

Working in partnership to transform the community nursing workforce model to meet changing demands

Doncaster Clinical Commissioning Group and Rotherham Doncaster and South Humber NHS Foundation Trust

What was the problem?

The CCG and the trust, as its community nursing provider, reviewed the community nursing service to ensure it could support patients safely in their own home, maintain their independence and avoid hospital admission. It found:

- a fragmented and disjointed care model that was task-focused rather than patient-centred
- a lack of holistic and seamless care affecting continuity, with unnecessary demarcation and transfers
- inconsistency at practice level straining relationships between primary care and community nursing.

What was the solution?

A community nursing model that focuses on levels of patient need, enhances quality, avoids duplication, improves productivity and efficiency, and enables robust contract management. The team adopted a planned and unplanned 'rapid response' care approach with 24/7 call handling and clinical triage. Each patient has a holistic complexity assessment at first visit to determine the level of care they require, including health and psychological needs along with environmental and carer impact. The team introduced a case manager model, which:

- clarifies caseload and holistic care delivery
- allocates patients to individual nurse caseload, enabling continuity of care
- identifies patients who need case management and matches them to the right professional using the complexity tool
- better aligns community nurses and GP practices.

What were the results?

- Vacancies reduced from 10% in 2014/15 to 1% in 2015/16.
- Improved capacity and demand management due to differentiating urgent and planned workload; a ringfenced team handles unplanned activity, allowing case managers to undertake allocated workload, therefore providing more holistic care.
- Improved pathways and case management based on patient feedback.

- Improved efficiency and less duplication, through appropriate staff deployment; staff in clinical triage can have a 'clinical-to-clinical' conversation with colleagues in primary care to ensure those with the correct skills visit the patient the first time.

What were the learning points?

- Exploring opportunities for greater connection with mental health services.
- Ensuring connectivity to other transformational change programmes, including care home intermediate care, end-of-life and urgent care work programmes.
- Ensuring discharge processes are efficient and seamless, with a joint CQUIN between the trust and the acute provider.

Find out more

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