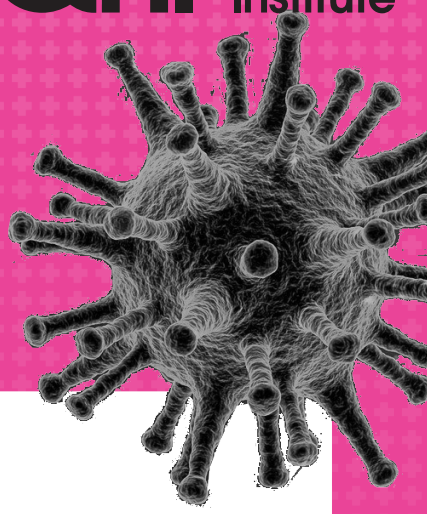
The Queen's Nursing Institute

Community Nursing Covid-19 Innovation/Best Practice

CASE STUDY

The development of a single point of access for the Community Home Visiting Service



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Personal details

Name: Chrissy Luff
Job title: CHC Assurance Manager: Interim Community Care Practitioner (During COVID)
Employer: NHS England & Improvement

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Please describe your practice innovation

I was redeployed from NHSE/I to Bollington, Disley & Poynton (BDP) Community team during the COVID pandemic. BDP Care Community has worked jointly with the Primary Care Network in response to the pandemic, co-ordinated by the Area Coach, Rhoda Gaylo. Rhoda's passion and commitment to caring for the local health population during the global crisis was at the heart of this innovation to provide a safe refuge in the face of the pandemic. As a result, the Single Point of Access (SPA) was developed to support the BDP's Visiting Service, to help streamline visits for urgent and non-urgent visits, including those that are associated with Covid19 symptoms.

The Single Point of Access is a process where all professionals including GPs, DNs, allied health professionals, social workers and hospital trusts can access an appropriate response from the right person at the right time. Patients and/or their carers receive a phone call from an experienced clinician to establish an individual's needs via a virtual holistic assessment. The clinician will then refer to the appropriate service, arrange a home visit or provide advice. Where a home visit is required, it will be assigned to a responder, nurse and or allied health professional, who will conduct a face to face assessment of the patient to ascertain which of these four care options is the most appropriate:

1. Visit and treat, where appropriate, includes element of prescribing competency.
2. Visit and treat with support of an On-call GP
3. Visit, treat, and collaborate with other service providers
4. Visit, treat, and refer to secondary care, as needed.

The concept aims to provide effective delivery of patient centred care, avoid unnecessary hospital admission, and avoid duplication of visits. The involvement of an On-call GP for community support makes this a unique single Point of Access model.

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How has this enabled you to treat/support patients/residents/families/carers more effectively and safely?

The development of the BDP Single Point of Access for home visiting service is to cover Bollington, Disley and Poynton footprints of Eastern Cheshire CCG. The service will have a number of benefits to the patient, to General Practice and to the wider health system. All home visits requested through the Middlewood GP Partnership will follow the pathway for assessment and, where appropriate, the delivery of that visit will be triaged by a senior clinical decision maker to ensure the individual receives the right care, at the right time, by the most appropriate professional.

The service currently runs five days a week from 8am-5pm. Visits that can be undertaken with prompt responsive service have a higher probability of allowing patients to remain at home, as they are able to access same-day diagnostics without the necessity of hospital admission. By enabling the review and treatment of patients to take place promptly in the working day, any subsequent use of services will be optimised. The service will also reduce the spikes in demand for admissions to hospital that are a consequence of an "on the way home" visit that is currently undertaken.

The Single Point of Access is our main road system which enables us to tailor healthcare based on real time population need. Links have been formed with the End of Life Partnership to work with team BDP, particularly for palliative patients and patients with Dementia. We have established pathways to support palliative and Dementia patients who may hit crisis point, to avoid risk of unnecessary hospital admissions and to preserve patients' preferred place of care.

The service is working well with approximately 300 patients assessed and approximately 50 hospital avoidances since its inception in mid-April 2020.

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How has this enabled you to work more effectively with colleagues/partner organisations?

In support of wider goals, our team and partnerships aim to deliver an effective responsive service with the inclusion of workforce support and their engagement with local partners in the wider care community. Significant system-wide changes has undertaken to support capacity to ensure sustainability on avoiding unnecessary hospital admission, streamline visits, avoid duplication, and provide patient-centred care at the right time and place.

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Do you see this new way of working as a temporary adaptation to current conditions, or a permanent/evolving change?

The implementation of the Single Point of Access is undoubtedly shaped by the covid19 pandemic. It was during this unprecedented time that we developed a high level of care model to meet the state of vision to support our local population. The service was initially supported through my re-deployment from NHS England, enabling BDP to trial new ways of working. Due to the benefits it has contributed to patients and the wider system, we aim to continue to have integrated care and partnership with the Primary Care Network in the hope to be able to continue to provide an effective responsive service for the delivery of quality patient-centered care. Systems and Processes are in place and regularly being reviewed to ensure its operational delivery is aligned to Cheshire East Partnership Five Year Plan and the NHS Long Term Plan.

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Please describe any particular challenges you had to overcome.

The challenge remains around sustainability in view of capacity and demand, matching speed with the high volume of patients required to be assessed. The requirement of a highly skilled clinician to triage the referrals proves to be the core role, in order to achieve the desired outcome in delivering the right care, at the right time, by the right professional. We achieve this by making sure we plan the rota for a triage clinician and the visiting team far in advance to make sure we can rectify any gaps.

Another challenge is around changing the mindset and culture of our workforce. At first, staff felt this new way of working was an added pressure to their daily workload and also felt overwhelmed about the triage and responder role. We overcame this by supporting our workforce through shadowing sessions, to enable the staff to understand the new roles and offered competency need analysis to map areas of development requiring support. We also delivered a team Q & A session to discuss the 'whys and hows' of the service implementation to give staff the opportunity to address their queries and concerns.

Rhoda Gaylo, the BDP coach and lead of this innovation and change, utilised her skills around the concepts of command, control, coordination, compassion, and support, alongside the importance of clear structure and guidance for staff.

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Please describe any continuing challenges you would like to address.

The need for social distancing and self-isolation have contributed to the reduced visibility of the social worker input in such a way that it makes it more difficult for staff to communicate urgent social care queries. However, we were able to bridge this gap by having a social worker who volunteered to be contacted virtually or via telephone call for urgent social issues about a patient referral.

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Please list any websites, online platforms or apps that have helped you.

Coronavirus guidance for health professional GOV.UK NHS England and Improvement guidance; SCIE; Webinars

9/

What are the main pieces of IT or other equipment you need (e.g. digital camera, phone, laptop, iPad).

Digital camera for digital consultations; Mobile phone for Triage and responder; Laptop for access to systems; ipad for virtual consultation with GP and patient

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Please give any individual examples, quotes or other information.

'Leadership is about empathy. It is about having the ability to relate to and connect with people for the purpose of inspiring and empowering their lives.' Oprah Winfrey

'The service is working well with approximately 300 patients assessed and approximately 50 hospital avoidances since its inception in mid-April 2020. Chrissy Luff