THE SEVEN CHURCHES PARISH NURSE PROJECT

Executive Summary: The Parish Nurse
Phase 1 – December 2015 to October 2016

Purpose

Our Parish Nurse (PN) project was the result of concern from villagers that there were people who were lonely and suffering with needs that were not being met by existing services in our community.

We wanted a Parish Nurse to

- Visit lonely and vulnerable individuals to identify their needs and see what could be done to make a difference
- Help ensure that people have appropriate and coordinated services, working in liaison with existing services and carers
- Support people and their carers by signposting and providing them with appropriate information and where appropriate, provide them with relevant knowledge and skills training.
- Improve the knowledge, skills and ability of villagers to help meet the needs of others.

We envisaged that the Parish Nurse would care for people holistically, and improve the health and wellbeing of individuals as well as the community as a whole. The plan was for a 3 year project, with built in evaluation and review to describe needs and how these are best addressed.

Structure

Many people covering a significant cross section of local communities were involved at the planning stages of the project.

When the Parish Nurse was appointed in December 2015, a Management Group comprising 2 Members from Hildersham PCC (the employing organisation and line manager), a GP (Primary Care),and a retired Public health Consultant (Evaluation) was formed to manage the project. This Group ensured that all relevant policies, pay and tax mechanisms, lone worker arrangements and communication systems were in place. Honorary contracts with both Sawston and Linton GP practices were secured. A NHS lap top computer supplied by the GP practice enabled the sharing of information between GPs and the PN. When Sawston and Linton GP practices merged in April 2016, the PN's honorary contracts became an honorary contract with Granta Medical Practice. Administrative support for the group is provided by the Parish Administrator. The PN was inducted to possible data collection mechanisms and a service user questionnaire was developed to obtain feedback from users/carers. Clinical and spiritual supervision, training and networking with other Parish Nurses is available from the Parish Nurse Ministries UK. (www.parishnursing.org.uk)

Unexpected personal and family circumstances caused the appointed Parish Nurse to resign from her role in October. We were fortunate and grateful that the Regional coordinator for Parish Nursing Ministries UK was willing and able to step in to ensure complete continuity of service and giving us time to review and re advertise the post in the New Year.

Activity

The Parish Nurse's first two months was spent primarily in getting to know people and "the patch" which included local primary and secondary schools, the S. Cambs locality team, pre-school groups, voluntary organisations working in the area e.g. Age UK and Care Network, the community services team, the multidisciplinary teams, churches, church groups and community groups. Links were established with Addenbrooke's (discharge planning), and with Arthur Rank Hospice. The Nurse met with more than 50 key people in the different villages and attended induction tea parties, church services and thus was made known to over 800 people.

Since appointment, the PN has provided help and support for than more than 70 different patients/carers, ranging from a year old to people aged over 90. Some patients are in their 30s and 40s, but a significant proportion are 65 and over; some live alone while others are living with their spouses and may have family near or further away. Referrals have been received through members of the community(many of whom are church goers), GP practices, the ministry team,

voluntary and statutory organisations including South Cambs District Council and self referrals. More than 80% of the PN's work has been with people who are not church goers.

A very small number of patients/carers (less than 5) have been supported for the whole 10 months. New patients are referred every month. Some patients have died or decided that they can manage without further input. For a small number of people input has been intensive. One patient needed daily response to innumerable texts and phone calls. At points of crisis or rapidly changing circumstances, patients have been visited or phoned daily but the level of input usually eases over time to weekly or fortnightly visits/phone calls as situations stabilise.

The PN has also regularly attended some local groups (~20-50 members), church events, and has also led a school event the purpose being to network, promote health/wellbeing and provide help and support for individuals. The PN attends multidisciplinary team meetings with health, and meets with other voluntary and statutory organisations monthly these meetings keep her informed of vulnerable individuals and enable her to coordinate input for clients and share information about security and safety.

Events
Prior to the PN's appointment a number of health information meetings had taken place in the villages covering: First Aid, Use of NHS, Child Health, Mental health, with average attendance of ~30 per session, and attendees saying how much they learned from these sessions. As the PN had identified a need to open conversations on dying, an event entitled "Things we do not talk about" – featuring Libby Purvis, Alisdair Coles (Academic Neurologist and Priest) and the Bishop of Huntingdon, was attended by more than 90 people. Feedback was excellent and we anticipate more detailed follow up discussions as a follow on from this event.

Description of needs:
Needs encountered have been wide ranging, from people asking for health advice on the street to:

- Crisis resulting from a poor discharge:
  Discharged at 6.30pm instead of 10 am. Patient had sat in wheelchair all day and was wet through. Various parts of the care plan were not in place, making transfer of patient back to home difficult. No pen to administer insulin. All this resulted in considerable distress for the patient, carer and potential for failed discharge.
- People with mental health problems including significant help and support for a long term patient known to many services with very complex social, psychological, mental as well as physical health problems
- Support and help with information, discharge, care arrangements, pain management, of patients and carers with e.g. dementia, people requiring palliative care, long term conditions. Cancer,
- Emotional and practical help for patients, carers and families to come to terms with bad news and long term conditions.
- People in distress or lonely
- Providing information and skills training pre and post op.

For these needs, the PN provided:

- On the spot, hands on input in crisis
- Emotional, health and spiritual support,
- Access and links for integration into villages/communities.
- An advocate for people, helping people articulate their needs, and improve their confidence
- A signpost, referral service to other services– statutory and voluntary:
- Secured care packages, identifying flexible options.
- Information to enable more informed choices/management of care and symptoms for patient, carer and family.,
- Protection for someone at risk
- Provided respite (no respite care available currently)

Outcomes of PN's input
Outcomes include:

- Prevented a nursing home placement: Persuaded consultant that patient can return home
- Successful reinstatement of patient in home in spite of high failed discharge risk.
- Secured systems for ongoing care including support and input from the local community.
- For a person originally alienated from statutory services, achieved compliance and attendance for a series of tests to check physical health.
- Instigated investigations to correct a misdiagnosis and proper treatment to be started.
- Improved quality of life e.g. no longer incontinent because of appropriate treatment.
- Families given choice and control over ongoing management. Carer back in charge.
- Ensured systems in place for daily living, enabling carer/spouse to be there for the patient.
- Stabilised situation e.g. for Mother caring for a child with complex needs.
- Secured a safe placement for a vulnerable person
- Improved skill and confidence of patients and carers e.g. administer injection post op
- Reduced social isolation: introduction to new social activity, making new friends locally
- Enabled dying well at home
- Reduced calls to services e.g, police

Our management structure has been resilient to change : resignation of Priest in charge and the PN within this first year of the project.

Work in progress
The PN had always worked with community members and in the last few months work has started to identify people who wish to be more formally involved with the project as volunteers.
The PN also now has a desk at Linton Health Centre, providing opportunities for closer team working with other primary care members and easy access and sharing of information.

Finance : The service is operating in line with the planned and funded budget.

Summary :
Feedback from the local people has been very appreciative of the work done: A quote from a returned questionnaire:

"The service has proven a great help in the care/pastoral care of both my elderly parents. Also the PN has been a great listening ear, and able to signpost me to various other agencies, resource, such as the Community Wardens, with whom contact was made and she also now supports my parents. Every parish should have a Parish Nurse"

The first 11 months of the service has done what we hoped it would do: identified what the needs are, made it clear what the service is about and how it can help. As we reflect and seek to learn from what has been done, we are grateful for the legacy that our first PN has left us and of the time and effort that everybody involved in the project has given so freely in so many ways to enable the project to take shape, and take place.

We are very pleased with the progress made but there are always questions raised and ways that we can improve. We have yet to work out if and how we formalise more volunteering" to help plug some of the needs identified. We have to find out how we make all this sustainable, financially and practically.

We always welcome comment, feedback, good or bad. This project is the communities' and it will only work if villagers/communities see what it means for them and can express their views, concerns, wishes, and help.

We look forward to describing the project as it progresses and develops as we seek to explore how and what we need to put in place to form a knowledgeable, resilient caring community.

Hildersham PCC, Parish Nurse Management Group - 23rd November 2016