PRIMARY CARE NURSING WORKFORCE PROJECT 2015

Proposal from Friary Surgery, Richmond

and Catterick Village Health Centre.

Summary of our Proposal:

1. **Chronic disease and frailty in housebound patients**

   Release members of our practice teams (nurses, HCAs and a pharmacist) to do home visits in order to proactively care for housebound patients with long-term conditions, identify frail patients at risk, promptly refer to appropriate services (e.g. memory clinic, HOT clinics, falls service) and discuss end-of-life care when appropriate.

2. **Care homes**

   Use our experienced Practice Nurses to educate and provide regular clinical support to Care Home Staff in the ongoing management of their residents, particularly with regard to chronic disease management, end of life care, expectations around antibiotic prescribing, calling 999, A+E attendance and hospital admissions.

3. **Integrated working**

   Improve collaboration and communication with the district nursing team and between the two practices by:

   - Sharing skills and offering training/ mentoring.
   - Offering services which the community nursing team find it difficult to provide, such as ear-syringing, influenza immunisation and ECGs.
   - Exploring ways of making district nurse service provision more time-efficient such as arranging clinics in surgery for catheter changes, dopplers etc in mobile patients.
   - Reorganising our working arrangements to make it easier for district nurses, Macmillan nurses, Community Matrons, Long-term Conditions Specialist Nurses and representatives from Adult Social Care to attend our Multi-Disciplinary Team meetings.
   - Liaising with district nursing managers to explore any other options which could realistically be implemented to improve the working setup and relationship between district nurses and general practice, so that Community Nurses feel part of the surgery team.

LEADERSHIP TEAM: Dr Rachel Parrott (GP) & Cherie Miles (Nurse Prescriber) from Friary Surgery.

Dr Ed Forsythe (GP) & Lyn Akers (Practice Manager) from Catterick Village H/C.

How do our proposals satisfy the HRWCCG strategic requirements?

CCG Objective	*CCG-suggested Mechanism*	*Our Proposal*
Ensuring quality of care for housebound patients (including those in care homes and Extra care Housing) equals ambulant patients.	Through outreach from the practice to enable better management of long term conditions for those most in need.	We will release Practice Nurses and HCAs to provide services to housebound patients and Care Homes, so that they can expect the same quality of care as those who attend surgery.
More examples of 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.	We would seek to encourage all members of the Community Nursing team to attend our MDT meetings by surgeries being more flexible regarding meeting times and venues. We will explore further ways of joint working to improve communication and integration.
Improved specialist management of long term conditions and frailty in the community to maximise health outcomes.	Through developing and sharing specialist skills between practices to ensure local access for patients.	PNs with expertise in LTCs will visit the housebound for more proactive management of their conditions, utilising Care Plans & referring on to geriatric "Hot clinic", falls team etc where appropriate. We have asked Heartbeat to provide us all with some training in Frailty at a Ch3 event.
Reduce professional isolation and ensure successful revalidation of practice nurses.	Through effective peer support and networks including with the CCG.	We will be sharing skills and ideas between the 2 practices and learning from each other's expertise, which will allow peer-mentoring to naturally occur.
Embracing new technologies to proactively identify patients and allow them to better manage their condition.	For example using RAIDR, Vitrucare, Florence or even telemedicine to connect remote locations.	We will use RAIDR to identify high risk patients. Both practices have started using Vitrucare and we would trial the use of this in appropriate patients.
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.	We will provide training where required and encourage discussion about end of life care when completing Care Plans for the housebound.
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.	We plan to provide education for Care Home staff through our Nurse Prescriber. We will encourage peer mentoring and training across both practices (e.g. wound management).
Sustainable financial and quality benefits for the future.	For example through 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 healthcare.	We are hopeful that more proactive care in the community and better education of Care Home staff will reduce emergency admissions and use of 999/ A+E. It may also reduce GP home visit requests which would free up GPs to spend more time on proactive care.

Background:

We are 2 neighbouring practices situated about 5 miles apart, with a slight overlap in our practice areas. Both practices are a mix of small town and rural population, and Catterick also covers the deprived area of Colburn, with several military dependents. We both have a large number of frail elderly patients, many of whom live in the 6 Care Homes in the area as well as Assisted-living and warden-controlled facilities. Both practices have recently signed up to working with a pharmacist and using Vitrucare, through Heartbeat Alliance.

	Friary Surgery	**Catterick Village**
List size	5821	6445
Premises	Friary Community Hospital.	Catterick Village H/C & Colburn H/C
GPs	3 Full time, 1 half-time and one F2 doctor	3 Full time, up to 3 registrars and an F2 doctor
Practice Nurses	2 part-time (3 days + 4 days)	2 part-time, 1 full time.
Health Care Assistants	2 sessions of phlebotomy/ INRs (also work as receptionist/ dispenser).	2 full-time
Computer system	EMIS	System One
Care Homes (with current number of residents in brackets)	The Terrace, Richmond (14 pts) Nightingale Hall, Richmond (9 pts) Rosedale, Catterick Garrison (3 pts) Maple Lodge, Scotton (1 pt) Morris Grange, Middleton Tyas (occasional) Hillcrest, Catterick Garrison (occasional)	Rosedale, Catterick Garrison (49 pts) Hillcrest, Catterick Garrison (30 pts) Morris Grange, Middleton Tyas (occasional) Maple Lodge, Scotton (5 pts) The Terrace, Richmond (occasional) Nightingale Hall, Richmond (occasional)
Assisted Living facilities	Greyfriars (30 patients) Balmaclenan (1 pt)	Elm Walk (4 pts) Balmaclenan (5 pts) Oaktree court (20 pts) Noels court (42 pts)

A skills and gap audit of our own nursing staff in July 2015 (see next page) showed:

- In July 2015, when the audit was done, Catterick had some spare capacity in having 2 full-time HCAs and were planning to significantly reduce hours. However since the audit, one HCA has decided to take the job advertised by the Scorton, Aldborough and Quakers Lane group in relation to their Nursing Project.
- Friary PNs do not feel confident in complex wound management, as historically all Friary patients have attended the Complex Wound Clinic at Friary Community Hospital. Currently we are told the clinic is full and so Friary PNs would like to become more proficient in this skill. At the time of audit in July, we had thought they could receive some training from Catterick PNs but we now plan to take on a new nurse who already has considerable experience in complex wound care as a former District Nurse, thus facilitating in-house training.
- Friary surgery has a Nurse Prescriber who has skills in education and minor illness and is keen to educate Care Home staff – some of her skills could be shared with Catterick nurses through peer mentoring. Friary HCA could receive some training from Catterick.

- We are keen to encourage peer-mentoring between the nurses in both practices. All PNs do chronic disease management but have different areas of expertise.
- Both practices are taking on a pharmacist, organised through the Heartbeat Alliance. They are expected to play a role in medication reviews of housebound patients and education of care staff regarding medications.

Skills Audit of Surgery Nursing Staff before Project

3 = very able 2 = competent 1 = in training 0 = do not do

Nurses/ HCAs Skills	FRIARY SURGERY					CATTERICK SURGERY			
	C-PN	D-PN	D-HCA	P-HCA		M-PN	L-PN	C-PN	J-HCA
Phlebotomy	3	3	3			3	2	3	3
Warfarin monitoring	3	0		3		3	1	3	3
Urine testing	3	3				3	3	3	3
Taking BPs	3	3				3	3	3	3
ECGs	3	3				3	2	3	3
Spirometry testing	0	3				2	0	3	3
Taking swabs	3	3				3	1	3	0
New patient checks	3	3				3	1	3	2
Well-man checks	3	3				3	1	3	2
Health promotion	3	3				3	1	3	2
Weight management	3	3				3	1	3	2
Cholesterol & diet	3	3				3	2	2	0
Ear syringing	3	3				3	0	3	1
Cervical smears	3	3				3	0	3	0
Breast examination	3	3				2	0	0	0
Contraception	3	3				3	0	2	0
Sexual health	3	3				3	0	2	0
Smoking cessation	0	3				3	0	3	0
Childhood Imms	3	3				3	0	3	0
Travel advice/ imms	3	3				3	0	3	0
Minor injuries	3	3				3	3	3	0
Complex wounds	2	2				3	3	3	0
Catheterisation (F)	0	0				3	3	3	0
Catheterisation (M)	0	0				3	0	3	0
Minor illness advice	3	2				3	3	3	0
Prescribing	3	0				0	0	0	0
Summarising records	2-3	3		3					
Long-term conditions:									
Diabetes Mx	3	0				3	1	2	0
Asthma/ COPD Mx	2-3	3				2	1	2	0
Hypertension Mx	3	3				3	1	2	0
IHD management	3	3				3	1	2	0
Heart failure Mx	2	2				2	1	2	0
AF management	3	2				2	1	2	0
Depression	3	0				2	0	0	0
Dementia	2-3	0				2	0	0	0
AmberDrug monitoring	3	3				2	2	2	2

A Skills & gap audit and General Discussions (July 2015)

with various members of the Community Nursing Team:

District Nurses are generally highly skilled in assessing the needs of and caring for housebound patients, particularly the frail elderly, those recently discharged from hospital and the terminally ill. There is a variation in skills across the 6 DNs that cover the Richmond area, but they work as a team which enables skills to be matched to specific needs.

District Health Care Assistants are trained in phlebotomy, catheter care, pressure bandaging etc.

We identified the following gaps in service provision:

- An ear syringing service is currently not available from the district nursing team.
- It is getting increasingly difficult to get district nurses to do Dopplers.
- District nurses have not routinely been doing flu vaccines on housebound patients and patients in care homes.

We find communication has become increasingly difficult with district nurses, community matron, long term conditions nurses and Macmillan nurses as they no longer appear to have time to reliably attend MDT meetings held in GP surgeries.

We observe (having spoken to a number of individuals on the District Nursing Team) that they are dissatisfied with the way they are currently working. They feel they are dealing with issues in a reactive rather than proactive manner and struggle to deal with a large workload over a huge geographical area. They feel disengaged from their managers at South Tees.

We feel that it would be helpful for all concerned if District Nurses and HCAs felt part of the surgery team, being responsible together for delivery of care to a practice population. This would allow greater flexibility of working, maximising use of each individual's skills. E.g. A District Nurse could manage complex wounds or a catheter change for ambulant patients in the practice while a Practice Nurse uses their expertise to do Long-term conditions checks or ear-syringing on housebound patients. We believe that if district nurses were more closely linked to GP Surgeries, they would be happier and less stressed, leading to better staff retention and less sickness absence. GPs and practice nurses would also feel more inclined to invest time and money into supporting the district nurses if they were a visible member of the team, actively involved in contributing to the overall care of our practice population.

Initial meetings have been held with Pam Thorne, manager of the Richmond Community Nursing Team, in order to explore options which would allow closer integration with practice teams. She agreed that this was important and plans to take the first step towards addressing this by talking to staff and encourage greater commitment to attend GSF/ MDT meetings. The practices in turn will make efforts to provide flexibility regarding meeting times and venues. She is going to consider what other options could be realistically explored to improve the working interface between district nurses and general practice.

Speaking to Greta Kirkbride, the nurse in charge at Rosedale Nursing Home, it seems there are skills there which are not being used. E.g. She is able to syringe ears but does not have the equipment. Most of the other homes are simply residential, so do not have nurses.

Delivery Plan:

PROPOSAL 1: Chronic disease and frailty in housebound patients:

Release members of our practice teams (nurses, HCAs and a pharmacist) to do home visits in order to proactively care for housebound patients with long-term conditions. We would identify frail patients at risk and promptly refer to appropriate services (e.g. memory clinic, HOT clinics, falls service). We would encourage end-of-life care planning where appropriate.

This would include chronic disease management, medication reviews, falls assessment, dementia screening, assessment of need for HOT clinic referral and end-of-life care planning. Where a need is identified, referral to the appropriate service would be made. There would also be an emphasis on educating patients and their carers in managing their conditions more effectively. If popular, we might consider offering some group education for carers in the community.

The term "housebound" can include patients who find it difficult to attend the surgery due to frailty and disability, even if they are sometimes able to leave the house with help.

1. We will use a large proportion of the funding to provide back-fill for PNs or pay for extra hours of nursing time to allow home visits:
   - Friary Surgery is planning to employ an extra nurse for one 8hr day a week and our HCA for an extra 4hrs per week, in order to free up 12hrs a week of Practice Nurse time for the project. This does not poach staff from any other organisations, but training will be required (see Appendix 2: Friary Workforce planning, Training and Provisional Spending Plan).
   - Catterick Village had recently established that they had spare capacity in having 2 full time HCAs, often with empty appointments. In our initial proposal document we had planned to use this capacity to address the objectives of this scheme. Unfortunately one of the HCAs has now resigned and decided to work for another practice cluster on the community nursing initiative. On reflection it has been decided that the scope of the scheme would be better met by a practice nurse and thus a decision has been made to fully replace HCA hours with nursing hours. Catterick plans to replace 26 hours of HCA time at with 30 hours of practice nursing time. The practice nurse will be used to provide visits to perform various services including chronic health checks, ECGs, phlebotomy, frail elderly risk assessments and ear syringing. To meet any lower level skill requirements not being met due to the reduction in HCA hours, Catterick would train one of their receptionists in phlebotomy. She would provide two sessions per week and backfill in reception would be financed using the project monies.

2. We would use technology to identify at risk patients in need of review. E.g. RAIDR.

3. In appropriate patients we intend to advocate the use of technology such as Vitrucare and would tutor the patient, carers or family in how to use this.

4. Funding may be used for purchase of portable equipment and IT devices as needed for home visits as this would improve record keeping and increase efficacy of assessments.

5. Both practices are now involved in a 3-6 month pilot utilising a pharmacist through Heartbeat Alliance, who we can release to do medication reviews on housebound patients, particularly those on multiple medications. This should have the effect of reducing the drugs budget,

improving compliance, reducing side-effects and interactions, thus improving overall quality of care.

PROPOSAL 2: Care homes

Use our experienced Practice Nurses to educate and provide regular clinical support to Care Home Staff in the ongoing management of their residents, particularly with regard to chronic disease management, end of life care, expectations around antibiotic prescribing, calling 999, A+E attendance and hospital admissions.

1. Education and regular support: Friary Surgery has a nurse prescriber who treats minor illness and is also a nurse educator. She is ideally placed to make regular visits to Care Homes to deal with day-to-day medical problems and provide education and support to staff. Her current working pattern makes immediate cover for all care homes unfeasible; however we would aim to pilot weekly visits to one or two of the residential homes initially with the aim of expanding this, if successful. We would compare the results of this to a recent pilot undertaken by Catterick Village health centre which has involved sending a GP registrar to do a regular weekly clinic in Hillcrest Care home, which had the benefit of reducing unplanned GP visits by 50% (see appendices). This comparison will help establish whether it is an effective approach to reducing care home visits and hospital admissions and the relative benefits of a GP vs Practice Nurse delivering this. Expansion of the nursing role could be delivered by training up one of the practice nurses at Catterick to provide clinical support and to deliver appropriate education. However if it were to become apparent that GP visits were more effective, then practices would consider potential ways to free up GP clinical time through use of the Alliance clinical pharmacist and / or an extra nurse prescriber for some elements of chronic disease care in the surgery, traditionally done by doctors (e.g medication reviews, titration of antihypertensive drugs).

2. Flu jabs – practice nurses would undertake care home influenza immunisation rather than involving the already stretched district nursing team.

3. Chronic disease care – at present routine chronic disease care and monitoring in nursing homes is often sporadic. Routine health checks for chronic disease (i.e. annual diabetic reviews) could be performed more effectively by freeing up practice nurses to spend time in the care homes.

4. We would like to have remote access to records in order to make reviews at care homes more effective and to improve record keeping. This would also make performing ECGs in the community more feasible. (e.g. EMIS mobile app costs £500 per annum).

PROPOSAL 3: Integrated working

Improve collaboration and communication with the district nursing team and between the two practices:

- **Sharing skills and offering training/ mentoring** - We will utilise funds to address training and mentoring needs across both practices. E.g. A Catterick nurse could have protected time to

shadow the Friary's Nurse Prescriber/ Educator on visits to Care Homes. Friary HCA Diana could receive some training from Catterick, e.g. in use of 24hr BP machine. PN Debbie from Friary may help mentor Michelle from Catterick in COPD. Pam Thorne also appeared willing to allow training opportunities for our practice nurses alongside district nurses.

- **Offering services which the community nursing team find it difficult to provide, such as ear-syringing, influenza immunisation and ECGs** – using our Practice nurses/ HCAs for home visits (Catterick village HCA is currently listed for training in ear syringing).

- **Exploring ways of making district nurse service provision more time-efficient such as arranging clinics in surgery for catheter changes, dopplers etc in mobile patients -** Explore the option of making a room available and providing transport (hopefully coming soon through Heartbeat Alliance) to GP surgeries for clinics, though we are unsure if there are enough patients to make this worthwhile.

- **Reorganising our working arrangements to make it easier for district nurses, Macmillan nurses, Community Matrons, Long-term Conditions Specialist Nurses and representatives from Adult Social Care to attend our Multi-Disciplinary Team meetings -** by being more flexible regarding meeting times and venues, considering back-to-back meetings of the 2 surgeries at the same venue.

- **Liaising with district nursing managers to explore any other options which could realistically be implemented to improve the working setup and relationship between district nurses and general practice, so that Community Nurses feel more a part of the surgery team** – we realise that having a DN attached to the practices may not be feasible due to the skill mix and need for cross-cover. However our initial meeting with Pam Thorne, Manager of the Richmond Nursing Team was positive and we look forward to hearing back from her when she has discussed ideas with her managers.

Expected Outcomes from the Project

1. Improved service provision for housebound patients so that there is equality of care with ambulant patients, particularly with regard to managing long-term conditions, frailty and end of life care.
2. Increased confidence of carers and Care Home staff in managing common conditions and appropriate and timely referral to GP or other services.
3. Improved working relationships between Community nurses, Case managers and the two GP practices.
4. We would hope that both an improvement in care and better education for carers might lead to a reduction in unnecessary GP home visits, emergency ambulance calls, attendances at A+E and hospital admissions.
5. Increased confidence of Friary nurses in management of complex wounds and better care for patients, since referral to the Friary Complex Wound Clinic no longer appears to be an option.

Measuring outcomes.

We have done some baseline audits at the start of the project and will carry out further audits at a minimum of 12 months and 24 months.

1. Audit of the management of patients with complex wounds.
2. Audit of number of GP visits both in and out of hours.
3. Audit of A+E attendances and hospital admissions.
4. Patient and carer satisfaction questionnaires (including Care Home staff).
5. Clinical Staff satisfaction questionnaires (PNs, HCAs, GPs, DNs, Case Managers etc).

Audits for Friary Surgery at start of project:

1. Audit of Complex Wound Management Clinic

An audit of patients attending the Complex Wound clinic at Friary Hospital revealed that there is only one patient from Friary surgery still being managed by the clinic. All the others are from Quakers Lane Surgery! Our 2 Practice Nurses are having to manage all the others themselves, as they have been told that the clinic is full and no longer accepting referrals. They are not always confident in doing this, so have found their own solution, which is to see the patients themselves but occasionally ask the nurse from the Complex Wound clinic to pop over once the wound is undressed and have a look in order to give advice. Unfortunately since we had not signed up to the Complex wound enhanced service, payment for our nurses time with such patients is proving difficult to obtain at present.

2. Audit of GP home visits, A+E attendance and hospital admissions

Numbers in past year	**All Over 75s**	**Patients in Nursing Homes**	**Patients in Residential Homes**	**Patients in Assisted-Living Accommodation**
Current patients (still alive)	587	Rosedale: 3 Maple Lodge: 1 TOTAL = **3**	The Terrace: 14 Nightingale: 9 TOTAL = **23**	Greyfriars: 30
Resident in past year (including those left or died)	698	Rosedale: 4 Maple Lodge: 3 TOTAL = **7**	The Terrace: 21 Nightingale: 16 TOTAL = **37**	Greyfriars: 50
Number of patients visited by a GP (in hours)	102	Rosedale: 3 Maple Lodge: 3 TOTAL = **6**	The Terrace: 21 Nightingale: 16 TOTAL = **37**	Greyfriars: 30
Total number of in-hours GP visits	312	Rosedale: 8 Maple Lodge: 7 TOTAL = **15**	The Terrace: 84 Nightingale: 67 TOTAL =**151**	Greyfriars: 112
Average number of GP visits per week (in hours)	6	Rosedale: 0.15 Maple Lodge: 0.13 TOTAL = **0.28**	The Terrace: 1.6 Nightingale: 1.3 TOTAL =**2.9**	Greyfriars: 2.2
Average number of GP visits for each patient visited	3.1	Rosedale: 2 Maple Lodge: 2.3 TOTAL =**2.1**	The Terrace: 4.0 Nightingale: 4.2 TOTAL = **4.1**	Greyfriars: 3.7
In hours visit rate	0.45	2.1	4.08	Greyfriars: 2.24
Number of OOH visits	78	Rosedale: 2 Maple Lodge: 0 TOTAL = **2**	The Terrace: 4 Nightingale: 9 TOTAL = **13**	Greyfriars: 12
OOH visit rate	0.11	0.28	0.35	Greyfriars: 0.24

Numbers in past year	All Over 75s	Patients in Nursing Homes	Patients in Residential Homes	Patients in Assisted-Living Accommodation
Number of all hospital admissions	159	Rosedale: 1 Maple Lodge: 0 TOTAL = **1**	The Terrace: 3 Nightingale: 4 TOTAL = **7**	Greyfriars: **35**
Number of admissions per patient	0.23	0.14	0.19	0.70
Number of A+E attendances	221	Rosedale: 3 Maple Lodge: 1 TOTAL = **4**	The Terrace: 10 Nightingale: 10 TOTAL = **20**	Greyfriars: **22**
Number of A+E attendances per patient	0.32	0.57	0.54	0.44
Number of emergency ambulances	Unknown	Unknown	The Terrace: Unknown Nightingale: 7	Unknown

Notes about the audit:

- *Visit rates are expressed as total number of visits per total number of residents in that group per year.*
- *The GP visit figures are likely to be under-reported by 5% as when patient records were looked at, about 5% of home visits were recorded as "GP surgery", since doctors forget to change the setting on EMIS.*
- *Hospital admissions were not always coded as elective or emergency so the total number of admissions was used. A manual search of records for patients in the Nursing homes and Care Homes showed they were ALL non-elective admissions. However the figures for "all over 75s" and Greyfriars residents includes planned admissions.*

BASELINE AUDIT OF ACTIVITY IN NIGHTINGALE HALL CARE HOME 4/9/14 – 4/9/15

One of the Care Homes (Nightingale Hall) was looked at in more detail, checking the patient's notes for cause of hospital admission or A+E attendance. No search had been possible for ambulance use in the overall audit as they are not generally coded, so a manual count from the patient's records was made for this Home, to give an indication of likely numbers overall.

NB. Where patients have had activity within this 12 month period before they became resident in the Care Home, figures are shown in brackets.

No	In-hours GP visits	OOH GP Visits	A+E Attendance	Non-elective Hospital Admissions	Emergency ambulances	Comments
1	8	0	0	0	0	
2	3	1	0	0	0	
3	6	0	0	1	2	
4	0	0 (1)	1	0 (1)	0 (1)	Moved in 5/15
5	2	0	0	0	0	
6	2	0 (1)	0	0	0	Moved in 7/15
7	3	0	0	0	1	
8	2	0	0	0	0	
9	3	1	0	0	0	Died 12/14
10	3	1	0	0		Died 12/14
11	3	1	0	0	0	Died 1/15
12	3	1	0	0	0	Died 1/15
13	5	1	3	0 (3)	0 (2)	Moved in 3/15, Died 7/15
14	5 (1)	0 (1)	4	1 (+1)	2 (+1)	Moved in 12/14, Died 3/15
15	3	0	1	1	1	Died 2/15
16	3	2	1	1	1	Died 1/15
TOTALS	**54**	**8**	**10**	**4**	**7**	

Causes of the above 4 non-elective hospital admissions were septicaemia due to UTI, pneumonia, abdo pain and constipation. One or two of these admissions might have been preventable with better preventative care (constipation) or earlier recognition and treatment of infections.

Of 7 ambulances used, 4 resulted in admission to ward, one was discharged from A+E (after assessment of head injury & wound being dressed) and two were assessed at the home with no further action required. It was felt at the time that these two were unnecessary calls and could have been prevented with better education/ increased confidence of staff. E.g A collapse in a patient with a DNAR in place.

All A+E attendances were thought to be necessary to exclude a fracture, suture a wound or they resulted in admission.

Catterick village – audit of care home and assisted living visits and A+E admissions

Numbers in past year	***All Over 75s***	***Patients in Nursing and Residential homes***	***Patients in Assisted-Living Accommodation***
Current patients (still alive)	*511*	*Rosedale: 49* *Maple Lodge: 5* *Hillcrest: 30* *TOTAL =* ***84***	*Oaktree court: 20* *Noels court: 42* *TOTAL =* ***62***
Number of GP visits in hours	*1056*	*512*	*103*
Visit rate per patient	*2.1*	*6.09*	*1.6*
Average number of GP visits per week (in hours)	*20*	*9.8*	*2*
Number of OOH visits	*306*	*113*	*21*
OOH visit rate		*1.34*	*0.3*
Number of A+E attendances	*52*	*14*	*4*
Rate of A+E attendance per patient	*0.1*	*0.16*	*0.06*
Number of emergency ambulances	*Unknown*	*Unknown*	*Unknown*

Observations from the audit:

- We have merged nursing and residential visits for the purposes of this audit as due to the fact Rosedale has mixed residential and nursing beds it was impossible to accurately separate out.

- The highest GP visit rate was unsurprisingly in our nursing and residential homes (6.09) which is above average.

- OOH visit rate was low but highest in nursing/residential homes (1.34)

Conclusion from the audit:

To have maximum impact, catterick village surgery will concentrate efforts on the 2 care homes (Rosedale and Hillcrest) as the majority of home visits and A+E attendances come from these locations in >75s and rate of GP visits per patient is high.

Potential Cost Savings through the Project

1. REDUCING USE OF SECONDARY CARE

A non-elective admission for an over 75yr old patient costs an average of £1500. If 5% of over-75s admissions could be prevented, this would amount to 8 patients per year for the Friary population, with a saving of £12000 per annum. Savings would be similar for Catterick patients.

An attendance at A+E costs an average of £80. However from the audit done, we do not feel we are likely to reduce this, as most A+E attendances were deemed necessary.

Calling an emergency ambulance is costly and there is scope to reduce the number of ambulances called, by better education of carers. It was impossible to obtain numbers for ambulance calls from EMIS searches as they are not coded. However a manual search of one Care Home led us to believe that 2 out of 7 calls were unnecessary, which if prevented would have led to a 28% reduction in use of 999 calls for this home. Unfortunately we are unable to audit this for all 75+ patients due to lack of coding, so it is difficult to predict or measure cost-savings.

2. REDUCING NEED FOR COMPLEX WOUND CLINIC AT FRIARY COMMUNITY HOSPITAL

The Complex Wound Clinic is currently overstretched and requires further funding to provide an adequate service to all Richmond patients. The use of the clinic by Friary surgery has already reduced due to the lack of resource (i.e. clinic not currently accepting new referrals). We hope to improve the quality of service provided to patients with complex wounds in the practice by employing a nurse with expertise in complex wounds and using her to both provide the service and train up our own PNs. We sincerely hope that the CCG will allow the Friary Surgery to sign up for the Complex Wound Enhanced service in recognition of the work being done.

3. REDUCING GP VISITS

Although this does not have a direct effect on the current CCG budget, we feel an important aspect of this project is to look at the long-term future of how our practices will cope with an increasingly frail elderly population. As recruitment of GPs gets harder and with the likely advent of 7 day opening in the future, which will require the workforce to be spread more thinly over more days, we need to find ways of preventing the daily workload of GPs from escalating. Home visits are not time efficient compared with a 10 min appointment in the surgery, so passing more of the visits on to extra nurses and pharmacists will be a positive step.

4. IMPROVED PATIENT CARE

Better management of housebound patients with chronic diseases by Practice Nurses and regular review of their medications by a pharmacist will result in better health outcomes overall. This may not be measurable in monetary terms, but is likely to have wide-ranging long-term benefits for the Health and Social Care budgets and workforce.

Involvement of Patients and Carers in the Project

We have not set up a formal "task force" to oversee the project, other than the 2 leads from each practice, as we want to increase the time spent with patients, not spend more time in meetings! However we are seeking to involve patients and carers at every step:

1. We sought feedback on our initial proposal from all our Care Homes and from our Patient Participation Groups (see below). This involved sending them a summary of our proposal with an invitation to provide feedback. In some cases this required chasing the Care Homes by telephone. We have taken various comments on board as a result. We have also had conversations with private carers in the community and staff in Assisted Living premises.
2. We will continue to invite feedback from these groups at various stages of the project, including questionnaires for patients, carers and other staff as part of our audit.
3. We anticipate offering education to carers in the community as well as care homes, which will allow a setting for both formal and informal feedback.

Initial Feedback from Patient Participation Groups and Care Homes (July 2015):

The Terrace: Very keen to have a nurse prescriber doing a weekly visit. They feel this is likely to reduce the number of visit requests for GPs. Glad to hear we will be able to provide an ear-syringing service.

Nightingale Hall: Very positive about a nurse prescriber doing LTC checks, minor illness and education. Also keen to have a pharmacist to review medications.

Rosedale Nursing Home: Recognised the value of what we are doing and happy to be involved in the project and use their own nursing skills more, e.g. ear-syringing if they can borrow our equipment. Their main suggestion was that new residents should have a clear discussion, with patient and family present, about thoughts regarding hospital admission if unwell - *nursing home staff could be trained in this.*

Hillcrest: Highlighted the fact that having a regular clinician (GP registrar) reviewing their patients weekly has been really good for them and they have had hardly any hospital admissions since it has been trialled. Their main concern was regarding 111 calls which often prevented them speaking to the OOH GP + automatically triaged to an ambulance even if they just wanted some advice. – *This might be something we could take up with the CCG or LMC. Clear care plans, perhaps shared on Adastra may help.*

Catterick Village PPG:

They raised a question about involvement of Social services in the project – *at present we feel this is beyond what we can realistically achieve and prefer to focus initially on nursing services. However the team will of course continue to make referrals to Social services when appropriate.*

They asked if there were nursing staff in Care Homes who should already be involved in educating carers – *This does happen in Rosedale as they are a Nursing home, but there are no nurses in Care Homes. Our educational focus will be on the Residential Homes.*

They asked about the advertised services of local Pharmacies offering Dm checks etc – *this is a limited service offering screening to the walking well, rather than the frail housebound patients that this project is intended to benefit.*

Friary PPG:

"This initiative is very welcome", "Excellent idea", "With the ever increasing numbers of frail and elderly people within our community it is refreshing to see that their needs are being thought about."

"In my opinion all these ideas are very good especially item 1. I think if we want people to stay in their own homes to ease pressure on Doctors, Hospitals and other departments, all the help we can give them can only be beneficial. I would be very pleased to have a home visit by a nurse if I needed it in the future, and I think a lot of people would feel the same."

"I feel that you have correctly identified 3 key areas of need, with regard frail and elderly patients within our community, in order to ease pressure on our already overstretched Hospitals and Doctors, However, when nurses visit and assess frail and elderly people, and indeed people living with dementia, I feel it would be a good idea to also include Social Services and families at this stage, because care packages may need to be altered in some cases. For example it would be no good a nurse assessing a health need involving diet or exercise if the need could not be met within an existing care package or if pressure on family carers were to be increased an intolerable level. If social Services and family were involved at this stage then any additional support and care could be arranged to meet any additional requirements" – *we will of course encourage nurses to involve families and carers when doing assessments and liaise with social services as appropriate.*

"I feel that nurses educating carers in certain areas i.e signs to watch for etc. could prevent or further halt the progression of some conditions i.e bed sores and other skin conditions and is always a good idea."

"How will patients be notified of this and will it be given good publicity?" – *We will identify housebound patients initially from those requiring frequent GP visits and those on our lists for domiciliary flu immunisation, but will also consider posters in waiting rooms to alert carers.*

"Is the term 'housebound' worth expanding? There are some people who find it extremely difficult to reach the surgery even though they may not be completely housebound" – *this has been taken on board and the wider group of patients has been included in the project.*

"Monitoring: Because of the many different aspects of care at home it will be difficult to isolate your scheme, so suggest that an evaluative framework be included in the design" – *we have identified ways to evaluate outcomes but had not initially included this in the info given to the PPG.*

Implementation of the Proposal once approved by the CCG:

For details of workforce planning, training and spending plans, see appendix 1 & 2.

The plan will be implemented in stages in order to manage workload and ensure effective implementation:

1. **Recruitment, training and provision of equipment**:
   Both practices will initially recruit staff as detailed, identifying their current skills and provide the necessary training for changed roles. Any equipment (portable IT systems, portable ECG etc) will be purchased and training in their use provided if needed.

2. **Set up regular communication:**
   Another meeting with Pam Thorne is to be held to discuss her suggestions of improved integration with District Nursing teams. A regular MDT meeting between community nursing team and both practices will be arranged. This will be a forum for on-going feedback and development of the proposal.

3. **Commence visiting:**
   Nursing staff and pharmacists will start proactively visiting known "visit-intensive" housebound patients and Care Homes, including educating carers. If new training or equipment needs emerge, these will be addressed. The team will feed back and be responsive to lessons learned along the way.

4. **Identify further patients:**
   Once the scheme is running smoothly we will identify more at-risk patients by use of RAIDR.

5. **Review:**
   We will informally seek feedback from patients and carers at any opportunity and keep in touch with our Patient Participation Groups. We will also carry out a planned review after 6-12 months, including questionnaires and audits as detailed on p7. This will influence how we continue the project into its second year.

APPENDIX 1: Provisional Spending Plan.

Friary Spending Plan:

With a list size of 5820, the £3 per head investment would amount to **£17460 per annum:**

PERSONEL:	Extra hours of receptionist: 4hrs x £11.01/hr x 52 =	£2290 per annum
	Extra hours of Nurse for 1 day per week: 8hrs x £17.74 x 52 =	£7380 per annum
	Estimated Overtime for Practice Nurses	£1150 per annum
	Salary rise for Nurse Prescriber for 12 hrs per week	£670 per annum
MANAGEMENT:	Overtime payments for lead GP (to oversee the project, perform audits etc)	£3120 per annum
	Extra admin time (PM/ receptionist)	550 per annum
TRAVEL COSTS:	For nurses doing home visits (Cost of additional car insurance + mileage)	£300 per annum
IT COSTS:	EMIS mobile:	£500 per annum
MISCELLANEOUS COSTS (equipment, training costs etc)		£1500 per annum
	TOTAL:	**£17460 per annum**

APPENDIX 2: Provisional Spending Plan

Catterick Village

The £3 per head investment would amount to **£19788 per annum.**

We plan to spend this on

PERSONEL: Extra hours of receptionist:

Salary rise for HCA rather than reception hours:

Extra hours for Nursing Staff 26 x £9.37 (difference between HCA and Nurses Wage) + 4 x £17.74 x 52

£16358 per annum

Estimated Overtime for Practice Nurses £1152 per annum

MANAGEMENT COSTS: Overtime payments for lead GP £3380 per annum (to oversee the project, perform audits etc)

IT COSTS: Systmone mobile / Away from my desk £500 per Annum

Total Cost £ 21390