Introduction

Welcome to the latest issue of our Coventry Out of Hospital newsletter. Read about the exchange visits with SWFT to each of our iSPAs to share experiences, plus an interview with a member of our iSPA team. In addition, there's an introduction to our new Care Navigators, our Clinical Reference Toolkit app pilot, and more...

Out of Hospital programme update to Stakeholders
December 2018

iSPA good practice sharing

Staff from our Trust and South Warwickshire Foundation NHS Trust (SWFT) recently visited each other's new Out of Hospital integrated Single Point of Access (iSPA) centres.

The iSPA functions have been established as part of the new Out of Hospital care model across Coventry and Warwickshire.

Staff from both Trusts visited the other's iSPA to share their experiences of the new functions.

Natalie Curran, Central Booking Service Lead, said: “We are very pleased to be able to showcase our iSPA with our partners. The visits gave us all the opportunity to see the excellent work within the iSPAs and share our experiences. We were proud to be able to show how we manage referrals, our clinician-led triage system, and our process for capturing data.”

iSPA staff (L-R back row) Keeley Whitmore, Community Nurse; Kerrie Haley, Community Nurse; Eileen Gittins, Sister Urgent Care and Reablement; Lynette Sutton, Lead Physio for Urgent Care and Reablement; (L-R front row) Aaron Jenner, iSPA Admin Support; Steven Wise, Advanced Nurse Practitioner
Pinnacle role of Care Navigators

As part of the development of the new Out of Hospital care model our Trust has recruited six Care Navigators within the new Place Based Teams.

Care Navigators will be play a crucial role in helping people to get the right support, at the right time to help manage a wide range of needs. This may include support with long term conditions, help with information and signposting to a range of statutory and voluntary sector services.

Claire Johnson and Penny Conroy (not in photo) are Lead Care Navigators. They will be supporting the newly recruited Care Navigators who are operating within each of the Place Based Teams. The Care Navigators have been building excellent community links - attending and observing local support groups to build connections and relationships. These include local community groups, charities, voluntary services, churches, libraries across Coventry.

The role of Care Navigators will be to build relationships, problem solve and help locate resources, serving as a link between community, health and social services.

They will advocate the needs of people, they are enabling and focused on recovery, to strengthen the work of the multidisciplinary team. A key purpose is to ensure patients experience seamless, joined up care and support.

Helen Anderson, Service Manager for OoH, said: “The care navigation service is a key element to the integrated care vision of our Trust and the OoH model. The care navigators will be focussed on supporting people to access community and voluntary sector services, helping them remain independent and well, and reducing the need or even preventing avoidable primary or secondary care activity.

“Care Navigators can take the time with patients, building a trusting relationship with them and establishing what they believe their care and health needs truly are. By understanding what motivates any patient, they can then support even our most vulnerable to engage with local voluntary and community services.

“It is often just the little things that can make a huge difference to someone’s physical and mental health and well-being, but the potential impact of this could mean less dependence on NHS-run health services through increased prevention, whilst empowering patients to take the lead in their own self-care.”

(L-R) Care Navigators: Susan Lewis, Louise Boulter, Doreen Mochia-Owusu, Donna Barnes, Sheryl Richardson, Aldona Saniewska, Claire Johnson (Lead Navigator)
Clinical Reference Toolkit app pilot

A new Clinical Reference Toolkit app is due to be piloted in December to support clinical practice within Out of Hospital services.

The Clinical Reference Toolkit is a resource for staff to use within clinical practice to assist in their decision making, with quick and easy access to accredited information.

A dedicated application has been created for our Trust iPhones and iPads which will support offline viewing of documents and information. In addition, the toolkit will be available in a web version to be accessed on PCs and laptops. Some of the information will also be available in handbook format.

Following feedback and a review in early 2019, it is hoped that the Clinical Reference Toolkit app will be available to all staff.

Hayley Best, Practice Development Facilitator, who has lead on developing the toolkit is very positive on how it can support staff and patient care. She said: “I feel staff will benefit immensely from being able to utilise the Clinical Reference Toolkit App, as they will be able to access accredited clinical information and guidance quickly and easily whilst working out in the community. It will also support staff in facilitating the care for their patients and support any decision making whilst increasing the clinician’s confidence.”

Successful Multi-Agency Discharge Event (MADE)

Staff from our Trust recently attended a Multi-Agency Discharge Event (MADE) co-ordinated by University Hospital Coventry and Warwickshire NHS Trust (UHCW) over two days in November. Senior representatives from Clinical Commissioning Groups, community services, the acute Trust and Local Authority services attended the two day event at UHCW to rapidly identify each patient’s discharge or transfer of care needs and work to resolve blocks and complexities.

The main aim of the two day event was to:
• support patient flow across the system
• recognise and unblock delays
• challenge and improve the complex processes we currently have

Staff from our Trust were part of small teams who visited allocated wards and joined both the morning and afternoon board rounds to capture the progress of each patient along their agreed care pathway, highlight, challenge and unblock delays and support safe and timely discharges.

Mary Wells, Advanced Nurse Practitioner was one of the team of staff from our Trust who attended the event. Mary said: “The event was beneficial for partners to understand the range of services available within the community and the new Out of Hospital care model including the Place Based Teams. The event helped develop vital communication links between the care teams, so the process of the patient journey from hospital to home becomes more seamless.

“From a process perspective it is important to identify trends for admission to acute care, and to look at how these patients can be cared for more effectively within the MDT model of the placed based teams.”

A further MADE event is to be planned in January 2019; details will be released as soon as they are available.
My view of the iSPA by Eileen Gittins, Sister Urgent Care and Reablement

Eileen is very enthusiastic and passionate about working in the new iSPA for Out of Hospital. Having previously worked with Immediate Care Services, Eileen has fully embraced working in the new iSPA since March 2018.

Eileen said: “The multi-disciplinary team working is great and we are able to discuss cases and how we best manage patients. The iSPA brings a wealth of skills from a variety of nursing and therapy staff. It’s useful that all calls and referrals come into one place and cases are then triaged and directed into the appropriate teams.”

Eileen feels some of the benefits of the iSPA and the new OoH care model include:

• Patients are getting supported by the right clinician
• Communication with patients is improved
• Patients are seen quicker
• Urgent visits are prioritised
• Each patient’s journey is clearer and easier for them to understand

She has created a staff photo calendar of the iSPA and Central Booking Teams and is currently preparing one for the Urgent Care and Place Based Teams.

Eileen continued: “The calendar brings people together, is a bit of fun and helps the team integrate with each other. I can really see the vision behind the iSPA and how it’s benefiting the patients.”

Coventry Out of Hospital service – December highlights

Below are some of this month’s highlights and our next steps:

Achievements

• We hosted an iSPA visit with SWFT staff which was received very well.
• Care Navigators are being integrated into Place Based Teams.
• Communication has been circulated to all GP cluster leads including names and contact details of key staff members in Place Based Teams and Central Hub.
• iSPA details added to GP Gateway to provide easy referrals.
• Patient engagement group has increased attendance and participation.
• Electronic Patient Record business case reviewed by Trust Board.
• Trust website updated and GP Out of Hospital poster and postcard circulated to Coventry and Rugby CCG for distribution to GP practices.

Next steps

• Electronic Patient Record business case taken to the next stage internally.
• Continue work to establish system wide multi-disciplinary teams (MDTs).
• Visit SWFT iSPA and MDT meeting to share good practice.

Get in touch:

If you have any feedback or suggestions regarding content for this newsletter, please email to communications@covwarkpt.nhs.uk and give your email heading ‘Out of Hospital Communications’. We would love to hear from you.

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