Primary Care Nursing Workforce

Proposal and Delivery Plan

25 July 2015

References:

A. CCG letter 'Developing the primary care nursing workforce' dated 27 Apr 15
B. Systm One search dated 30 Apr 15
C. Set up funding letter Reeth Medical Centre/HRW CCG dated 18 Jun 15

Background

The CCG letter (Ref A) has identified that across the locality there is an unsustainable use of the primary care workforce. The letter identifies rurality as a problem and states that management of long term conditions is generally poorer for housebound compared to ambulatory patients. There is a need to share skills across the workforce in order to better deliver care to our most needy patients. The CCG aspires to achieve equity of care across all patients, whether they are ambulatory or housebound.

Reeth Medical Centre looks after some of the most remote areas in England. Almost 10% of the patients are over the age of 75 years and there is higher than national average prevalence of chronic disease across virtually all indicators (Ref B). There are no care homes (residential or nursing) in the practice area. The public transport infrastructure is almost non-existent; there is a bus service which runs along the main arterial road, but the main problem for residents is that they have to make their way to the road from their homes. Local residents have set up a local transport initiative (Reeth District Community Transport) which is a charitable organisation to try and bridge the gap.

Reeth Medical Centre provides a daily home-visiting service for patients who are unable to attend the surgery. This is easily accessed by telephoning or e-mailing the practice and requesting a visit. Visits are conducted on the same day by the GP. This system allows the practice to identify acute and sub-acute conditions at an early stage and manage conditions in the home-setting. For clarity, this service will continue to be available during the project.

Reeth Medical Centre proposes a project to provide a transport scheme for relatively housebound patients to allow them to access care at the practice (Ref C). This scheme would be for patients who require management of their long term condition and are currently being seen by the community nursing team. The care would be delivered jointly between community nursing staff and practice staff, with the aim to improve overall patient care of long term conditions as well as an opportunity for skill sharing between the different teams involved in patient care. In addition the practice will use new technologies to proactively identify and support patients who are at-risk of frailty and who have not attended a GP/Nurse consultation in the last year. This may increase the level of opportunistic referral to other CCG services such as the 'HOT' clinics, which would have a knock-on effect of reducing unscheduled admissions.

Current Establishment

The practice has one GP partner and one salaried GP, plus one practice nurse.

An assessment of extra skills was undertaken and identified:

STAFF MEMBER	SKILLS
GP partner	Palliative care diploma Pain management diploma Diabetes diploma Pre-hospital care qualifications Marie Curie/RCGP Clinical Fellow for end of life care
Salaried GP	Registered nurse Health visitor
Practice Nurse	Former district nursing sister Asthma diploma Nurse prescriber Current in complex wound care, diabetes, respiratory conditions, cardiovascular conditions

The Managing Partner met with Pam Thorne (Clinical lead for Richmondshire virtual ward) and Penny Hutchinson (District Nurse Sister) from the Community Nursing Team on 08 Jul. The purpose of the meeting was to ascertain the skill gaps and needs of the community nursing team and to discuss the project proposals to see if they were workable and acceptable to the community nursing team.

The Community nursing team is made up of two very experienced nursing sisters, several newly qualified nurses and several very experienced healthcare assistants. The main challenges faced by the nursing team are that they are finding it difficult to meet many of the tasks requiring trained staff. The healthcare assistants are very experienced, but some duties require a trained nurse to be carried out. The nurses are newly qualified and have not completed their speciality training, so are not deemed competent to carry out the tasks for which they have yet to receive training. The community nursing team would therefore benefit from mentorship/clinical oversight which could potentially be achieved under the project at the practice.

The Managing Partner and GP Partner also met with Gill Collinson (Associate Director Transformation and Service Redesign) to discuss the project and how it would integrate within the wider 'Dales Project' that she was developing. The Dales project was still in the initial scoping phase, but one area of exploration was looking at learning points from the Dutch Buurtzorg project[1]. This is a project using community nursing services to deliver a wide range of services to patients in which the nurses operate as autonomous teams. Providing a supportive base at a GP practice such as Reeth Medical Centre would be integral to providing clinical governance, particularly as the newly qualified nurses were lacking experience and specialist training in order for them to carry out their roles.

[1] http://www.rcn.org.uk/__data/assets/pdf_file/0003/618231/02.15-The-Buurtzorg-Nederland-home-care-provider-model.-Observations-for-the-UK.pdf accessed 11 Jul 15

Background to the project proposals

During 2014, 36 patients were referred to the district nurses for some aspect of their care. These patients were deemed to be housebound at the time of referral. This may be absolute or relative housebound status. Patients who are relatively housebound could be because of lack of transport availability (public or family). Patients who are absolutely housebound are usually severely disabled or end of life care. The patients were assessed and the reasons for referral and their housebound status were documented.

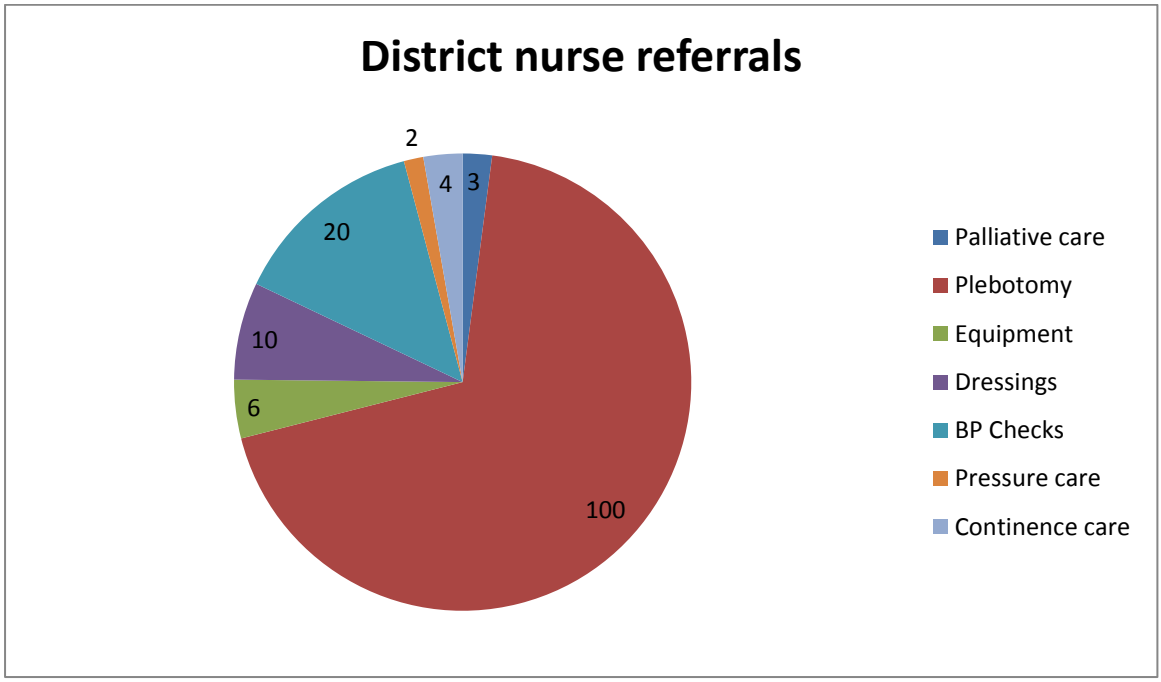

Figure 1 Types of referral to district nursing team during 2014

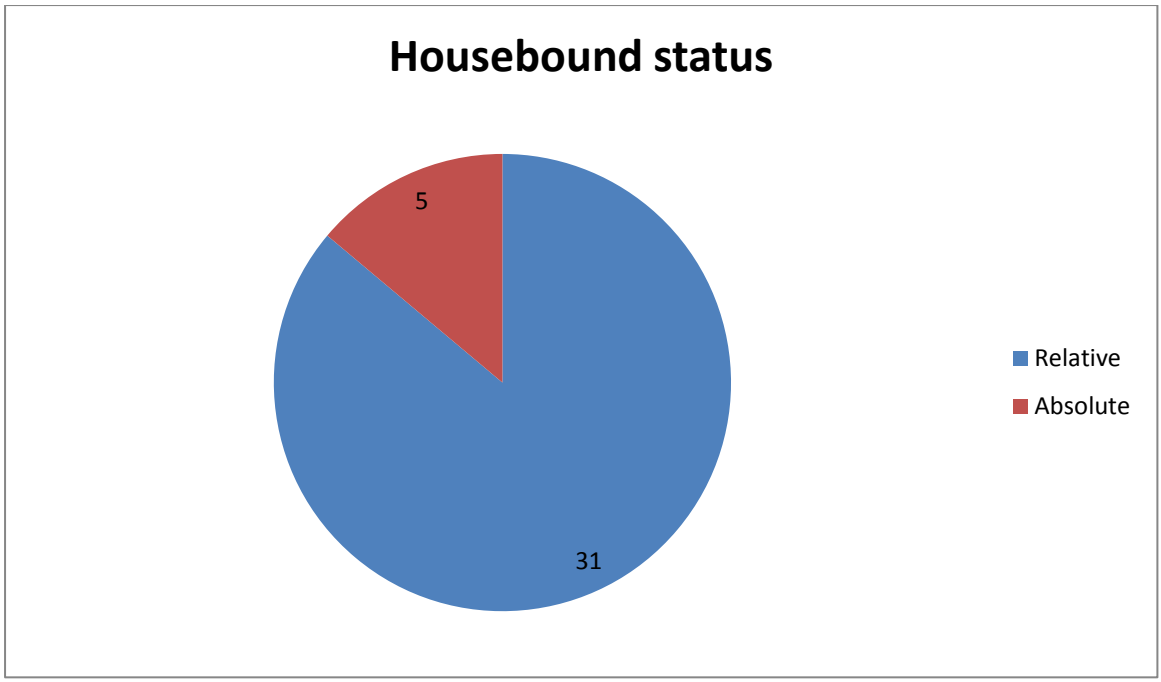

Figure 2 Status of housebound patients receiving district nursing team care during 2014

During 2014, there were 145 referrals to the community nursing team which involved 36 patients. The majority were for isolated episodes of care, such as a blood test or blood pressure check. 31 patients were deemed to be 'relatively' housebound, i.e. they could be able to attend the practice in the right circumstances (usually transport related).

Proposed interventions

1. The practice proposes to develop a patient transport service to bring relatively housebound patients to the practice for their interventions. The service would be developed in partnership with the existing community bus service, which has the capability to pick people up from the front door and is equipped with a wheelchair ramp. The practice will allocate protected clinical time for the patients using the service. The community nursing team will also be able to utilise the service, where they could travel to the practice to see a number of patients in a booked session, rather than travelling to individual homes. This would reduce time wasted on driving between visits and also mileage costs. It would provide an opportunity for timely care, such as providing influenza vaccinations and it would also provide an opportunity to engage in mutual supervision within the practice, with the opportunity for shared learning. The time saved by the community nursing team could be invested in training, delivery of other new services (such as community IV therapy) or used to increase patient contact time for existing services such as end of life care.
2. The patient transport service would be open to all people living in Swaledale and Arkengarthdale – this may include patients registered at Central Dales Practice and the Richmond practices, as these patients would come under the care of the same community nursing team.
3. Improve end of life care by allocating protected time for the salaried GP to gain a postgraduate certificate in palliative care.
4. Improve practice nursing and critical appraisal skills by allocating protected time and funding contribution for her to attend a diploma level course at Teeside University. This would then have a secondary benefit of being able to provide up-to-date learning to the community nursing team and also the rest of the primary care team.
5. Identify and support at-risk of frailty patients by conducting monthly searches and combining reports from RAIDR and the Frailty Index score within clinical record and then producing care plans for those deemed appropriate. Care planning with the patient could occur either at patients home or in the surgery setting (with or without community transport).

Rationale for the interventions

From the 2014 data, it is apparent that there are very few people who are truly housebound and only a minority of interventions require the specialist skill set of a district nurse. Substantial reductions in district nurse referrals could be made by using a transport scheme to bring patients who are relatively housebound to the practice. Most interventions are isolated events, not reliant on continuity from the district nurses.

The substantial practice area means that clinicians seeing patients at home will spend a great deal of time travelling, where their skills are not being put to use. Protected time to see the relatively housebound patients at the practice ensures that clinical skills are used in the most efficient way

possible. It also allows patients to access other services directly at the practice, such as the dispensary, GP and also for opportunistic interventions, such as influenza vaccination or smoking cessation. Social isolation is associated with depression and malnutrition and reduces the quality of life of housebound patients. Attending the practice reverses the social isolation faced by people otherwise confined to their own homes and encourages their confidence to utilise the community transport service for other situations, such as attending a luncheon club. Working together with a community asset such as the transport service strengthens the ties between the local NHS and the community as well as serving as a catalyst for future innovations with other local organisations and the third sector. As there is virtually no existing public transport infrastructure, such as taxis, there is no risk of destabilising current transport arrangements by developing a service exclusively with the Reeth and District Community Transport organisation. Supporting the voluntary service would increase the profile of the service, provide a stable source of income and may actually strengthen and encourage local transport services.

Developing the GP skill base with end of life care is also an area in which to make substantial gains in the quality of patient care. The recent Parliamentary and Health Service Ombudsman report into end of life care[2] highlights serious deficiencies in end of life care across the health spectrum. The Teeside University certificate in palliative care has a good balance between practical and theoretical skills. The training is provided by Teeside and St Teresa's Hopsices and Teeside University. The diploma is a practical qualification, providing best evidence for current practice. The different modules cover all areas of end of life care and address medical and non-medical interventions. This helps the clinician deliver care in a holistic manner, recognising when to refer and the skills offered by other professionals. This is possible through the development of knowledge and reflection on practice as part of the diploma. Being able to deliver effect palliative and end of life care is also crucial with current focus on reducing non-elective admissions. Increased confidence, skills and awareness in palliative care improves care planning with patients with long-term, life limiting illnesses, which can in turn reduce crisis episodes and help to develop strategies to recognise deterioration and have an action plan in place for these circumstances which is acceptable to the patient.

Developing our practice nurse is also important, particularly as we are moving towards integration of the community and practice nursing services. A university postgraduate qualification would recognise the development of a good knowledge base, as well as the ability to critically appraise evidence. This is a transferable skill, which the nurse could use in other situations to the advantage of the service. The practice nurse would enrol on a diploma course accredited by Teeside University ideally in October 2015.

Exclusions from the service

The types of patient who would be excluded from this proposal would be end of life care, absolutely housebound patients, and patients refusing to use the service and requests to provide equipment if a home assessment is required.

Contingency planning

[2] http://www.ombudsman.org.uk/reports-and-consultations/reports/health/dying-without-dignity

In the event of a service failure, such as vehicle breakdown or adverse weather conditions, the service would be temporarily suspended and the clinician would visit the patient at home as is currently the case. The community transport service has two vehicles so there is a backup contingency plan. Adverse winter weather usually causes a few days of road closures, but the practice 4x4 response vehicle is usually able to overcome most problems.

The vision

The following are two worked examples:

78 year old man living on a remote hill farm develops a leg ulcer. Currently dressed at home as no transport and frail. There is no access to ankle brachial pressure index (ABPI) testing for community nurses, so they are unsure as to whether they can use compression dressings to treat the ulcer because a satisfactory ABPI is needed before they can apply the compression. Compression dressings are the gold standard treatment. There was a concern about infection, and the district nurse contacted the GP, who arranged to visit and assess. Antibiotics were prescribed, and these needed to be obtained from the dispensary, which was logistically difficult. He smokes and there is no access to domiciliary smoking cessation support.

Under the new scheme, the patient would have transport arranged for one of the 'housebound' clinics. He would be seen and assessed as per the practice protocol. This involves assessment of ABPI early on in the treatment, compression dressings as appropriate following this and also a screen for diabetes, as this can be associated with ulcers. If there was a concern about infection, the GP would review at the same time and the patient would leave with his antibiotics from the practice. Smoking cessation support can be provided at the practice at the same consultation with subsequent clinic or telephone follow up. The patient would then be taken home, with the opportunity to be taken to local services en route, such as the post office or local convenience store or even the luncheon club.

90 year old woman living alone with poor eyesight and no transport. A visit was requested for routine blood tests to monitor her type 2 diabetes. She was found to have an irregular pulse. This was passed on to the GP who visited and then suggested an ECG. There is no facility for an ECG through the community nursing service. A week later, the patient was able to arrange transport to the practice, but was then found to have a normal pulse rhythm and ECG. The GP suspected that she had atrial fibrillation, and given her age and risk factors, there was a substantial risk of stroke. Atrial fibrillation can come and go, and without documented proof, starting medication to 'thin' the blood and prevent clots can be medico-legally risky if the patient subsequently has a bleed. The only other option in this case was to refer to the cardiology clinic for a monitor to be fitted.

Under the new scheme, the patient would be seen at the practice for her diabetes check. If an irregular pulse was detected, she would have an ECG performed at the time, which would be interpreted by the GP. If AF was found, given her high risk factors for stroke, the GP would be able to initiate anticoagulation therapy, which the patient could collect from the dispensary before being taken home. There would be no requirement for a secondary care outpatient referral.

How does this address the CCG aims and objectives?

Objective	***Mechanism***	***This project***
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	The project enables previously housebound patients to be ambulant therefore improving access to quality care
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	Integrated working with local community assets to find a sustainable and mutually beneficial solution as well as making the practice a hub for the community staff
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	Increases patient availability to the specialist skills already at the practice
Reduce professional isolation and ensure successful revalidation of practice nurses	Through effective peer support and networks including with the CCG	Shared skill mix and supervision with practice nurse and community nurses Development of individual skills through higher qualifications
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	Combining RAIDR and FI Score to identify and support at-risk individuals. Ongoing use of our eGP ™ service for patients to submit data such as home blood pressure readings or peak flow measurements
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	Cross pollination from work with community nurses and also GPs to provide training based on their palliative care diploma experience
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	Shared learning and training between practice and community nurses

Sustainable financial and quality benefits for the future	For example through reducing non-elective admissions (NELs) by helping to proactively manage a patient's condition and ultimately reducing potential years of life lost to conditions amendable to healthcare	As the population ages, so will the number of relatively housebound patients. Providing more home visits is a non-sustainable solution, whereas increasing transport to meet demand is more realistically sustainable. Optimising LTC care and recognising and planning palliative care is likely to reduce unplanned admissions.

What changes need to happen to implement the scheme?

CHANGE	OUTCOME	DATE ACHIEVED
Discussion with patient representatives (Marie Brookes)	Telephone survey of ten patients. All agreed it would be a good idea. Requests that we coincide the transport times to fit in with carer provision and availability of other services such as market day or luncheon club	9 Jul 15
Discussion with RDC transport team to agree regular schedule and costs (Marie Brookes)	Cost agreed, schedules to be confirmed	22 Jul 15
Assign practice nursing time for extra patients on transport (Marie Brookes + Carol Wade)	Time assigned	22 Jul 15
Discussion with Community Nursing Teams (Marie Brookes + Pam Thorne)	Agreement and support for the project from community staff	8 Jul 15
Practice Time Out sessions to work on details of proposals to sense-check and work through administrative and logistical processes (All practice members)	All agreed	15 Jul 15
Assign protected time to the salaried GP and practice nurse for academic study (Marie & Mike Brookes)	Time assigned	22 Jul 15
Establish a task group to oversee the project (Marie Brookes)	Group consisting of the Managing Partner, GP partner, Pam Thorne (Community Nurses). A representative from the group will also feedback to the quarterly Upper Dales Area Partnership meeting to receive feedback from patients, social services and local community leaders.	18 Aug 15

Liaise with RDC transport re DBS checks	All drivers are DBS checked.	18 Aug 15

Key performance indicators

1. Quarterly report on the number of patients using the transport service who ordinarily would have had domiciliary visits to manage/monitor their long term condition.
2. Quarterly report on patient satisfaction survey post-use – qualitative and quantitative.
3. Quarterly review of service-users to look at outcomes from using the transport service versus usual care at home using disease specific indicators e.g. QOF outcomes or other national standards.
4. Quarterly review of district nurse visits outside of the scheme to ascertain whether a saving has been made in nursing hours and travel time compared to expected numbers.
5. Quarterly staff satisfaction survey and feedback sessions.
6. Percentage of influenza vaccinations given before 01 Nov 15 and compare to previous time period last year. The uptake should be much higher in 2015 as the transport service will reduce the delay in vaccinating 'housebound' patients, and therefore more vulnerable patients will be protected sooner.
7. Evidence of satisfactory completion of higher learning from salaried GP and Practice Nurse in the form of University Certificates.
8. Monitoring NELs rates using quarterly data during the project period to assess the impact of the project on this parameter. Any reduction would give an indicator as to whether the monies saved by reduction in NELs could be used to fund the transport project in the future beyond the scope of the ES.

DELIVERY PLAN & PROPOSED BUDGET

Ref	Milestone	Deadline	Comments
1	**Deliverable 1: Programme management and delivery**		
1.1	Finalise work plan	Oct 15	Administrative and logistical details to set up clinics and transport arrangements with RDC transport including purchase of wheelchairs
1.2	Map budget against work plan	Jul 15	
1.3	Produce a quarterly report on progress against deliverables	Ongoing	
1.4	Ensure QI approach is taken in delivery	Ongoing	
1.5	In second to last quarter of project develop an exit strategy and legacy plan	Jun 17	
2	**Deliverable 2: Partnership and working**		
2.1	Engage patient participation	Sep 15	Attendance at Upper Dales Area Partnership, article in Reeth Gazette +/- Darlington and Stockton Times
2.2	Produce a quarterly report and feedback to all stakeholders	Ongoing	Includes staff satisfaction, numbers of patients using the service, number of home visits
2.3	Higher academic qualification for practice nurse	Oct 16	
2.4	Higher academic qualification for salaried GP	Oct 16	
3	**Deliverable 3: Impact on patient experience**		

3.1	Post use patient survey compiled and reported quarterly	Ongoing	Qualitative and quantitative feedback from patients after each use
3.2	Quarterly review of patient outcomes with comparison to usual care at home	Ongoing	Using QOF indicator standards or national guideline standards where no QOF indicators exist
3.3	Report on percentage of influenza vaccinations given by 01 Nov 15	Nov 15	Compare to uptake percentage at same time last year

Ref	Milestone	Indicative cost (£)	Comments
1	**Deliverable 1: Programme management and delivery**		
1.1	Finalise work plan	210	2hrs PM time (£40 ph) 2hrs GP time (£65 ph)
1.2	Purchase 2 x wheelchairs	500	
1.3	Reeth District Community Transport	2400	2 x month journeys @£50 each
1.4	Administration and coordinating clinics	300	24 sessions at 0.5hrs @£12.50ph
1.5	Practice nurse clinical time	1080	48 sessions of 1hr @£22.50ph
1.6	Room service charge	288	48 sessions of 1hr £6ph for community nursing team inc district nurse/case managers and also others such as primary care mental health worker or to use room for MDT style meetings
1.7	GP time for joint clinics/advice at sessions	0	Practice expense as should be cost saving to practice by bringing patients to practice
1.8	Produce a quarterly report on progress against deliverables. Identification of at-risk patients.	1470 (includes cost of delivering 2.2, 3.1, 3.2, 3.3 over the two years)	7 x quarterly reports including collection of data in the form of questionnaires/feedback on a quarterly basis: 2hrs PM time (£40 ph) 2hrs GP time (£65 ph)
1.9	In second to last quarter of project develop an exit strategy and legacy plan and produce final report	630	6hrs PM time (£40 ph) 6hrs GP time (£65 ph)
2	**Deliverable 2: Partnership and working**		
2.1	Engage patient participation	250	Attendance at Upper Dales Area Partnership, article in Reeth Gazette +/- Darlington and Stockton Times

2.2	Produce a quarterly report and feedback to all stakeholders	See 1.8	
2.3	Higher academic qualification for practice nurse	900	5 x study days:5x 8hrs nurse time (£22.50ph) Distance learning over year of course and practical placements + travel at practice expense
2.4	Higher academic qualification for salaried GP	1000	5 x days of hospice placement: 2 x days of practice backfill (£500 per day) 3 x days at practice expense
2.5	Provide joint training session for practice nurse and community nursing team on good end of life care	325	3 hrs prep GP time and 2 hrs trg time @£65ph. Practice nurse attend at practice cost. Provide room and refreshments at practice cost. Also allow for in- practice training for newly qualified nurses to DN team at nil cost to project to aid in increasing competencies for benefit of practice and community nursing teams.
3	**Deliverable 3: Impact on patient experience**		
3.1	Post use patient survey compiled and reported quarterly	See 1.8	Qualitative and quantitative feedback from patients after each use
3.2	Quarterly review of patient outcomes with comparison to usual care at home	See 1.8	Using QOF indicator standards or national guideline standards where no QOF indicators exist
3.3	Report on percentage of influenza vaccinations given by 01 Nov 15	See 1.8	Compare to uptake percentage at same time last year

Available funding at £3 per patient per year £9480 (based on list size as of 1 Jul 15 1580)

Projected estimated costs for project £9353