COMMUNITY NURSING AND FAMILY HEALTH ABSTRACTS

(Abstracts 1, 2 and 3 comprise Workshop E2)

ABSTRACT 1: Improving Dementia Care through Care Navigation and Social Prescribing In General Practice

Sheinaz Stansfield, Practice Manager, Newcastle Gateshead CCG Alliance Board Member
Oxford Terrace and Rawling Road Medical Group, Gateshead

The idea
Improving dementia care through care navigation and social prescribing in General Practice

Describe the unmet need or problem the innovation addresses
Oxford Terrace and Rawling Road Medical Group (OTMG-RR) is a GP practice, situated in Central Gateshead. The population of about 15,200 patients is predominantly deprived, with high numbers of refugees and asylum seekers. Our prevalence of patients with dementia is 200%.

With growing numbers of patients receiving a dementia diagnosis, it was becoming increasingly challenging to manage their needs through 10 minute GP appointments, predominantly because their needs related to social care and wellbeing rather than acute clinical need. In addition, carers were not being identified and therefore not receiving the support they needed. The majority of this case finding was undertaken by GPs and Senior nurses. The on-call doctor was overwhelmed, patients and carers frustrated, staff were struggling and the quality of care in danger of being compromised. There was a high level of unplanned admissions.
We developed a Primary Care Navigator role to case find and support both patient's, their families and carers though better navigation to access a very fragmented and complicated health and social care system. In addition, we needed to sign post these patients to wellbeing services through social rather than clinical prescribing.

Describe the solution and how it works

This is a new role in General Practice to help support the needs of patients and carers with signs of or having been diagnosed with dementia. There was no additional funding for this post, existing health care assistant and receptionist roles were redesigned to undertake this function. The Primary Care Navigator role is to:

- **Communicate** with patients and carers, asking open questions and actively listening;
- **Guide** people to all-sector sources of help and support, from the most local to national, and;
- **Support** case finding through referrals from clinicians and opportunistic screening in clinics

What is the benefit of this innovation over current methods or products used?

This is a new role in General Practice; it enables specific targeting and fast tracks patients, their families and carers to health and wellbeing support. Usually appointments in the practice are time limited and very focused on clinical tasks/interventions. Some of the benefits of this role include:

- wider practice engagement, achieved by introduction of the programme and expectations at practice meetings and multi-disciplinary staff meetings;
- agreeing individual care plans and accountable GPs;
- providing nursing homes with a single Point Of Contact for prescriptions and requests for visits;
- supporting doctors and nurses in their interaction with vulnerable patients by enabling them to refer to the PCN for longer consultations;
- working with and supporting the nurse practitioner and frailty nurse
- Being a core part of co-ordinated care planning and MDT meeting/planning

Dealing with patients and their carers involves:

- open invitations to the surgery for a "catch up and cuppa"
- "Getting to know You" events
- identifying people's needs and sign-posting to available help and contacting organisations on their behalf if they have difficulties doing so themselves
- regular fortnightly contact via telephone or a drop in to see how progress is being made and what is still needed

- updates on events that are being held that might be of interest
- making contact within three days of discharge from hospital.
- The intervention has also improved productivity, motivation and morale of staff as outlined below

What is the current status of the innovation?
The Primary Care Navigator role has now been extended to support all social prescribing for people with complex care needs in the practice. In addition, this will be the foundation of implementing house of care approach to the management of long term conditions in the practice to support self-care and self-management.

Evidence;
Improved learning and morale amongst staff undertaking the role.

PCN feelings at the very beginning	Feeling after Three Months
• concerned that didn't have enough experience • anxious and scared about ability to take on the role • fear of the unknown and what was expected • A little bit lost and worried about whether could commit enough time to project	• Confident as a result of the training • more in control • familiar with the role • happier in general in working for the practice • needed and valued • better organised and positive about the job

Outcomes for patients and caters in the first three months

Support provided to patients	Support for GPs and nurses	Other notable changes
• Dementia Screening increased by 117 • Assessment for Dementia increased by 38 • Carers Register increased by 43 • Veterans Register increased 20	• Care Plans completed 396 • NHS Health Checks completed 95 • 86 Post discharge calls none of whom needed a physician as PCN sorted. Usually all these calls would have gone to the on-call GP. • Reduction in discharge letters suggesting avoided admissions – from 7 to8 a day to 2-3 a week, within first six months.	• more effective in ringing patients following emergency admission • less fragmentation • reception managing better • improved communication • less prescription errors • more co-ordinated personalised care

Development
Adoption and Sharing of Good Practice
This work can be replicated with limited resource**.**

Has your idea been disclosed to others?
Yes, though learning and sharing events. Gateshead CCG has included this role in its broader primary care strategy and practices have used this model to inform their £5 per head funding spend.

Describe any challenges that may need to be overcome to further develop and/or implement your idea
- Lack of training and capacity building for health care assistants to understand frailty, dementia and social prescribing;
- Lack of workforce development in primary care;
- Capacity and capability in general practice to support this type of change
- Workforce pressures to free staff to become involved and undertake adequate measurement.

Which other organisations have been involved with the development/implementation of your idea?
Whilst this work was undertaken in the practice and led by the practice manager with the full support of all practice staff and partners: the following organisations have also been involved:
- National Association of Primary Care;
- Gateshead CCG;

- Gateshead Older Peoples Assembly;
- Age UK Gateshead;
- Gateshead Local Authority;
- Oxford Terrace and Rawling Road Practice Champions (patient volunteers)

Adoption and sharing best practice
This work has recently been evaluated by Deloitte and will inform workforce development nationally. Gateshead CCG has adopted this approach for their primary care strategy, and practices in Gateshead have used this approach for service development to inform the £5 per head national initiative to improve care closer to home.

Are you aware of anyone conducting research or trying to solve the same problem? If so, who?
The learning form this practice is being used by the National Association of Primary care to inform workforce developments nationally with NHS England. Also see above.

Should this idea go further, would you be prepared to invest your time in its development?
Yes it needs to go further, if we are to manage workforce challenges and improve quality in general practice. With current financial and demand pressures on general practice we have to move to more intergrated care and place the patient at the centre of everything we do. In addition, with growing numbers of patient's being diagnosed with dementia, they and their carers will need this type of support as a single point of access.

ABSTRACT 2: Improving Access and Managing Long Term Conditions Effectively and Efficiently In General Practice

The idea
Improving Access and Managing Long Term Conditions Effectively and Efficiently In General Practice.

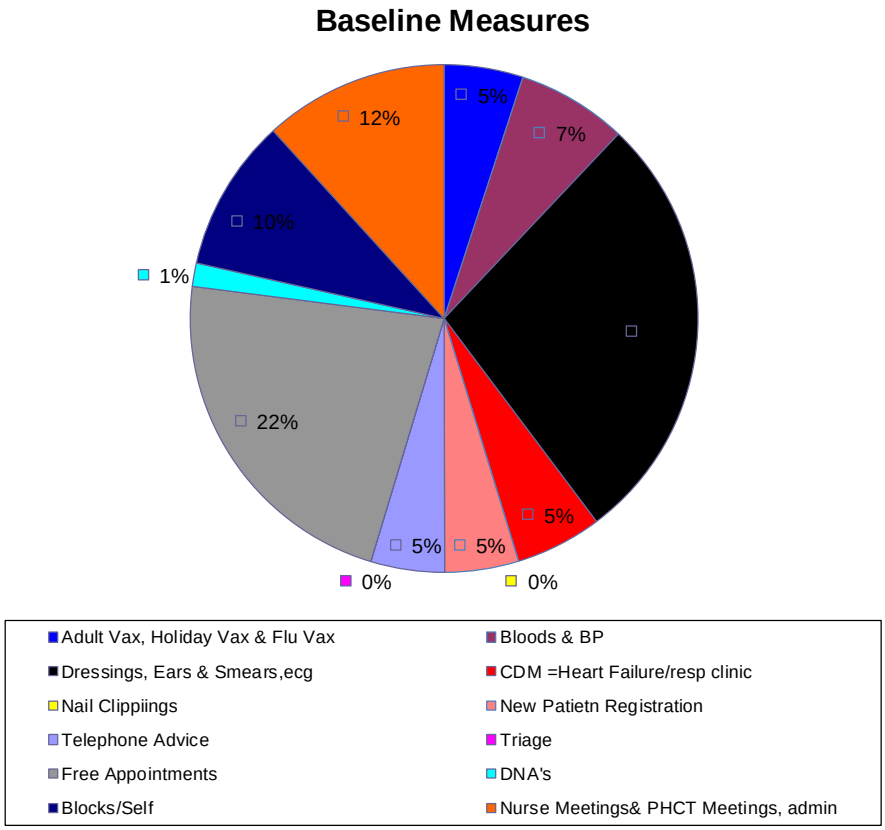
Describe the unmet need or problem the innovation addresses in primary care

Oxford Terrace and Rawling Road Medical Group (OTMG-RR) is a GP practice, situated in Central Gateshead. The population of about 15,200 patients is predominantly deprived, with high numbers of refugees and asylum seekers. We have a particular passion for patients with complex care needs and using a risk stratification tool we identified that about 2500 of our patients with multiple comorbidities were at high risk of being admitted to hospital.
Our practice population suffer poor general health and have significantly higher rates of life limiting long term illness than counterparts across England. Older people in deprivation, obesity, emergency admissions for CHD, stroke, MI and COPD are also significantly higher. Once admitted to hospital their length of stay is over double the national average. Standard mortality rates are high with deaths from all cancers, all circulatory disorders, coronary heart disease, stroke and respiratory disease being the highest. These also cause premature deaths with rates being significantly higher than the national average.

The problem we had was that there was a chronic shortage of GP appointments and we were not meeting all our targets for the management of long term conditions, resulting in patients attending and being admitted to hospital though A&E for preventable conditions. Also nurses were not managing long term conditions effectively or efficiently, as a result of "what" at the time we thought was lack of nursing and GP capacity.

Describe the solution and how it works
We embarked on a project to improve access to acute GP appointments so that we could improve both acute access and chronic disease management. Most mornings by 8.30 all routine appointments were taken, leaving both patients and the receptionists irate and unhappy. On review of our appointment system we found that our appointment system was set up to deliver 9.5 appointments per patient per year,(double the national average). A further audit indicated that we were actually delivering 5.4 appointments per patient per year (exactly the national average). GPs undertook a retrospective review of their surgeries and found that a third of the patients they were consulting could be seen by a nurse. A similar review of nurse appointments showed that they had 27% self-blocks and 22% of their appointments were not used. Clearly there was a lot of waste in our system with approximately 49% of the nurse appointments were wasted. Nurses had no access to clinical supervision and they were reactive in most of their intervention. There was variation in timings for clinical tasks and clinical recording. Although we were high achievers of QOF, our patients were attending a&e and being admitted for conditions that could be better managed if patients engaged in self-care up stream. Review of our A&E attendances and admissions indicated that frail elderly patients with UTI, Upper respiratory conditions and Asthma were frequent flyers.

Our baseline measures indicated:



In addition nurses were not undertaking work commensurate with their clinical grading as is outline above.

What is the benefit of this innovation over current methods or products used?
Nurses became actively involved in quality improving. However, from our team of 3 A4C band 6 nurses and 2 band 4 Health Care Assistants (HCA), one band six retired and one HCA left the practice when we started this work. We used some of the tools of LEAN methodology to observe and measure the tasks the nurses undertook. The outcome of this was:

- The appointment system was changed;
- Time undertaken to do clinical tasks reduced – e.g smears from 20 minutes to 15 minutes (observation had indicated that the majority of smears were completed and recorded in 12 minutes);
- Review of call and recall systems, and delegation to admin team;
- Six weekly clinical supervision and performance review, and;
- Review of all clinics.

A national review indicated that there was no national clinical competency framework for practices nurses, there was no standard job description or clinical supervision process that we would draw upon. The job descriptions were redrafted using the agenda for change competencies and a clinical supervision policy and processes were put in place. Within 10 weeks of starting this work our nurses became more effective, efficient and productive. In addition, we were able to free them to become involved in developing a tool for risk stratification and undertake proactive management of patient's with COPD.

Despite two nurses leaving the practice we were able to free up 280 nurse appointments per week. Those two staff were not replaced, and resulted in a saving of £54,000. The waste stripped out of nurse appointments equated to one WTE GP providing 8 sessions of 10
minute appointments per week, which made a significant difference to our GP appointment availability. This enabled us to improve access to GP appointments and free GP time to undertake ward rounds in four nursing homes. In effect, we were doing more work with reduced workforce, but improving quality of care both in the practice and in nursing homes, with an initial saving of £54,000. This funding was used to fund additional GP time to support our increasing list size.

We used some aspects of LEAN and PDSA's as our quality improvement tools. These have enabled us to tack changes and engage the whole practice team in a culture of continuous quality improvement.

Using the risk stratification tool enabled us to identify patients who were at high risk of admission. Proactive case management of this patient's though integrated working with our community matrons, self-care, and referral to pulmonary rehab enabled us to make a significant reduction in both attendances and admissions to hospital for patients with chest conditions. In addition, we were able to achieve further reductions in attendances and admission to a&e for frail elderly patients in nursing homes, through care planning and proactive case management of those patient's and better palliative care and end of life planning

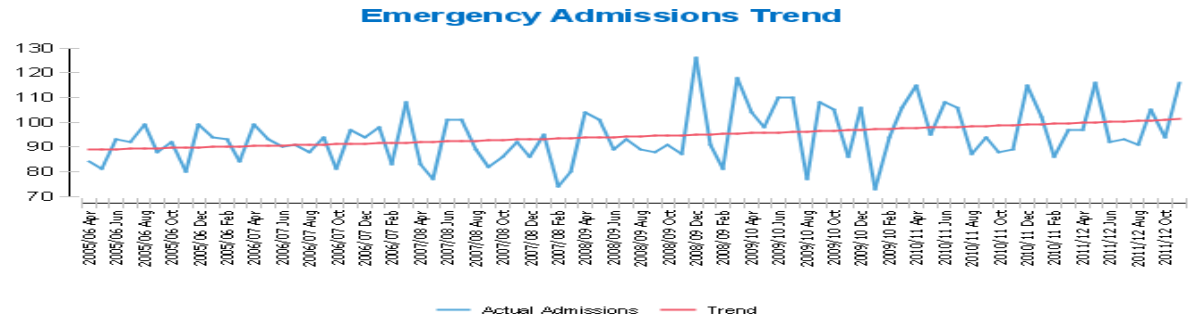
What is the current status of the innovation?
This innovation has enabled us to strengthen the nursing team with the right skills. In addition, it has enabled us to move towards more patient centred, care planning approach to managing patients with long term conditions. In April we are moving to the House of Care approach to the management of long term conditions. This will further remove waste from our system by reduce the number of appointments patients need for the management of more than one long term condition. It will also enable us to engage patients more actively in self-management/self-care.

ABSTRACT 3: Managing Frailty in the Community Though Personalised Care Planning

The idea
Managing Frailty in the Community Though Personalised Care Planning

Describe the unmet need or problem the innovation addresses in primary care

Oxford Terrace and Rawling Road Medical Group (OTMG-RR) is a GP practice, situated in Central Gateshead. The population of about 15,200 patients is predominantly deprived, with high numbers of refugees and asylum seekers. We have a particular passion for patients with complex care needs and using a risk stratification tool we identified that about 2500 of our patients with multiple comorbidities were at high risk of being admitted to hospital. 100 of these patients were house bound and did not meet the criteria for access to community matrons. Despite having community matrons attached to the practice our trajectory for attendances and admissions to hospital were increasing.



Describe the solution and how it works
An experienced Older Persons Specialist Nurse (OPSN) was recruited by South Tyneside NHS Foundation Trust and released on secondment to implement the principles of Comprehensive Geriatric Assessment to achieve continuity of care for elderly patients with complex health and social care needs.
What is the benefit of this innovation over current methods or products used?
What is the current status of the innovation?

In the first 8 months of this project to May 31st 2014 , **94 housebound patients** with an **Average Age** of **85 years** ,were referred to the OPSN and had care planned and implemented, using the principals of Comprehensive Geriatric Assessment .
This role was based directly within the practice and provided the benefits of co-production with the core members of the PHCT, patients and their carers working as equals in collaboration to optimise the health and well- being of frail older people. Equally, there were rewards to the practice in terms of opportunities for peer support; networking and sharing, and multi-disciplinary working. The appointment of a Nurse Specialist as a clinical leader with knowledge and skills in the care of older people, wide experience of effective multi-disciplinary and interagency working and awareness of the local and national drivers affecting the care of older people was a key component in the success of this.

Referrals in First 8 Months

Referred female patients	62	67%
Referred male patients	32	33%

Place of Residence	Numbers	%	Comments
Own Home	83	88%	Largely housebound population Equally 53 carers / family members were actively supported by the OPSN
Assisted Living Scheme	17	18%	e.g.Housing 21, LA Schemes with on site carers / facilities. Potential for use of on site proactive clinics if numbers attached were significant enough
Sheltered Accommodation	*4*	*4%*	*General schemes without on-site carers*

Referral Sources

Referrer	Number	%	Comments
General Practitioner	37	39%	10 GP's within the practice made direct referrals to OPSN
Practice Based Nurse Practitioner	19	20%	Referrals from 2 Nurses within the practice
Proactive Casefinding	25	26%	Conducted in initial month of project , focusing on over 80 years - cross referencing against the Housebound Flu list , previous 6 month housecall requests and RADIAR
Self / Carer	5	5%	2 - HCP 's aware of OPSN role re: family members 2 – spouses of patients on caseload 1 – spouse stopped OPSN in corridor of sheltered accom.

This post has become substantive in the practice. In addition, we have negotiated with our community services providers to have our community matron directly linked to the practice, making her more visible, available and a core part of our multi-disciplinary working. innovation has enabled us to strengthen the nursing team with the right skills. She also use the practice clinical reporting system to ensure patient safety through improved communication.

Evidence

Is there any evidence to demonstrate the effectiveness of the innovation?
Very early in this project the outcomes were reassuring, showing a downward trend in the use of several aspects of unscheduled care and home visits.

Use of Unscheduled Care Findings in First Nine Months of Project

Unscheduled Care	9 months Pre Project	Post Project	Comments
A&E Attendance	66	30 54% reduction	
Admissions	63	29 54% reduction	3 people were directly admitted by the OPSN – 2 to EAU and 1 to St Bede Unit directly for End of Life care.
House Call requests	318	63 – 81% reduction	

In addition:

- All patient's on the case load had a comprehensive care plan that was uploaded onto the adastra system for external organisations to enable integrated working;
- 53 carers were identified and also received support and were signposting to appropriate services;

Are you aware of any companies/CCGs who deliver similar products or service innovations?
Similar interventions are normally provided through community services providers. However, access to these services is challenging as they are neither available nor visible in the practice. They have a reactive approach and referral criteria tend to exclude the group of patients we were targeting for this intervention. There is no incentive to manage these people proactively in general practice, other than the annual review required through the quality and outcomes framework. This is a process measure

that evidences little improvement to outcomes for patients. With this intervention we aimed to move beyond the qof, to manage patients proactively in their own homes.

Has your idea been disclosed to others?
Yes, though learning and sharing events. Gateshead CCG has used this intervention to inform commissioning of future community services and it has informed service developments for the £5 per head funding recently allocated to practices to support patient's out of hospital.

Describe any challenges that may need to be overcome to further develop and/or implement your idea

- Reluctance of community service providers to base staff in GP practices and correspondingly the lack of accommodation for community staff to be based in practices;
- The mind-set of nurses and others working in general practice/community services and their desire to change;
- Capacity and capability in general practice to support this type of change
- Workforce pressures to free staff to become involved and undertake adequate measurement;
- Lack of training to support the needs of people with complex care needs and frailty.

Which other organisations have been involved with the development/implementation of your idea?
The initiative was led by Sheinaz Stansfield Practice Manager. She was supported by all the staff and partners at Oxford Terrace and Rawling Road Medical Group, Mrs Lesley Bainbridge, Angus McLennan, and Lynn Shaw from South Tyneside NHSFT: Community Services were involved. There was involvement and support from the Director of Adult services from Gateshead Council, the Urgent Care Lead from Gateshead CCG also was also involved with the support of the CCG Executive.

Adoption and sharing best practice
This intervention is easily replicable and has been shared with Gateshead CCG to inform future commissioning of community services.

Are you aware of anyone conducting research or trying to solve the same problem?
If so, who?
I am not aware of any formal research, however, Gateshead CCG have used this to inform commissioning of community services. In addition, practices in Gateshead have used the outcomes for service developments for the national £5 per head initiative, to manage complex care and reduce attendances and admissions through A&E.

Should this idea go further, would you be prepared to invest your time in its development?
Yes it needs to go further, if we are to manage workforce challenges and improve integration of services around patient need. In addition the skills set for practice nurses will have to change going forward, to manage the long term conditions tsunami and demographic changes and frailty that lie ahead. The emergent impact of frailty being classified as a long term condition will also require nurses to work differently and move away from task based care to personalised care planning. The approach we have taken has enabled us to become early adopters and inform commissioning of community services. The ideas are easily replicable with limited resource. There is also an urgent need to do this.

ABSTRACT 4: NHS/Local Authority Integration of CAMHS: A unique opportunity to establish an effective early stage CAMHS pathway

Richard Shircore, Independent Adviser in Public and Community Health, The Shircore Consultancy

Child and Adolescent mental health services are acknowledged to be in crisis.

The Third Report of the House of Commons Health Committee, entitled: "Children's and adolescent's mental health and CAMHS (2014-15)" cited deficiencies in accessing information for parents, weak and inadequate early intervention, extensive waiting times for first consultation and parental battles for CAMHS access.

A significant part of the current problems is centred on the split responsibility and organisational pre-occupations of the agencies involved: Social Services, NHS (Public Health, Primary and Community Care and CAMHS), Education and Youth Offending Services. A consequence for this division is that there is no oversight in respect to mental health promotion/prevention, early stage assessment and intervention. Each agency carries out its own assessments using its own criteria.

Simple reconfiguration of serves without new skills or approaches is unlikely to be effective. A thorough transformation is required. The integration of NHS and local authority functions creates an excellent opportunity to carry through this much needed reform.

A new integrated and comprehensive pathway approach is described for Tier 1 and Tier 2 level CAMHS to ensure that a comprehensive early stage assessment is carried out. This new approach utilises methods to create an evidence base for deciding on best therapeutic option at the earliest opportunity.

The new pathway configuration would be based on:

1. Putting the child's needs first
2. No assumption (*tabula rasa*) as to cause
3. Utilization of empirical evidence
4. Assessment criteria open, transparent and relevant
5. Values collaboration, learning and reflection
6. Interventions seek to maximise child strengths and to minimize weaknesses
7. Alert to the contextual influences on cognitive and affective behaviour

A new type of interdisciplinary training is described that reflects the above criteria and which can create an "effective team around the child".

ABSTRACT 5: Clinic-in-a-Box, on the move! Taking Sexual Health Services to where young people are

Viv Crouch; Sexual Health Lead for the School Nurse Team Sirona Care and Health, Sirona Care and Health, Ash House, St Martins Hospital

Rationale

Young people's sexual health is a public health concern. Traditional clinical settings often don't meet the needs of socially disadvantaged teenagers, where access is often difficult – especially in rural areas. Vulnerable young people who are socially disadvantaged don't always have motivation or social skills to be able to access services.

Although Bath is a small city we have a large rural spread, as with any district, there are hotspots of high teen pregnancy and areas of social deprivation. It became evident that young people living in rural locations have huge problems accessing services. Many of these young people are bussed in and out of schools therefore exacerbating the access problem. We needed to think more radically about how to reach young people in non clinical settings

Our Aim

Provide a service to young people in young people friendly locations in and out of school. We wanted our service to be more than a contraceptive service where the emphasis is to stop young people getting STIs or pregnant. We wanted time to get to know those vulnerable young people, helping to raise their self esteem;

How we went about it

The service needed o be what young people wanted, focus groups were established to explore the perceptions and attitudes of clinical service delivery "They wanted us to go where they were". Public Health and the Youth service were part of the initial negotiations. We started the project very quickly; negotiations with the commissioners are ongoing

What happened?

Clinic in a Box has been a resounding success. But we are mindful that we must not get stuck in a rut, we are therefore branching out even further with other locations for example the Youth Offending Team and The Drug and Alcohol service

Impact and Evaluation

- Our teenage pregnancy rates continue to follow the downward trend over 40%
- By providing Clinic in a Box in young people friendly locations, more young people are accessing contraception and safer sex advice
- We have seen a real increase in the number of vulnerable young people seeking help and advice because we took the service to them
- Evaluation Is mainly done by the Sexual Health Strategy group where we submit our findings
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Key references or policy initiatives

Easy access to contraceptive services was found to be the most important factor in reducing teenage conception rates (DFES, 2006)

- So, changing the service time, place and venue can make a difference for young people

- This includes confidential, non judgemental staff and accessible locations, including schools and colleges

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ABSTRACT 6: Neighbourhood Teams

Tracy Means, Clinical Team Leader/ Complex Case Manager, Skegness Community Nursing Team, Lincolnshire Community Health Services

Lincolnshire Health and Care (LHaC) is a programme of work which started in 2013. Health and care organisations in Lincolnshire recognised current services did not adequately meet the needs of residents. Due to growing demands and financial pressures the different organisations realised that doing nothing about the issue was simply not an option, early financial modelling had established that in five years' time, health and care organisations in Lincolnshire will have a combined budget deficit of over £100m per year.
It aimed to improve quality, safety and sustainability for health and care services, by improving joint working for health and care professionals. A seven day services for local people through '**community neighbourhood teams**', supported by urgent care centres across the county would be implemented.
Early implementer sites commenced in August 2014, the second phased started early 2015 with plans for all Neighbourhood Teams to be in place by the end of 2015.
The Skegness NT was formed from a collaboration of staff from primary, secondary and tertiary services all with a vested interest in improving patient care. It has a strategic and operational groups.
Skegness NT has worked hard to transform the services for residents by ensuring more joined up working. The strategy group have identified and cleared many 'blockers' to integrated working. The operational team have helped many residents, which has had a significant impact on the use of emergency and acute services within Lincolnshire.
A newsletter is circulated to all services participating in the NT, sharing relevant information for the newer NTs to help prevent repetition. Pod casts about NT have been recorded.
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ABSTRACT 7: Improving Early Health Intervention to Support Residential Homes

Deborah Cheadle - District Nursing Sister, Colwyn Bay Hospital

The District Nursing service in North Wales covers a large area with a high volume of residential homes, 318 in total (CSSIW 2015). A Residential home is classed as a care home that only provides personal care for their clients (DH 2000), they usually have no qualified nurses present and rely on their local District Nursing team to provide day nursing care for their patients. Due to an ageing population, specifically pocketed in coastal regions, the need to support our elderly care services is paramount, ensuring care can be provided to meet the increasing level and complexity of our population (Office for National Statistics 2011, Conwy County Borough Council 2013). National and local drivers have recently identified that the vital importance of the role and contribution of the care home work force is not sufficiently recognized. There is insufficient investment in the sector and a lack of support to care home workers (Francis Report 2013, Cavendish Report 2013, WG 2013, Bradley & Wilson 2014, Rochira- Care Commissioner for Wales 2014).

The project intention was to develop the role of the Residential Home Liaison Nurse (RHLN). This involved a qualified community nurse based within the District Nursing team initially supporting three identified residential homes, offering training and development for their care staff in areas that were identified as being the main reasons the home was receiving District Nursing input. Data was gathered from the computer data base 'myrddin' which is utilised to input all the District Nursing visits. On examination it was evident that the main reasons the Residential homes required support these being; tissue viability, nutrition and hydration and continence management, diabetes and phlebotomy.

Aims and Outcomes

The main aims were

- **Increase the knowledge and skills of care staff within the residential home setting by providing training for at least 30% of the staff.**
  The total amount of staff who successfully received training was;
  31% Nutrition and hydration
  41% Continence

45% pressure area care and *first dressing initiative*.

First dressing initiative was developed with the pharmacy team, and the homes were provided with training in simple wound care such as skin tears. They were then given a supply of dressings from the wound care formulary so they could promptly treat their patients and then phone the District Nurses for a follow up, thus providing a proactive approach to care.

- **To decrease referrals to the District nursing team.**

  Our findings are tentative based on a single site sample of one residential home with 33 beds. Referrals to the District Nursing service within a six month period have decreased from the total in 2013 being 26 compared to 16 referrals in 2014.

- **To prevent avoidable hospital admissions**

  Although our data demonstrates no decrease in hospital admissions, when we analysed the data it was evident that there were no admissions for conditions such as UTI, blocked catheters and falls which we deem avoidable.
  In Jan – July 2013 there were 10 admissions from the one 33 bedded residential home, in Jan-July 2014 the figure is 17. The reason for the acute admissions demonstrated to us that in 2013 there were at least 4 avoidable admissions these being anorexia, Urine Infection, head injury through a fall and hyperglycemia. In comparison in 2014 there were no avoidable admissions recorded. They were admissions which needed acute admission such as heart attack, septicemia and pneumonia. These results indicate that the intervention in the home has assisted to prevent avoidable admissions.

As an additional outcome we provided phlebotomy training for 7 care staff from the three homes. They are currently completing their competencies. We hope to reduce District Nursing contacts by 80 % for phlebotomy when care staff completes their training. In total in just the three pilot homes over a year period the District Nurses performed 404 visits for phlebotomy. If we reduced that by 80% this would mean 323 less visits.

Alongside hard data we gathered soft data

- Soft Data through carer questionnaires show positive feedback and general satisfaction within the Residential Liaison Nurse service.
- Dichotomous data demonstrated that both carer and residents were positive about the role and the support they received from the Residential Home Liaison Nurse.
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ABSTRACT 8: Developing a community nursing centre for ambulatory patients – a case study

Karen Highmore, Specialist Community Nurse and **Louise Clayton**, Community Staff Nurse, North Devon Healthcare Trust

Our Trust has a strong and clear vision to deliver care closer to home with a record of developing innovative ways to develop community.

The success of these services is constrained by increasing demands and the national nursing shortage.

The Community Nursing Centre, set up in April 2014 aimed to respond to this challenge.

The service aimed to:

- Free up capacity for the increasingly complex case load by referring ambulatory patients to the Nursing Centre
- Ensure nurses spent maximum possible time delivering patient care (not travelling between patients)
- Innovate rather than use agency staff

Referrals to the centre come from community nurses working in Exeter. Patients visit the centre for a range of clinical interventions including:

- Catheter management
- Chemotherapy
- Leg ulcer management
- Wound management
- Pleurex drain management
- IV therapy

Within seven months, the centre reached full capacity and following discussions with the Clinical Commissioning Group the project was extended.

Initially some patients raised concerns over cost of transport, the distance to travel, the responsibility to bring their dressings in and remembering to bring their notes. In response the centre staff arranged storage at the centre and devised more streamlined documentation.

The evaluation has demonstrated the following benefits:

- Greater patient control, independence and empowerment as well as social confidence.
- Improved patient outcomes, particularly of leg ulcer and wound management.
- Improved healing rates.
- Improved management and control of symptoms
- No evidence of acquired infections.
- This service has been effective in reducing the community nursing caseload and has increased the wider team's ability to focus on less ambulant patients
- Reduced hospital admissions and more rapid discharge from hospital.

Following the success of this pilot similar services are now being developed across the County.

ABSTRACT 9: Community Patient Administration System (ComPAS)

James Fellows, Clinical Systems Lead, Northern Devon Healthcare Trust

Our Trust manages acute and community services across a large rural area, including 11 community hospitals 9 integrated health and social care clusters.

We have a strong and clear vision, shared with our main commissioners, to deliver care closer to home.

The major challenge facing community services in the past has been availability of accurate, robust data to support service developments, service evaluation and discussions with commissioners.

ComPAS was developed to support the capture and storage of activity data across community services. A hand -held system, it is used for case management, to plan and run the working day and enables over 800 staff to enter data using encrypted tablets.
The system aimed to provide information which would:

- Support staff to make decisions
- Support teams to review skill mix
- Ensure consistency of services
  Develop services to meet challenges now and in the future

The system and supporting IT infrastructure was developed (and continuously improved) with input from staff from all disciplines, senior operational managers, finance and patient safety.

The system has been developed using an iterative process, where data has been shared, feedback received and the system modified to reflect user requirements.

Since initial implementation, the system has become embedded in Trusts working practices to the extent of now recording 500,000 annual patient contacts.

Trust has been able to demonstrate the following benefits:

- Improved data volume and quality.
- 15% growth in home-based care.
- £1.27 million of new funding for community services, despite being in a financially-challenged health economy.
- Tangible community services efficiency improvements – 18% increase in patient-facing time, 25% for lowest-performing team.
- Savings from reductions in hospital admissions projected at £3.4M

The project has been shared widely, was a finalist in the HSJ Value in Healthcare Awards and won a national IT award.

ABSTRACT 10: Care Homes Team

Tracey Morrish. Northern Urgent Care Nursing Team Manager & Care Homes Team Lead, Northern Devon Healthcare Trust

This project was developed following an audit which showed unacceptably high numbers of people admitted to acute hospital from care homes with preventable UTIs and CAUTIs.
The project aimed to

- Reduce the number of people affected by UTIs and CAUTIs, thus avoiding distress, pain, discomfort and hospital admissions for residents and unnecessary expenditure for the NHS
- Strengthen ties between the NHS and the care home sector, which have not, historically, been strong.
- Deliver a structured education and training programme which compliments existing statutory training to residential and care homes with nursing within Northern Devon.

The team consisted of two Band 6 Nurses with administrative support who cover 19 care homes. The team delivered training sessions and follow-up support visits. There was a robust process in place to ensure that the training has been effective.

The initial pilot focussed on UTIs and CAUTIs however, the team and the homes quickly identified additional benefits:

- Better quality of care for people living in care homes
- Reduction in emergency admissions
- Prevention of safeguarding
- Recruitment and retention of care home staff
- Ability to influence and improve quality of care in care homes
- Building relationships with homes

On the back of the successful pilot, in October 2014 the team expanded to cover 60 Care Homes throughout the Northern Devon locality. The team expanded to include a Band 7 Lead Nurse, an additional Band 6 Nurse, a Safeguarding Nurse and a Band 6 Occupational Therapist.

The team now offer training and support on a variety of subjects and also offer more bespoke training to cover individual Care Home need.

The project has recently won the Guardian Public Sector Award for Excellence in Partnership and recognised by the Chief Executive of NHS England as something that would be welcomed across the NHS as good practice

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ABSTRACT 11: The development of a practice nurse led complex wound clinic

Trudie Young, Director of Education and Training and **Sian Cryer,** Welsh Wound Innovation Centre, Pontyclun, Rhondda Cynon Taff

The development of a practice nurse led complex wound clinic
GP practices and their nurses have generally been overlooked as potential contributors to successful wound healing. A GP practice located in South Wales in conjunction with the Welsh Wound Innovation Centre (WWIC) (the national centre for excellence in wound healing), developed a complex wound clinic, to improve patient outcomes, reduce referrals and minimise cost, which involved the following;

- An education and training needs analysis and subsequent bespoke education and training program.
- Identification and supply of the resources to support a complex wound clinic.
- Development of referral pathways to specialist wound healing and lymphoedema services.
- Development of a wound dressing, emollient and compression therapy formulary
- Documentation was developed to obtain consent for photography of wounds.
- Development of a database of wound-relevant descriptors to allow accurate documentation of wound assessment and management facilitating audit of wound care outcomes and costs.

The practice nurse and director of education and training (WWIC) worked together to implement evidence based care within the clinic.

In the three months before launch of the wound clinic 28% of patients with wounds healed during treatment, in the first three months of the wound clinic over 60% of patients' wounds healed. The people attending the wound clinic have ranged in age from paediatric patients to the elderly and have presented with a wide range of wound aetiologies; skin tears and grafts, arterial and venous leg ulcers, malignant wounds, dehisced surgical wounds and diabetic foot ulcers.
This initiative has established a new innovative service delivering high quality wound care within a GP practice and has brought together a wide range of professional groups; practice nurse, GP, wound care industry, practice manager and WWIC staff.

Extending this initiative further may create awareness that GP practices and the practice nurses may have a significant role to play in the management of wounds.