Primary Care Nursing Workforce Project

A plan to deliver a new model of care for patients of the Central Dales and Leyburn Medical Practices

25th September 2015

Contents

Summary

- This project, based around the cluster of our two practices – Central Dales Medical Practice and Leyburn Medical Practice, representing a patient population of 10,200 patients, has been developed with the full involvement of both practices, the district nursing staff, their management and the community matron and case manager.
- The priority for this project is to focus on those patients that are more difficult to reach, either through being housebound, in residential care, through poor engagement or those who struggle with medicine or lifestyle concordance.
- The aim is to utilise a mixture of trained nursing staff and health care assistants, working alongside GPs and clinical pharmacists. A HCA with highly developed, advanced skills will work across both practices and will also help with back office and frontline support to the trained staff, both practice and district nursing staff.
- Cooperation between the practices and the community teams remains a key aim of this project and the further, structured and ongoing training of the nurses will enhance on this, expanding their range of contacts to include social services and the local voluntary services including carers support. We will make use of specific, highly-developed skills that exist with some members of staff and use them to develop those in staff in the other practice. This cross-over, delivered through mentoring and cross-site working, is a novel and important development.
- The team aim to identify a member of nursing staff in each practice that can take on a care coordination role, to coordinate and deliver health and allied care to targeted patients.
- The nursing team will be supported by a working group that will monitor the project and provide leadership and oversight. This group will be multidisciplinary and where possible there will be representation from each discipline and each organisation/practice, plus a patient representative. The workgroup will ensure the project reaches its established milestones, as well as the anticipated quality and outcomes measures. It will also ensure that all organisations commit to the success of the project and to resolve challenges as they arise.
- We are aware that we are committing to a novel way of working and that this will require flexibility of approach form everyone. We are confident that the progress made and the positive discussions to date will serve as a solid platform upon which to build and deliver this project.

Our Priorities

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There are a number of potential redesign opportunities which meet the programme objectives as set out by the CCG and which are also consistent with practice and wider network development needs. Our cluster will focus on the following:

- Less mobile or isolated patients who do not receive comprehensive management for their long-term conditions at home, compared to those who can regularly access practice-based services;
- Care coordination of patients with complex co-morbidities, who are below the higher level of need currently targeted by most community matrons and case managers, but who make high demands on practice resources as well as the local hospital network;
- To provide a more equitable service between practice-based and home based care;
- To work more proactively with patients in the relative wellness phase, to prevent exacerbations or other acute crises, which currently often require an unscheduled care response;
- To ensure effective targeting of patients and identify them pro-actively during the relative wellness phase;
- To enhance and standardise best practice in advanced care planning;
- Flexible working between practice-based nursing staff who have traditionally delivered practice-based care and district nurses offering home-based care to ensure optimum patient continuity, coordination and not least staff efficiency.

The project has been planned to dovetail with the wider Dales project by adopting a holistic approach to patient assessment and management. Implementation is based on up-skilling current practice nurses, and extending the role and function of current HCA staff. These staff will use mobile working and share care planning templates on the practices systems to improve communication and team work. The electronic Frailty Index (eFI), a tool integrated into the clinical systems, will be employed to identify patients who have needs other than their immediate long-term diagnoses

Specific Project Aims

Benefits to Patients

- To address the operational inequities between the care of ambulant patients with long-term conditions who access our practices and those that are less mobile, housebound and / or difficult to engage
- Enhance the role of our Practice Nurses, and support District Nurses, Case Managers and Community Matron by improving integration and team working across primary and community care.
- Break down boundaries between organisations
- Support all nurses with training and up-skilling
- Identify and differentiate between the patients who can benefit, but are not currently on the caseload of District Nurses, Case Managers or Community Matron
- Improve patient education, motivation and self-management skills, to allow them to have better control of their long term conditions

System-Wide Benefits

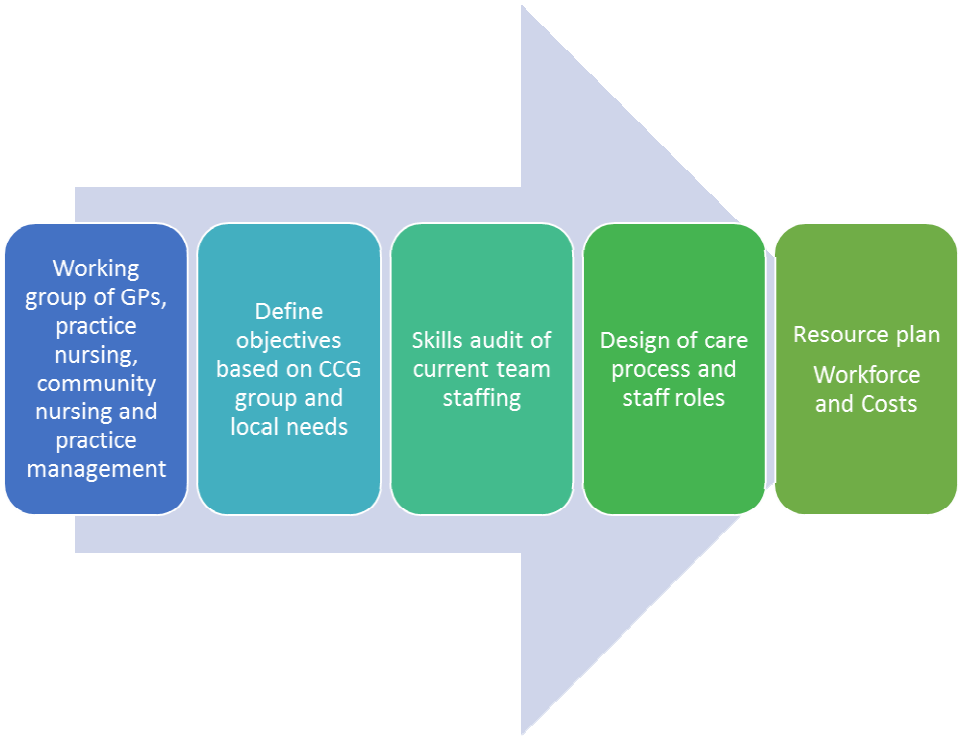
- Assist all nurses through re-validation
- Encourage the sharing of skills/expertise amongst the nurses
- Improve the use of shared technology and embrace new technology to assist with mobile working and shared data – one patient, one record approach
- To work together to ensure patients across both of our surgeries are receiving equal care in the community
- Improved communication between professionals
- Collaborative working between practices utilising the skills of the nursing workforce
- Dovetail the new service with the Dales Project;
- Encourage practice nurses to work with community nurses to support advanced care planning
- Define and measure valid and realistic outcomes.

Plan development process

The plan has been developed by a multi-disciplinary working group drawn from our cluster of practices, plus the district nursing and community matron services that work with us. We received support from Heartbeat Alliance and Conrane-IHS in the development of these plans.

We have followed a logical 4-stage process.

- Firstly we have interpreted the CCGs brief in terms of local patient needs and our views on the clinical priorities for these and current staffing resources.
- A skills and current process audit was then undertaken focusing on these clinical priorities, notably the current management of the most significant long-term conditions, including mental health, co-morbidity and care coordination.
- We developed a phased approach to the delivery of a new care model and process, considering how current staff could support this, as well as the need for any new staff and/or roles.
- We modeled options for supplying additional capacity using existing or new staff: both development (including training) and employment costs. We have also considered process and system issues.



Key Findings in the Skills and Process Audit

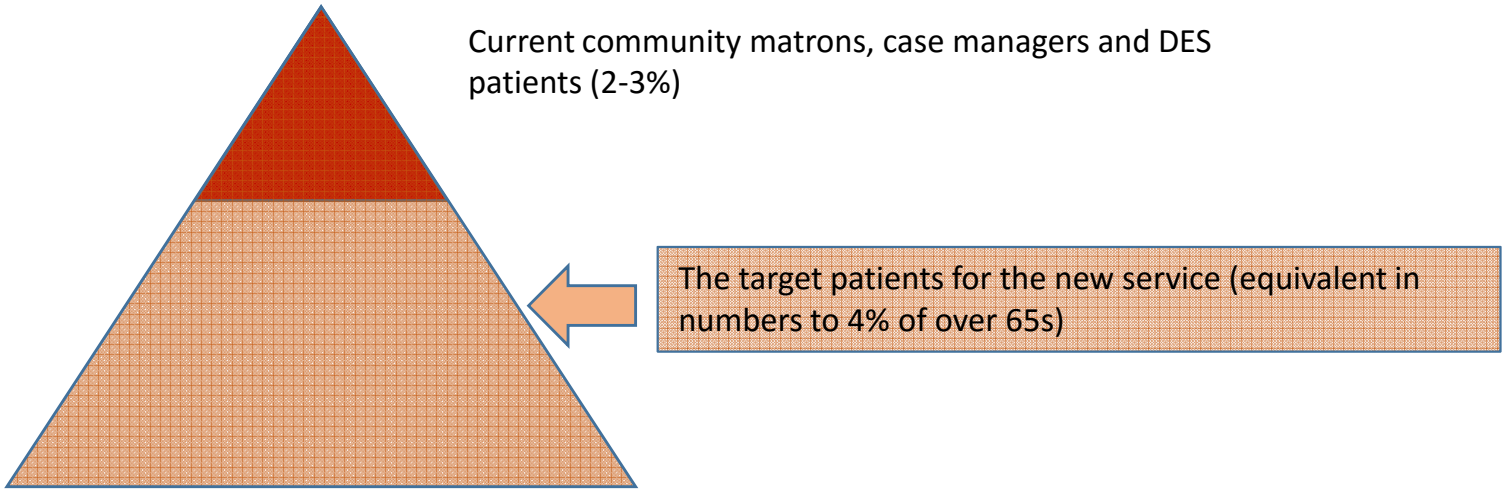
Skills

- Variations in the scope of practice and training of nursing staff
  - By type of condition
  - By Healthcare Assistant staff in practices
  - Scope of practice vis-à-vis the GP role
  - By nursing staff in the community (community matrons, case managers, district nurses);
- Variations in roles along the management pathway
  - Diagnosis
  - Assessments
  - Monitoring
  - Medicines review
  - Prescribing
  - Motivational work and self-care skills;
- Challenges to monitoring in the home due to both skills gaps, and access to equipment (eg spirometry);
- Training and skills in mental health needs are less well developed – particularly cognitive problems;
- Scope to improve availability of care coordination skills
  - Applying risk assessment to proactive care
  - Medicines management
  - Motivational work and self-care skills training
  - Outcomes definition and monitoring undeveloped.

Process

- Significant differences in capacity in long-term condition management between the practices and the community
  - Community nurses report full caseloads
  - Practices accordingly hesitant to refer
  - Varies by conditions;
- Systems issues creating barriers to more integrated, anticipatory working
  - E.g. case managers access to risk stratification and priority for high utilising patients
  - Perceived poor functionality at practice level limits referrals
  - Access to 'discrete units' on system 1 limited to specified staff only
  - Nurse practitioners not linked into MDTs on long-term condition patients
  - Some patients not giving informed consent to district nurses;
- Administrative workload of community staff;
- Lack of knowledge across staff groups of each other's roles, skills, processes and assessment tools.

The Target Patient Group



Evidence indicates that in a population of typical age sex and deprivation, some 5% of the population will have multi-morbidity associated with social and psychological needs and consequently, relatively high, reactive healthcare resource usage. On average, 80% of these are aged over 65.

However in a population such as ours, with an older population, this proportion rises to 7%-8%, of whom 90% are over 65. Therefore, in this project, it is important to differentiate the patients who could benefit from the new service from those targeted by the current community matrons and case managers, as well as those who fall within the DES programme for patients with established patterns of unscheduled care admission.

These two groups together account for the most complex 2-3% of the local population. A special exercise has therefore been undertaken in the Central Dales practice to identify other patients who could benefit. This has found that some 50 patients meet the criteria. They are all aged over 65 and constitute 4% of the over 65 population. An equivalent figure for Leyburn Medical Practice, which has a similar demography, would be 70 patients.

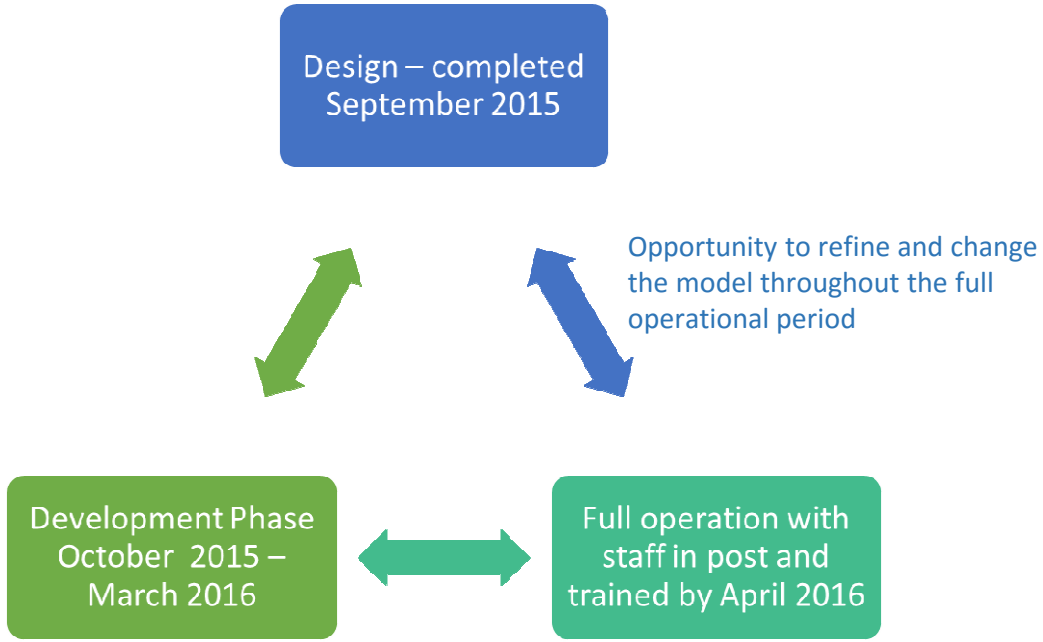
Our Operational Approach

- We will identify patients who are housebound or frail, who are not currently on the workload of the District Nurses, Case Managers or Community matron. This will be done using the Electronic Frailty Index within System One and/or by deploying evidence-based referral criteria. A register of patients will thereby be created.
- We will identify the individual needs of this cohort of patients as far as possible from clinical records in order to prioritise prior to offering them the service;
- We will assign the role of Clinical Lead Nurse or Care Coordinator (who will review the patient's notes) to members of the existing workforce for each practice. This post will be supported by a healthcare assistant function as part back-fill and part caseload support. The Care Coordinator will arrange a visit to see the patient;
- An individualised Care Plan will be created – the same Care Plan to be used by Central Dales Practice and Leyburn Medical Practice (based on the structure used by the Community Nursing Team);
- Each Practice Lead will be responsible for the Register and for overseeing the care of these patients, they will assign who needs to visit the patient and what needs to be undertaken to ensure the patient is receiving the appropriate level of care. They will also liaise with the community nursing team if they have input with a patient on the Register at any time
- If a patient has multiple LTCs *and has complex health needs,* they will be referred to the practice's Case Manager for intervention and support (in-line with current guidance and pathway from HRWCCG)
- The Care Coordinators will participate in multi disciplinary team meetings to ensures better integration between the Case Manager and the clinical teams.
- When a Case Manager has completed an intervention with a patient, they can refer the patient back to the practice to add the patient to the Register for the Care Coordinator or healthcare assistant to monitor. This will increase the case manager's capacity to take on more new patients.
- Training will focus on developing practice staff to make good the current skills gaps in each practice. This will include management of diabetes for Central Dales and mental health assessment and motivational working for both practices. Both practices have nurses with specialist knowledge in respiratory health.
- The clinical Care Coordinators will work closely with the clinical pharmacist when in post who will provide mentorship on medication adherence risk assessments, medication review and case-review.
- All providers are using System One so this allows for the ability to share templates, searches and ways of working
- A single clinical system also allows for better communication within the patient record, allowing all providers to be up to date and informed of any changes
- IPads will be purchased to allow for mobile working – nurses will have the ability to download a full record onto an IPad and take this with them into the patient's home to allow a better consultation and informed decisions to take place without delays – any entries made in the patient's home will then be uploaded once the nurse is back at the practice.

To optimise integrated working, South Tees are requested to align the Case Manager specifically to the two practices to improve communication and handover. The preferred model of mobile working should optimally be extended to the Case Manager who would therefore need a mobile device. We understand that this is currently being expedited.

Phases of Work in 2015-16

- We envisage 2 phases of work;
    1. A development phase including training of current staff, and recruitment and training of any new staff and implementation of process redesign;
    2. Full implementation beginning March 2016 when all staff are in post (if recruitment is needed), trained and fully operational.
- This allows a full year of operation and outcomes measurement to inform a review in March 2017 or with 6 months still remaining on the current CCG funding.
- Hence time for evidence to be provided on the advisability of sustaining or even extending the programme.



The Clinical Care Coordinator Role

As outlined already, our approach will be to proactively identify and target specific groups of patients that would benefit from a coordinated and integrated approach. Whilst we aim to raise the overall skills and confidence of all our nursing staff, practice and community based through cross-boundary training, mentoring and practice, we also recognised the need to create a specific role to undertake the majority of the work with this targeted group of patients. The clinical Care Coordinator role, which will be undertaken by specific members of staff in each practice will have the following key competencies that we will develop in the early stages of the project:

- Patient selection and prioritisation with the GP
- Patient engagement in the home
- Holistic assessment
- Care planning
- Medication review
- Motivational work
- Contingency planning (which maps a patient's individual disease trajectory and empowers the patient to be pro-active at onset of early symptoms)
- Participate in outcomes monitoring
- Attendance at clinical meetings such as MDTs

Whilst many of these competencies mirror those of the community matron and case manager roles, it should be made clear that the Care Coordinator will be focusing on the patient cohort already referred to, that fall outside the case load of these two existing roles.

This role will be delivered by current practice nurses by extending their current hours and protecting time.

Advanced HCA role in primary care for patients with Long Term Conditions

Through the Skills and Process Audit, we identified a need and opportunity to further develop the existing Health Care Assistant (HCA) role. It was identified that there was potential for a HCA working in the Central Dales practice to increase her hours and the scope of her role to cover both practices, providing valuable support that parallels that of the Medical Assistant function in accountable care organisations in the US. As highlighted in the table below, the competencies for this role extend significantly beyond those of a typical HCA. We feel that the combination of Care Coordinator and Advanced HCA, integrated with a generally more highly skills nursing workforce will deliver improved care for our patients.

Proposed Medical Assistant role		
General patient care	**Specific Long-term conditions care**	
Phebotomy	height, weight, BMI	Patient recall, follow-up
I.N.R	BP	patients who miss appointments
ECGs	Care plans	are overdue for services, or
Injections (B12)	Info for DES	or need closer follow-up
Simple dressings	Remind GPs on QOF	based on risk assessment
Simple wound care	Understand disease registers	
Assist minor procedures.	Diebetic review except meds	
Dopplers	LTC recalls	
Flu jabs		
minor injuries	**More advanced functions with traininng and development**	
Access EMR	Health coaching	
Input EMR within boudaries	Motivational inteviewing	
	Insulin in controlled patients	

Not currently in HCA role but scope to develop over time with training
Currently in the role of exisiting HCA staff in the two practices

Workforce Requirements

- *Target patient group*
  - Patients not on caseload of other services, but in the difficult to access practice groups
  - 50 patients in Central Dales and 70 in Leyburn
- *Requirement for nursing staff*
  - 0.5 wte (Source Castlefields Practice-based model plus 2005 DH LTC framework planning parameter)
    - 0.2 wte in Central Dales (1 day per week)
    - 0.3 in Leyburn (1.5 days per week)
- *Requirement HCA staff (back-fill and support)*
  - O.4 wte across both practices (2 days per week)
- *Proposed supply*
  - A current nurse in each practice given the necessary protected time
  - The HCA from Central dales has extended skills already and can offer the necessary additional hours including to Leyburn Medical Practice
  - This is deliverable within the full-year effect £3 per head budget, or £30,540
  - In the first year, some of this budget will be allocated for training plus one-off system and equipment (eg: mobile system 1 module, Ipad,) and this supply model involves the least training resources as only 3 staff involved
  - The non-staff costs fall within a budget which is equivalent to 6 months of the annual £3 per head allocation.
  - These costs are set out in detail on the next page.
- Each full-time practitioner could manage 50 patients at any one time
- Each patient stays on the case-load for 12 weeks
- A full-time staff member could manage 150-200 patients *per year*
- The proposition is for 0.5 wte equivalent
- Hence there is sufficient capacity to manage the expected 120 patients *over the two years inclusive of staff development time etc.*

Financial Feasibility – Available funding and requirements

The tables below show the use of resources. There is a total of £30,540 for each full year. In year 1 this will be allocated 50% to development costs (see action plan) and 50% to full staff costs for the first full deployment stage. Table 1 shows that in a full year this equates to 0.5 wte nurse staff and 0.4 wte HCA capacity, which is the additional capacity required. Hence the proposals are affordable. Table 2 shows the use of resources for the first 6 months of year 1 that will be used to meet non-recurrent development costs.

Table 1

Practice	Skill mix	£ (Nurse)	£ (HCA)	Total £
Central Dales	75% Nurse 25% HCA	9,630	3,210	12,840
Leyburn	75% Nurse 25% HCA	13,275	4,425	17,700
Total		22,905	7,635	30,540
		N_WTE	HCA_WTE	Total staff
Central Dales		0.22	0.16	0.38
Leyburn		0.30	0.22	0.52
Total		0.52	0.38	0.90

- Equates to 2.5 days per week nurse and 2 days per week HCA time (both practices combined)
- Staff costs used to develop WTE are indicative and based on equivalent gradings in NHS providers plus on-costs and travel

Table 2

Other resource in year 1	First 6 months	£
Staff costs (back-fill)		6,776.00
Training		6,000.00
Systems/Devices		2,500.00
		15,276.00

Non staff costs include:

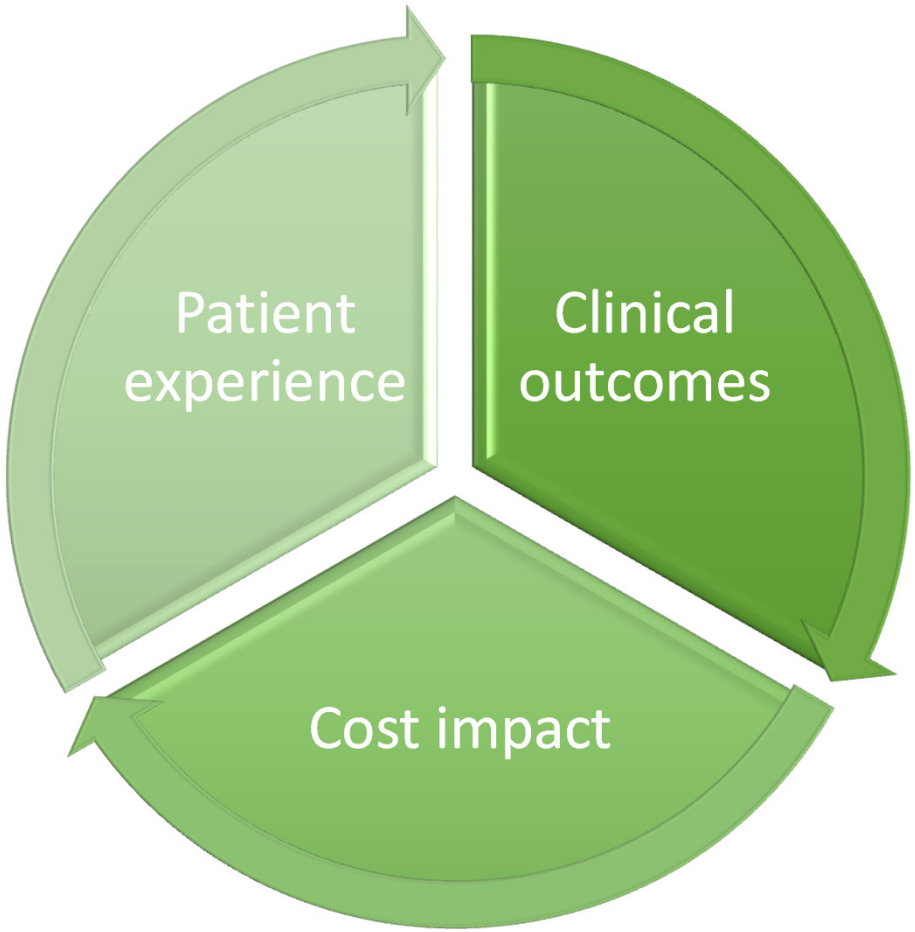
- Mobile system devices and
- Module
- Training and staff back-fill

Measuring Outcomes – ‘Triple Aims’

Outcomes will be monitored quarterly using the ‘triple-aims’ framework of patient experience, clinical quality and cost impact.

- *Patient experience* will be measured using an adapted version of an instrument currently in use by our community matron and case managers;
- *Clinical quality* will be measured by the standard QOF measures which show each patient’s parameters in relation to their specific diagnoses;
- *Cost impact* will be measured by utilisation and pharmacy data, including: unscheduled hospital and primary care utilisation, and community activity such as district nurse contacts. This data will be collected for each patient from the practices’ systems by the HCA in a clinical admin role.

Outcomes reporting will be instigated in month 7 once the full staff deployment takes place. However a baseline for each patient in the target group will be developed in advance.



Action Plan for Development Phase – October 2015 to March 2016

(1) *Establish project governance* A small project team comprising representative disciplines drawn from each practice and including patient representative drawn from the practices' Patient Participation Groups[1, 2]

(2) System development – standard, shared templates on system one for care and contingency plans

(3) Training and up-skilling to comprise one practice nurse from each of the two practices and one HCA to work across both practices will be given training to enhance their skills and knowledge as required by the role. This will include:

- Bi-monthly nurse training to take place at Leyburn Medical Practice according to a structured programme aimed at developing the required skills. This will cover care and contingency planning, diabetes, mental health assessment and medicines management (delivered by the clinical pharmacist when in post);
- Expert mentorship for nursing staff to fully embed the pro-active role;
- A specific module on motivational interviewing will also be sourced;
- Training will be structured within individual professional development plans require for revalidation etc.

To support nurse validation, this training resource will be available to all nursing staff within the two practices.

(4) Awareness raising meetings will also be arranged for practice administrative including reception staff

(5) Finalisation of patient target group from each practice

(6) *Development of outcomes reporting* methodology and generation of baseline for target patients

(7) *Development of a register of local allied health, social and voluntary sector services* which could benefit the populations of both practices. This will be inputted onto system one and become a resource to all staff when developing care plans for patients who may be isolate, and/or have social and functional needs alongside their health care requirements.

[1]The proposals in this plan have been subject to prior consultation with our patient participation groups, who have expressed strong support and willingness to be participate in the implementation.

[2] The project team will be responsible for ensuring that all organisations commit to delivery of this plan and to address any issues that may arise, facilitating resolution as quickly as possible.