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HOME ENTERAL FEEDING: DEVELOPING THE GLOUCESTERSHIRE SERVICE TO SUSTAIN THE FUTURE

The Gloucestershire Home Enteral Feeding Team (HEFT) is going through a rapid but exciting period of growth following recent testing and uncertain times.

Adopting Tuckman's (1996) development phases of 'forming, storming norming and performing', has been key to the journey for our team to deliver the results we aspire to. The service we provide is commissioned by Gloucestershire Clinical Commission Group (GCCG) through a block contract with Gloucestershire Hospitals NHS Foundation Trust (GHFT) that covers various healthcare services. The HEFT remains part of GHFT, but manages the commercial feed and ancillary supply contract day to day on behalf of GCCG, alongside the patient responsibility.

For too long the team struggled, whilst overall patient numbers grew organically, but the growth within specific patient groups and the associated increase in patient complexity allowed us to prove that change was needed to meet demand. We are delighted that the subsequent investment has resulted in additional recruitment, particularly as it has enabled the creation of a dedicated paediatric arm to the team and further recruitment is underway. We are also excited about the introduction of a comprehensive mobile IT platform, enabling us to deliver both efficiencies in working practices and the optimum HEFT service for the patients of Gloucestershire. The learning curve has been steep, but key to this whole process has been working closely with GCCG to ensure that all service users were invested in our vision.

BACKGROUND

We had been reporting for several years that the HEFT had been under growing pressure from increased demand. In March 2012, the service reached crisis point and a decision was made to only operate a limited provision from that point. Levels of service, such as time between reviews, continued to decline through 2013 as patient growth continued at around 8% per annum. Our first step was to record the service at high risk on the Trust risk register.

In parallel, we had identified a caseload change from that used to originally size the team, with a significant increase in both paediatric patients and patients with learning disabilities (LD). We were able to prove that these two groups have a much higher than average impact on the team per patient than the average

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adult patient. Our records showed that a paediatric patient will in general consume twice the HEFT resources of an adult patient and a LD patient four times. With such large and still increasing numbers of these patient types within our cohort, a requirement to develop and maintain specialist skills within the HEFT was indicated.

Table 1 demonstrates the numbers of patients in our current caseload and compares them by type to the number on the service at the time of the previous tender.

The variances are clearly visible, and we also noted an additional impact in an increase in the volume of patient turnover. Significant time is required to process a patient when they join or leave the service, and this naturally has a high priority, especially in the paediatric and LD cohorts.

We could also compare staffing levels against overall patient numbers over time. Figure 1 shows clearly and simply that the caseload per hour worked has increased significantly over time and was the cornerstone of the argument in our business case.

TARGETS AND KEY PERFORMANCE INDICATORS (KPIS)

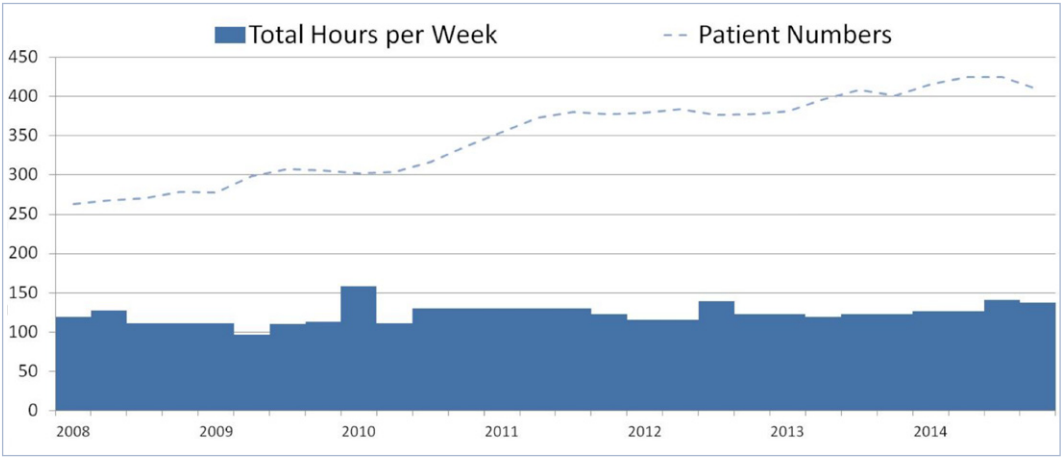
The measurement and communication of achievement to target remains a vital part of managing the service. Quantifying a service like ours isn't always simple, but at a basic level is essential in the modern health service. One example is that our HEFT aim is to make an initial home visit to all new patients to the service within 14 working days from receipt of handover. This is easy to report against and can then offer a comparison over time. Quantifying enhancements then also becomes simpler; for example, we have found it valuable for our coordinator to make telephone contact with the patient/carer within 48 hours of discharge. Our coordinator uses a checklist to ensure that adequate supplies are provided on discharge, to triage any nursing or dietetic issues and to agree a date for the initial visit. We believe this action has helped to reduce patient anxiety and helps in identifying issues quickly ensuring planned rather than reactive intervention.

With regards to ongoing care, the team fully supports the CREST 2004, NICE 2006 and benchmarking indications that patients should be reviewed by home visit on a three- to six-monthly basis. Regular face-to-face follow-up consultations with patients ensure that the feed continues to be appropriate for the patient's current condition and ongoing requirements, as well as monitoring their tube and stoma site for problems. We maintain that home visits remain an essential part of the patients review as it is important to undertake subjective global assessments of the patient and their living environments. This allows us to tailor

Table 1: Patient numbers - breakdown by condition

Patient type	Patient numbers April 2010	Patient numbers March 2016
Head and neck cancer	54	54
Neurology	51	88
Other adult	89	70
Paediatric	64	122
Learning disability	37	74

Figure 1: HEFT staffing and patient numbers



NB: The additional short-term injection to staffing in 2010 was used to assist with the implementation of the new feed contract.

Table 2: Patient caseloads per one wte specialist dietitian

	Adult	Paediatric	LD
Clinically Recognised Safe Caseload (CRSC)	100	50	25
CRSC with the correct IT platform	125	70	45

individual feeding regimens, to ensure feed and equipment are being stored correctly and that stock levels are appropriate.

Over the past few years, the HEFT continually refined their service processes, ensuring that they were as efficient and as cost effective as possible. Against the backdrop of increasing patient numbers and caseload complexity, the only way in which the team managed to continue to function was to reduce the level of service delivered.

KPI reporting clarified that the demand on the service had outstripped the capacity at even the lowest level of service delivery. Only an increase in resources would enable the team to deliver an effective service.

BUILDING A RESOURCE MODEL TO SUPPORT PATIENT DEMAND AND PATIENT INCREASE

Following the HEF service move on to the trust risk register, it became evident that more radical action was required in order to meet demand to expected levels of quality. The team's first action was to reduce the clinical workload of the lead, enabling a strategically focused quality improvement project to commence.

Following collation of data, analysis showed a patient growth trend of around 8% per year from 2007 onwards. Discussions with stakeholders such as clinicians and the CCG were held that suggested the trend was likely to continue. To avoid the same issues occurring in the future we created a demand based model to initially cover staffing levels, but then developed it to also encompass non-pay cost such as travel expenses and assessment equipment. This model was shared with both the Trust and the CCG to enable management and financial expectations to be set.

The primary challenge when creating this model was defining a safe caseload for its dietitians. The team identified and focused on three primary patient types within our cohort - adult, paediatric and LD - which was based on local knowledge, typical contact time and skill sets required. One key lever for us is that we have a disproportionately high level of LD patients in our county. This is mainly attributable to a large local provider of specialist further education and residential services for people with physical and learning disabilities and acquired brain injuries, many of whom transfer to and from our service several times per year.

. . . the biggest lesson we've learnt on this journey is to never forget the importance of nurturing your team, especially during a period of rapid change. . . . Maintaining a positive environment and cohesive team ensures you strive for excellence.

We found that there were limited published caseload figures, so we reached out to other HEF services across the country asking for data in order to benchmark our service against other comparable trusts. That data indicated that a safe caseload would be less than half that managed per dietitian in the team! The team were confident though, and given support from a modern IT platform and the ability to specialise within the indicated larger team, they could take on a higher caseload and still meet or exceed all KPIs. Table 2 shows the patient caseloads that the Gloucestershire HEF service believes one whole time equivalent (wte)specialist dietitian should be expected to manage per type.

In addition to the dietetic categorisation, the model calculates other team members as a percentage of the wte of dietitians. This was historically set at around 60% for Enteral Nutrition Nurse Specialists (ENNS) and 30% for admin and clerical support (A&C) and this has worked well for our team, delivering that confidence to take on the higher caseload levels. Staff management has also been modelled, given that the overall wte figures had grown, and we included time to account for the contract management tasks that are delegated by the CCG.

We also ensured that the model remained flexible. As an example, we uncovered an increase in the average patient contact time due to a corresponding increase in patient complexity. Adding contact time as an input to the model meant that we were able to easily display tangible service options as part of a business case.

We have ensured that the model processes and output is formally reviewed annually by all stakeholders, using actual patient numbers as they become known at the end of the calendar year. This ensures that funding is released to staff through the following 12 months. For us, this forms part of the normal block contracting round that our Trust has with the CCG. That annual review of staffing levels includes detailed inspection of all KPIs agreed between the HEFT and the CCG, along with the caseload figures that drives them. This delivers confidence to all involved that the model properly reflects the service needs.

CONCLUSION

The HEFT feel that we have made significant steps towards improving the service provided to the patients in the county through working closely with our providers and CCG. Regular reviews with all stakeholders are essential to the success of any significant change and, while we have not managed to implement all that was set out within the initial business case, we continue to work with the CCG to reach this aim.

We prioritised the greatest areas of risk for the initial fund release which included Paediatrics and Nursing and both of these improved services are being well received by clinicians and patients alike.

Finally, the biggest lesson we've learnt on this journey is to never forget the importance of nurturing your team, especially during a period of rapid change. Our Chief Executive always reminds us that your staff will always be your greatest asset and we are very grateful to our local Learning and Development team who have supported us during this phase. Maintaining a positive environment and cohesive team ensures you strive for excellence.