HRWCCG
Whitby Locality
Egton, Danby & Staithes Surgery
23rd July 2015

PRIMARY CARE NURSING WORKFORCE
PROPOSAL AND DELIVERY PLAN

Introduction

It is in the patients' best interest to stay well and at home as far as possible, and it is what most prefer. We are all aware that we must adapt to the demographic change of our society as people live longer and many more patients spend many more years in old age. This requires a primary care service that is mindful of and capable of responding to a larger number of people with long-term conditions, numerous medication, as well as care and support needs. Not only are these various and numerous medical and social care needs, they are also individual, very different from person to person. Our response needs to be personalised, providing the right information and support in the patient's home, involving the right additional services for each individual as required. Our approach also needs to be pro-active, looking out for emerging risks, such as the risk of falls or conditions that can flare up, ensuring these risks are adequately addressed and plans agreed. Last but not least, a personalised approach also brings the opportunity to support patients to understand and manage their illness better, bringing a greater sense of control and reducing the risk of sudden admissions to hospital, or the need of having to move into residential care. This can be a real contribution to not only increase patient's health and quality of life but to contain costs incurred by acute admissions, for example.

It has been valuable to look at our set of skills and to sit down together and plan how we could address this need. None of these aims are new, and attempts have been made in various ways before. We realised what is required now is to go one step further and commit a dedicated person at the interface of home and surgery, medicine and social care, capable of spending a little more time to understand the person's needs, capable of formulating a plan with them, understanding the system to provide the right information and involve services as required for that person, and keeping actions on track, reviewing what was done and reinforcing advice. We do not have the impression that we are reinventing the wheel but that we take a more committed step to creating a dedicated post for an experienced nurse focused on implementing a variety of relevant and effective interventions.

A skills / gaps audit was undertaken and provided to the CCG. It was also used to inform the development of the proposal. The audit showed skills in these areas between the practices.

The skills audit showed a combination of practice and community expertise in the following areas

Frailty

- Catheter care
- Skin tunnel catheter care
- Complex wound care
- Bowel care
- Continence assessment
- Dementia care
- Palliative care
- Pressure relieving care/advice

Sub-acute & Chronic Disease Management

- Palliative care
- Dementia Care
- Diabetic Care
- Heart Failure Care
- COPD
- Asthma

It also identified the following gaps and issues

- Chronic Disease Management in the Community with housebound/care home patients, especially COPD and diabetes
- DNARs
- BP reading in nursing/care homes
- Knowledge in developing care plans & care pathways and which voluntary sector agencies are available to work with
- See spreadsheet of skills audit

Other issues:

- Include DN and Nursing/care home staff in practice nurse training
- Include DN in practice nurse clinical meetings

The core of the proposal is as follows:

- Staithes, Egton & Danby to recruit a band 6 nurse see (**attached job description**)
- The successful applicant will be employed to go into the community and work with patients with long term conditions especially those that are housebound, in

care/nursing homes and those that are already identified on our unplanned admissions register with a focus in frailty.

- We have contacted Dr Rachel Murdoch's secretary at James Cook University Hospital who has given us contact details of Andrea Cowlin who is the link for the frailty model being implemented in the community.
- We would expect the person appointed to liaise with Andrea regarding the role out of this model in our practice areas.
- We are confident we will be able to recruit a nurse with appropriate skill levels but any training for the appointed person would need to be sensitive to their learning needs. Training sessions to be carried out across the Whitby locality to include practice, nursing/care home and DN staff. These sessions will be run in conjunction and consultation with Whitby Group Practice and Sleights and Sandsend Medical Practice therefore gaining best value for accredited training. These sessions would also give the opportunity for peer support and peer review, from our combined training budgets. Liaise with voluntary sector (Carers Resource & Alzheimer's Society) to develop an outreach type service using the practice premises as a base as well as the possibility of domiciliary visits.
- Dr Richard Rigby with the appointed nurse will lead the project working in collaboration with the practice nurses, and GPs. There will be monthly clinical meetings rotated between the 3 practices to monitor the clinical aspects of the project.
- A task group of clinical and non clinical staff would review non identifiable data, audit results and financial statements. The task group meetings would be open to patients. Carers/ social care and community services.

How the proposal has been developed

Initially developed from looking at nursing skills gap and patient needs.

Consultations with the following teams/representatives have taken place:

- GP's from the Whitby locality
- District nursing team
- Practice nursing team
- Nursing/Care Homes
- Patient Groups
- Voluntary sector

We would expect the post holder to be responsible for developing relationships action and care plans with other agencies and colleagues as required. We would hope this would result in less duplication and clear responsibilities for patient care.

Explanation of how the plan will achieve the project aims and what will be the expected impact and benefits of the changes on patient care and outcomes

1. Ensure quality of care for housebound patients (including those in care homes and extra care Housing and those on the unplanned admission register) equals ambulant patients. Housebound patients will receive the same level of detailed care eg in the assessment and management of long term conditions. There is a current gap in standards as D/N are not commissioned to provide long term condition assessment reviews and management plans. D/N does not have access to computerised notes and templates. The appointed person would have access to all records ensuring holistic care particularly in long term condition management developing care plans to be shared with other sectors as necessary.
2. The targeted cohort of patients would include patient on the Gold Standards Framework list, Admission avoidance patients, housebound patients with long term conditions, patients over 50 with learning disabilities, frail patients in care and nursing homes, patients who have had frequent hospital readmission and recent discharges even if those patients are not yet on the unplanned admission register.
3. Integrated working with community nurses, case managers, care home staff and social care to ensure better co-ordination of care. Through joint care plans and participation in local multi-agency meetings to further build partnerships and break-down barriers, clerical meeting would take place monthly and would alternate between the three surgeries.
4. Improved specialist management of long term conditions and frailty in the community to maximise health outcomes. By collaborative working with specialist nurses eg diabetic, respiratory and heart failure. This will enable the possibility of joint home visit, thus better outcomes for these patients who due to their isolation have difficulty accessing such a level of expertise.
5. We have already put in place regular meetings between senior practice nurses and district nurses encouraging peer support and peer review. This has already reduced professional isolation and developed greater team working.
6. Embracing new technologies enabling access to It via EMIS Web – use of templates, protocols, patient leaflets, management plans enabling patients to have information to help them and their illness. To also proactively identify patients and allow them to better manage their condition e.g. using Vitrucare. Care plans will be put in place to teach patients. Those patients who do not wish to or are unsuitable to use Virtucare to self manage their illness and alert the team when feeling unwell.
7. Significantly improve end of life care so death is not always seen as failure and can occur in patient's preferred place. Ensure all practice nurses have been trained to talk about death and surrounding issues. Training sessions to be arranged within the Whitby locality to include all sectors of nursing. Involvement in GSF meetings.

8. Successful joint working and sharing of skills across different nursing groups. By seeking shared learning and training opportunities across primary and community nursing and the care home sector eg offering training to care home and nursing home staff
9. For patients already known and cared for by D/N there needs to be an individual discussion between all the nursing staff, producing a joint care plan with an agreed role for each member of staff.
10. Sustainable financial and quality benefits for the future by reducing non-elective admissions by helping to proactively manage a patient's condition and ultimately reducing potential years of life lost to conditions amendable to health. This has to be audited in terms of unplanned admission

Discussions with patient representatives as part of finalising the plan prior to submission.

Discussions as follows:

1. Egton patient group 21.07.15
2. Danby patient group 21.07.15
3. Staithes patient group – is a newly formed group and this is on the agenda for the next meeting in September

After consultation with patient groups no modifications were necessary and they are fully supportive of the development plan. Egton patient group are looking to develop a "good neighbour scheme" which will fit in with the frailty nurse role. Initially the good neighbour scheme would be for housebound patients and those with co-morbidities. The frailty nurse would be able to identify patients that could use the good neighbour scheme for prescription delivery and transport. The group are hoping to develop this further once it starts to take off. The patient group are also keen to see care teams such as social services drawn into the service and we would hope to develop links as the role of the frailty nurse role develops

We intend to continually involve patients and patient representatives throughout the duration of the scheme through the Task Group.

What investment will be required (up to £3 per head).

The total amount available given the list size of the three practices is £22000.00

Summary to date:

Higher rate band 6 nursing hours 12/15 hours per week (between the three practices) @ approximately £18 per hour (£11232.00 per annum). Calculations are based on 12hrs but we would like to extend this to 15 if finances allowed, finances would be monitored monthly by Debbie Harrison & Alison Williams, Practice Managers. They will produce a financial report

report for the quarterly meeting of the Task Group. Additionally we will have the following approximate costs to take into consideration:

- Recruitment (advertising £400.00)
- PAYE (£1168.13 -10.4% employers NI)
- Pension (£1572.48 – NHS pension)
- Mileage (£3120.00 due to rurality approx. 150 miles per week at 40p per mile)
- Insurance (£100.00)
- Indemnity (will be employed by the practices and covered on their indemnity insurance)
- Training - £750.00
- Management and administration costs (1 hours per week admin support £646.88 including PAYE & Pension)
- Voluntary Sector (we would like to keep £2000.00) to enable us to meet some of the costs incurred by the voluntary sector to provide services/session that can be attended by our patients. Where possible we would use existing services that are available, but would like to have money available for additional services where necessary. Allocation of this money would require authorisation from the Task Group.

Costs for involving the voluntary sector are a bit of an unknown factor at the moment, but all three surgeries are keen to involve them and allow the use of the surgeries to develop an outreach type of service which the frailty nurse could refer into. We have had confirmation that the Alzheimers Society has secured funding to run a monthly Dementia Support session at Danby Surgery for the patients of Danby, Staithes and Egton Surgeries commencing in September 15. We are also keen to encourage Carers Resource to use Danby Surgery as a base for regular Carers support sessions, they have previously run sessions from the practice. Memory Lane Lunches is a social enterprise providing old fashioned food and company in the village hall for those patients with early onset dementia and their carers. Esk Moors Lodge in Danby also host "The Good Old Days" "Golden Oldie Film Matinee" and other activities. We would expect the nurse employed thorough the program to liaise with these and other organisations to enable patients to be referred to these services.
We would anticipate securing future funding in the expectation that we would be able to demonstrate benefits to patients and we would be able to demonstrate saving to the NHS in terms of a reduction in unplanned admissions

A description of the key performance indicators and other information that will be measured to assess the impact and confirm that the plan is achieving the intended outcomes..

We are hoping the development will be able to continue after two years. To prove its effectiveness we will measure the following:

1. Data for non-elective admissions taken at the start of the development and at 3 monthly intervals to ascertain whether reductions have been obtained

2. Re-evaluate skills mix and skills gap
3. Evaluate end of life care to ascertain patient died in preferred place
4. Patient satisfaction questionnaire
5. We plan to audit our date every 3 months and report to the Task Group ie rates of unplanned admission, rates of GP visits, use of OOH, measurement of certain parameters such as BP control in chronic disease, HBA1c in diabetic patients.
6. Stakeholder questionnaire

Finally, the proposal should set out a linked delivery plan, with appropriate milestones, that will explain how the project will develop and be taken forward by the practices and partner organisations involved.

1. Ascertain whether we have the capacity for our current nursing team to fulfil the role by 31st July 2015 (completed, we do not)
2. Develop job description by 31st July 2015 (completed)
3. Advertise for post if necessary by 31st August 2015
4. Nursing workforce in place October 2015
5. Agree and arrange set up of task group by Oct 15
6. Agree and arrange nurse training with collaborative practices by 31st July 2015 and to commence by October 2015
7. Speak to voluntary sector by 31st August 2015 to discuss how their involvement will evolve (started Alzheimer's Society already on board)
8. Meet stakeholders to evaluate the development plan and progress to date by end of December 2015. We envisage that we would be evaluating the plan on a quarterly basis thereafter.

In conclusion we feel this is a sound proposal. Danby, Egton and Staithes surgeries are committed to working together to achieve the project aims. We hope that the measurable outcomes demonstrated throughout the scheme will allow the continuation of this project beyond the two years.

Job Title:	Community Liaison Practice Nurse
Main Purpose of the Post:	To contribute to the Health of Practice Patients by Providing treatment, preventative care, screening and patient education. This is a short-term post to specifically review and manage patients in care or nursing homes and patients on the Care Register in their own homes
Responsible To:	GP Partners - clinical Practice Manager - administration

---

Main Duties and Responsibilities of the Post

This is a temporary post from September 2015 to August 2017 which we expect will help the practice build relationships and expectations with care and nursing homes while managing / reviewing patients for chronic disease management plus also develop or review care plans for patients on the Care Register in their own homes.

- Monthly attendance to all nursing and residential care homes – within practice
  - Medication optimization.
  - Advanced Care Planning in conjunction with GP's
  - Dementia reviews
  - Meet relatives and chat about advanced care plans, power of attorney, wishes regarding end of life care, DNAR
  - Liaise with Community team and GPs to manage caseloads according to patient requirement.
  - Refer to specialist community services, i.e. heart failure nurse, physiotherapist where appropriate.
  - Support, advice and educate nursing and residential home staff.
  - Train care home staff in urinalysis, BP monitoring, weighing for the heart failure patient, pulse measurement, signs and symptoms of exacerbatory illness etc.
  - Prompt follow-up of appropriate discharged patients.

Generic Duties:-

1 **To provide assessment, screening treatment services and health education advice**

- Provide treatments to patients in participation with general practitioners or independently to agreed protocols.
- Provide general and specific health screenings to the practice patients (within agreed protocols) with referral to general practitioners as necessary.
- Advise patients on general health care and minor ailments with referral to general practitioners as necessary.

2 **Pathological specimens and investigatory procedures**

Undertake specific procedures on a case by case basis as requested by GP's. Onward referral to D/N team when more appropriate.

4 **Administrative and professional responsibilities**

Participate in the administrative and professional responsibilities of the practice team.

- Ensure accurate notes of all consultations and treatments are recorded in the patient's records.
- Ensure accurate completion of all necessary documentation associated with patient health care and registration with the practice.
- Ensure collection and maintenance of statistical information required for regular and ad hoc reports.
- Attend and participate in practice meetings as required.
- Assist in the formulation of practice philosophy, strategy and policy.

5 **Education and training of senior care home staff**

Identifying specific learning needs and ways in which any skill gaps can be signposted. This may include carrying out the training in person if those skills wold be specific to an individual pateints needs e.g measuring glucose in a diabetic pateint

7 **Liaison**

Maintain effective liaison with other agencies and staff concerned with patient care and with all other disciplines within the practice, with appropriate regard to confidentiality.

8 **Professional development**

- Maintain continued education by attendance at courses and study days as deemed useful or necessary for professional development.
- Take responsibility for own development, learning and performance.

9 **Monitor and maintain a healthy and secure workplace**

Ensure familiarity with Practice Health & Safety Guidelines, COSHH, Risk Assessment and Control of Infection Guidelines. Report any risks to the Practice Manager or Practice Administrator. Record all accidents in the "Accident Book" held in Dispensary.

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
- Staff are required to sign a Practice Confidentiality Agreement

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 recognizes 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-judgmental and respects their circumstances, feelings priorities and rights.

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

Communication:

The post-holder should recognize the importance of effective communication within the team and will strive to:

- Communicate effectively with other team members
- Communicate effectively with patients and carers
- Recognize people's needs for alternative methods of communication and respond accordingly

Contribution to the Implementation of Services:

The post-holder will:

- Apply Practice policies, standards and guidance
- Discuss with other members of the team how the policies, standards and guidelines will affect own work
- Participate in audit where appropriate