PRIMARY CARE OR COMMUNITY SERVICE REDESIGN INITIATIVE

WINNERS

PRIMARY INTEGRATED COMMUNITY SERVICES (PICS)

ACUTE HOME VISITING SERVICE

What is it?
A responsive and effective home visiting service for patients that prevents them attending A&E and relieves GP workload (Reference 1).

Who is involved?
Any housebound or care home patient requiring an acute same day visit from a GP was seen by a highly skilled and experienced Advanced Nurse Practitioner, with non-medical prescribing skills, highly experienced in Primary Care with good skills and competencies in urgent conditions, including acute respiratory and cardiac conditions.
Who we serve
Acute Home Visiting Service was piloted Newark in 2017, providing support to 7 general practices in the locality serving 76,000 patients.

JUDGES COMMENTS

The judges felt that Primary Integrated Community Services has a hugely impressive service with a wide impact and spread, that closely involves multiple system partners. This winning team has very clear transformation ambition and a good deal of this need for change is recognisable in other parts of the country. The savings returned on the initial investment is impressive. This service demonstrates very well efficiencies that benefit commissioners, clinicians and most importantly patients.

HIGHLY COMMENDED

Northern Devon Healthcare Trust
Improving outcomes through the Lower Limb Leg Ulcer and Well Leg Service

The Lower Limb Leg Ulcer and Well Leg Service was set up by Northern Devon Healthcare Trust in July 2018. Historically the service was provided by individual GP surgeries. Through an ambitious service redesign project, we have drastically improved heal rates for patients, patient experience and professionally developed community nurses in northern Devon.

Patients with open wounds on their lower legs or with a history with leg ulcers are now able to attend any clinic in a community hospital in northern Devon or a well leg event, and the service can be flexible, such as through home visits.

JUDGES COMMENTS

The judges commented on how clear to see the passion and pride in this nurse led service was. The judges were impressed to learn how the service has adapted during the current pandemic with the self-care aspect of this project and how empowering this has been for patients. It is no wonder that Northern Devon Healthcare Trust have received incredible feedback from patients with 100% of patients recommending the service for the last 18 months.

FINALISTS

Brigstock & South Norwood Partnership
Embedding group consultations for people with Type 2 Diabetes

The Brigstock and South Norwood Medical Partnership serves a diverse Black and Minority Ethnic (BME) and Eastern European community of 11,000 people in an area of acute deprivation in Croydon. The practice's prescribing pharmacist and nurse prescriber have introduced group consultations as their 'first contact' for General Medical Services (GMS) Quality and Outcomes Framework (QOF) diabetes reviews. They have reviewed and followed up 60% of the practices' 1,054 patients with Type Two Diabetes in group clinics, and measured positive outcomes and quality and efficiency impacts for the team, patients and the practice.

Kent Community Health FT and Maidstone Borough Council
Rough Sleeper Project (Maidstone)

As temperatures plummet in the winter months, cold weather can prove fatal for people sleeping on the streets.

Many already have health issues and these can be made worse by the freezing cold weather.
With statistics showing that the average age a homeless man dies is 44 and for a woman, 42, our Complex Care Nurse Community Service is helping some of those in need.

Last April KCHFT were approached by Maidstone Borough Council to provide a nurse led clinic for the rough sleepers in the town. The drop in clinic also provides support to those living in temporary accommodation.

Bristol, North Somerset and South Gloucestershire CCG
Reducing unwarranted variation in primary care chronic disease monitoring

The aim was to reduce over-testing in primary care for chronic disease monitoring across Bristol, North Somerset and South Gloucestershire (BNSSG). Over-testing increases staff workload, wastes patients' time and causes patient and staff anxiety.

The BNSSG CCG Clinical Effectiveness Team standardised the blood tests by working with local GPs, a practice nurse and biochemists from our three hospitals to redesign this important area of care.

BNSSG serves a population of 1 million people who live in urban and rural areas and has 83 GP practices that have 923 GPs, 488 nurses, 182 HCAs and 41 phlebotomists between them.

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FINALISTS

Lewisham and Greenwich Trust, South London and Maudsley FT and Lewisham CCG
CATFORD Care Homes Project

257 falls were recorded in 15 Lewisham Care homes over a six month period. The greatest numbers occurred in residential homes and 71% of those that had fallen had dementia.

The service redesign initiative involved collaboration between Lewisham Community Falls Service, Lewisham Care Home Intervention Team and Lewisham Clinical Commissioning Group. The starting point was the development, delivering and evaluation of a joint falls training programme for care home staff which had a specific focus on residents with dementia.

Post training evaluation demonstrated improved identification of physical and psychological falls risk factors and a reduction in resident falls.

NHS 24
Primary Care Triage Scotland

Demand for 'same day' access to Primary Care has been consistently rising and redesign of primary care models is needed to support sustainable safe services.

Scotland's national digital healthcare provider NHS 24 partnered with Riverside Medical Practice and East Lothian Health and Social Care Partnership to develop a new clinical pathway to:

- Support primary care demand through NHS 24's bespoke care navigation
- Effectively triage patients with 'same day' needs to most appropriate healthcare professional
- Increase GP capacity to focus their expertise on the most complex patients
- Raise awareness of the community multidisciplinary team's high quality skills and expertise

North Bristol Trust and Hanham Secure Health
HMP Bristol Hand Injury Project

Violence levels within prisons are high. Hand injuries represent a significant cause of morbidity, and impact upon rehabilitation. The challenges of transporting prisoners led to missed appointments and wasted resources.

Clinicians at Bristol Prison and North Bristol developed tools for triage in the prison setting and a pathway for access to clinic, surgery and physiotherapy. A "one stop shop" reduced number of visits required. Missed appointments and delays to treatment were both significantly reduced.

Patients received better care, sooner, in fewer visits. Prison and Hospital resources were saved, improving care for other patients & prisoners, along with significant financial savings.

Northumberland CCG, Northumberland County Council and Northumbria Healthcare FT
The Northumberland Continuing Healthcare Partnership

The Northumberland CHC partnership is an innovative agreement which enables Northumberland County Council to manage the CHC process on behalf of NHS Northumberland Clinical Commissioning Group, with nurse assessment carried out by Northumbria Healthcare, and managed under the council and trust's integrated management structure.

The aim is improve patient care and mitigate the impact of increasing CHC costs.

Both objectives were achieved this year with the CCG coming out of financial special measures and the CHC team achieving 95% on the 28-day target, with patients receiving seamless integrated services as they move between CHC and social care funding streams.

Tameside and Glossop Integrated Care FT
District Nursing Service Redesign – A service fit for the future

Anecdotally, the District Nursing Team reported low staff levels and an increased demand in complex patient care across the Tameside & Glossop population. However, the core activity data did not support this theory as activity had remained static. Working in partnership with our Corporate Information Team the District Nursing Team wanted to take an innovative approach to redesign their service. The ambition of the project was to create a level of detail and insight which highlighted changes in complexity, to facilitate safer caseload management and demonstrate additional resource requirements in terms of staffing numbers and skill mix.

University of Manchester, Health Innovation Manchester, Heywood, Middleton and Rochdale CCG, Bury CCG, Salford CCG, Wigan Borough CCG
The DECIDE™ Education Programme; supporting community clinicians

This project is was an education innovation (The DECIDETM programme) supporting primary care decision making skills. The programme was undertaken by GPs, practice nurses and advanced nurse practitioners from 39 practices across one CCG. This project involved collaboration between Heywood Middleton and Rochdale (HMR) Clinical Commissioning Group, the University of Manchester and Health Innovation Manchester. The aim was to improve patient outcomes, change referral and prescribing patterns: addressing skills gaps to change clinicians' practice through evidence-based education. By developing this at an organisational level we were able to target health priorities for local populations and services.