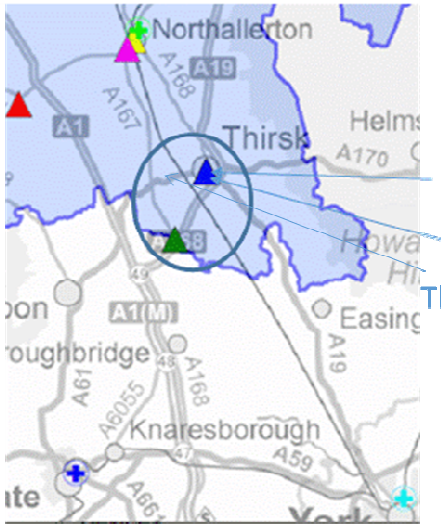
Primary Care Nursing Workforce Project

A plan to enhance coordination and integration of staff across three practices in Thirsk and Topcliffe.

25th September 2015



Lambert Medical Centre Thirsk
www.lambertmedicalcentre.co.uk

The Surgery Topcliffe
www.topcliffesurgery.co.uk

The Doctors' Surgery Thirsk
www.thirskdoctorssurgery.co.uk

Contents

Summary

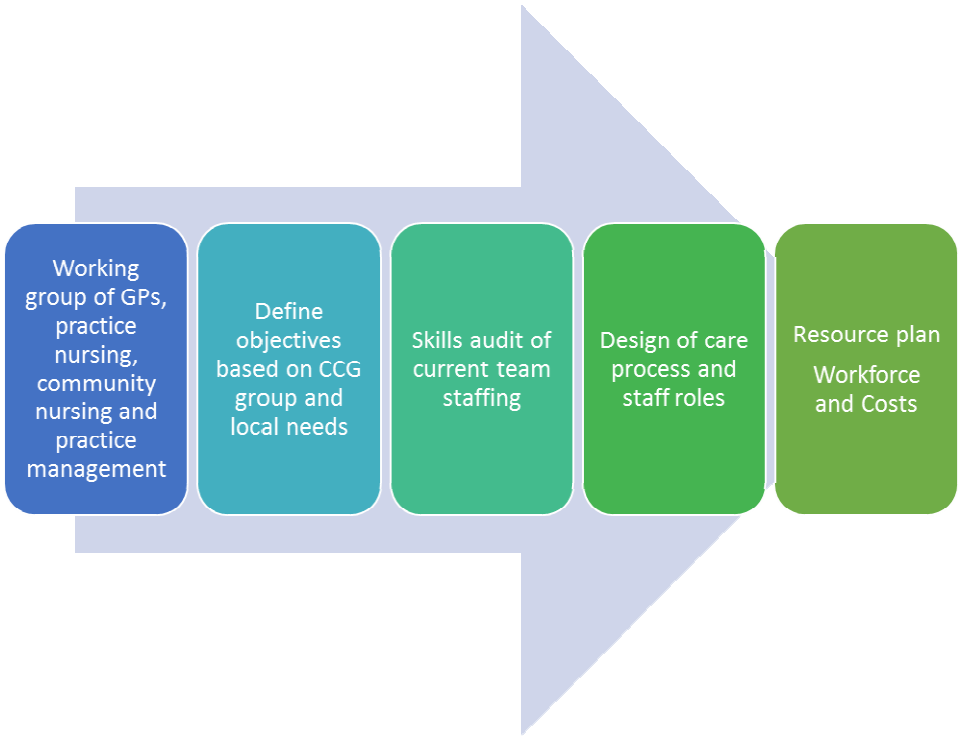
- This project, based around the cluster of the 3 practices of Topcliffe, Thirsk Health Centre and Lambert Medical Centre, representing a patient population of 18,200 patients, has been developed with the full involvement of all three practices, the district nursing staff, their management and the Long term Conditions nursing team.
- There has been significant cooperation and enthusiasm that has led to a model that aims to build on these teams.
- In this project, we aim to target the more difficult patients to reach, who are such either through being housebound, in residential care, through poor engagement or 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. The HCAs will provide some backfill at the practice, along with back office and frontline support to the trained staff, both practice and district nursing staff.
- Cooperation between the practices and different community teams remains a key aim of this project and the further 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. The training will also be aimed at developing motivational skills, to help patients to understand the causes of their illness, preventative actions they can take, early interventions they can deploy and then seeking support before crisis intervention is needed.
- Within this project is a plan for closer working within the residential care setting, bringing surgery based care to the residents, developing care plans including advanced care directives and supporting the care home staff with training and experiential learning.
- Over time, the team aim to identify a member of nursing staff 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 will be multidisciplinary, along with having a representative from each practice. The workgroup will ensure the project reaches its established milestones, as well as the anticipated quality and outcomes measures.

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.

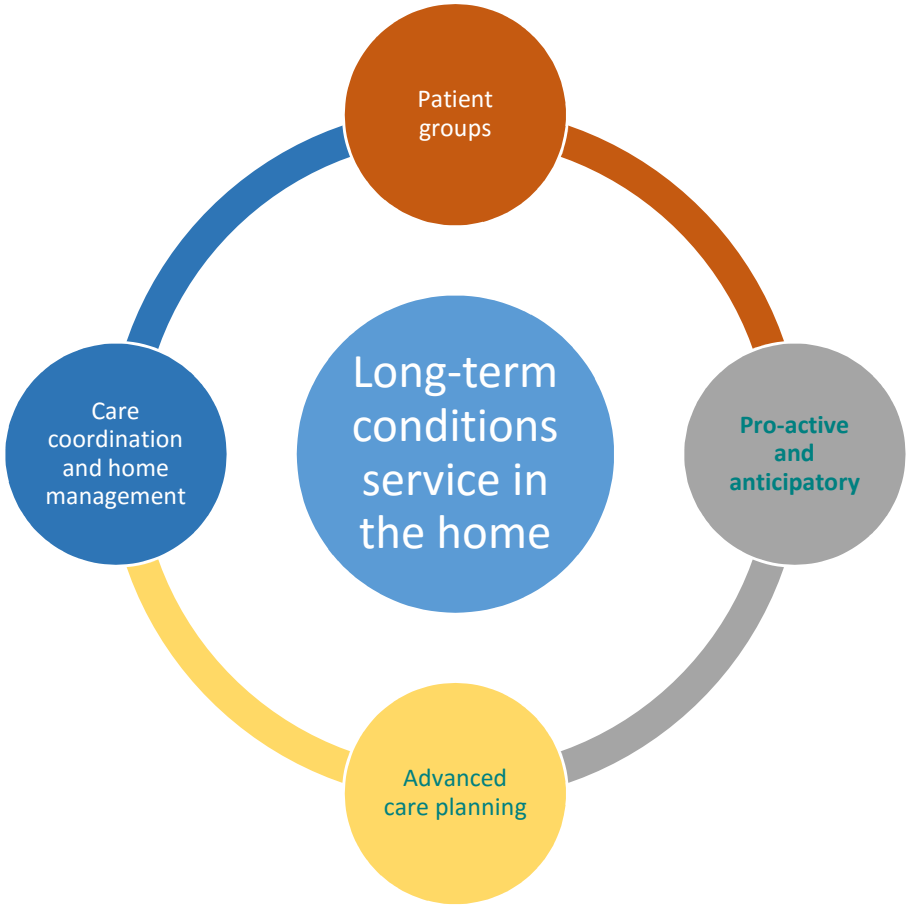
We have followed a logical 4-stage process.

- 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.



Our Objectives

- **The Patient Groups** Our priority for the project is patients with long-term conditions who find it challenging to come into the practice. This may well be due to limited mobility and access to transport and/or who to-date have proved difficult to engage with conventional services. The service will address current inequities for these patients versus those who access the practices. We will also develop care coordination for more complex patients not in receipt of any other out-of-hospital care.
- **Pro-active care** The aim is to provide care which is more pro-active and anticipatory. This means working with patients in their relative wellness phase. For some patients this will comprise home-based testing, monitoring and health coaching.
- **Holistic, co-production model** We aim to develop an innovative model of care which places the patient at the centre of multi-domain advanced care planning and programme delivery. The programme is initiated in patients own homes on an out-reach basis, with the aim of progressing to 'virtual' management before transition to self-management and monitoring only.
- **Systems and tools** There are system requirements and tools such as: mobile diagnostics and monitoring; mobile access to clinical systems; development of care planning and outcomes indicators and reporting templates.



Skills and Process Audit – Key Findings

Skills

- GPs lead on diagnosis in all long-term condition;
- Variations in roles along the management pathway
  - Assessments;
  - Monitoring;
  - Medicines review;
  - Prescribing;
  - Motivational work and self-care skills;
- Variations in the scope of practice and training of nursing staff
  - By type of condition;
  - By nurse staff in practices;
  - Scope of practice vis-a-vis the GP role;
  - By nursing staff in the community (community matrons, case managers, district nurses);
  - Due to the range of case-mix and significant procedural components of the current role, involvement in LTC management is constrained by capacity, although diabetic patients are monitored at home. Generally initial assessments and care plans are completed by the RN for the HCA to then follow the care plan;
- Mental health
  - Cognitive management skills are well represented across staff groups;
  - However management of depression rests largely with the GP with support from specialist mental health in moderate to severe cases.

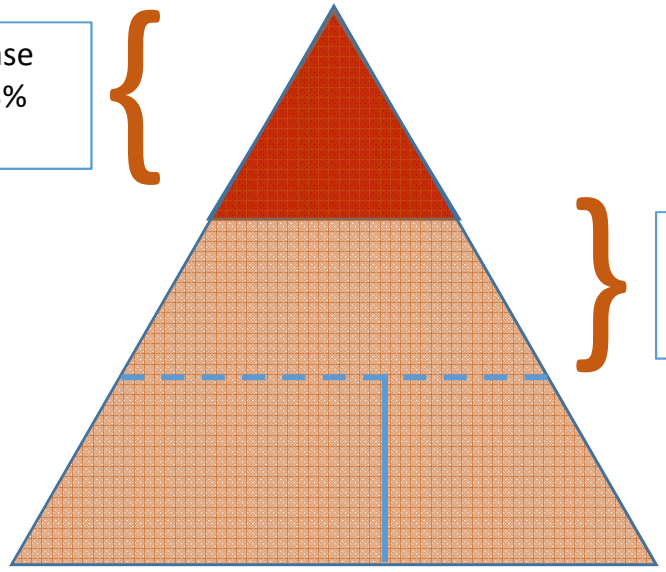
Process

- Scope to improve care coordination
  - Applying risk assessment to proactive care;
  - Medicines management ;
  - Motivational work and self-care skills training;
  - Outcomes definition and monitoring undeveloped.
- Systems issues creating barriers to more integrated, anticipatory working
  - Access to the patient record systems limited to specified staff only;
- Lack of knowledge across staff groups of each other roles, skills, processes and assessment tools;
- Challenges to monitoring in the home due to both skills gaps, and access to equipment (e.g. spirometry for community matrons);
- Need to improve advanced care planning;
- Lack of staff capacity re: screening and early diagnosis;
- Access to patient education/support services;
- Community matron reports not always shared.

This page shows the key findings summarised. Detailed skills analysis by major condition is available across diagnosis, assessment, monitoring and medication review. This information is presented in the Appendix.

The Target Patient Groups

Current community matrons, case managers and DES patients (2-3% complex needs high utilisation)



Sub-group 1: Patients needing care not currently engaging with services and requiring care coordination

Target group is the next 4-5% who have a wider range of needs

Sub-group 2: Patients needing LTC testing, monitoring, and coaching (housebound and care home residents)

In this project, we feel that it is important to differentiate the patients who could benefit from the new way of working, from those targeted by the current community matrons and case managers, as well as those who come 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.

Based on data from elsewhere including a local practice, we would anticipate there being a further 4-5% of the population of our practices. It is recognized that this wider group will have a range of needs; from those requiring care coordination, to those who need better monitoring, testing of their long-term conditions and some health coaching. These patients include those who do not access the practice-based services due to lack of mobility and/or the residents of care homes.

We will use a blend of risk-stratification and local, collective knowledge to identify the patients within these groups and that we will target.

Our Approach – a phased plan

First 6 months

Patients in Sub-Group 1

- Practice nurses provide a care home service, along with support from HCAs. This will be mobilised immediately to take advantage of this year's flu-season
- This initial service will deliver the following:
  - LTC checks
  - Flu-jab
- Benefits:
  - Improved care
  - Improve skills and confidence with all staff, including care home staff and HCAs
  - Increase exposure to this group of patients to enable practice and community staff to better understand the healthcare needs and how to meet them
- How:
  - Two practice nurses have capacity as currently working part-time
  - Some HCAs working part-time and wanting additional hours
  - Additional administrative support to be built into new support capacity to free time for nursing staff
  - Training of HCA staff

Month 7 onwards

Continue to serve sub-group 1 and develop service for sub-group 2

- Based on the learnings from the initial work in care homes, delivery of targeted care, working closely with care home staff and with support from other staff, such as the clinical pharmacists, tailored to the specific needs of patients in the care home setting
- Period of more advanced training
- Reflective practice / self-directed learning / self-appraisal / mentorship
- As well as delivering and developing the teamwork and integrated care, targeted at initially "housebound/less-mobile/difficult to engage" patients, this will be expanded to include lower level high-risk patients, development towards care coordination for year 2 of practice
- Care coordination, delivered by trained member(s) of existing staff, in a protected role who would wish to develop to take on this enhanced function within the team
- There will be flexibility with scope for each practice to decide its priority of balance of patient sub-group or case-mix targeted according to its own, specific population needs and outcomes data

Equipment

- The workforce skills and process audit highlighted that opportunities were being missed: for example there is potential for the community matron and case manager to deliver LTC checks and for the community team as a whole to do more monitoring and diagnosis in the patients' homes
- We identified that specific items of equipment, if made available to the community team and the practice nurses when visiting patients in their homes, would enhance care given to patients.
- It is also strongly felt that mobile access to the clinical systems would improve not only the care given to patients, but also the level of teamwork between our community and practice-based staff

- The following items of equipment were agreed as essential to realise aims of integrating community and practice nurse and increasing collaboration:
  - Laptop for use with ECG and spirometry equipment
  - 3 x EMIS Mobile user licences
  - 3 x additional iPads to enable mobile working
  - Community Doppler (Whitby model quoted as being one of high standard that could ultimately form basis of a centralised service)
  - ECG and spirometer
  - Equipment and consumables for diabetes foot checks

Capacity – requirements and supply

Capacity Requirements

- Local data indicates that 5% of the population are in the target patient groups
- Management of 5% in the way that we are planning would require 1 whole time equivalent (wte) nurse for 18k resident population and this would include the case management function
- Management of 4% indicates that 0.8 wte nurse would be required across all three practices
- We have assumed back-fill of equivalent wte HCA time

Capacity Supply

- Current staff will be given the opportunity to extend hours to supply additional capacity needed to manage this patient population
- Topcliffe has available nurse capacity but needs back-fill by increasing HCA capacity significantly
- Thirsk and Lambert need to increase available capacity mostly in nurse hours with some HCA capacity as back-fill
- There is opportunity for those in community and practice to cross-cover each other to learn new skills and ensure that demand is met
- Time will be allowed/created for staff to co-visit and work across sites
- Development of skills and confidence in practice nursing staff will facilitate transfer of patients from case managers and community matrons. This will enable better continuity of care and enable greater throughput from these more specialist staff, who focus on the most complex end of the case-mix spectrum
- Advanced Care Planning – our community matron and case manager will work with practice nursing staff to develop their advanced care planning skills in order to provide more opportunities for this key function to be carried out by more staff and for more patients.

Workforce Plan – preferred option to ensure additional capacity

The tables below show the use of resources. There is a total of £54,672 available for each full year. Table 1 shows that in a full year this equates to 1 wte nursing staff member and 0.8 wte HCA. As per previous section, this is deemed sufficient additional capacity and the proposals are therefore affordable. In year 1 this will be allocated 50% to equipment and development costs (see action plan) and 50% to full staff costs for the first full deployment stage. Table 2 shows non-staff costs in year one.

Table 1

Budget for staff - full year effect	FYE
	£
Lambert	24,669
Thirsk	21,318
Topcliffe	8,685
Total	54,672

Preferred option		Budget Nurse	Budget HCA
		£	£
Lambert	75% Nurse 25% HCA	18,501.75	6,167.25
Thirsk	75% Nurse 25% HCA	15,988.50	5,329.50
Topcliffe	50:50% HCA	4,342.50	4,342.50
Staffing in WTE		Nurse_WTE	HCA_WTE
Lambert		0.46	0.3
Thirsk		0.40	0.3
Topcliffe		0.1	0.2
	Total	0.97	0.79

Table 2

Development and Training	
Activity	**Cost**
Training, development and project governance	£16,266
	£16,266

Equipment	
Item	**Cost (inc VAT)**
Laptop	£1,000
Doppler (inc software)	£1,500
ECG (inc software)	£1,200
iPads x 3 (Wifi+data)	£1,500
Spirometer (inc software)	£1,800
Diabetic Foot Kit	£1,100
EMIS Mobile Licences x3 for two years	£3,000
	£11,100

Nursing staff and HCA costed @ equivalent community provider grading - full-cost including salary plus 25% on-costs. Actual employment costs at practice level may prove lower and thus enable marginally higher staffing levels.

Action Plan

(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*

(2) Care home intervention A team comprised of practice nurses and a HCA will target patients in care homes to deliver LTC checks and flu vaccines, commencing immediately and following contact with the care homes

*(3) Detailed operational planning Definition of individual s*taff member roles and responsibilities

(4) Equipment purchase and mobilization Equipment to be sourced and purchased. Procedures for use, maintenance etc to be established

(5) System development and mobile working – establishment of EMIS Mobile for community team and for practice nurses to use when conducting home visits and therefore have patient records to hand

(6) Training and up-skilling to make use of advanced skills and knowledge of respective practice and community staff to raise overall skill and confidence in nursing team

- Regular nurse training to take place according to a structured programme aimed at developing the required skills. This will cover a range of topics including advanced care planning and medicines issues.
- A specific module on motivational interviewing will also be sourced;
- Training will be structured within individual professional development plans required for revalidation etc.
- The aligned clinical pharmacists will be able to provide training and mentorship on medicines and prescribing issues

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

(8) Identification of patient groups from each practice Using risk stratification and other tools, the groups and sub-groups of patients that will benefit from this service will be identified

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

(10) Development of a register of local allied health, social and voluntary sector services which could benefit the populations of both practices. This will be held either within the clinical system or other accessible location and become a resource to all staff when developing care plans for patients who may be isolated, and/or have social and functional needs alongside their health care requirements.

*We will share these plans with our respective PPGs as soon as practically possible to gain their input and ensure that there is alignment of expectations.

Project Governance and Outcomes

Governance

- A small project team will be established comprising representative disciplines drawn from each practice and including a patient representative drawn from the practices' Patient Participation Groups. We anticipate the membership of this group to be:
  - 1 x GP
  - 1 x Practice Nurse
  - 1 x Community Matron or Case Manager
  - 1 x Patient Representative
  - 1 x District Nurse
  - 1 x Practice Manager
- The group will meet fortnightly in the initial 3 months of operational delivery and it is anticipated that this will be extended out to monthly

Outcomes

- Outcome measurement and evaluation is critical
- We intend to focus on 4 sets of outcome measures:
  - Patient experience / satisfaction
    - Gathered through questionnaires that we will develop
    - Preferred place of care and place to die
  - Activity / time utilisation of staff
    - Number of home visits
    - Number of LTC checks delivered
  - Resource utilisation / demand on system (primary and secondary care)
    - Unscheduled admissions to hospital
    - A&E attendances
    - GP and PN appointment utilisation
  - Patient health outcomes (inc surrogate markers)
    - Medicines concordance / medicines related interventions
    - QOF exceptions

Leadership and oversight of the project with all disciplines represented will be key to its success. Evaluation of appropriate metrics will equally be crucially important in demonstrating the long-term viability of this new way of working. We aim to be able to demonstrate that coordination and integration between community and practice staff, supported by appropriate training, development and infrastructure will improve patient care and lead to less pressure on both services.

Project Development Team Membership

- The following practice and community staff have contributed to the development of this plan:
  - Thirsk Doctors Surgery
    - Dr Andrew Trzeciak
    - Dr Eric Robertson
    - Esme Hadley
    - Anne Reed
    - Linda Makin
    - Nicky DiStasi
  - The Lambert Medical Practice
    - Dr Kay Smith
    - Dr Sally Tyrer
    - Vicky Morton
    - Susan Cann
  - Topcliffe Surgery
    - Dr Charles Parker
  - Community Team
    - Donna Bowen
    - Darrel Mulholland
    - Lorraine Bone
    - Sally Hardcastle
    - Christine Smith
- The development of the models, facilitation of group meetings and support for the writing of the plan has been provided by the following:
  - Conrane-IHS
    - David Cochrane
    - Jayne Molyneux
  - Heartbeat Alliance
    - Iain Murray