NHSBN CASE STUDY

Community Nursing Discharge Team within Procare Health Ltd

Procare

BACKGROUND

Procare Health Ltd is a federation of GP surgeries across Guildford and Waverley. Procare represent 19 of the 20 GP practices within their area, with the surgeries remaining independent organisations. The aim of the federation is to work together at scale to further develop patient care.

Adult community services for Guildford and Waverley are run in a joint venture between Procare and Royal Surrey Foundation Trust. It's the first contract of its kind in the country, with an acute trust partnering with a GP federation. Adult community health services provide care to patients in the community; maintaining their health and independence and preventing unnecessary hospital admission. They include services like district nursing, podiatry, rehabilitation beds and therapists.

This case study will specifically focus on the Procare Community Nursing Discharge Team (CNDT). This team's focus is around driving person centered care closer to home. It does this through integration and clinical leadership, providing adult community nursing 24-hours-a-day, 365-days-a-year.

With a key focus on providing advice and treatment for people in their own homes, the team is made up of community matrons, district nurses and community night nurses. The ambition in running these services is to improve the integration between GP, community and hospital services so that they work more closely together. The community team provide a better service for the individual if the system works as one, allowing teams to work more closely together and the information to be available to support patients throughout their illness.

The aim of this initiative is to place people within community nursing, freeing up capacity in the acute setting and reducing the chance of re-admission for the discharged patient.

DESCRIPTION OF INITIATIVE

The initiative for the project came from a district nurse within the team. The nurse identified the need for community nursing input at the point of discharge from the acute hospital. This was to ensure an efficient, smooth and safe discharge home for patients, who required referral in to the community nursing service.

In 2021, approval was granted via Better Care funding for two nurses to work as part of an in-reach model within the local acute hospital for a three-month pilot. This started in January 2022, the impact resulted in further funding year-on-year, but now for three nurses and an administrator.

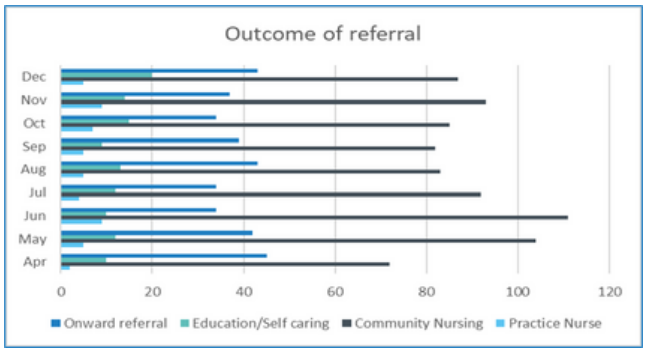
The role has evolved to not only support referrals to the community nursing service, but also to support with the discharges of patients that have no criteria to reside. Furthermore, proactively managing the high intensity users jointly with the acute trust to support flow within the hospital.

BENEFITS

What have CNDT achieved:

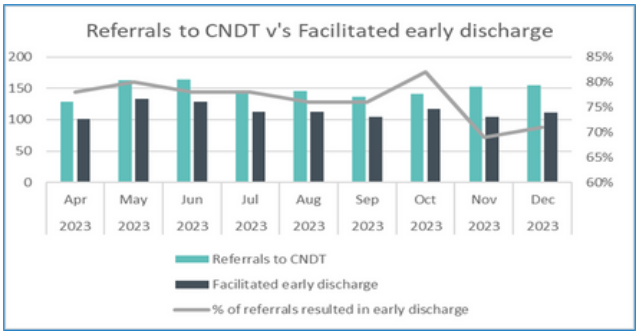
- Benefits to the community nursing teams, the acute hospital and most importantly the patient.
- Improved collaborative working with the acute hospital/building relationships.
- Promoting how the community nursing team can support safe discharge, reducing risks for the patient.
- Education and training to the wards to support effective onward referrals, ensuring a seamless service for the patient.
- Improved patient flow by facilitating timely discharges, so increasing availability of acute beds.
- Signposting patients to the right care/support before discharge, minimising impacts on community nursing resource and reassuring patients leaving the acute setting.
- Areas to develop - preventing unnecessary hospital admissions by identifying patients known to community nursing and turning them round at the front door if appropriate.

BENEFITS (CONTINUED)



Procare's chart on the left demonstrates that majority of referrals are successfully placed with community nursing, showing the effectiveness of the community nursing discharge team's input. Those that are onward referrals are typically where community nursing is not approporiate but other input is needed, e.g., a specialist nurse or where the patient's residence is out of the community nursing team's area.

Procare's chart (right) shows the number of referrals into the CNDT (teal columns) and the consequent number of facilitated early discharges (black columns). The grey line on this chart then shows the percentage of referrals into the community nursing discharge team that resulted in early discharge. Notably, on average, around 75% of referrals to the CNDT successfully resulted in early discharge.



Procare's chart on the left shows the average number of bed days saved per patient. The chart shows that there is some variation month on month but shows the trust was able to successfully save around 1.5 to 2.0 days per patient. Therefore, increasing patient follow and increasing capacity to admit and treat more patients.

SEE THE IMPACT OF THE INITIATIVE IN THE NHSBN DATA

Through the 2023 NHSBN District Nursing project, we established that 13% of referrals originate from an acute hospital ward or emergency department (2023 NHSBN District Nursing Data).

Procare receive an above average proportion of referrals from acute hospitals and EDs.

We also established from the same project that on average 96.6% of all referrals are accepted by District Nursing teams, again Procare has an above average referral acceptance rate.

THANK YOU FOR READING

INTERESTED IN SHOWING HOW YOUR ORGANISATION HAS USED NHSBN DATA?

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