DOCTORS LANE/ QUAKERS LANE/ SCORTON SURGERY CLUSTER WORKFORCE DEVELOPMENT PROPOSAL.

Background

It has been recognised by the Royal College of General Practitioners, British Geriatric Society and NHS England that the number of patients with multiple morbidities is increasing. The current approach to managing single conditions can lead to harm from multiple medications. It is also time intensive and can lead to multiple attendances for the patient. It has been suggested that the 'House of Care' (http://www.england.nhs.uk/house-of-care/) should be implemented. The first facet is to develop collaboration between professionals. The second is to develop personalised care with empowerment of the patient and their carer to enable supported self-management. For those with more severe health problems a care plan can help to identify the issues for the patient, resources required to address these problems and serve as communication between professionals in different settings.

In 2014 the Enhanced Service for Unplanned admissions was taken on by practices locally. 2% of patients in the practice population identified as being high risk were reviewed and care plans produced by GPs. The level of detail and patient input into these care plans has varied due to pressures on time. In addition it has not changed the way care is delivered or developed the workforce. Anecdotally no demonstrable effect has been seen to date from this Enhanced Service.

The level of integration in Primary Care locally varies across practices dependent on personalities and staffing. Good practice already exists in the integration of District Nurses into the Practice Team at some sites and with Practice Nurses going out on occasion to see patients with limited mobility in their own home for Chronic Disease reviews and vaccinations.

In addition to the above there has been increasing evidence and guidelines with regards to the importance of recognising and addressing Frailty in terms of improving Quality of Life and reducing unplanned admissions and mortality in our increasing older population. The British Geriatric Society in association with the Royal College of General Practitioners produced a guide 'Fit for Frailty' (http://www.bgs.org.uk/campaigns/fff/fff_full.pdf) to aid the diagnosis and management of this syndrome. Management overlaps with the principles of the House of Care and Care planning. Medication reviews are also a key feature.

Following correspondence from the CCG, the above practices agreed to work together with an identified named lead from each practice. As a result of meetings, analysis was undertaken by each practice of its current workforce in terms of current skills, time and to consider its interaction with District Nurses, Specialist Nurses and Community Matrons. It was identified that best practice already exists in terms of the integration of the District Nurse into the Practice Team at Aldbrough St John.

Searches of electronic records were performed to identify the number of Over 75's in each practice; levels of Chronic Disease; current read coding for frailty and falls; and to identify

those at risk of Frailty through the use of the electronic Frailty Index (eFI) on System One and tools such as SHARE-F175+ in EMIS Practices. In order to address the concerns of nurses with regards to indemnity, Practice Managers contacted their relevant Medico- legal providers to ascertain what would be covered under their current policy and what the additional cost would be for work outside of the Practice Population.

The following aims were agreed as a result of the above.

Aims

- To replicate and build on current best practice in terms of increasing the integration of existing nursing (District Nurses and Community Matrons), medical, social and third sector services across all practices, in order to provide compassionate care to elderly/ frail housebound patients. In doing so a truly multi-disciplinary team will be created with increased peer support between Nurses.

- To build on and complement the existing commissioned District Nurse, Intermediate Care service and GMS/ Enhanced Services provided by practices. This will increase capacity of nursing services in the community. Create a continuous learning culture supported by integrated multi-disciplinary team working, learning logs, significant event analysis; and through testing new ways of working using small scale tests of change and plan-do-study-act cycles

- Improve the delivery of patient centred care by:
    - Delivering holistic Chronic Disease Management to patients in their own homes/ Care homes/ Nursing homes utilising guidelines but avoiding single disease focus.
    - Increase/ improve the use of supported self-management. To include the use of IT, Vitrucare and Care Plans.
    - Reduce over-medication and optimise the use of medication through the use of the STOPPSTART Toolkit and Community Pharmacist led medication reviews available through the GP Federation (GPF).
    - Care planning to include discussions regarding End of Life preferences when appropriate.
    - Completion of DNACPR when appropriate.

- Frailty. To use screening tools such as eFI and SHARE-F175+ to identify those at risk of Frailty. Once identified to perform an assessment and refer those at risk for a Comprehensive Geriatric Service with MDT input ‘Hot Clinic’ in line with literature/ best practice.

- Refer to Age UK and Richmond Voluntary Service for support when appropriate.

Design

Building on the aims, discussion above and a meeting with a representative from each practice, District Nurses and the Community Matrons a draft design was produced.

A further meeting was then held to present the proposal to Practice Nurses, District Nurse Leaders, Community Matrons, Social Services and the Richmond Volunteer Service. Feedback was discussed and incorporated into the design were appropriate.

Contact was made with Dr Andrew Clegg. Honorary Consultant and Senior Lecturer at the Academic Unit of Elderly Care & Rehabilitation, at Bradford Institute of Health Research and the Clinical Lead for the eFI in order to clarify the thresholds for Fit, Mild, Moderate and Severe Frailty. The question of availability on EMIS was also raised.

A response was received and led to a further discussion with Sarah De-Biase, AHSN Improvement Academy Health Ageing Collaborative Programme Manager, who is leading on the implementation of the eFI with CCGs/ GPs in Yorkshire & Humber region and nationally. Discussing the proposed design with Sarah we identified that the proposed design is more holistic and different to work taking place in other areas. The proposed outcome measure of preventing admissions was identified as not being sensitive (particularly in the short term) and with the size of the population unlikely to identify a change. This supports the recommendations in the Quality Improvement Productivity Programme 'The guide to the implementation of the long term conditions model of care'. Changes in primary care use, out-of-hours and referral rates to the third sector, Social Services and Secondary Care were identified as alternatives. We also discussed trying to generate a control group by staggering the role out of the intervention and capturing a baseline data set to allow any changes seen to be attributable to the intervention i.e. by looking at patient's use of resources and medication lists before and after the implementation. The Case Study laid out in Appendix A will be submitted to York Health Economics Consortium to examine the Return of Investment/ Health Economic benefits of services design around the needs of people with Frailty – the hope is this will demonstrate whether the proposal offers value for money.

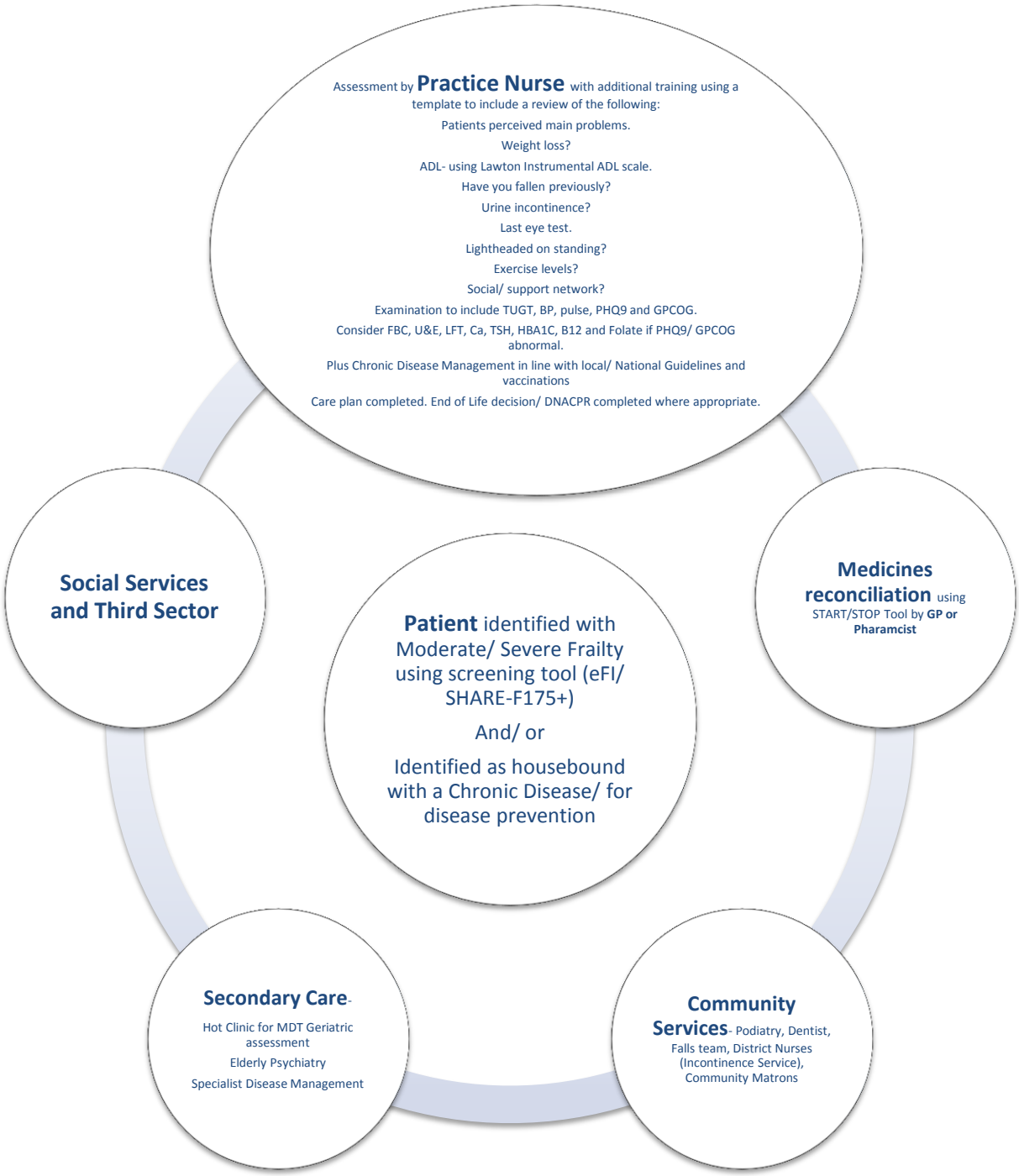
Part of the Care planning will involve educating patients and their carers to monitor for changes in condition and to contact the Practice Nurse/ GP if and when this occurs.

A STOPP tool protocol has been created as part of the implementation of the eFI in Devon. It should be possible for the practice using System One to access this and include it in the Practice Nurse assessment, running feedback to the GPs. Work is currently ongoing in supported self-management of those with mild frailty utilising the 'Practical Guide to Health Ageing' and exploring barriers to self-management. At present we intend to use the guide opportunistically and once there is further evidence from other work, an intervention for people with mild frailty could be implement at a later date. We plan to share our proposal and work with Sarah and the other Practices/ Teams engaged in the project.

The proposal has also been presented to the Patient Participation Group and received positive feedback.

This will be rolled out to all patients registered within the cluster including those residing in care homes.

The agreed design is as follows:



Implementation

As the proposed funding is currently for two years, we envisage the proposal being implemented in 2 phases. We will use outcomes to evaluate the first phase with the existing task group and PPGs. Modification of developments will be implemented in the second phase.

Phase One

In order to implement the design, we propose to recruit a Health Care Assistant as a job share between the three practices in order to release the Practice Nurses to visit our housebound/ frail patients. The HCA would be employed, appraised and reported on by Quaker Lane Surgery due to the fact they will work most hours at this surgery. Proposed start date: 1st November 2015.

Cost:

Band 3 (£19,461) plus 20% on cost = £23353.
Estimated Mileage Cost for Practice Nurses visiting patients at home= £5034.40
Recruitment of HCA= £887.98

The skills audit identified that the Practice Nurses are already trained to provide Chronic Disease management. The majority require additional training on assessing frailty, falls, dementia screening and to facilitate discussions on end of life care preferences. Where skill gaps exist we will aim to ensure training is provided through peer support and external resources. Links have been established for Practice Nurses to engage with the current training available for District Nurses. The Practice Nurses will shadow the Community Matrons prior to the implementation of the project. We have been unable to identify any existing training for nurses on frailty, falls and dementia screening other than that which is part of the Community Matron training. A request has therefore been sent to Ashfield Clinical to see if this is something they would be able to deliver. A full response is awaited.

Cost: Estimated £1800

To achieve integration of existing services we have already taken steps to increase their inclusion at individual practice meetings and we hope to increase integration of medical and social care through cluster MDT meetings. The use of a template and care plan visible to all users on System-One / Adastra/ sent to all Professionals involved in the patient's care including the patient themselves should also facilitate integrated management.

As the service plans to refer patients +/- their carers into existing services within the Voluntary sector there is no cost to this.

Equipment:

IT hardware and software to enable the use of clinical systems on home visits. *Cost: EMIS mobile (£550 x2). System One Mobile TBC.*

To investigate purchasing of a 24hour rhythm monitor/ cardiac event monitor to increase the identification/ diagnosis of Paroxysmal Atrial Fibrillation.

Phase Two

We would look to modify the service above based on initial outcomes as below. In addition we may be able to target mild frailty more formally including the use of Tai Chi; explore the use of transport resources, such as that being explored by the GPF; and review the need for increased Community Matron time/ an experienced Community Sister across the cluster using the remaining funding.

Outcomes

We aim to measure the following outcomes to assess the effectiveness of the proposal:

- Improved Patient Satisfaction and Quality of Life
- Improved recognition and diagnosis of frailty – (proxy indicator is increased prevalence in the number of patients with a read code of Frailty)
- Reduction in the number of Primary Care GP Consultations
- Reduction in the number of Out of Hours Consultations.
- Reduction in Disease Specific Secondary Care referrals (likely to be an increase in referrals for the Hot Clinic and Elderly Psychiatry)
- Increase in Social Care referrals.
- Increase in referrals to VCS
- Evidence of de-prescribing amongst patients with a frailty diagnosis (Key recommendation in NICE guidelines currently being produced for multi-morbidity)

Appendices:

A. Case Study of the proposal to be submitted by Healthy Ageing Collaborative (www.improvementacademy.org) | Academic Unit of Elderly Care and Rehabilitation | Bradford Institute for Health Research, Temple Bank House, Ground Floor, Bradford Royal Infirmary.
B. Job description for HCA position
C. Advert for HCA position posted on NHS Jobs and in the Northern Echo
D. Timeline for the proposal

Appendix A:

8 Case Study: NHS Hambleton, Richmond & Whitby – Practice Nurse led modified CGA for patients with severe/moderate frailty

In a nutshell: Guidance from the British Geriatrics Society (2014) suggests that it is not feasible for everyone with frailty (from mild up to severe, life-limiting frailty) to undergo a full multi-disciplinary review with geriatrician involvement. Nevertheless, all patients with frailty will benefit from a holistic medical review based on the principles of CGA. NHS Hambleton, Richmond & Whitby are testing an adapted CGA model for people with moderate & severe frailty identified using the eFI delivered by a Practice Nurse.

In NHS Hambleton, Richmond & Whitby CCG a cluster of GP Practices including Doctors Lane Surgery are piloting a service which offers patients with severe and moderate frailty a home based modified comprehensive geriatric assessment (CGA) delivered by the Practice Nurse, who will shadow and receive support from the GP Cluster's Community Matron. The team are using the eFI to identify patients with moderate – severe frailty. Backfill for open access clinics at the GP Practice will be provided by a Health Care Assistant.

The modified CGA will incorporate a holistic approach, including:

- What is important for the patient (and their carers)
- Gait assessment using the TUAG
- Full blood count
- Sight & hearing tests
- Dementia screening
- Long-term condition management
- Medication review (potentially using the STOPP protocol within SystmOne) with support from a CCG funded community pharmacist

Practice Nurses will work alongside patients to develop individualised care and support plans. They will link patients with community services including MDT 'hot' clinics; Richmond Voluntary Services (which includes access to VitruCare); GP cluster based integrated MDT meetings, and the community matron for care and support planning.

The overall aim of the programme is:

- To improve the care for older people >75 years with long term conditions and/or frailty

Outcomes being used to measure impact include:

- Patient experience of service – perceived QOL
- Reduction in primary care utilisation
- Reduction in out of hours care
- Frailty Read Code prevalence
- Reduction in medication (evidence of de-prescribing)

The Team involved will have access to support from the Y&H Improvement Academy to support continuous learning and the use of quality improvement tools such as the PDSA cycle.

Contact: Dr Halina Clare, Doctors Lane Surgery, NHS Hambleton, Richmond & Whitby CCG

Email: halina.clare@nhs.net

Appendix B:

QUAKERS LANE SURGERY

JOB DESCRIPTION

Job Title: Healthcare Assistant

Grade: Salary dependent upon experience (Band 3)

Base : Quakers Lane Surgery, Richmond, North Yorkshire DL10 4BB

Reports to: GP Partners and Practice Nurses /Practice Manager

Accountable to: Partners/Senior Nurse – for clinical matters

Practice Manager – for administrative matters

Key Relationships:

Internal: General Practitioners

Practice Manager

All other members of the Practice Team

External: Health Visitor

District Nurses

Community Team

Secondary Care Colleagues

Other Primary Care Team members including social services

Hambleton Richmondshire and Whitby Clinical Commissioning Group

Heartbeat Alliance

NHS England

North Yorkshire County Council

Partnership Agencies

Job Summary

The post holder will work as part of the Primary Healthcare team, providing personal medical services to the patients of Quakers Lane Surgery, Scorton Medical Centre and Doctors Lane Surgery. The post holder will work collaboratively with the practice to deliver nursing care, within the boundaries of their role and under the direction of the nursing staff and GP's.

Duties will be carried out in accordance with the UKCC Code of Professional Conduct and with regard to practice protocols.

Principal Duties and areas of Responsibility

- Basic wound care
- Removal of sutures
- Urinalysis
- ECG's
- Venepuncture

- Blood pressure measurements
- Ear Syringing
- Routine Flu Immunisations
- Chaperoning and assisting patients where appropriate, who are being examined by another clinician
- Assisting GP's with minor surgery and coil fitting
- Requesting basic pathology tests, for example urine culture or swabs
- Following agreed clinical protocols with referral to senior nurses or GP's as appropriate.
- Maintaining and cleaning equipment used by the nurses and GP's
- Maintaining Nurses rooms, stocking and rotating items as required
- Housekeeping duties including general tidiness and cleanliness of Nurses rooms and treatment rooms
- Ordering of stock from Hospital Stores and Suppliers
- Participation in the administrative systems within the practice
- Maintain accurate records
- A duty to advise senior nurses of potential problems or errors with the range of assigned tasks
- Attend and participate in Practice Meetings
- Ordering vaccines and maintaining stock

- Any other delegated duties appropriate to the post

Special requirements of the post:

- An understanding, acceptance and adherence to the need for strict confidentiality
- Ability to use own judgement, resourcefulness and common sense.
- A commitment to maintain a high professional standard of nursing care and keep up to date with all aspects of nursing care relevant to the post.
- A commitment to ensure all Health and Safety requirements and Infection Control measures are met and to report any problems to the Practice Manager
- A commitment to the effective use of Practice and NHS resources
- An awareness of own limitations and experience
- To work only in accordance with the UKCC Code of Conduct within the Scope of Professional Practice
- To have a written professional development plan and to maintain an up to date portfolio that meets the requirements of registration with the UKCC.
- Cooperate with annual appraisal meetings.

In addition to the above duties and responsibilities, the post holder must be prepared to undertake such additional duties which may result from changing circumstances, but which may not of necessity change the general character or level of responsibility of the post.

Confidentiality

- In the course of seeking treatment, patients entrust us with, or allow us to gather, sensitive information in relation to their health and other matters. They do so in confidence and have the right to expect that staff will respect their privacy and act appropriately.

- In the performance of the duties outlined in this Job Description, the post-holder may have access to confidential information relating to patients and their carers, Practice staff and other healthcare workers. They may also have access to information relating to the Practice as a business organisation. All such information from any source is to be regarded as strictly confidential.

- Information relating to patients, carers, colleagues, other healthcare workers or the business of the Practice may only be divulged to authorised persons in accordance with the Practice policies and procedures relating to confidentiality and the protection of personal and sensitive data

Equality and Diversity

The post-holder will support the equality, diversity and rights of patients, carers and colleagues, to include:

- Acting in a way that recognises the importance of people's rights, interpreting them in a way that is consistent with Practice procedures and policies and current legislation

- Respecting the privacy, dignity, needs and beliefs of patients, carers and colleagues

- Behaving in a manner which is welcoming to and of the individual, is non-judgemental and respects their circumstances, feeling priorities and rights.

Personal / Professional Development

The post-holder will participate in any training programme implemented by the Practice as part of this employment, such training to include:

- Participation in an annual individual performance review, including taking responsibility for maintaining a record of own personal and/or professional development.

- Taking responsibility for own development, learning and performance and demonstrating skills and activities to others who are undertaking similar work.

Quality

The post-holder will strive to maintain quality within the Practice and will:

- Alert other team members to issues of quality and risk.

- Assess own performance and take accountability for own actions, either directly or under supervision.

- Contribute to the effectiveness of the team by reflecting on own and team activities and making suggestions on ways to improve and enhance the team's performance.

- Work effectively with individuals in other agencies to meet patients' needs.

- Effectively manage own time, workload and resources.

PERSON SPECIFICATION – Health Care Assistant

	Essential	Desirable
Personal		
Good general health and attendance record	Y	
Full UK driving licence and access to a vehicle	Y	
An understanding, acceptance and adherence to the need for strict confidentiality	Y	
Understanding of National and local policy affecting Health Care delivery		Y
Qualifications		
Relevant qualification(NVQ Level 3 or equivalent)	Y	
Skills		
Competent in basic Health Care Assistant duties required for the post	Y	
Excellent communications skills	Y	
Excellent computer skills	Y	
Good working knowledge of Systm1or EMIS Web		Y

Able to demonstrate enthusiasm to developing nursing skills	Y	
Ability to work under pressure	Y	
Ability to work without direct supervision and determine own workload priorities	Y	
Ability to work as part of integrated multi-skilled team	Y	
Ability to work in a changing environment	Y	

Appendix C:

Experienced Healthcare Assistant Required

To work effectively across 3 surgery sites - Quakers Lane Surgery/Aldbrough St John/Scorton

Excellent hands on technical skills in phlebotomy, ECG, wound care, and health checks with a commitment to offer outstanding patient care

This new and exciting opportunity is a fixed term 2 year contract with possibility of extension

Good IT Skills required

Salary Band 3 dependant on experience

30 hrs/wk – possible job share

Please forward handwritten application and CV to:

Mrs C Harker

Scorton Medical Centre

Stags Way

Scorton

Richmond

DL10 7HB

01748 811320

Closing Date: 31th July 2015

Appendix D:

Timeline for implementation

- 22 Jul 15- Initial proposal to HRWCCG submitted.
- 31 Jul 15- Closing date for HCA application
- 24 Aug 15- Submission of final proposal to HRWCCG.
- 1 Sept 15- Decision from Co-Commissioning board meeting
- 2 Sept 15- Interviews for HCA post
- Sept- Nov 15- Training of Practice Nurses
    - Shadowing of Community Matrons
    - Training from Ashfield Clinical
- Training from Healthy Ageing Collaborative on lessons learnt from other case studies nationally, utilising the Age UK leaflet 'Practical Guide to Healthy Aging.' and use of the STOPP template.
- Sept- Oct 15- Modification of Community Matron template and upload onto Clinical system.
- 1 Nov 15- HCA starts initially with an Induction period.
- May 16- Review of Outcomes Phase 1.