Seven Churches Parish Nurse Project

Notes for Little Abington Parish Council – April 2017

1. Purpose

Little Abington Parish Council have financially supported the Parish Nurse Project. Councillors have asked for some information regarding the governance, management and activity of the Project and this note seeks to meet that request.

2. Governance and Management

2.1. The Parish Nurse is employed by Hildersham Parochial Church Council on behalf of the Seven Churches. The Parish Nurse has an honorary contract with the Granta Medical Practices which enables her to have access to the clinical team and systems in the practices and, with appropriate consent, to patient's notes.

2.2. The management of the project is delegated to a Parish Nurse Management Committee which is formally constituted committee of the PCC. The membership of the Management Committee comprises:

- Dr James Morrow – Managing Partner Granta Medical Practices
- Dr Suan Rowland – Retired Consultant in Public Health Medicine
- Mrs Kate Huntsman – Practicing Registered General Nurse (PCC Member)
- Keith Day (Chairman) – Retired NHS Director and Chief Executive (Ministry Team and PCC Member)

2.3. The nurse is paid a salary equivalent to the mid-point of NHS Band 5. I am the line manager for the nurse and we meet regularly on a 1/1 basis.

2.4. In addition to her relationship with the individuals mentioned above, the nurse has a named professional supervisor with whom she has regular documented contact.

2.5. Parish Nursing services in the UK operate under the accreditation scheme run by Parish Nursing (Ministries) UK. In order to qualify as an accredited service it is necessary to meet 38 quality standards which cover both the organisational arrangements for the individual service and the practice of the nurse. Arrangements for the CPD, training and revalidation of the nurse are all included within these standards. Our service underwent an assessment visit conducted by Dr Ros Moore, Chief Executive of PNMUK earlier this year and was accredited without reservation. Further quality assurance visits will take place on an annual basis.

2.6. As well as being a Christian and a Registered Nurse, a Parish Nurse cannot practice until she/he has successfully completed a two week training course operated by PNMUK.

3. Activity

3.1. The Parish Nurse Project is subject to a formal evaluation process using the "action evaluation" methodology. Although initially it was the intention to capture information on a village by village basis this was dropped at an early stage as it was clear that in small communities it would be very difficult to maintain confidentiality if details of activity were identified to individual location particularly the smaller ones.

3.2. Given the nature of the service numbers of individuals requiring interventions can vary considerably from week to week in any given location as can of course the amount of time that it is necessary to devote to any particular case and without complicated weighting formulae such numerical data is in danger of being meaningless. The whole emphasis of the evaluation process adopted it to assess impact and effectiveness for the patient which is demonstrated in the full Evaluation Report of the first 10 months a copy of which has been provided to the Clerk.

3.3. The Parish Nurse has made a significant number of interventions in the Abingtons both individually and collectively at the Forget Me Not Club. One user of the service was recently prepared to give testimony to the value of the service at a recent Diocesan event promoting parish nursing and others have made entirely unsolicited financial contributions to the service in token of their appreciation.

4. Conclusion

I appreciate that it may well be difficult, from these brief notes, for Councillors to gain a measure of the scope and value of the work of the Parish Nurse in Little Abington and thus I would be more than happy, if that were your wish, to bring Claire Gillett to a meeting of the Council in order that we could describe to you in more detail the type of work she has been performing and the significant ongoing demand which we perceive.

Keith Day
16th April 2017

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APPENDIX PHASE 1 REPORT

The Parish's Nurse
Phase 1 – December 2015 to October 2016

1. Background, aims and objectives

Teresa Letimier was appointed as our part time (3 days a week) Parish Nurse on 1st Dec 2015.

We made the appointment because several of us living in the villages were concerned that there were people who were lonely, suffering with needs that are currently not met.

We wanted a Parish Nurse to

- Visit individuals who are lonely and vulnerable to identify their needs and see what can be done to make a difference
- Help ensure that people have coordinated and appropriate 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.

We wanted the Parish Nurse to care for people holistically, and improve the health and wellbeing of individuals as well as the community as a whole.

Supporting community carers/volunteers was a crucial part of the plan. We believed that need would be greater than a part time Nurse could fulfil on her own and that we would eventually need the help of a workforce which includes organised skilled residents. We envisaged that this project will also help identify what improvements we, in the community can make, and where it is necessary to highlight limitations and constraints in current service delivery so that statutory organisations had a clear understanding of what they need to do.

The project has taken 3 years to plan, put in place the necessary organisational structures and secure the funding we needed to employ a PN for 3 years. We were pleased to be able to appoint Teresa who " passionately wants to help people in the place which matters most to them, that is, in their home and community and address their needs as whole persons".

It is with considerable regret that as a consequence of unexpected personal and family circumstances, Teresa has reluctantly found it necessary to resign from the role of Parish Nurse. Her last day of service was on 14th October 2016.

We had undertaken to evaluate/review the project at least on a yearly basis. As Teresa leaves us after being in post for 10 months, it seems appropriate to undertake a review at this point. This is a report of her activities and achievements to date.

2. Parish Nurse Activity

2.1 Induction

Teresa spent the first two months getting to know the people and "the patch". During this

time, the Management Group ensured that appropriate equipment, policies, procedures were in place. Not including direct line management contacts, over 100 contacts were made during this two month period, averaging 4 per working day.

Contact was established with local primary and secondary schools, the S Cambs locality team, with Linton College, preschool groups, voluntary organisations working in the area e.g. Age UK and Care Network, the community services team, Sawston and Linton GP Practices, the multidisciplinary teams, churches , church groups as well as community groups. Teresa also developed links with Addenbrookes' and enhanced her ties within the palliative care team in Arthur Rank. She met with more than 50 key people in the different villages and attended induction tea parties and church services and was made known to over 800 people.

The Management team had earmarked these two months as protected induction time but she was approached for help when she visited groups. In January, she made 20 client/carer contacts. 4 of these were by telephone; 16 face to face. More than half of these were people were not church goers.

2.2 Contact with patients and carers and the community

The average contacts per working day for the following three months (Feb – April), was around 4, totalling over 140 contacts, but the pattern of activity shifted. Clients/carers accounted for 67% of all contacts, an increase from under 20% in the first two months. More than 80% of all contacts made in Feb-April was in person with less than 20% of contacts being made on the phone.

It was becoming increasingly clear as we progressed, that some weeks, Teresa had been working/receiving and responding to calls almost every day of the week, including occasional weekends so that it is not appropriate to describe number of contacts per week. Data input into the spreadsheet designed also became more difficult as we realised that we would not understand needs and responses without greater detail.

In July, we shifted to recording cases seen on a weekly basis as narratives. It has been a privilege to capture these stories which describe what we want to know: the issues, needs of people, the input from the Parish Nurse and what, if any difference has been achieved.

Since her appointment, Teresa has been in contact with and provided help and support for more than 56 patients and 18 carers. A very small number of patients/carers (less than 5) have been supported for the whole 10 months. New patients have been referred every month. Some patients have died or decided that they can manage and do not need ongoing input.

For a small number of people input was quite intensive – with visiting/ phone calls even daily but generally, the level of input over time eased to maybe a weekly or fortnightly visit/phone call as situations stabilised. Many are contacted either weekly or fortnightly.

Age of people seen and supported range from a year old to people aged over 90, and include people in their 30s and 40s, although a significant proportion are 65 and over. Some live alone but others are living with their spouses and may have family near or further away.

In any one week, more than 80% of Teresa's work has been spent with people who are not church goers.

Referrals have been through members of the community, many of whom are church goers, practice nurses, GP, ministry team, other voluntary and statutory organisations including South Cambs district council. People also approach her directly themselves.

In addition to seeing and addressing needs of individuals in the community, Teresa has regularly been attending some local groups (Forget me not, [~50 people] Balsham Mays Avenue coffee morning[~20? People], some church events, and has also led a school event. These groups have offered people the opportunity to get to know her, provided her with a way to promote health and wellbeing and enabled her to provide help and support to individuals.

2.3 Regular group meetings with the statutory and voluntary sector

Teresa met with the statutory and voluntary sector on a regular basis. The monthly meetings with the multidisciplinary team comprising of GP, mental health nurses, community matron, Addenbrookes discharge coordinator, social workers, and with the ,locality team (police, social, housing and other voluntary agencies) have been crucial in keeping her informed of those vulnerable and enabled her to coordinate input for clients as well as share information about security and safety.

2.4 Events

Prior to Teresa's appointment, the Parish Nurse Steering Group had held a variety of information meetings: First Aid, Use of NHS, Child Health, Mental health. Attendances at these were around 30 for each session and people found these informative and useful, resulting in at least one known instance of reducing GP attendance[1].

In the course of her work, Teresa identified a need to open conversations on dying. An event held on 3rd October on "Things we do not talk about" – featuring Libby Purvis, Alisdair Coles and the Bishop David, 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.

2.5 Description of needs: This data is derived from an analysis of the 8 cases seen by the Parish Nurse in a week and are summarised below:

1. An elderly patient experienced a poor discharge:

- Patient was due to be discharged at 10.00am but did not get home till 6.30 pm
- Patient was wet through when she got home, having sat in a wheelchair all day. Patient generally only sits in a wheelchair for 2 hours at a time.
- Though considerable time had been spent on a discharge plan, things were not in place:
  - the hoist was not appropriate for transfer of the patient into the house
  - Call alarm was not in place
- Carer was very distressed at the end of the day.
- Home insulin pack did not contain the pen for administration
- Carer needed help with complex medication regime
- Carer needed support with all the tasks to be fulfilled: shopping, cooking and looking after the patient.

2. Since she started Teresa has provided support to a long term patient with very complex social, psychological, mental as well as physical health problems. The patient is known to many services and was referred to her by GP practice as well as the vicar. As usual, during this week, the patient continued to express a high demand for support and input via numerous daily texts and phone calls.

3. An initial request for help from a distressed carer 2 months previously, had, through Teresa's intervention, resulted in correction of a misdiagnosis. Patient and carer need support to access appropriate local services, and information to enable the family select appropriate choice for care and respite.

[1] "I don't take my baby to the clinic everytime she has a fever anymore"

4. A patient met Teresa on the street and asked for advice on a swollen lip.

5. Carer of a patient with dementia who has own health problems, needs help and support with care arrangements.

6. Patient is a child with very complex needs. Mother describes the event that has led them into a situation of multiple hospital visits, and an unpredictable future, She needs ongoing support and respite as the social circumstances are complex, long term, continually changing and emotionally stressful.

7. Patient with Cancer whom Teresa helped with discharge home. Patient needed help to adjust to changing circumstances including pain control. Patient wants to die at home but is concerned about how the family will cope

8. Break down in care plan for a patient who has Parkinsons Disease because of changing dates and different care agencies. Also patient's status is changing but patient is unaware that he can no longer do what he could do. Night time care, in particular, is a problem. Carer has stepped in to provide the care but carer has own needs and needs respite.

The needs described above are hugely variable, including a crisis situation, to long term ongoing requirements and include:

- Crisis on discharge leading to patient and carer distress and risk of failed discharge
- Patient/carer/family support for patient requiring Palliative care and pain management
- People in distress,
- People with dementia/cognitive loss/long term conditions such as Parkinsons, and people with cancer.
- People with Mental health problems, including someone feeling alienated from society with anxiety, low confidence and mood change.
- People (patients and carers) needing help with information, advice, and support in caring
- Carers who themselves have considerable needs
- People/carer/family responding to Life changing events, eg. Bad news
- People who are lonely:
- Mother needing emotional and practical support e.g respite with very limited options or no access to respite services.

2.6 The level of input:

During the week, Teresa was in touch with 13 people: 8 Patients and 5 Carers. 11 out of the 13 people were not Church Goers and their ages ranged from 1 to 85 years. 9 out of the 13 people were aged 65 and above.

Type of contacts ranged from a phone contact (with a planned monthly visit), a brief face to face contact, a visit during the week, to intensive 5 day support and daily response to innumerable texts and phone calls.

2.7 Type of input

For the patients and carers this week, Teresa:

a: For patients:

- Provided solutions to a crisis situation by
    - Providing on the spot/ timely "hands on" input to ensure patient returned and stayed at home: securing help with hoist to transfer patient.
    - Obtaining emergency prescriptions and blister packs to ensure proper

medication was given.
    - Securing care package/care call to enable patient's safe care at home
    - Ensuring appropriate support systems were in place
- Provided emotional and spiritual support, and supported patients and carers to link and integrate into their own community.
- Was an advocate for people – helping them articulate their needs. This included challenging professionals, instigating proper investigations and diagnosis.
- Signposted, opened the door to other services, referred to a variety of different services – statutory and voluntary:
    - Helped with forms and procedures e.g. registration with local GP for more appropriate provision of health service, referred to organisation to secure Blue Badge parking for carer
- Identified flexible care options e.g. arranged for a private carer who is also a friend to someone who did not like "formal carers" .
- Secured care packages e.g organised home meals delivery,
- Encouraged local activities. She has taken clients who have been lonely at home to groups and introduced and helped familiarise them to the groups
- Provided information to enable more informed choices for patient, carer and family, local and wider afield.
- Provided information to enable better management of symptoms e.g. pain.
- Provided information and ongoing support as people and their families adjust to changing health, illness, family and emotional circumstances as their perceptions and wishes changed over time in their illness journey.

b: For carers:

- Provided information (e.g. about services and options available), training when needed, support when distressed, action when needed e.g.provided respite, hands on practical help (e.g ensuring they eat[2]),
- Provided advice on how to improve variety for those unused to cooking[3] and advise on nutrition.
- Provided support/training about medication.
- Encouraged local activities and links to locals.
- Helped people find ways to re-establish their "own space" when people feel that their home is no longer their own because of increasing number of care givers/professional visitors

c: Linking in and referring to other services to secure care package and better coordination

- Liaising and referring to neighbours, other local community including church members, Multidisciplinary team, specialist services to improve care to patients and their carers.

Case studies from other weeks reflect similar needs but also include :

- Post operative needs e.g with learning how to give their own Heparin injections or what to do/not do or cope, particularly when someone is on their own.
- Support, clarification of information for people before they go in for an operation.
- Help with dying at home: e.g Supporting a dedicated carer who had cherished and cared for her loved one with no family support for a number of years, with help and support from other agencies and professionals. The client had very complex needs, yet was enabled to die at home, as he wished, in a dignified and peaceful manner.

[2] "scrambled eggs for a carer to ensure that she ate that day, and watched over the patient to enable the carer to have a shower"

[3] "How to make jelly" for a treat instead of yoghurts everyday

For someone else, Teresa was able, with guided imagery to help someone reach a positive place before he died

- Generating conversations between members of the family who might have differing views of management, (e.g Palliation/treatment)
- Help to manage bereavement and reintegrating into the community – particularly for those who have cared for their loved ones for years. (in some cases for 7 years),
- Support for people who have long term problems/illness, living alone, and for their families living near or not so near.
- Accompanying, support attendance to health clinics e.g. accompanied someone with a phobia to the dentist, and others to specialist/hospital services, to help "hear" what specialists have to say and as an advocate.
- Working with others to protect someone at risk, possibly needing protection.
- Assessing need/situation: Teresa was asked by a GP to visit because someone had uncontrolled diabetes. On a home visit, Teresa was able to ascertain that there was a possible explanation for this but more importantly, the person was lonely, having lost her neighbour recently.
- Achieving a GP home visit for a post op patient who had pneumonia
- Advocating for a carer so that he could use the same transport (ambulance service) to accompany his wife (who has a stroke) to a hospital appointment .

2.8 Knowledge, attitude and practice needed to meet needs:

- Needs have been wide ranging, difficult to predict and not necessarily the presenting issue. Needs were specific to individuals and individual's needs changed over time and with their social circumstance, and resilience. (which might reduce when caring for a long time)). In these situations, it was important that a trusted **health care professional/nurse**, was available and accessible to properly assess the situation and make the appropriate response. A **health professional** was needed for advice on medication, to be an advocate, speak to other health professionals.

- **Knowledge about available services** was needed to provide patients and carers with appropriate advice about their possible care packages/available choices

- **Knowledge of local groups**/key people is crucial to signpost and create appropriate links back into the community. – established networks into local communities.

- **A Holistic approach**– looking beyond a health problem to dealing with people's wellbeing encompassing their physical, mental, emotional and spiritual health. It was not about dealing with just "a problem" but looking and dealing with people as **individuals,** living in and functioning in their homes and communities, all of which could affect their health and wellbeing.

- The Parish Nurse was not only a professional, helping identify the problems but also a "**professional friend".** People did not have to state a specific problem to access the PN. They were helped to articulate their need and then directed accordingly.

- **The PN (the professional friend) –**did not shirk from being "**hands on",** (eg cooking a scrambled egg to ensure a carer ate**)** or provide **support**, a **sympathetic shoulder**, or be **advocate** (fighting/speaking up for the patient/carer), as necessary. One patient described Teresa like a "dog with a bone" – she would not let something go till there was a result.

- Patients have commented on how generous the PN was of her time and the PN did not make judgements of what patients/carers *should* do. There was none of the clock watching that people saw and found so off putting in some professionals. She **listened.** The space offered by this approach enabled people to articulate their

needs, and the **non-judgemental** approach gave people the space to make their **own choices.**

- **Links and contacts** with health and other carer systems were needed to enable liaising, coordinating, sharing of information.

- Mental health problems in the patient or related family has proved particularly difficult to manage.

2.9 Gaps in services

In our area, no agency provides a respite care service and people still need help with transport to access different services, in particular, social activities.

3. Outcomes

The outcomes identified for the patients recorded included:

- Prevented a nursing home placement: Persuaded consultant that patient can return home
- Successful reinstatement of patient at home in spite of considerable problems with discharge plan implementation
- 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, resulting in a treatment plan for an identified condition and agreement that mental health assessment is needed. This person was also accompanied on a private visit to church for some peace and space.
- Reduced calls to GPs and vicar (but at a considerable cost to the PN!).

- Instigated investigations to correct a misdiagnosis and enable proper treatment to be started.
- Patient achieving better quality of life e.g. no longer incontinent because of appropriate treatment.
- Family given choice and control over ongoing management.
- Appropriate systems in place for cleaning, gardening, caring, allowing the spouse the space and energy to continue to do what she wants to do for the patient.

- Improved care provision to make caring more sustainable and safe – reducing risk of admission to a home.
- Patient and carer attending local clubs

- Situation stabilised for Mother caring for a child with complex needs. Mother less distressed and coping better.

- Enabled home discharge.
- Systems in place to ensure that death can occur at home.

- Carer back in charge of care

Other outcomes achieved in other weeks include:

- Securing a safe placement for a vulnerable person: A lady found in the street, inappropriately dressed, unable to say who she was, was found a safe placement after considerable effort.
- Improved skill and confidence e.g. to administer own injection post op
- Reduced social isolation through visit, introduction to new social activity, making new friends locally
- Enabled dying well at home
- Reduced calls to services e.g, police

4. Local support and management structure:

A considerable number of people were involved at the planning stages of the project, covering a significant cross section of local communities. When the Parish Nurse was appointed, a Management Group was formed comprising of the following:

Name		**Role**
Rev Julie Norris	Priest in charge of Seven Churches Ministry (till Aug 2016)	Line Manager, Chair Hildersham PCC
Keith Day (MBE)	NHS Director/Charity Chief Executive (1995-2011)	Member Hildersham PCC
Dr James Morrow	GP Sawston (2007-	Primary care link and lead
Suan Goh/Rowland	Public Health Medicine Consultant (1992-2007)	Evaluation

Administrative support for the group was initially ad hoc, then available from the administrative support for the ministry team.

Keith Day took on the chairmanship and line management of the group when Julie Norris left in August. Kate Huntsman (Registered nurse and member of Hildersham PCC) has joined the group.

The early months of the project were a steep learning curve for the management group. Policies, including Lone worker policy had to be developed, and pay and tax mechanisms set up.

The support of an efficient administrator has been crucial. A PCC member secured a working mobile phone, lone worker arrangements and email connection. We resolved issues around confidentiality of emails, between clinicians and between clients and the nurse.

Honorary contracts with both Sawston and Linton GP practices were secured and enabled the potential sharing of information between the practices, other professionals and the PN.

The provision of IT support from the practice will ensure ongoing IT support sustainability. When Sawston and Linton GP practices merged in April 2016, the PN's contract became an honorary contract with Granta Medical Practice.

The PN met regularly with her line manager which worked well. The PN managed her own diary. Referrals were from the Ministry team, community members, the GP practice, South Cambs district council, police, and included self referrals.

The PN also met regularly with people supporting her with evaluation and experimented with input of data into a spreadsheet to collect and collate data. Although this seemed fine initially, it proved too complex and we have turned to collecting cases studies as stated above.

A Service user questionnaire was developed and users can either fill in hard copies or electronically.

5. Discussion:

The work done so far clearly demonstrates that there is a significant level of need in our villages. Many of us can relate to the stories told. This in spite of significant numbers of people who are very caring, watch out for their neighbours and very willing to do whatever they can to help.

Quoting Teresa:
"Our community is so compassionate and caring, yet still there are those that are lonely and isolated, who feel of no worth or value. Some feel like they are a burden by living, the underlying cause may be one of their past experiences or situational events .I struggle to come to terms with this in today's world and yet it is a reality. I must admit that what we have found so far has confirmed our fear and even exceeded our expectations on the incidence of unmet healthcare needs and hidden suffering."

It seems quite clear that to meet the needs identified, we need a nurse.

Early planning had included the examination of a variety of models (including community warden scheme, older people's coordinator), via small groups and a couple of larger events. We chose The Parish Nurse model after considerable deliberation, because although it was very clearly Christian based, it offered us the ability to provide a service to all, fitted our objectives and still fulfil our clear vision of a wider community project. We chose it for the safety and support it offered us and the nurse. Built into the model was training, clinical and spiritual support which was crucial in this potentially lonely community post.

Although "The Church" (Hildersham Parochial Church Council) was the employer, the services of the PN was available to all and more than 80% of her work was with non church goers. One carer who was not a church goer and originally against the project, was surprised that the PN was available to her and was very glad of the input. Religion did not come into the frame of this service. People, and their needs, determined what was provided and this was generously given: time, compassion for what people were going through, and respect for their wishes and choices.

Apart from the key role of employing the nurse, other members of the church community had input to the project. Many people (including many non church goers) were referred to the PN by church goers many of whom do a significant amount of community work and are part of many village networks. They work alongside significant others who may not be "of the church" but who also have the wellbeing of people and the community at heart.

Feedback from the local people has been very appreciative of the work done. I 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"

Another person chose not to fill in the questionnaire but has taken the time to write a 2 page long report of her experience of the service. She describes what the service meant to her: a long time carer of a husband who had complex health needs and then needed palliative care.

"It is difficult to summarise the impact Teresa in her role of Parish Nurse has made on my life and that of my husband. She has been the right person in the right place at the right time bringing him comfort and helping him to "die well" and giving me guidance and support through an excruciating experience and loss when I could have easily become overwhelmed either before or after the event. I have noticed that she is a highly professional nurse, practical and down to earth, with a sparkling sense of humour yet emotionally intuitive and with a spirituality and depth of character. She can also be firm when necessary but never, ever pushes personal boundaries. Despite all the sickness and pain my husband suffered over the years and my own emotional burnout and troubles in more recent ones, this time when it mattered most, all of the services worked together for us. I have no doubt that Teresa's enduring contributions and holistic approach have been essential to create the best outcomes for both of us.

The first 10 months of the service has done what we had hoped it would do: identified what the needs are, made it clear what the service is about and how it can help.

But there is much yet to do. Teresa had worked with local key people and groups and Parish Nurse support workers were starting to be recruited but this work is in its infancy.

She had identified the need for the possible extension of Helping Hands to include Weston Colville and volunteers are now being recruited so that this can happen. But many other tasks which she had undertaken, which might be undertaken by local people have yet to be identified, systems set up, people trained. When this starts, we will need to include it into the evaluation.

In general, members of the General Practice team feel that the Parish Nurse is a positive role. Clinicians who have worked with her or referred cases to her have been happy with the input. They say she has been professional in her approach and communication, always feeding back and keeping people informed of what has been done. Someone used the term "respectful". But they also felt that she was not part of their team and was not as visible as she might have been to clinicians. This is a key point and something we will need to consider and work on in the future. But we need also to remember that this year has been a time of considerable change for the General Practices which merged in April this year to form the Granta Medical Practice.

Teresa might also be described as a “technophobe” and have not really used the IT links to the GP practice. These IT opportunities need to be explored.

As we reflect and seek to learn from what has been done in the last 10 months, we are grateful for the input that Teresa and 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 identified some key points but we always welcome comment, feedback, good or bad. This project is ours – the “communities” project – it will only work if villagers/communities see what it means for them and it needs villagers/communities’ input to make it into what it is they need.