Sleights and Sandsend Medical Practice
Hambleton, Richmondshire and Whitby Clinical Commissioning Group

PRIMARY CARE NURSING WORKFORCE
PROPOSAL AND DELIVERY PLAN

Introduction

It is in the patients' best interest to stay well and at home as far as possible, and it is what most patients prefer. We are all aware that we must adapt to the demographic change of our society as people live longer and many more patients spend many more years in old age. This requires a primary care service that is mindful of and capable of responding to a larger number of people with long-term conditions, numerous medication, as well as care and support needs. Not only are these various and numerous medical and social care needs, they are also individual, very different from person to person. Our response needs to be personalised, providing the right information and support in the patient's home, involving the right additional services for each individual as required. Our approach also needs to be pro-active, looking out for emerging risks, such as the risk of falls or conditions that can flare up, ensuring these risks are adequately addressed and plans agreed. Last but not least, a personalised approach also brings the opportunity to support patients to understand and manage their illness better, bringing a greater sense of control and reducing the risk of sudden admissions to hospital, or the need of having to move into residential care. This can be a real contribution to not only increase patient's health and quality of life but to contain costs incurred by acute admissions, for example.

It has been valuable to look at our set of skills and to sit down together within our locality and plan how we could address this need. None of these aims are new, and attempts have been made in various ways before. We realised what is required now is to go one step further and commit a dedicated person at the interface of home and surgery, medicine and social care, capable of spending a little more time to understand the person's needs, capable of formulating a plan with them, understanding the system to provide the right information and involve services as required for that person, and keeping actions on track, reviewing what was done and reinforcing advice. We do not have the impression that we are reinventing the wheel but that we take a more committed step to creating a dedicated post for an experienced advanced nurse practitioner focused on implementing a variety of relevant and effective interventions.

A skills / gaps audit was undertaken and provided to the CCG. It was also used to inform the development of the proposal. The audit showed skills in these areas between the practices.

The skills audit showed a combination of practice and community expertise in the following areas:

Frailty

- Catheter care
- Skin tunnel catheter care

- Complex wound care
- Bowel care
- Continence assessment
- Dementia care
- Palliative care
- Pressure relieving care/advice

Sub-acute & Chronic Disease Management

- Palliative care
- Dementia Care
- Diabetic Care
- Heart Failure Care
- COPD
- Asthma

It also identified the following gaps and issues

- Chronic Disease Management in the Community with housebound/care home patients, especially COPD and diabetes
- DNARs
- BP reading and basic observations in nursing/care homes
- Knowledge in developing care plans & care pathways and which voluntary sector agencies are available to work with

Other issues:

- Invite district nurses and nursing/care home staff in practice nurse training.
- Invite district nurses in practice nurse clinical meetings.

The core of the proposal is as follows:

- The Practice to recruit an advanced nurse practitioner (as a locum) An Advanced Nurse Practitioner currently works at the Practice who has the skills required to fulfil this role. (**attached job description**).
- The successful applicant will be employed to go into the community and work with patients with long term conditions especially those that are housebound, in care and nursing homes with a focus in frailty, on-going medical/social needs and care-planning.

- We have contacted James Cook University Hospital who has given us contact details who are the link for the frailty model being implemented in the community in South Tees.
- We would expect the person appointed to liaise regarding the role out of this model in our practice area.
- We are planning to appoint an advanced nurse practitioner with appropriate skill levels. Training sessions to be carried out across the Whitby locality to include practice, nursing/care home and district nurse staff. These sessions will be run in conjunction and consultation with Whitby Group Practice, Egton, Danby and Staithes therefore gaining best value for accredited training. These sessions would also give the opportunity for peer support and peer review, from our combined training budgets.
- Dr Graeme Little with the appointed advanced nurse practitioner will lead the project working in collaboration with the practice nurses, and GPs. There will be quarterly clinical meetings to monitor the clinical aspects of the project.
- A task group of clinical and non-clinical staff would review non identifiable data, audit results and financial statements. The task group meetings would be open to patients, carers/ social care and community services.

How the proposal has been developed

Initially developed from looking at nursing skills gap and patient needs.

Consultations with the following teams/representatives have taken place:

- GP's from the Whitby locality
- District nursing team
- Practice nursing team
- Nursing/Care Homes
- Patient Groups
- Voluntary sector

After analysing the best way forward it was realised that each Practice within the locality had slightly different ways of working, mainly due to the list size, locality and spread / number of homes catered for. As Staithes, Egton and Danby are of a similar dynamic it was sensible for them to work together on the project. It was also agreed that the difference in working practice, patient list size and the different care homes covered by Whitby Group Practice and Sleights and Sandsend Practice, engaging a separate Nurse for each surgery was much more efficient. However, all Practices agreed that a common area is training needs and we will work together to ensure training will be offered over the locality to avoid duplication.

Across the locality there are eleven residential homes. two nursing homes and eleven extra care housing establishments covered by the five Practices. Analysis of the number of patients cared for in each home by each Practice supported the decision for Danby, Egton and Staithes to employ one nurse as their numbers were relatively low compared to Sleights and Sandsend Practice and Whitby Group Practice. Similarly it was clear that Whitby Group Practice have patients in all but one of the Extra Care Homes and Sleights and Sandsend Practice have none. Also, Whitby Group Practice have a relatively high number of patients in seven care homes where Sleights and Sandsend Practice have either none or small numbers of patients in those homes. It was therefore agreed that appointing a Nurse for each Practice separately would be the most efficient way forward.

We would expect the post holder to be responsible for developing relationships, action and develop care plans with other agencies and colleagues as required. We would hope this would result in less duplication and clear responsibilities for patient care.

Explanation of how the plan will achieve the project aims and what will be the expected impact and benefits of the changes on patient care and outcomes

1. Ensure quality of care for housebound patients including those in care homes equals that of ambulant patients. Housebound patients will receive the same level of detailed care eg in the assessment and management of long term conditions. There is a current gap in standards as district nurses are not commissioned to provide long term condition assessment reviews and management plans. District nurses do not have access to computerised notes and templates. The appointed person would have access to all records ensuring holistic care particularly in long term condition management developing care plans to be shared with other sectors as necessary.
2. The targeted cohort of patients would include housebound patients with long term conditions, frail patients in care and nursing homes and patients who have had frequent hospital readmission and recent discharges.
3. 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, clinical meetings would take place monthly.
4. Improved specialist management of long term conditions and frailty in the community to maximise health outcomes. By collaborative working with specialist nurses eg diabetic, respiratory and heart failure. This will enable the possibility of joint home visit, thus better outcomes for these patients who due to their isolation have difficulty accessing such a level of expertise.

5. We have already put in place regular meetings between senior practice nurses and district nurses encouraging peer support and peer review. This has already reduced professional isolation and developed greater team working.
6. Embracing new technologies enabling access to IT via EMIS Web – use of templates, protocols, patient leaflets, management plans enabling patients to have information to help them and their illness. To also proactively identify patients and allow them to better manage their condition e.g. using Vitrucare. Care plans will be put in place to teach patients. Those patients who do not wish to or are unsuitable to use Virtucare to self-manage their illness will be advised to alert the team when feeling unwell.
7. 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. Training sessions to be arranged within the Whitby locality to include all sectors of nursing.
8. 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 eg offering training to care home and nursing home staff
9. For patients already known and cared for by district nurses there needs to be an individual discussion between all the nursing staff, producing a joint care plan with an agreed role for each member of staff.
10. Sustainable financial and quality benefits for the future by reducing non-elective admissions by helping to proactively manage a patient's condition and ultimately reducing potential years of life lost to conditions amendable to health. This has to be audited in terms of admission.
11. Training of residential care home staff in routine medical assessment, e.g. Basic Observations.

Discussions with patient representatives

The project was discussed in a Patient Participation Group meeting on the 18th June 2015. No modifications were necessary and they are fully supportive of the development plan. We intend to continually involve patients and patient representatives throughout the duration of the scheme through the Task Group.

What investment will be required (up to £3 per head).

The total amount available given the list size of the practice is £35,987 over the 2 years

Summary to date:

An advanced nurse practitioner currently working part time at the Practice will be commissioned to work 2 extra sessions (8 hours) in the community per week and project

manage the process at £36 per hour (£15000pa). Finances would be monitored monthly by the Practice Manager and will produce a financial report every six months and present to the task group. Additionally we will have the following approximate costs to take into consideration:

- Mileage - £2340 over 2 years; due to rurality approx. 50 miles per week at 45p per mile)
- Training - £750.00
- GP lead, Management and administration costs - £1900 over 2 years; half an hour per week admin support.
- Voluntary Sector-we would like to put aside £1000.00 to enable us to meet some of the costs incurred by the voluntary sector to provide services/session that can be attended by our patients. Where possible we would use existing services that are available, but would like to have money available for additional services where necessary. Allocation of this money would require authorisation from the task group.

Costs for involving the voluntary sector are an unknown factor at the moment, but we are keen to involve them and allow the use of the surgery to develop an outreach type of service which the frailty nurse could refer into. We would expect the advanced nurse practitioner to liaise with organisations to enable patients to be referred to available services. We are currently taking part in on-going discussions with DAG and Coast and Vale Community Action to improve awareness of resources available.

To link with this project, we would anticipate securing future funding from other sources in the expectation that we would be able to demonstrate benefits to patients and we would be able to demonstrate saving to the NHS in terms of a reduction in unplanned admissions

Key performance indicators and other information that will be measured to assess the impact and confirm that the plan is achieving the intended outcomes.

We are hoping the development will be able to continue after two years. To prove its effectiveness we will measure the following:

1. Data for admissions taken at the start of the development and at three monthly intervals to ascertain whether reductions have been obtained.
2. Re-evaluate skills mix and skills gap.
3. Evaluate end of life care to ascertain patient died in preferred place.
4. Patient satisfaction questionnaire.
5. We plan to audit our data every six months and feedback learning points to the task group i.e. rates of all admissions for the patients involved in the project, rates of GP

visits, use of OOH, measurement of certain parameters such as BP control in chronic disease, HBA1c in diabetic patients.

6. Stakeholder questionnaire.

Delivery plan

1. Develop job description by 31st July 2015 (completed)
2. Develop a daily work schedule by 31st July 2015 (completed)
3. Commission Advanced Nurse Practitioner to commence role from October 2015 (in place).
4. Agree and arrange set up of task group by October2015
5. Agree and arrange nurse training with collaborative practices by 30th September 2015 and to commence by November 2015
6. Speak to voluntary sector by 31st August 2015 to discuss how their involvement will evolve. (Discussed with CVCA (21/07/15), voluntary sector groups at Church House (28/07/15) and a subsequent meeting with DAG (15/09/15)).
7. Meet stakeholders to evaluate the development plan and progress to date by end of December 2015. We envisage that we would be evaluating the plan on a quarterly basis thereafter.

In conclusion we feel this is a sound proposal and hope that the measurable outcomes demonstrated throughout the scheme will allow the continuation of this project beyond the two years.