbidities and needing complex interventions. We need innovative approaches to our health and care systems to meet the needs that arise from these changing health problem and enable people to remain as well as possible for as long as possible within their own homes and communities. This means that more care will be delivered out of hospital and in people’s homes as well as in the wider community. This will reduce the pressure on our local hospital and allow the hospital to focus on treating those who are acutely ill and in need of hospital treatment.

We need community services that deliver high quality, safe, integrated services that put patients in control where possible and enhance patient and carer experience as well as achieving positive health outcomes. To achieve this will require sustained relationships to support people manage their long term conditions and community nurses, as part of multi-disciplinary teams, will be key in planning, providing and managing this care. However they will have to increasingly be required to find new ways of working within teams and with other professionals and agencies to support complex care and manage workloads more efficiently.

Delivering care in a way which is integrated around the individual patient is essential to a new way of working which truly puts the patient at the heart of what we do. Our community nursing service will play an important role in supporting the delivery of integrated community care in Waltham Forest. Our community nursing strategy aims to give the population of Waltham Forest the transformational, affordable and sustainable service model that improves local health outcomes.

Existing Priorities that support the implementation of our Waltham Forest vision

Integrated Care and Care Management is a key transformational change programme for Waltham Forest. The local health and social economy is entering the second year of embedding integrated care to help people with the highest need. The CCG and local authority have joined with health and social care partners across East London to build a model of integrated care that looks at the whole person i.e. physical and mental health and social care needs. We will expand this programme to include rapid response, case management and self care.

Integrated Commissioning with the local authority to make best use of the Better Care Funding which will be spent locally on health and care to enable closer integration to improve outcomes for people with care and support needs.

Community Health Services is a priority for the CCG’s strategic direction.
Our Vision, Values and Commitments

Our values and priorities:
• We will act with integrity, treating everyone with respect and equity
• We will actively listen to enable everyone to maximise their potential and fully contribute to the organisation
• We will work in close participation with our partners across health and social care

Our principles in developing this strategy reflect our values and priorities:
• Ensure patients’ views and experience are taken into consideration
• Be clinically safe, clinically sustainable, resilient services that meet demand and performance requirements
• Meet all applicable standards, ensuring quality, patient safety and addressing clinical interdependencies
• Be co-created – led by clinical commissioners in collaboration with local providers and senior clinicians
• Be affordable to health and social care commissioners and in line with our Commissioning Strategy
• Be deliverable within a 3 year timeframe

Key measurable ambitions that will be used as indicators of success
• Reduce avoidable admissions to hospital
• Improving the health related quality of life of people with one or more long-term condition, including mental health conditions
• Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital
• Increasing the proportion of older people living independently at home following discharge from hospital
• Securing additional years of life for the people of Waltham Forest with treatable mental and physical health conditions
• Increasing the number of people with mental and physical health condition having a positive experience of care outside hospital, in general practice and in the community
• Reducing emergency admissions, particularly for people with long term conditions

Links to other strategies
Our strategy for community care/nursing sits within our overall strategy to commission better health services and making best use of our financial resources.

It is linked to a number of key strategies:
• Better Care Funding Plan
• Health and Wellbeing Strategy
Our Vision – Commissioning Strategy Plan

The Community Nursing strategy needs to fit with the goals and priorities set out the Commissioning Strategy Plan, December 2013

Commissioning Strategy Plan – Strategic Goals
• To improve the health outcomes of our local population
• To deliver high quality services through effective commissioning
• To balance our books financially by delivery of our QIPP (Quality, Innovation, Productivity and Prevention) programmes which identify areas where services can be redesigned to improve care and be more cost-effective
• To establish collaborative commissioning arrangements with a focus on Barts Health (which includes Whipps Cross University Hospital)
• To deliver effective patient and public engagement in line with the NHS constitution
• To maximise clinical engagement with GPs in our three localities and other health professionals from hospital and community services and Public Health, through effective engagement and development
• To improve patient satisfaction of GP and GP out of hours services

The the Commissioning Strategy Plan describes the top priorities for the CCG as follows:

1. Integrated Care and Care Management which is a key transformational change programme for Waltham Forest. The local health and social economy is entering the second year of embedding integrated care to help people with the highest need. The CCG and local authority have joined with health and social care partners across East London to build a model of integrated care that looks at the whole person i.e. physical and mental health and social care needs. We will expand this programme to include rapid response, case management and self care.
2. Integrated Commissioning with the local authority to make best use of the Better Care Funding which will be spent locally on health and care to enable closer integration to improve outcomes for people with care and support needs.
3. Community Health Services which is a priority for the CCG’s procurement pipeline. We are developing new service specifications for community nursing that will support the delivery of the integrated care programme.
4. Urgent Care and Ambulatory Care services are being re-designed and we will set out how the ambulatory care service fits as part of the urgent care strategy for Waltham Forest, focusing in particular on the inter-relationships and inter-dependencies that it has with the integrated care programme and the Whipps Cross Urgent and Emergency Care Centre.
5. The Development of GP Provider Networks to ‘scale up’ primary care to enable it to meet the challenges it faces in delivering a wider range of co-ordinated services, that are closer to patients.
Our Vision – A new way of working: supporting the delivery of integrated care

Our overarching vision for how care will be delivered is through an effective integrated care model that focuses on prevention, early identification and intervention as well on those with complex care needs. The integrated care model includes community nursing. By bringing together primary and community care (including social care) the model ensures:

- Patients are in control of their health and their care
- Tailored, personalised care including co-ordination and care planning for whose who would benefit
- Co-ordination of care including lifestyle support and advice with an emphasis on self-management
- Senior clinicians (within a team) taking full responsibility for people with multiple long term conditions
- Reduced admissions to hospital and early supported discharge where admission is necessary
Our Vision – Community Nursing supporting the delivery of integrated care

Our vision for how community nursing will support the delivery of integrated care is through bringing primary care, community nursing, integrated care management, end of life care, rapid response, allied health professionals and social care together to deliver the interventions or ‘functions’ that have been identified to prevent people going into hospital unless necessary and to facilitate early discharge when hospital treatment is required. Our community nursing strategy sets out how community nursing will support the delivery of integrated care.

“We recognise that community nursing is a key component in transforming healthcare in Waltham Forest” Commissioner

“We should work with all our community colleagues to deliver integrated care” Local Community Nurses

“We need to change the way we deliver community nursing” Local GPs

“Current community nursing services are not delivering what we need” Local GPs

Care model innovation, evidence-based
Through engagement with local clinicians we have identified a number of ‘functions’ or interventions (e.g. assessment, case management) that we will need our community nursing service to carry out, as part of a wider integrated model, if we are to enable people to remain as well as possible for as long as possible within their own homes and communities. This will mean that there will be a focus on prevention, early identification and early intervention as well as working with people with very complex needs. This means that more care will be delivered out of hospital and in people’s homes as well as in the wider community. This is particularly important for those people with long term conditions and frail elderly. Our core principle is that ‘functions’/interventions should be delivered, using the right expertise and skills at the right level that is appropriate for the patient.

**Our Vision – Community Nursing supporting the delivery of integrated care**

Safeguarding
We will work with our key partners and stakeholders to deliver our vision for community nursing that will provide the people of Waltham Forest with services that focus on helping them to keep healthy, help them to self-manage their care as much as possible and provide them with co-ordinated care when they need it.

To enable us to deliver the functions/interventions effectively we have identified a number of key priorities listed below:

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<th>Priority</th>
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<td>Single point of access and referral</td>
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<td>Agreed process for single/joint assessment,</td>
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<td>care planning and care co-ordination</td>
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<td>Developing community nursing 24/7</td>
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<td>Establishing multi-disciplinary working and</td>
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<td>education including primary care, community</td>
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<td>nursing, integrated care management, rapid</td>
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<td>response</td>
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<td>Regular multi-disciplinary meetings to</td>
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<td>discuss very high risk patients</td>
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<td>Improve communication and sharing of</td>
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<tr>
<td>information across health and social care</td>
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<td>Co-location of multi-disciplinary staff</td>
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<td>across locality areas</td>
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<td>Transformation of the skill mix to have a</td>
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<td>mix of generic nurses, utilising highly</td>
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<td>specialist staff where agreed as well as</td>
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<td>the use of Health Care Assistants</td>
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<td>Agreed defined roles and responsibilities</td>
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<td>across the pathway</td>
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<td>Effective use of IT and mobile community</td>
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<td>working</td>
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<td>Improve the interface with acute services</td>
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<td>and ensure services provided by the acute</td>
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<td>trust works in an integrated way with</td>
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<td>community care</td>
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<td>Involving voluntary and community partners</td>
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<td>where appropriate</td>
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<td>Self-management support for patients</td>
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**How we will deliver – Community Nursing supporting the delivery of integrated care**

**Pharmacy**

**GP Practice**

**Health Centre**

**Preventative Care**

**Vaccinations**

**Telecare & Remote Technology**

**Risk Assessment**

**Core Navigation**

**Selecting the Best/Effective/Inappropriate**

**Assessment/Review**

**Health Promotion**

**Attracting People**

**Care Support**

**End & Eor Care**

**Dentistry**

**Recognition & Assessment**

**Faiths Organisation**

**Assessment/Management of Mild Symptoms**

**Moderate/Complex Presentation**

**Day Care**

**Voluntary Organisation**

**Specialist Input**

**Acute/Oher 24hr Care**

**Pharmacy**

**GP Practice**

**Care Education**

**Health Education Inc. school/college**

**Family Planning/ Sexual Health**

**Healthcare Staff**

**Guided Self Help Groups**

**Educating Patient Self Management**

**Continuity Management**

**Environment Management**

**Wound Care Management**

**Trauma & Ortho**

**Medical Management**

**Supporting Care**

**Counselling/Behavioural Therapy**

**Assessment/ Risk Assessment**

**Risk Assessment**

**Vascular Care for LTC**

**Dentistry**

**Family/Friends/ Carers**

**Dentistry**

**Family/Friends/ Carers**

**Dentistry**

**Family/Friends/ Carers**

**Dentistry**

**Family/Friends/ Carers**

**Dentistry**

**Family/Friends/ Carers**

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**Family/Friends/ Carers**

**Dentistry**

**Family/Friends/ Carers**

**Dentistry**

**Family/Friends/ Carers**

**Dentistry**
How we will deliver – Community Nursing supporting the delivery of integrated care

In Waltham Forest we are served by 45 GP surgeries. Our Commissioning Strategy Plan identified the creation of GP Networks – GP practices in a geography operating together as a single entity to provide primary care services not included in their core GMS/PMS contracts – as the preferred means of strengthening primary care. They are organised in three GP networks: Chingford, Leyton and Leytonstone, and Walthamstow. All our GP practices will remain at the centre of patient care, providing routine care near where patients live. Practices will continue to assist patients in making complex care choices. They will retain overall accountability for a patient’s health and coordinate care for patients with long term conditions.

These provider networks of care will be better placed to interface with other elements of an integrated care system, including supporting Community Multi-Disciplinary teams. We will therefore organise our Community nurses to support these three GP networks to improve the co-ordination and integration of care. Our community nursing service will incorporate all community nurses including District Nursing, Community Matrons, Palliative care nurses and specialist nursing services. However where it makes sense clinically and financially, interventions/activity will happen across the borough.

The same three areas are also used for localities for commissioning by GP surgeries in their role as commissioners (as distinct form providers). We will build on this development and work with our partners and stakeholders to agree the best way to commission community nursing in a way that supports our three localities in delivering integrated care.

With the core functions agreed we will:

• Plan how this will be delivered across the three localities
• Agree the levels of integration – we have agreed this will include all our community nursing services
• Agree the skill mix for different levels of complexity of need
• Define roles and responsibilities for community nursing e.g. the roles of practice nurses and community nurses
• Address our workforce issues, particularly recruitment
• Agree how we will ensure joined up pathways with other elements of the wider integrated care strategy

We know that if we want to deliver improved care and improved outcomes we need to continue working with our partners including:

• Waltham Forest Council – to work with our social care colleagues more effectively
• Acute Trusts – primarily Barts Health at Whipps Cross; Community Trusts (NELFT)
• The voluntary sector and local community organisations – as valued partners in delivery
• Healthwatch

We also recognise the need to explore greater links with Redbridge and West Essex community nursing services, to further support admission avoidance and effective discharge processes.
**How we will deliver – Community Nursing supporting the delivery of integrated care**

We have thought about the way we might address the key priorities we have identified to enable us to deliver the functions/interventions effectively and made some indicative assumptions of the potential implications on staff and cost:

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<th>Single point of access and referral</th>
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<td>There are a number of ways of accessing non-emergency healthcare. For community nursing we will agree a single point of access, dealing with urgent cases within 4 hours and non urgent cases within 24 hours.</td>
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<tr>
<td><strong>Assumptions</strong></td>
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<tr>
<td>• Agreed pathways and protocols assumed to be covered above.</td>
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<tr>
<td>• Assume need for routing via existing admin team with access to experienced clinician 24/7.</td>
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<tr>
<td>• Assume say 1 WTE Band 6 recruited/redeployed to supplement existing resources used to manage referrals and enquiries so say £55,000 fully loaded costs.</td>
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<thead>
<tr>
<th>Developing community nursing 24/7</th>
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<tbody>
<tr>
<td>Use the single point of access to provide a 24/7 contact point. Develop more flexible patterns of work (e.g. twilight shifts) and staff on standby for overnight needs.</td>
</tr>
<tr>
<td><strong>Assumptions</strong></td>
</tr>
<tr>
<td>• No change to staffing levels, because assumed that revised rostering could provide daylight cover.</td>
</tr>
<tr>
<td>• Assume some increased cover for nights.</td>
</tr>
<tr>
<td>• Assume that NELFT can fill vacancies to deliver the service more fully; savings from reduced ambulance responses and use of A&amp;E</td>
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<table>
<thead>
<tr>
<th>Regular multi-disciplinary meetings to discuss very high risk patients</th>
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<tbody>
<tr>
<td>We will ensure that regular multi-disciplinary meetings will take place for all very high risk patients (the 0.5%-1% of the adult population i.e. c1,000 patients). Risk stratification will support identifying the very high risk population.</td>
</tr>
<tr>
<td><strong>Assumptions</strong></td>
</tr>
<tr>
<td>• Assumed to be included in the current time spent by staff, so no change in cost but an improvement in productivity and effectiveness.</td>
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<table>
<thead>
<tr>
<th>Agreed process for single/joint assessment, care planning and care co-ordination</th>
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<tbody>
<tr>
<td>Develop standardised pathways and documentation; set up protocols for planning and coordination based on nominated responsibilities in each locality.</td>
</tr>
<tr>
<td><strong>Assumptions</strong></td>
</tr>
<tr>
<td>• Develop agreed pathways – assume £20,000 of one off cost</td>
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<tr>
<td>• Adopt new protocols; assumed to be marginal and offset by reduced duplication of effort and re-work from increased clarity</td>
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<thead>
<tr>
<th>Establishing multi-disciplinary working and education including primary care, community nursing, integrated care management, rapid response</th>
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<tbody>
<tr>
<td>We will organise community nursing into multidisciplinary teams organised to support the three GP localities with borough wide team for Rapid Response. we will need to ensure we have the appropriate skills and professional mix to deliver effectively with an emphasis on innovation, effective communication and knowledge sharing.</td>
</tr>
<tr>
<td><strong>Assumptions</strong></td>
</tr>
<tr>
<td>• Expansion of ICM team to double current size (say £800,000 a year - based on current team structure - plus set up costs</td>
</tr>
<tr>
<td>• Investment in education and training (say £50,000 a year)</td>
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<tr>
<td>• Later years should see reductions in admissions in line with WELC strategy up to say £800,000</td>
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<tr>
<th>Improve communication and sharing of information</th>
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<tbody>
<tr>
<td>Use the “Shift to Digital” strategy to provide the foundation for improved data sharing. Supporting standardised pathways, protocols and pathways as well as developing registers for specific groups patients, particularly with complex needs.</td>
</tr>
<tr>
<td><strong>Assumptions</strong></td>
</tr>
<tr>
<td>• WFCCG adopts a GP IT strategy that provides standardised IT. This will enable the sharing of data between acute, GPs and Community services.</td>
</tr>
<tr>
<td>• This has the potential to improve productivity through the elimination of duplication of data entry, reduced confusion of information, less re-work, quicker information retrieval and better decision making.</td>
</tr>
<tr>
<td>• The implied saving has not been separately costed to avoid double counting of the benefits.</td>
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</table>
## How we will deliver – Community Nursing supporting the delivery of integrated care

### Co-location of staff across locality areas
We will organise community nursing to support the three localities. Each team to be based on multi skilled generic teams able to call off specialist expertise.

**Assumptions**
- No change to staffing levels, so no change to pay costs
- May be some one-off costs as new working arrangements but assumed to be no major infrastructure changes required i.e. changes are made opportunistically

### Agreed defined roles and responsibilities across the pathway
Ensure that all roles and responsibilities in the community nursing specification are clearly articulated. There may be a difference in emphasis given that community nurses will focus on prevention, early identification and early intervention as well as working with people with very complex needs. The delivery setting(s) may also change with more flexible approach to where interventions are delivered. We also need to ensure that roles and responsibilities that sit with other professionals e.g. GPs, practice nurses, social workers are made explicit.

**Assumptions**
- Assumed that costs and savings of the changes are marginal to others already listed

### Improve the interface with acute services and ensure services provided by the acute trust works in an integrated way with community care
We will explore the opportunities to have outpatient clinics in the community. We will work closely with our acute trust to reduce the level of unnecessary admission, particularly through use of our rapid response service and to facilitate early, supported discharge.

**Assumptions**
- No change to staffing levels because of the increased resources for Integrated Care Management
- Assumed that protocols for new working are covered in changes above
- Should help to speed discharges from acute care, contributing to savings of say >£200,000 a year.

### Transformation of the skill mix to have a mix of generic nurses, utilising highly specialist staff where agreed
Through recruitment, aim to create community based career pathways through skill mix to enable recruitment and retention. Aim to increase the number of HCA’s, using the framework of the Cavendish Report. Utilise the right level of expertise and experience at the right level of intervention that is appropriate to the individual patient, enabling re-investment in services.

**Assumptions**
- Potential saving of say £50k a year through an increase in the proportion of HCA (Band 3) and more junior nurses (Band 4).
- Some additional training for generic staff (say £40k a year) once the team is fully established

### Effective use of IT and mobile community working
Build on the Shift to Digital IT strategy
Introduce more hand-held devices to improve the productivity of the workforce.

**Assumptions**
- No change to IT costs that have been accounted for elsewhere
- Assume that NELFT would invest in better mobile IT assume say £1000 per customer facing staff member per year, but would gain equal improvements in productivity

### Involving voluntary and community partners where appropriate
We will work closely with our voluntary and community providers to develop our specification to deliver our strategy, to identify opportunities where they may support different ‘functions’/interventions on the pathway, working with our community nursing teams and to develop community programmes. This may include areas such as self management, early identification and intervention, either by providing direct support or venues for community nursing to deliver services.

**Assumptions**
- No specific change to staffing levels, initially, so no change to pay costs

### Self-management support for patients
Ensure that every person with a long-term illness or disability has a personalised care plan suited to their needs – to empower them to develop the knowledge, skills and confidence to take control of their own care. Patients will be able to access these online or on their mobile phone, if they want to and feedback direct to their clinician. Provide group education, peer support, patient activation and health literacy.

**Assumptions**
- Local teams to identify scope for increased self-management.
- Some investment in guidance material and equipment for patients, say £10k a year
This is a schematic of the sequence of investments and savings that the community nursing strategy needs to encompass. The challenges are exacerbated by the different financial incentives for providers and pressures on commissioners. The performance management needs to adopt a similar systems approach so that the impact of the interventions can be measured and sequenced. An integrator may be required to monitor performance and manage the resource transfers.
How we will deliver – Community Nursing supporting High Impact Interventions

The priorities in our Community Nursing Strategy also contribute to the High Impact Interventions identified for urban areas in NHS England’s guidance for commissioners (the right hand columns). The interventions do support the interventions with the higher financial impacts (i.e. reducing variability and coordinated care)

- Single point of access and referral
- Agreed process for single/joint assessment, care planning and care co-ordination
- Developing community nursing 24/7
- Establishing multi-disciplinary working and education including primary care, community nursing, integrated care management, rapid response
- Regular multi-disciplinary meetings to discuss very high risk patients
- Improve communication and sharing of information across health and social care
- Co-location of multi-disciplinary staff across locality areas
- Transformation of the skill mix to have a mix of generic nurses, utilising highly specialist staff where agreed as well as the use of Health Care Assistants
- Agreed defined roles and responsibilities across the pathway
- Effective use of IT and mobile community working
- Improve the interface with acute services and ensure services provided by the acute trust works in an integrated way with community care
- Involving voluntary and community partners where appropriate
- Self-management support for patients

1. Early diagnosis
   - Early detection and diagnosis to improve survival rates and lower overall treatment costs

2. Reducing variability within primary care by optimising medicines use and referring
   - Reducing unwanted variation in primary care referring and prescribing

3. Self-management: Patient-carer communities
   - Self-management programme for those suffering with a long-term condition

4. Telehealth/Telecare
   - Health apps, telehealth and telecare equipment which help people to manage their own long term conditions in conjunction with their clinicians, introduced to empower people whilst at the same time ensure that their own actions remain embedded in the care they receive from the NHS

5. Case management and coordinated care
   - Multi-disciplinary case management for the frail elderly and those suffering with a long-term condition

6. Mental Health – Rapid Assessment Interface and Discharge (RAID)
   - Psychiatric liaison services that provide mental health care to people being treated for physical health conditions

7. Dementia pathway
   - Fully integrated network model to improve health outcomes and achieve efficiencies in dementia care

8. Palliative care
   - Community based, consultant-led palliative care service
There are a number of key enablers that will support community nursing supporting the deliver of integrated care

<table>
<thead>
<tr>
<th>Engagement with patients, carers and the public to:</th>
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<tbody>
<tr>
<td>• Gain their views and include them in the development of our specification</td>
</tr>
<tr>
<td>• Embed effective mechanisms for patient engagement, patient in control, patient outcomes and experience</td>
</tr>
<tr>
<td>• Engage hard to reach groups</td>
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<tr>
<td>• Support patients with self-management</td>
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<thead>
<tr>
<th>Governance and performance management:</th>
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<tbody>
<tr>
<td>• Establish locality plans to ensure good performance and manage variation</td>
</tr>
<tr>
<td>• Peer review and learning</td>
</tr>
<tr>
<td>• Identify issues to once and share</td>
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<tr>
<td>• Establish clear metrics, targets and accountability</td>
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<tr>
<td>• Hold regular performance meetings</td>
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<tr>
<td>• Track performance effectively</td>
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<tr>
<th>Contracts and incentives:</th>
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<tbody>
<tr>
<td>• Align financial incentives with patient flows</td>
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<tr>
<td>• Commissioning for outcomes</td>
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<tr>
<td>• Develop new payment methods that encourage multi-disciplinary working</td>
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<thead>
<tr>
<th>The information and tools required:</th>
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<tbody>
<tr>
<td>• Use the “Shift to Digital” strategy to provide the foundation for improved data sharing</td>
</tr>
<tr>
<td>• Introduce more hand-held devices to improve the productivity of the workforce</td>
</tr>
<tr>
<td>• Develop standardised pathways and protocols</td>
</tr>
<tr>
<td>• Develop simple, single assessment/risk assessment and care planning formats</td>
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<tr>
<td>• Develop registers for specific groups patients, particularly with complex needs</td>
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<tr>
<th>Organisational and workforce development:</th>
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<tr>
<td>• Establish key leadership behaviours including clinical leadership</td>
</tr>
<tr>
<td>• Training for staff to deliver new ways of working</td>
</tr>
<tr>
<td>• Ensure appropriate skill mix</td>
</tr>
<tr>
<td>• Innovative recruitment and retention plans</td>
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How we will deliver – A focus on high quality care

The quality of patient care and patient safety should come before all other considerations in local NHS services. There are a number of dimensions to quality with patient safety being a key dimension.

Dimensions to Quality

Ensuring high quality care requires providers, commissioners and individual professionals to work together and consider the different facets of quality to enable the system to:

- Systematically drive continuous improvements linked to the overarching outcomes or domains set out in the NHS Outcomes Framework
- Ensure essential standards of quality and safety are maintained

To effectively improve and sustain high quality care and patient safety we will ensure:

- An open and honest culture exists across the system
- Continual learning and improvement
- Patients are proactively engaged, empowered and involved
- That robust, relevant and timely information available at every level of the system
- There are agreed quality and patient safety metrics (qualitative and quantitative) that are routinely and effectively measured
- Effective use of comparative quality indicators
- Development and implementation of innovative approaches to delivering healthcare

The quality curve showing the different facets of quality
**How we will deliver – A focus on high quality care**

We recognise the importance of quality and are developing our approach to quality with a focus on clinical leadership and embedding quality in the commissioning and contracting processes.

Quality is assured through a wide range of metrics, indicators, dashboards, information and intelligence gathered nationally, regionally and locally.

**Our key priorities in our approach to quality are:**

- To seek assurance that the community services commissioned for the population are of appropriate quality and offer value for money through the development of a timely and comprehensive quality assurance system
- To work with our providers to ensure that the patient remains at the centre
- To work in collaboration with all providers, the public, patients and other commissioners to promote quality improvement across the local healthcare system through a culture of openness and transparency
- To intervene where appropriate quality standards are not being met
- To link to the local Quality Surveillance Group (London region) to share information and intelligence
- To work with providers to ensure that the CQUIN scheme delivers quality services
- To address recommendations from Francis/Berwick/Winterbourne /Cavendish and Keogh reports

We recognise that we can’t work in isolation if we are to make a difference to the quality of our local population. Wherever possible partnership working opportunities will be explored.

**Our approach will include:**

- Patient experience – acting on what patients tell us, strengthening their voice in making decisions about their own care, service improvement and improving personal dignity, information sharing and communication
- Good clinical practice – ensuring all clinicians and services are working systematically to accepted good practice and recommended guidelines. Also that there are good systems in practice of clinical communication and information sharing that are timely, accurate and relevant
- Effective Clinical Leadership
- Safety of clinical practice – utilising local intelligence to target areas of concern including proactive assurance of performance ensuring that action from lessons learnt is implemented effectively
- Local intelligence will be brought together with information from a broad range of data sources including lessons learnt, patient feedback, trend data etc to proactively identify quality issues for action
- Quality improvement & innovation – working with clinical and care staff in health and social care to identify opportunities for quality improvement and innovation
How we will deliver – Implementation roadmap

To enable us to achieve our vision for community nursing we have developed an implementation roadmap that sets out the things that we need to think about, plan and do now, over the coming months and in the longer term. We recognise that we can’t do everything at once and this will help us to do the right things at the right time to achieve our vision. We have decided that the key things we need to do fit into five core themes:

- Patients – being in control, experience and engagement
- Workforce – ensuring we have an adequate workforce with the right skill to work in the new way
- Integration – integration of community nursing, supporting integration in the wider system
- Contracting and performance – reflecting new ways of working in our contracts and how we manage performance of those contracts
- Culture change – to support the new ways of working

Now (by end June 14) Soon (by end Dec 14) Later (by end March 15) Beyond March 15

Effective, Quality Service(s)

| Patient in Control, Patient & Public Engagement and Patient Experience |
| The right workforce with the right skills |
| Integration of services |
| Contracting/Performance Management |
| Culture Change |

Colour key:
- Things to think about
- Things to plan
- Things to do
- Embed
## Next Steps - 1

<table>
<thead>
<tr>
<th>Key Area</th>
<th>Recommendation</th>
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| Community Nursing and Workforce | • Review and agree minimum core ‘functions’ required to be delivered by community nursing across the pathway including prevention, early identification, early intervention as well as more complex care  
• Review and agree short and medium term priorities  
• Agree skill mix required – increasing the generic base suitably trained health care staff  
• Identify technology innovation that can be used e.g. to support mobile working  
• Development multi-disciplinary working incorporating a range of professionals and roles, linked to the GP networks  
• Identify innovative solutions to recruitment issues  
• Ensure effective clinical leadership in place  
• Ensure effective governance in place to reflect new ways of working  
• Create a single point of access for patients and other users  |
| Wider stakeholder engagement  | • Further engagement is required to develop the detailed specification for community nursing, particularly with patients, GPs and public. Broader engagement with primary care is key to effective implementation  
• Ongoing engagement with the current workforce as part of a change management process  
• Engage with local voluntary sector/community organisations to support development of the specification  |
| Integration                   | • Align the community nursing strategy with other strategies/work under way to ensure ‘fit’ within an overarching integrated model of care for Waltham Forest. This includes the Better Care Fund programme and Walthamstow and East London Integrated Care.  
• Engage in early discussions with the Waltham Forest Council to identify/agree opportunities for integration between community nursing and social care  
• Adopt a locality structure for all services that are big enough (i.e. for all services other than the small, specialist teams)  
• Identify early opportunities to improve communication and reduce duplication of assessments and paperwork  
• Develop a systems-view for performance management so that the impact of e.g. early intervention on unplanned hospital admissions can be measured. Consider the need for a distinct integrator role to manage these processes.  |
| Implementation                | • Set up a Community Nursing and Integrated Care implementation programme, ensuring that the related projects are either included in the programme or have governance arrangements that support a consistent approach  
• Confirm the steps in the implementation road map and identify more detailed timelines and associated implementation plans for each strand of work  
• Confirm the timetable for implementation – be realistic about the pace of change  
• Identify and implement any quick wins by building on the strategy workshop participants  
• Ensure sufficient resources are in place to support implementation  
• Identify and manage key risks  
• Confirm the constraints of the procurement timetable  |
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<tr>
<th>Key Area</th>
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| **Finance** | • Help NELFT to carry out a service costing exercise that will enable them to provide the detail that is required for a reshaping of the current services  
• Develop an outline model for costing the reshaped services  
• Cost the identified core functions and integrated model required  
• Develop a simplified systems view of the service to evaluate an outline of the impact on other services e.g. showing the linkage from this strategy to the initiatives in the CCG, such as coordinated care packages, that have an impact on outputs and finances, allowing for the contribution of various strategies (Community Nursing, Integrated Care Management, IT etc) on those initiatives to avoid double counting.  
• Align this systems view with the contracting strategy (see below) so that the contract specification is consistent with the financial strategy  
• Agree financial envelope for agreed service, including staged funding where appropriate to support and facilitate change  
• Open up a discussion with the providers involved to discuss how the integrated model can overcome the financial disincentives that exist  
• Develop the financial perspective on the implementation plan so that the quickest payback is prioritised |
| **Contracting, Performance Management & Procurement** | • Identify the procurement/contract timeline as soon as possible to ensure that the process can be completed within the required timelines  
• Arrange a provider event to:  
  • Further develop the community nursing specification  
  • Test market interest where appropriate including local GP networks  
  • Explore integration options  
• Ensure plans are in place to ensure continuity of service  
• Agree future data/information requirements including:  
  • Key performance indicators  
  • Quality metrics  
  • Outcome measures  
• Identify opportunities for early implication of priority key metrics  
• Ensure triangulation of contracts e.g. community nursing contract with other contracts including the acute trust:  
  • To demonstrate impact on service delivery across the system  
  • Identify/confirm impact of activity and finance across the system |
| **Quick Wins** | • Prepare a Directory of Community Nursing services that can be used by GPs and others  
• Draft agreed pathways defined for each locality, signed off by the relevant providers  
• Standardise documentation e.g. care plans  
• Standardise processes e.g. assessment |