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Sheffield Teaching Hospitals NHS
NHS Foundation Trust

Board of Directors
Transforming Community Services (TCS)
Progress Report - September 2011

1. Introduction

The second phase of the TCS process concludes on 30 September 2011. This paper reviews the achievement of actions and outcomes scheduled for phase two, updates progress on the "early wins".

2 Phase Two targets and progress

The phase two targets were set out in two papers dated 12 May 2011 and 14 July 2011 that were both discussed at Board meetings. A consolidated table is provided below;

2.1 Transfer staff under TUPE from NHS Sheffield provider arm to Sheffield Teaching Hospital (STH) by 31 March 2011.
The TUPE transfer process was achieved, with 92 posts being transferred on 01 April 2011.

2.2 Implement a plan to reduce community corporate management costs by £1m recurrently, minimising the cost of change by 31 July 2011.
A comprehensive staff support package was introduced for all transferred staff which alongside the staff redeployment process meant that there have been no compulsory redundancies, and only four voluntary redundancies in achieving the corporate management cost target, minimising the cost of change. The balance of savings will be achieved through the restructure of the middle corporate management team. The majority of savings have therefore been achieved through post reduction with the majority of staff finding alternative posts through the redeployment process. This target has therefore been achieved.

2.3 Create a ninth care group, recruit a new managing clinical director by 01 October 2011.
Discussions at TEG and the Board of Directors strategic session confirmed the establishment of the ninth care group, with the new managing clinical director (Penny Brooks) starting on 05 September 2011. This target has therefore been achieved.

2.4 Identify a number of "quick win changes" by the end of December 2011, that demonstrate the sort of potential opportunities emerging from the merger.

2.4.1 Diabetes (Leader; Dr Adrian Scott)
The programme commenced with a review of outpatient services but will proceed to include inpatient services. The change has been driven by the results of the successful pilot of a community based specialist diabetes team established within central GP Consortium. As a result of the pilot evaluating favourably by the Central Consortium and Sheffield PCT, Sheffield PCT approached STH as their preferred provider of choice to roll out the community service city wide. A service specification has been drawn up by the PCT for patients who have been designated as level 1 and 2 (essentially oral agents, incretin mimetics and insulin management of people with Type 2 diabetes on once or twice daily regimens) to be managed, where appropriate, in primary care with support from a community specialist diabetes team.

This model of service delivery will see a reduction of up to approx 700 new GP referrals/attendances to the STH service and up to approx 3,000 follow up attendances. Work is underway to reduce the clinic capacity to enable funding to be released to be invested in the redesign and re provision of specialist community teams.

Funding and contractual arrangements for 2011/12, have been discussed and agreement reached with the PCT and STH. The agreement is for 12 months in the first instance, the contractual arrangements will be to deliver the outpatient diabetes service within a block contract for a fixed financial payment, there will be no tariff payments for any Sheffield outpatient Diabetes activity, the only exception to this will be Paediatric Diabetes services which will have a separate national tariff which Sheffield PCT will continue to fund separately. Patients from outside Sheffield will continue to attract tariff income and are unaffected by the agreement between the Sheffield PCT and STH. The expectation is that the service will be fully rolled out by December 2011

Objectives; The objectives for the service redesign are to improve access for patients with diabetes to a specialist team, ensuring patients are seen in the most appropriate setting and to improve the knowledge and education of practice based health care professionals and improve patient experience and outcomes. The outcome of the redesign must deliver a number of key objectives:

- To ensure that every inpatient with diabetes has appropriate and timely care during their admission and that blood sugar control is optimal
- To ensure that primary care teams are appropriately trained and supported to provide high quality care to people with Type 2 diabetes requiring injectable therapies
- To support primary care to reduce the morbidity and mortality associated with diabetes by providing specialist services to complex patients
- To provide structured education and training to people with diabetes, their families and health care professionals involved in their care to empower patients to self manage their condition
- To maintain our international reputation for engaging in cutting-edge clinical research

Proposed Changes;

The main changes to the service are in 4 areas:

1. A reduction in the provision of routine outpatient care for the stable patient with insulin treated type 2 diabetes, with the expectation that the majority of these patients would be under review by their GP and practice nurse
2. Enhancement of hospital outpatient services for complex patients with diabetes and its complications. In particular people with foot ulceration, painful neuropathy, hypoglycaemia unawareness, psychological adjustment difficulties, uncontrolled diabetes despite community specialist team input and people on renal replacement therapy etc. In addition we would be the providers of diabetes care to pregnant women with diabetes and adolescents.
3. Enhancement of in-patient services to people with diabetes (21% of patients at NGH) have diabetes) to improve glycaemic control, reduce harm events and excess bed days due to diabetes and its treatments
4. Provision of specialist support to all GP practices across Sheffield to enable them to provide enhanced care to patients with insulin treated type 2 diabetes and where appropriate to initiate injectable therapies in the community

2.4.2 Sexual Health and HIV services (Leader; Dr Christine Bowman)

Aim; To create an Integrated Sexual health and HIV service managed centrally from the Directorate of Communicable Diseases, Sheffield Teaching Hospitals NHS Foundation Trust. Phase 1: Integration of Sheffield Contraception and Sexual

Health service (SCaSH) with Genitourinary medicine (GUM) within the Directorate of Communicable Diseases**.** Phase 2: Integration of the Centre for HIV and Sexual health (CHIV) with the Integrated Sexual Health and HIV service

Objectives

- To improve access to high quality, evidence based sexual health and HIV services across Sheffield PCT
- To provide a shared Clinical Governance Framework for the management of Sexual Health and HIV in all settings
- To reduce duplication of elements of service provision
- To increase competence of staff to allow efficient use of resources and improve access to all elements of the service in a variety of provision settings.
- To improve cost-effectiveness
- To improve patient satisfaction
- To enhance staff satisfaction and morale
- To reduce teenage pregnancy and incidence of STIs within the served community
- To reduce the proportion of patients with HIV presenting late to health services

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- Work to resolve the issue of management of termination of pregnancy, a working group comprising key members from SCASH, GUM & O&G (chaired by Jo Fletcher – Consultant nurse in O&G) has been formed to review and improve the existing patient pathway for TOP.
- An initial discussion has taken place between Ann Burke (Clinical Service manager SCASH) and Dr Christine Bowman (Clinical Director for Communicable Diseases) and a time-out process agreed upon. Suzie Bailey has been asked to facilitate the time out session(s).
- An initial discussion between Penny Brooks (CD of the Community care directorate) and Christine Bowman has taken place.

2.4.3 Heart Failure; Introduction of pro BNP testing to support implementation of the NICE diagnostic pathway for patients with suspected heart failure. (Marie McKenniff)

- This workstream is aiming to implement the recommendation from the Sheffield Heart Failure Pathfinder Project to address the deficiencies in the diagnostic pathway for patients with heart failure
- The key feature is the implementation of pro BNP blood testing in Primary Care
- Introduction of this simple blood test as a rule out tool will provide a platform for transformation and improvement of care pathways for patients with a positive diagnosis of heart failure
- There is a strong likelihood that effective implementation of pro BNP with a programme of training for General Practitioners would reduce the number of emergency admissions for patients with underlying heart failure and no previous diagnosis. This will have a substantial patient benefit as well as reducing spend in the acute sector.

2.4.4 Telecare (Leader; Ruth Brown)

The purpose of this workstream is to increase the number of patients accessing in-home Telecare devices to monitor their daily vital signs with the objective of avoiding preventable admission to hospital by providing early community intervention. Part of the programme was based on an EU research grant for a programme called DALLAS. Unfortunately STH was not shortlisted for the next stage of the project so the scope of this workstream will be scaled back.

2.4.5 COPD (Leader; Dr Jennifer Hill)

This work programme has recently started, the following gives progress to date;

- primary and secondary care teams mapping the ideal pathway for patients with stable and unstable COPD
- Team reviewing skill mix and service needs to ensure care provided by the right person.
- Proposals are being developed examining moving appropriate outpatient COPD work to primary care and to ensure clinics are fully utilised.
- The team will assess 600 patients on home oxygen not registered with the respiratory service to ensure oxygen required and adequately monitored.
- Workstream underway to unify assessments and documentation for COPD patients within primary and secondary care service and improve communication between the two using SystemOne.
- Consideration is being given to specialist nurse-led acute COPD assessment service within secondary care to reduce admissions and improve patient experience.

2.4.6 SystemOne (Leader; Kirsten Major)

This workstream aims to provide access for STH acute clinical staff to the community based information system called SystemOne to share patient information, particularly diagnostic results. Access to SystemOne is essential for projects where acute clinical teams transfer services into community locations. The programme proposes buying a site licence for STH giving access via the STH network to SystemOne.

2.5 Create a shared vision for integrated health services and develop a supporting transformation programme by 31 October 2011.

Four workshops have been held to date with a concluding workshop held on 13 September. The workshops have involved patients, staff and key external partners helping to identify benefits and service transformation opportunities. This workstream merged with the Strategy Refresh programme from July. The process has been well received by the 200 or so participants, with a consistent >98% satisfaction rating for each workshop. The programme is on target to deliver a shared vision for the newly integrated clinical services and set out top level vision and strategies by 31 October.

2.6 Review inter-organisational recharge for corporate services contract by 30 September.

A number of community based support services were transferred to the Care Trust with agreement from 01 April as part of the TUPE transfer of community staff. These include such services as estate and facility maintenance, a number of hotel type services and distribution services. Historically these services have not had detailed service specifications. Under the Business Transfer Agreement, all Foundation Trusts in Sheffield agreed not to take any action to consolidate these services into their own provision for a period of 6 months to 30 September 2011. TEG having considered the position has decided to give six months notice to the Care Trust for all of the group of services defined under the BTA as corporate support services that were transferred to the Care Trust. Work is underway to produce service specifications and disaggregate the finances so that STH takes over responsibility for running these support services to the community services and facilities transferred.

The Board is asked to note this report.

Andrew Riley
Corporate Development Director
14 September 2011