Harewood Medical Practice

Primary Care Nursing Workforce

Proposal and delivery plan

22 October 2015

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1. Introduction

Harewood has a different practice profile to the Richmondshire locality and as such we have agreed to develop this service ourselves and not to link with another practice.

Our list size is currently 7128 with a different age sex split due to being on the Army Garrison. We have higher numbers of children and young mums and lower numbers of elderly.

Age Range	Male	Female	Total
0 - 4	484	471	955
5 - 14	687	619	1306
15 - 24	441	574	1015
25 - 54	1001	1893	2894
55 - 64	220	257	477
65+	212	269	481
Total	3045	4083	7128

We have aimed this service at patients who are effectively 'housebound' and at risk due to their health needs i.e.

Nursing home patients (40 patients)
Unplanned admissions enhanced service patients (126 patients)
Housebound elderly and frail patients and other patients with multiple health problems and special needs (circa 30 patients)

Regarding the nursing team and reducing isolation and revalidation we have a team made up of:-

2 Advanced Nurse Practitioners
3 Practice Nurses
1 HCA.

2. Proposal

Nursing home patients

The main nursing home we work with is Maple Lodge in Scotton.

Currently we visit Maple Lodge on a weekly basis by a designated GP to review patients in addition to ad hoc visits requested during the week.

In discussion with the matron at Maple Lodge we believe the following will improve the health care of residents and avoid unnecessary hospital admissions.

- Our HCA will attend the weekly visit with the GP so that she knows the patients, understands their health needs and knows the staff.
- The HCA assistant would then be a further link between Harewood and Maple Lodge to facilitate a more seamless provision of our service.
- The HCA will monitor the patients to ensure that they receive the appropriate reviews and care for patients with chronic diseases.
- There will be instances where the appropriate practice nurse for the chronic disease would attend Maple Lodge to review or see patients.
- The HCA will be able to do ECG's, bloods re warfarin, immunisation injections, dressings etc. at the nursing home.
- The HCA can review and update DNR's

We have already initiated this development with effect from 1 October 2015 by increasing the HCA hours by 3 per week.

At risk patients – Community service

Review all hospital discharge letters for housebound and at risk patients to ensure their needs post discharge are catered for.

Carry out a holistic review of 'housebound patients' approximately every 3 to 6 months as appropriate.

Nominate a lead Practice Nurse and District Nurse who will maintain continuous liaison between the 2 organisations and arrange appropriate care for patients should a gap or need arises.

The lead practice nurse will maintain liaison with the case manager linked to the practice (Rosie Walker-Smith) to ensure the needs of patients under the case manager are also appropriately catered for and avoid duplication of services.

Practice nurses already have all the required skills and knowledge to do the care however they will need to undertake lone worker, risk assessment and adult safeguarding training.

End of Life Care

We have identified a skill gap and are enrolling nurses on the following courses to increase their understanding, awareness and skills

Carol McArthur (Advanced Nurse Practitioner) – Teesside University Palliative Care Diploma for GP's and Prescribers. The course is from October 2015 to April 2016 involves one contact evening early September and 1 week palliative care placement during the course and a 400 word case study . Otherwise it is mostly delivered on line, estimated on average at half a day a week plus a week's placement. Course fees are directly funded by Teesside University.

Elizabeth Maxwell (Practice nurse) - Macmillan Cancer Support Course for Practice Nurses. The course aims to look at the practice nurse role in long term management and support of people after primary treatment for cancer. The commitment is one day a month from October 2015 to March 2016. There is no course fee for this.

Reducing isolation and revalidation of practice nurses

We will increase the liaison and dialogue between DN's and Harewood nurses with the aim of keeping all informed of patient need and service issues with ultimate aim of improving services to housebound and other at risk patients in the community. This will be done by having a nominated PN and DN who will liaise on a regular basis and set up MDT type meetings as appropriate.

We will be supporting PN's with appropriate training and time to undertake the work necessary for revalidation.

We anticipate that each nurse will need an additional day a year for some appropriate training and preparation time for their revalidation. This to commence from April 2016.

3. Delivery plan

Manpower and leadership

To achieve these outcomes we will increase the hours and thus availability of our nursing team so that there is additional capacity to undertake these actions. Additionally this project will be led by the senior partner, Dr Sioban Watt and Practice Manager, Grahame Dickinson with day to day responsibility being held by Jane Martin (PN) for the community service and Andrea Corfield (HCA) for the nursing home

Skills / gaps audit –

- Harewood staff

Our nursing team currently have the full range of skills needed for chronic disease management; additional training is needed re End of Life as well as Lone worker and risk assessment relating to working in the community.

We anticipate using our HCA more and again training issues will be identified as the project develops. Other training needs may become apparent for the PN's as the project develops.

- DN's staff skills –

As we are not altering the role of the DN's their skill set remains appropriate to their role.

- Maple lodge staff skills

Staffing at Maple consists of

4 Registered general nurses
1 Enrolled nurse
Senior care staff
Care staff

The Maple nursing staff have all the skills felt appropriate for the patients, i.e. inserting catheters, taking bloods, dressings etc. There were not felt to be any gaps needing addressed.

We will ensure that staff have suitable equipment available to carry out the work / tasks required which will include the availability of mobile devices for them to access patient records when out of the surgery (subject to this being available via our clinical system, SystmOne)

4. How has proposal been developed

The proposal has been developed by Dr Sioban Watt and Grahame Dickinson from Harewood Medical Practice following discussions and meetings with

Jill James – District Nursing
Cheryl Macias- Maple Lodge sister
Rose Walker-Smith - Case manager

5. How the plan will achieve aims and expected impact and benefits

The plan will achieve the aims by:-

- Increasing capacity in the nursing workforce to enable them to
  - act proactively for 'vulnerable' groups of patients
  - regularly liaise / meet with and work with other community staff
  - undertake appropriate additional training
- To work jointly with community nursing to enable 'housebound' patients to be seen at home for their care
- To work and liaise with nursing home staff and the lead GP to aid the care of patients
- To undertake training in End of Life Care.
- To have a lead GP for the project and to support the nurses
- To support nurses in reducing their isolation by encouraging liaison with community nurses, other practices and the CCG.
- To support nurses in their continued professional development and revalidation.
- By building stronger links with specialist nurses

The expected impact and benefits are:-

- Chronic disease management of housebound patients to be as good as for ambulant patients
- Break down boundaries and increase joint working and sharing of skills; between district and practice nursing, between care homes and community, providing reactive and proactive care
- Reduce professional isolation & support successful revalidation of practice nurses
- Optimise specialist care of LTC in the community so more patients have their disease better controlled
- Good End of Life Care is delivered with confidence and is respectful of the patients choice
- Sustainable financial and quality benefits for the future by reducing inappropriate hospital admissions.

6. Discussion with patient representatives

The proposal has been forwarded to the Chair of the PPG and has been discussed at a PPG meeting on the 21 October 2015 and received their full support.

7. Investment required

We propose to increase our HCA post (AFC band 3 point 8) by 9 hours a week and make available 2 hours a week PN AFC (Band 6 point 25) time. In addition to make the time available for an ANP (AFC Band 8a point 34) and PN to do the training re End of Life Care.

Other training, e.g. lone worker etc. will be covered within working hours. This will enable capacity and skills within the nursing team to develop this proposal.

Costs

November to 31 March 2016	
9 hrs HCA per week from November	£2307
2 hrs PN per week	£ 834
45 hours PN - (one off training re EoL)	£ 886
149.5 hrs ANP – (one off training re EoL)	£3913
0.5 day a month GP input	£1625
Total	£9565
April 2016 to March 2017	
9 hrs HCA / week	£5537
2 hrs PN / per week	£2003
0.5 day a month GP input	£3900
1 day a year per nurse for revalidation	£ 834
Total	£12274
April 2017 to October 2017	
9 hrs HCA per week	£3230
2 hrs PN per week	£1168
0.5 day a month GP input	£2275
0.5 day a year per nurse for revalidation	£ 417
Total	£7090
Grand total	£28929

The total available to the practice is £3 per head for 2 years, i.e. circa £39,000, costs above come to £28929. Approval is requested for heavier investment in year 1 which will be compensated for in years 2 and 3.

8. Key performance indicators

Measurable (some potentially)

- Unplanned admissions to hospital (CCG figures)
- Frequency of attendance at GP practice for housebound patients
- Visits by nurses to housebound patients
- Workload of Case manager
- Workload of DN's

Unmeasurable

- Quality and access of care
- Patient understanding of health issues and own management of condition

9. Delivery plan

July / August	Discussions with practice staff and other agencies to identify the detailed working of the proposal. Identification of further skills gaps and sourcing of training.
September	Pre implementation work with all agencies
October	Identification of patients to be included in project Palliative care training starts
November onwards	Commencement of project Training re skills gaps. Ongoing monitoring and review of project. Regular meetings/reviews between practice and community staff.

10. Leadership and overseeing / monitoring project

This project has been led by Dr Sioban Watt (GP), Grahame Dickinson (Manager) with support from Jane Martin (Practice Nurse) and Andrea Corfield (HCA).

We will maintain ongoing leadership and monitoring of the project by Dr Sioban Watt, Grahame Dickinson and Jane Martin through regular (monthly) reviews of patient needs and support given.

Additionally we will set up a quarterly meeting with stakeholders which will include the above plus representatives of community staff, nursing home, Patient Participation Group and if possible patients and carers.

Grahame Dickinson
22 October 2015