Great Ayton Health Centre

Hambleton, Richmondshire & Whitby Clinical Commissioning Group

Primary Care Nursing

Workforce Project

Great Ayton Health Centre
Proposal and Delivery Plan

30th October 2015

BACKGROUND

Great Ayton Health Centre has a population size of 5,500 patients and is situated on the border of Hambleton, Richmondshire & Whitby CCG, neighbouring with Middlesbrough and Teesside, East Cleveland and the North Yorkshire Moors.

Within the geographical area covered by the practice one Extra Care Housing facility is located, one Residential Home and two Nursing Homes. However, none of these accommodations are situated within Great Ayton, with local residential and nursing homes closing several years ago. The number of patients registered at the practice living in a 'care home' is currently very small (less than 20), as they are located on the peripheral area (Marton, Nunthorpe, Stokesley). Many people choose to retire to Great Ayton and the surrounding villages or have previously moved to the area to work at former industrial plants, so there are increasing numbers of older people being supported in their own homes, and as the national trends indicate, with increasingly complex health and social needs.

As Great Ayton is on the border of the CCG it offers a limited choice identifying a locality group. Initial consultations were made with the neighbouring practice at Stokesley which identified different needs from the project (for example Stokesley is a larger practice and does not have GP training scheme doctors). Both practices share the same community services team (District Nurses, Community Matron, Case Manager) and therefore Great Ayton is very willing to work together, sharing ideas to support and enhance practice where possible.

PLAN

We are aware that our ageing population is growing and the demands on Primary Care are increasing and we have to be able to deliver care and support to patients with long term and chronic disease conditions, medication issues and social care, involving the voluntary sector. We believe that the personal touch is valuable with older people, providing good support and information for individuals in their homes where appropriate, helping them to manage their conditions, promoting independence and hopefully reducing emergency and unplanned admissions into hospital.

A nursing skills and gaps audit of activities was undertaken (Appendix A) which formed the basis for the proposal and utilising nursing skills available.

As the practice does not yet have an active PPG, patient views and representation were sought and obtained following an article in the Health Centre Newsletter and practice website inviting comments and suggestions on the proposal. Favourable written and verbal feedback has been received.

Aims

- Target housebound, less mobile patients who currently do not have access to long term conditions assessment/reviews.

- To provide an equitable service for long term conditions assessment and management for patients at home as well as those attending the health centre appointment system.

- Care co-ordination through practice outreach nursing, liaising and referring appropriately to support/voluntary agencies and well as with other health care professionals required.

- Working closely with community and practice attached pharmacist for medication reviews and advice where appropriate and reducing medications/ensuring cost effectiveness.

- Improve patient self-management skills with their long term conditions to reduce exacerbations, improve quality of life and independence through education and monitoring.

- Improve and develop team working across all nursing groups such as practice based, community and specialist nurses through joint working, training and meetings, reducing isolation and supporting revalidation, by sharing skills and expertise.

- Support staff in residential and nursing homes by providing a nurse link within the Health Centre.

- Collaborate and support neighbouring practice through closer communication, sharing training and ideas.

- Implement the use of technologies to improve patient self-management and ownership of their long term health condition.

- Reduce unnecessary GP visits, and unplanned hospital admissions.

IMPLEMENTATION

The top 2% 'high risk' for hospital admission list and chronic disease registers were used to identify patients who have not had a comprehensive review for at least one year. An existing member of staff with appropriate skills and recent community nursing experience and capacity to increase hours will offer reviews and assessment to the target group of patients. This would develop and enhance current services, working in a protected outreach and co-ordination role liaising with community nursing staff, where good working relationships already exist to provide an integrated nursing service.

The practice outreach nurse will take a lead role in implementing the plan with the support from a Task Group to ensure the project remains focused, within budget and monitoring outcomes. The group will have representation form a GP, the practice manager, community nurse, patient representative, and residential/nursing home representative, meeting 4-8 weekly initially.

See Appendix B

ACTION PLAN	TIMESCALE
- Training and development for outreach nursing - (modules for asthma, COPD, diabetes recently completed) - Arrange shadowing of community matron, respiratory specialist nurse, diabetes nurse, spirometry - Training to enhance diabetes care skills and attend diabetes clinic	Nov/Dec/Ongoing
Prescribing Course	Year 2 of Project
Liaise with "Frailty Assessment Unit at JCUH"	March 2016
Professional Development Plan and revalidation	Ongoing
Task Group Members Meetings	Commence December
Identification of target population	Completed November
Commence Home Visits	January 2016
3 month review of project	March 2016
Raise awareness with Primary Health Care Team	November & December
Contact with neighbouring practice/identify any joint training	December
Liaising with Residential/Nursing Homes/Extra Care Housing regarding service commencing	December
Review voluntary/social services support available	January 2016

First phase of project aimed at providing long term/chronic disease assessment reviews for housebound or patients who have difficulty attending the Health Centre.

Once this is established 2nd phase of project (from September 2016) aims to be more proactive identifying and classifying frailty when more information regarding local projects and assessment tools are known.

FINANCE/INVESTMENT

Up to £3.00 per head the total amount given the list size of the practice is £33,000 over a 2 year period.

Employment of a Grade 6 (Current Practice Nurse) to work in the community and manage the process for approximately 8 hours per week.

Finances would be monitored by the Practice Manager and a six monthly report to be produced and presented to the Task Group.

There would be the following additional costs:-

Mileage - £2340 over 2 years, approximately 50 miles per week at 45p per mile

Training/ Backfill to cover Training - £1500

GP Lead/Management/Admin costs - £ 1500 over 2 years, half an hour per week admin support

Voluntary Sector – We would like to put aside £500 to enable us to meet some of the costs incurred by the voluntary sector.

Equipment – We would like to put aside £1500 to purchase essential items of equipment

OUTCOMES AND EVALUATION

Outcome measures for the project will include:-

- number of home visits and long term conditions reviews undertaken
- monitoring of long term conditions against target level based on templates for chronic disease management and QOF targets
- number of unplanned hospital admissions from within target group
- medication reductions and utilisation
- patient satisfaction from feedback/questionnaires regarding outreach service

We would hope that the project will continue after the initial two years and we will measure its worth by re-evaluation skills/mix and any gaps.

This is our proposal which we hope you will give your careful consideration and await your further instruction.