The Northallerton (M & M) Nursing Project

This project covers a population of approximately 29 500 patients with a core mass of patients within a 2 mile radius of the two surgeries.

The staff skills analysis (Appendix 1) has been carried out by an ex district nurse team leader and the full (unaltered) documents are attached. What it fails to show is the lack of experience of the District Nursing team, which continues to be in flux. Recent clinical cases have identified a lack of some core skills within the team, e.g. No ear syringe training.

The Case Managers have been included in discussions and are positive in their support.

The Practice Nurse teams have little extra capacity to increase their hours. Mayford have identified some increased hours which are included in the costings but Mowbray, which is a stable, experienced team, has little scope to expand hours.

The situation therefore lends itself to the creation of new posts. This maybe challenging as the 'new' posts may not have ready-made applicants and a fixed term contract may not be attractive.

The feelings of the 'working group' was that there are a number of 'extra-care' facilities where residents are all registered with the two practices. These clients are by definition high users of care and generally have multiple health problems. Many move to the extra care facility from outside the practice area. Residents may be able to attend the surgery or require District Nurse visits.
There is a distinct feeling that a nurse working in these facilities could:

1) Improve patient experience and outcomes
2) Co-ordinate care needs to
    a) reduce District Nursing input
    b) reduce practice visits
    c) reduce care managers input

The benefits of this would be felt by, most importantly, the resident, but as a consequence there would be increased capacity in the District Nursing, Practice and Care management teams to take on extra work.

Areas clearly identified as priorities would be:

- An initial assessment within one to two weeks of someone moving to a care facility
- Post discharge review
- Weekly clinics in the more high need facilities
- Less frequent clinics in the others
- Flu/Shingles clinics early in the flu season to maximise potential benefits
- Co-ordination of INR testing to prevent multiple visits
- Creation of a 'first port of call facility' for carers/managers in the care facility.

Our project nurse identified and visited 7 'extra-care' type facilities within the Northallerton area (Appendix 2). 330 residents are identified in these developments with varied care needs. Common comments from staff include poor communication with GPs and care agencies and the potential benefit of a 'clinic' or a nurse point of contact.

There is also a feeling that very few residents die in their own homes in these facilities. Death usually occurs in hospital or patients requiring terminal care are transferred to Nursing Homes. A key role for the new nurses could be to support carers and co-ordinate input from the District Nursing Team in EOL care; thus enabling residents to die at home. Some discussion on Palliative Care has taken place (Appendix 7).

We are therefore convinced that new roles of 'extended care' nurses would have significant benefits in the Northallerton area. These nurses would be embedded with Practice Nurse Teams to provide training, experience and professional support, but would work collaboratively with District Nurse and Case Management teams to approve care and increase capacity.

We therefore feel the best approach is to appoint two new nurses to work within and between the two practice nurse teams, advert enclosed (Appendix 3).

These posts are covered by the financial envelope available and extra Mayford House nursing hours are included (Appendix 4). These hours would provide direct Practice Nurse Input to the project.

Until the nurses are appointed there will be some uncertainty as to what additional skills will be available and what training needs emerge.

The adverts will be posted as soon as possible with the aim of recruiting by October, though this may change due to availability or notice periods.

Time Line

Advert early August
Interviews early/mid-September
Appointments made with start date October

In the meantime Practice staff to visit homes to identify clinic rooms and arrange for vaccination clinics.

October
Initial staff time spent with Practice teams to assess skill competences, training needs and build relationships. New staff to visit the Extended Care facilities, to develop relationships and arrange clinic days/scope etc.

November
Clinic staff in homes
Practice Nurses brought in for specific chronic disease checks

December
Post discharge follow up visits

January
New residents visited and needs assessed
Initiate daily telephone contact with home managers
Ongoing development will be reviewed depending in progress

Other ideas floated:
Community clinics in village halls- e.g. Appleton Wiske, Osmotherley

Training

Training needs will be assessed and delivered via strong links with Heartbeat Alliance. A diabetes education package is already in place and respiratory training will follow shortly.

A major feature of the training needs will be the 'new' nurse undertaking the nurse prescribing course, supported by the GPs. The date of appointments may mean that the course cannot start until Year 2 of the project.

Technology

Both practices are keen to use mobile technology. Different systems are used by each practice but there are mobile versions of each system which will allow nurses to have access to all patient records.

Mowbray House are involved with the use of Vitrucare which may be of benefit and could certainly provide the means of communication between the practices and residents.

Nurses will need a mobile phone and if this is a smart phone then Skype consultations could be developed- all residents are within a small radius and phone reception is good.

Patient Involvement

The project has been discussed with a member of the PPG who was formerly a resident in an 'extended care' facility. Further discussion will take place at a joint Mayford/Mowbray PPG meeting in early August (the first joint meeting of the PPGs). The patient representative formerly attended residents meetings at the facility and has suggested the nurse(s) could attend part of this meeting.

Further Stakeholder Involvement

Once the nurses are appointed there are some key relationships to be developed.
Most importantly social services need to be involved in MDT meetings in extended care facilities.
Mowbray already have a strong link with the Carers Centre via Heartbeat Alliance. This can be developed.
The key link between Practices and District Nurses will be developed once the new nurses are appointed and a new senior district nurse arrives in September.

Care homes have been visited (Appendix 5) and feel well supported by the Community Matron. Links with District Nursing teams need development and co-ordination and hopefully can be achieved with new staff and increased capacity released from extra care homes.

Mental Health

There is an acknowledged shortfall in elderly mental health services locally (recent appointment of CCG Dementia lead).

Dr Rogers is in negotiation with TEWV about a joint funded one year pilot position along the lines of a Dementia Care Navigator. Mowbray would contribute £15000 towards this pilot which would extent the costs beyond the £3 per head envelope.

The benefits of this would be for patients identified as having memory problems, but not formerly diagnosed with Dementia- either those waiting for assessment or diagnosed with mild cognitive impairment. These individuals are deemed to be high users of services and likely to be admitted to hospital acutely; either due to difficulties with coping with acute illness or due to medication compliance issues.

A joint post would provide a clear point of contact for the new nurses, case managers, district nurses and practice teams for individuals with memory problems but not established diagnosis.

KPIs would include baseline and post project acute hospital admissions for this group of patients.

Other Links

Paramedic in Northallerton
Pharmacy project

As part of the change in Paediatrics and Maternity services, a new ambulance has been made available for transfer of patients urgently to James Cook. The Paramedic available to this vehicle is now available for urgent calls in the Northallerton area. The new nurses can link with the Paramedic for appropriate assessments which are beyond their range of clinical skills.

Mowbray House have appointed a Pharmacist and Mayford House have access to a Pharmacist via the Heartbeat Alliance Pharmacist Project. The Pharmacist will be available for nursing staff for advice or formal face to face review of medications with patients.

KPI's

The bottom line of project assessment in the current climate is- do interventions prevent hospital admissions?

Baseline assessments from the two largest socially funded extended care homes show that there were 32 admissions for Mowbray patients alone in the first six months of this year. We will continue to collect data and use this as a baseline comparator for success of the project.

Patient satisfaction would be the next KPI- patients will be asked about the potential benefits of specific interventions in the first six months. Follow up surveys will measure success/ benefits of these interventions.

Patients are the key stakeholders, but to show benefit of the project, staff will be surveyed to assess benefits at the end of the year one and at 18 months, prior to bidding for further funding or practices continuing employment of the nurses in one role or another. Local District Nursing services have been struggling to provide what patients and GP's feel to be an adequate service; they will be key participants in the staff survey.

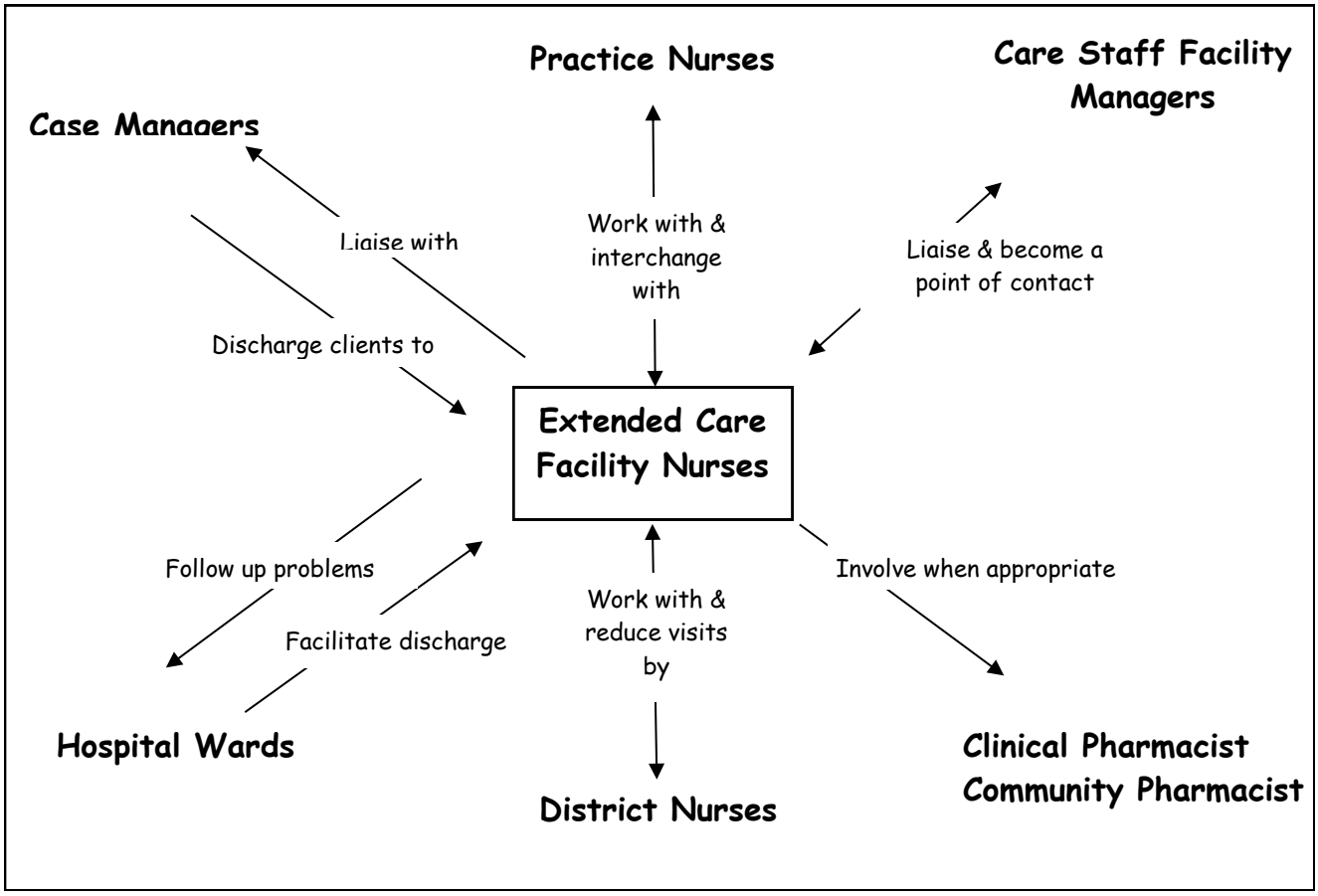
Project Development

Further joint practice meetings will take place in August/September to follow on from previous meetings (Appendix 6).
These will look to develop relationships, outline job descriptions and contracts & explore costs. Set up funds will be used to engage expert resources in project

evaluation and to explore facilitated events for the new team (via Heartbeat GP Alliance).

Overview

The aim is to establish new posts to provide improved care for a group of residents in care facilities. These people may currently receive care from the Practice or Community teams, but in way which is not co-ordinated and may not provide optimum care. The new roles will liaise between the teams to bring in the most appropriate nurses or other health professional in a time efficient manor, freeing up nursing resource to deal with the increasing needs of the frail, elderly population elsewhere.



Appendices:
Please note: These have been heavily edited for publication (confidential information removed)

Appendix 1

Skills analysis

This document is a comparison between skills of Practice Nurses and Community Nurses with an objective of providing seamless care of the patient using the best practice of both services.

The objective is to highlight training shortfalls and an approach to provide developing new partnerships and look at ways to identify key personnel to be responsible for delivering viable practice.

In relation to the Primary Care Nursing Workforce Project I have I have looked at the skill gap analysis identified as

1. Chronic Disease Management
2. Long Term Condition Management
3. Motivational Work
4. Technology in Care Planning

The identified goals are-

1. Flexible work between Practice and home
2. Professional support networks to avoid isolation
3. Avoidance of unnecessary admissions to hospital
4. Support end of life care

Referring to the attached Matrix 100% of all Nursing staff at all grades can carry out venepuncture and some form of wound care. The majority of staff (74%) are involved with diabetic patients. However only a small number are able to review these patients or initiate insulin or other medications.

Long term condition patients have three designated Community Case Managers at present at Band 6. Practice Nurses appear to supply long term condition and chronic disease management reviews in the Practice area. Presently between four and eight Practice Nurses manage long term condition reviews in various fields. However these nurses do not hold a specialist qualification in long term condition management and or clinical examination skills.

Self-management and motivational work with patients is covered by most staff members in one form or another. 6.25% of staff have been identified as having formal training in the subject.

Other enhanced skills vary across the board with the District Nursing Team at Band 5 and above having a range of extended skills including LTC, clinical examination, palliative care skills, assessment and ordering of equipment, Lymphoedema care, advanced care planning (12.5%) DNACPR and Catheter care.

Practices Nurses enhanced skills consist of: - ear irrigation, smoking cessation, asthma, cytology, travel & immunisation.

Other skills such as end of life care (25%) and verification of death (9%) occur only amongst community staff. Dementia and Learning Disability Skills (12% and 9% respectively) are found in both the Community and Practices.

The teams have a small number of nurse prescribers 5 nurses prescribers and three full prescribers one other nurse with full prescribing would be the nurse practitioner based at the surgery.

I feel in my skills analysis it is fair to say that the Community Nurses strengths are in long term disease and palliative care management. Practice Nurse skills are strongest in Chronic disease management. Therefore the most cost effective approach to utilising these skills would be to Practice Nurse to visit identified patients in clinic type settings i.e. in supported living environments where a large catchment exists. Some training for staff may be addressed within free training courses available at York University and Rotherham Respiratory. Diabetes care training is presently being resourced through Sanofi. This is to be made available to all project team members.

Some funding may be allocated infill shortfalls in staffing. It has been identified in the workforce planning meeting between Mayford and Mowbray that a two pronged approach to provide the appropriate extended care for some of our patients should be as follows:

1. Practice Nurse to use clinical skills in small satellite clinics in residential homes (rooms have been identified). Here we could hold 'well person' clinics where we could also deal with flu/shingles and disease management/ongoing support. Appropriate staff will identified optimising on skills at their present state. HCA staff and RGNs in both areas are trained in administering vaccines. This would be beneficial in clinical areas. No emergency consultation will take place. However the START team have identified the need for an advice option for patients supported by them in the community e.g. dipping urine samples before approaching GPs.
   The project team also believe that holding nurse led clinics in rural areas would be beneficial to the practice population. Areas would be needed to be agreed on and a pilot scheme run to help identify further issues. The team clearly believe the two surgeries could run these on a rotational system or a nurse from each practice may develop cohesion between the two practices.

Another option for this clinic would be to signpost patients or engage them with other professional support. The option for District Nurse to assist in these clinics to give injections or dressings may be considered. It has been suggested by the Project Committee that a Nurse who can prescribe and provide clinical examinations would be beneficial. All staff working remotely would require the use of a mobile phone, with lone working monitoring. Personal Indemnity insurances would need to be checked for staff who were normally surgery based. The clinics need to be clearly structured, most residential home teams state they will assist in notifying residents on weekly/monthly basis. It has been identified that Nursing staff should attend these clinics for backup. One RGN and one Healthcare has been suggested. One could be from each surgery to minimise impact on teams. Matrons and Case Managers may be able to assist, or to pick up referrals handing over to a key nurse at assessed stage.

It has been identified that approximately 330 patients in supported living environments may benefit as a result of this project.

Support pack suggested:

Portable ECG Machine
BP Machine
Stethoscope
SATS monitor
First dressing pack
Doppler
Weighing scales
Oroscope
Peak flow monitor
Tape measures
Appropriate trolley case

A key fund would need to be identified for repairs, calibration and stock.

2. A key nurse to facilitate Community and Practice Nurse Meetings to cement cohesiveness and good working partnerships in a problem solving environment. This may either be a community nurse or a practice nurse.

   A key nurse could be identified and enlisted to address poor Hospital discharges. This could take place within the patients' home to link with care homes, pharmacies and practices. This should have a positive impact on the re-admission rates by ensuring patients have the support and resources to re-engage them in their home environment and lifestyle. The aim is to prevent failed discharges and the burden on hospitals.

Key nurse would be identifiable to residential homes and supported living homes as point of contact. One option would be to train a member of staff on proactive care.

- Key nurses will pick up identifiable 'Frail Vulnerable' patients identified by extended Nursing Team and GPs, the Key Nurse will engage in supporting this patient by
- Signposting to other services
- Agreed follow up with phone calls at intervals
- Visits arranged if major concerns raised by other Health Professionals
- Links to be made with families if permission given by patients. This would help in a shared care approach with the frail and vulnerable type of patient, or indeed early concordance with palliative care patients.
- Telephone contacts may be shared with District Nurses or Practice Nurses.

Appendix 4

Primary Care Nursing Workforce Funding

Band 6 Nurse	x 1	x 2
Salary	£26,041.00	£52,082.00
Pension	£3,723.86	£7,447.72
Employer's NI	£1,861.60	£3,723.20
Clinical Supervision / Management	£2,000.00	£4,000.00
Training	£2,000.00	£4,000.00
Travel	£2,000.00	£4,000.00
Indemnity	£500.00	£1,000.00
Equipment	£4,000.00	£4,000.00
IT	£1,500.00	£1,500.00
Mobile Telephone	£360.00	£720.00
Total Estimated Cost	**£43,986.46**	**£82,472.92**

STAFF COSTS	
Nursing - 12 Hours a month	2700
HCA - 12 hours a month for 3 months for Flu clinics	450
IT Staff - Set up Time	200
TOTAL STAFF COSTS	3350

NON STAFF COSTS

Mobile Phone	480
Travel Costs	500
Stationery etc	100
Personal Indemnity	500
TOTAL NON STAFF COSTS	1580
TOTAL ESTIMATED COSTS	4930
Mowbray/TEWV Joint Fund Post	15000
Total Estimated Cost	**£102,402.92**