To fully utilise the skills of Senior Nurse Care Managers across the Learning Disability and Transitions Teams in Leeds Adults and Health (formally Adult Social Care). To provide specialist nursing knowledge and to support and upskill Social Work Colleagues to enable them to create robust packages of care, that meet the needs of complex health clients and improve their health outcomes.

Introduction

There are 3 Learning Disability Teams, one Transitions Team and a Development Team in the Leeds Local Authority LD Services. They support 2500 clients with a learning disability. The teams work within the auspices of a pooled budget and are responsible for managing the care of all people who have a learning disability including 250 people with continuing health care (CHC) needs. Until recently there was one Senior Nurse Care Manager (SNCM) and two Nurse Care Managers (NCM) across the 5 teams. The NCMs were holding a full caseload. The SNCM who worked in the Transitions Team undertook a pilot scheme, holding a smaller caseload of CHC clients and then providing consultancy within the team to support and upskill the other staff (Social Workers/Senior Social Workers/Well -being workers) to increase their skills and knowledge thus providing improved packages of care and health outcomes. In recognition of the significant health element involved in this work the service was successful in obtaining funding to increase the number of SNCMs within the service. The long term aim is to have 2 SNCM in each team

Improvement methodology

Discussion with Team Managers/Service Delivery Manager and staff within the teams to identify current challenges/gaps in knowledge. Commenced consultation across the service and this will remain ongoing. Set up a Forum for SNCM to develop and implement their role, utilising learning from the pilot scheme in the Transitions Team. To develop an evaluation tool to be used with stakeholders e.g. Social work colleagues/team managers/service users/carers/ other professionals to measure the effectiveness of SNCMS involvement.

The approach

What we were trying to accomplish – Aims Statement

To fully utilise the skills of Senior Nurse Care Managers across the LD and Transitions Teams. To provide specialist nursing knowledge and support and upskill Social Work colleagues to enable them to create robust packages of care, that meet the needs of complex health clients and improve their health outcomes.

What we measured to understand if our change was an improvement

This work is still in progress. Aim is to measure the following
Number of clients where SNCM is Lead Assessor, Secondary Worker and where SNCM has provided advice to SW.
Use evaluation tool to gain feedback from stakeholders. Assess if learning has been valuable and have stakeholders felt supported.
Review number of clients receiving Personal Health Budgets.
Review Role / tasks that are completed when Undertaking Duty Work
To utilise review process to assess the impact of the individual's health outcomes and well being where a SNCM has been involved

What changes we made / are making

Senior Nurse Care Managers to work across all teams and hold a reduced caseload and have oversight of complex cases.
To identify areas of need/improvement and develop a plan.
To have regular SNCMs forums facilitated by Transitions Team Manager and Development Team Manager who are both highly experienced LD Nurses and former SNCMs. For SNCMs to access specific training or attend stakeholder and strategic planning events e.g. PHBs/CHC/ Epilepsy/ Improving Terminology and to then disseminate this to the whole team at Service Away Days or Team Meetings/Peer Review and Workshops Sessions. To continue to have positive working relationships with health colleagues e.g. CLDT, consultants, paediatricians CAMHS, Hospital Liaison Team, CHC Nurses. LAC Nurses and School Nurses – to explore ways of developing these even further
To develop a Nurse Led Induction package for new SNCMs
To work in collaboration with other health colleagues to achieve outcomes.
SNCMs to be involved in hospital discharges/end of life plans for clients and to attend stakeholder meetings to develop Hospital Discharge Planning Process.
To develop an evaluation tool to assess if learning has been valuable and if stakeholders felt supported.

The impact

- SNCMs to be Champions in LD and Transitions Health Care and have increased expertise in all areas
- To have stronger and improved links with Health services
- To have clear understanding of networks and pathways in health
- Improved outcomes for people with LD and complex health needs
- Improve quality of life and standards of care.
- Increase Creative and Strength Based Support Plans and Care Packages
- Social workers within the team to have increased skills and knowledge and to know who to contact to get the support they require.
- To embed a consistent approach to Personal Health Budgets across all teams building on existing good practice.
- To review CHC care packages and ensure that they are safe and effective and good Value for Money

Leadership learning

This project and leadership programme has provided me with a 'robust toolkit' to develop the skills and knowledge I have needed to undertake work that I have been passionate about developing for several years. It has enabled me to explore all of the ideas that I have had, and to break them down into manageable areas and to be more solution focused.

The overall course has supported me to transition from my role as Senior Worker to Team Manager. It has helped me to understand my strengths and qualities and develop and enhance my leaderships skills. I have enjoyed meeting other LD Nurses and sharing our experiences. I have thoroughly enjoyed the course and I am now very inspired and already planning to complete another QI project focusing on improving information to families and stakeholders about the work of the Transitions Team.

Next steps

Clear plan to enhance the Senior Nurse Care Manager Role. with a focus on developing champions in specific areas/ health conditions.
To explore areas of health/Learning Disability specialisms e.g. Autism/ Epilepsy/Rare syndromes/conditions/ complex health needs/ Positive Behavioural Support/ Young People – Health Transition.
To access training opportunities in these areas to keep up to date with CPD and NMC standards and to then disseminate this information to social work colleagues and other SNCM's to increase their knowledge and thus improve the service provided to clients with complex health needs.
Providers may also be sourced to provide specific training
To strengthen all health pathways and have champions within each area
To have a Case Discussion/Peer Review item on future SNCM forums.
SNCM Forum to be embedded within the LD Service and meet on a regular basis. .

Lynn Dunion
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