Developing Primary Care Nursing Workforce Initiative

Stokesley Health Centre Proposal

Introduction to Proposal

It is well documented that a focus on proactive management of patients, particularly those who risk preventable hospital admission is key to the future survival of the NHS. Despite this knowledge, and many audits, projects and pilots across the country, it seems we are yet to find a universally successful programme to address the problem of unplanned admission to hospital. The reasons for this are less clear but it is our view that the division of funding and different priorities which exist between primary and secondary care can and does result in professional rivalry between departments, compromising collaboration, integration and whole system working.

Currently nursing within the primary care setting consists of community nurses managed by secondary care and the nurses working within the surgery who are managed by General Practice. We believe in the long term that community nursing should be managed in the community by community physicians and managers who understand collectively the needs of the population they serve, thus facilitating nurses to work seamlessly between the patient's home and the surgery. For this to be successful it does require a shift of funding to support the work and a change of mind set regarding 'ownership' of resources if we are to have any hope to achieving the elusive aim of admission avoidance.

Our vision for the Primary Care Nursing Workforce project is to introduce and develop a nursing post that can incorporate both practice based and community based work under the management and support of General Practice. The objective would be to look at the needs of those patients who can attend the practice for their care generally but from time to time would benefit from their care being delivered at home. During this process we will endeavour to begin greater integration across the nursing team serving our practice population.

Development of the Plan

Since 2004 the Department of Health has had the explicit aim to reduce unplanned admissions and to look at interventions to avoid these. 11 years on we are now in a position to look at what has worked, but perhaps more importantly what has not, so to avoid bad investment and repetition of interventions that have shown little or no beneficial effect. Part of our set up funding was used to analyse the data which was key in the generation of ideas for the proposal. Further work was carried out to identify current skill gaps and working practices between the practice staff and those from other agencies, including the Community Nursing Team. We also looked at external influences on our unplanned admissions and management of vulnerable patients in the community. This included the impact of the 111 services, the ever increasing workload for GP's and general practice teams, funding issues within Primary Care, the imbalance of power between the commissioners and providers and how these variables, which are partly beyond our control, would fit with our proposal.

We had a joint meeting with the Great Ayton practice to develop our thoughts and proposal. Following this it became evident that we had differing visions of how to progress our proposals. We identified cross over areas of need which we would hope to take forward together especially the integration of the community nursing team that covers both practices. Our practice proposal specifically acknowledges the need to integrate the primary care nursing team over the next few years. We acknowledge that the proposal could be seen as a stand alone project but our aim is to show that this plan will improve integration across the nursing team producing benefit not only for our practice but the other 2 practices covered by the community team through lessons learned. We look forward to taking ideas from other areas that might enhance our proposal.

The Stokesley proposal intends to look at a new nursing role that bridges the gap between the traditional Practice Nurse and those employed by secondary care to work solely in the community. Our aim is to look at the needs of patients who fall between those able to be seen in the surgery without any compromise to their health and those that are deemed 'housebound' and fit with the core service currently provided by the Community Nursing Team. We are looking to appoint a nurse with knowledge and skills in the care of older people, with wide experience of effective multi-disciplinary working and awareness of local and national drivers for the management of long term conditions and admission avoidance. Ideally the candidate will be an independent prescriber and be confident in clinical skills; however the practice is happy to invest in this training if required both within the practice and with outside training if needed to develop the role fully. It is difficult to outline in the plan what training may be needed as it depends on the interest in the position once advertised and the quality of candidates applying. We are aware that some of these candidates may come from a community setting but like all new roles we see this as an exciting and challenging opportunity for a new nurse to the primary care team. We have noted that during the last 3 years in Stokesley we have had 4 different district nursing sisters who have all moved onto different roles within the local area. We are looking at a full time post for our 2 year pilot. We are aware the funding within the initiative will not cover these costs. We do however feel so strongly regarding this proposal we will supplement the funding from the CCG from practice resources to achieve this.

Aims of the Project

PROBLEM/ISSUE	INTERVENTION	BY WHO	PERCEIVED OUTCOME
Frailty management	*Frail elderly register *Implementation of assessment tool *Advance care planning including palliative care should it be appropriate *Interagency working practices	All practice staff All practice staff Practice frailty team led by New Post Hot clinics where appropriate	Reduce unscheduled hospital admissions and limit increasing dependency on services. Improve outcome of hospital stay when admission necessary and thus reduce the requirement of service and resources to help them recover

Exacerbation of long term conditions	Acute onset to be managed by Dr/Nurse specialist, follow up at home once stabilised by Nursing team	Practice Nurse specialist in long term condition. New Post if appropriate and if not then relieve the most appropriate person in the practice	Ensure the patient is cared for by the most appropriate person, ensuring that chronic disease is managed as well for house bound as those who can attend the surgery. Continuity of care and better control of LTC Back fill in place to facilitate this, sharing and maximising skills within practice team
Identification of 'housebound' and isolated patients	Working with community staff and other agencies to look at care packages and co working. Protected time to co review care packages and patient need	GP, New post, case Managers, Community Matron. Capacity from new post will enable this	Joint ownership, shared knowledge and networking to improve communication and patient experience. Ensure most appropriate agency/personnel are involved Identify and act on issues to address unmet need

Reduce unplanned Admissions

Problem:

Work has been carried out over recent years to identify patients who are at risk of unplanned admission and readmission and prolonged hospital stays. However the knowledge of the patients is not a solution. At Stokesley we are aware of this cohort of patients and work closely with the case management team to try at look at solutions to address this. We are aware that despite case management and current ways of working, the unplanned admission rate is increasing. It would seem that only certain aspects of case management are helpful in addressing the problem so by looking at these we may make some progress in stopping this increasing rate.

Intervention:

To work alongside the current case management team to be more proactive in the management of patients with longterm conditions. To look at more integrated working with the surgery and social care whilst recognising the barriers to this. Our hope is by having the jurisdiction of the proposed Nurse we will be able influence working practices and relationships with external agencies and bridge gaps that currently exist.

We also want to look at preventing re admissions and this does require timely and accurate information from the hospital. We would like to look at working with hospital colleagues to provide

a single point of co-ordination, and whilst this is ambitious, we would like to use some of our new resources to release time within the current practice team to explore this.

We also recognise that health anxiety can influence unplanned admissions, often out of hours when the surgery is closed. This is a more difficult area to address but have looked at self- management tools with patient groups and feedback from our focus groups are that this is something that they would welcome. Once established and if successful providing the funding continues to be available, we would look to expand aspects of this to appropriate patients. Self- management and ownership requires support in the first instance but the aim is to provide an additional non face to face link between patients with LTC and the clinicians. We have signed up to Vitrucare and look forward to assessing the impact of this tool on the patients enrolled.

By Who:

New Post to look at hospital liason with support from surgery administration

Vitrucare lead ongoing promotion and monitoring of self-management

Outcome:

Self-management models to promote self-care or shared care.

Financial proposal

Full time Band 6 Nurse Salary + Pension + NI

£31321 - £41946

Income at £3 per patient across 12/12 approx £28,500

Shortfall £2821 - £13446 made up from practice resources to ensure most suitable person appointed to post with appropriate skills

Aim to advertise asap and get into post as early as possible ? October 2015

We would hope to make this role into a permanent post having proved its value. We are however governed by the limitations of continued funding through the CCG. We would hope that the continuation of this funding stream would be looked at alongside other funding streams aimed at providing care closer to home in the community. We feel our plan offers a different way of looking at the problem of increasing NEL and we hope will prove a more cost effective use of scarce resources.

Patient Involvement

The proposal once worked up was delivered to a joint meeting of the PPG and the patients currently being enrolled on the Vitrucare pilot. This group therefore provided a reasonably representative group of our practice population. The proposal was outlined and responses received. The overall message was extremely positive. The need for greater integration of the primary care nursing team

was seen as essential to the challenges faced in the community in the future. There was certainly no awareness that currently the community nurses are under the management of a secondary care service rather than under the management of primary care. There was significant buy in to this being the start of a process rather than the end point. We committed ourselves to feeding back to the group the response from the CCG and the development of the project in the future.

Implementation Plan

Sept 2015 : Confirmation that proposal acceptable to CCG

Sept 2015 : Creation of job specification and advertising of new role

Oct 2015 : Interviews and recruitment to new post

Oct to Dec 2015. New role commences. This depends on success of recruitment and then assessment of training needs of individual.

Jan to June 2015 : Initial working phase. Current proposal suggests split between clinical role/training/working towards integrating nursing team.

The new role will have direct contact and supervision on a daily basis with the GPs/nurse practitioner/lead practice nurse. This will allow identification of the specific patients to be targeted. We would expect that the local care home and extra care home would be initial areas where this new resource would be targeted.

June 2015 onwards : Fulltime clinical role within practice. A significant part of this role will be to encourage and develop the integration of the community team. This will be dependent on the ability of the community team to become engaged in this project.

Evaluation of new role at 6/12 stage with report to CCG if appropriate (? outcome data as compared with case management team)

Regular meetings with community management team to report on development of integrated working.

Review with care homes as to success of new role.

Feedback to and from PPG regarding new role including soft intelligence from patient feedback.

KPIs

During the course of the project we will actively measure a range of indicators to demonstrate impact. These will cover a range of quality, activity and outcome measures. These may include:

Number of patient contacts inc. face to face/phone/other means of contact ie Vitrucare where appropriate to count. This will be an ongoing procedure as new role will have daily contact with remainder of primary care team.

Regular peer review by other members of primary care team including medical and nursing team.

Review of patients seen and audit of NEL and A&E attendances for this group. Feedback from audit to practice and CCG to develop service that may impact this in the future. Important to learn lessons as project develops to modify approach if needed.

Soft intelligence from community team and patients regarding additional service. Detailed discussion ongoing with community team regarding integration of nursing team across area. Both practice and community service can provide feedback to CCG re this.

Patient feedback from users of service and PPG.

Summary

It is clear from the summary of the evidence that despite all the pilots and trials that have been evaluated around the country the ability to reduce the increasing number of unplanned admissions has thus far proved impossible. The increased resources from the CCG initially into the district nursing service and last year into the case management/community matron service has failed to achieve this aim. This was made clear at the Chapter 3 event presentation by Jo Harding.

The objective of this scheme is to improve the health of our patient population. Previous studies trying to prove that success is based around reduction in NEL have never shown positive results. We would be very keen to access the KPIs used by the CCG in assessing the impact of the case management service and use similar assessments in reviewing our new service. This would allow this new investment to be compared against a service already in place . The new role will have a "caseload" of 9500 patients ie the whole practice population and be utilised in the areas where they are needed most at a given time. This varies significantly from the caseload based service that currently runs in community services which can be " full " and thus not immediately accessible.

Since our proposal we have met with clinical representation from the CCG and also the community nursing team manager in this locality. Several issues were identified. We have proposed that we have regular contact with the community nursing management to develop increasing integration. We suggested some positive steps that could be made within the community nursing services at a management level that may making working together more productive. We have offered increasing support from the practice to the community team to enable this. It has been acknowledged that some of the systems devised by south tees are not always as appropriate for HRW CCG area. Our aim has always been to integrate the whole of the nursing service in primary care but we feel it is important for us to be the drivers of this rather than through a more remote management structure.

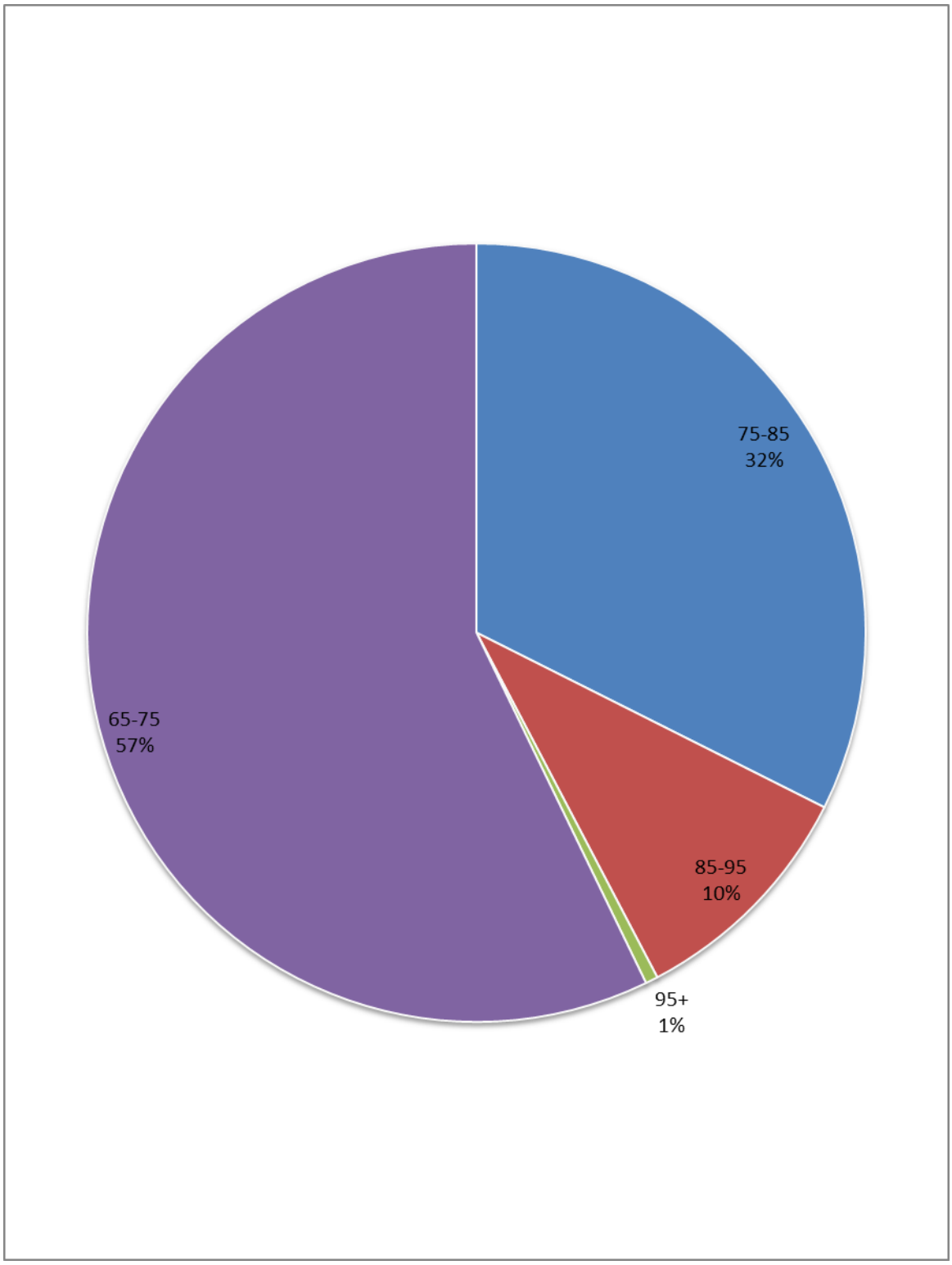
With an increasingly frail and elderly population this will only become more difficult. As a practice we are committed to achieving the best care for our patients in the most appropriate setting. We feel strongly that this initiative allows the money to start following the patient into the "real" community setting in primary care and hope this will be the first stepping stone in reforming the nursing services available to patients outside the hospital.

Appendix 1

Break down of percentages of practice population over the age of 65 years

Practice Population = 9284

Patients over 65 yrs = 2503



Appendix 2

Distribution of disease of patients registered with Long Term Conditions