Whitby Group Practice (B82017)

Primary Care Nursing Workforce Plan

The Local Project

- We have had discussions with GPs and Nurses within our own practice
- We have had discussions with the other four local GP Practices – Sleights & Sandsend Medical Practice, Staithes Surgery, Egton Surgery and Danby Surgery and jointly produced a nursing workforce skills analysis to aid us in identifying gaps – attached – and we have all agreed to work together on our plans
- We had a further meeting at the Chapter 3 Event in June 15 to further discuss our ideas, agree to continue to work together where we can combine resources and outline our plan
- We had a meeting with our Community Locality Manager, Sue Milner and she has agreed to be involved with our Project Team for implementation and monitoring the outcomes from our plan

The Practice Plan

Objectives

- Quality of care for housebound patients – *outreach*
- Integrated working – *joint care plans*
- Management of long term conditions – *develop specialist skills*
- Reduce professional isolation – *peer support*

We want to improve patient care by enabling housebound patients to have as good care as those that can attend the surgery. This will result in improved patient satisfaction and also deceased admissions.

Project Team

- Dr Lynda Carter – nurse liaison
- Dr Martin Linton – teaching role for wider community nursing team
- Dr Tara Hazledine – PPG Lead
- Melanie Dunwell – nurse manager
- Linda Bennison – nurse visiting the care homes
- Elaine Campbell-Smith and Sue Reading Diabetic Nurses and Laura Purves the new Diabetic Nurse / Kate Brown and Donna Clarkson Respiratory Nurses
- Trish Rutland – practice management
- Sue Milner – Whitby Hospital Community Locality Manager, York Hospitals NHS Trust
- Pat Cusson - PPG representative

Use of Funding

- Diabetes nurse training
- Mentoring training
- Nurse Prescribing training – for one of the new post holders plus for an existing Practice Respiratory Nurse
- We will be employing two additional nursing posts

- Post one - to employ an additional nurse to free up time for our senior nurses to visit patients at home. We plan to upskill, train and employ our Treatment Suite nurse as a Practice Nurse – in particular training to specialise in Diabetes initially followed by Respiratory and then Nurse Prescribing. This post will also replace time within the practice to allow our experienced Respiratory Nurses to go out in to the community to see our housebound patients, or those who have not attended practice clinics and found it difficult to attend the surgery, to improve their long term care. The eventual aim at the end of the training programme would be for the additional nurse to be based in both the practice and the community. We will be replacing our Treatment Suite nurse and have done the preparatory work for the recruitment process once funding is agreed. The nurses doing the outreach will be our nurses who have the appropriate specialist skills i.e. our current experienced Diabetic or Respiratory Practice Nurses. The patients will be able to have their diabetes and respiratory conditions management optimised at home reviewing their BP, oxygen saturations, bloods etc. The nurses will then liaise with the patient's own GP to ensure the patient's medications and care plans are up to date.
- One of our existing Practice Respiratory Nurses is actively looking at registering on a course for Nurse Prescribing Training.
- Post two - Linda Bennison Outreach Nurse Pilot to care homes – the funding would not be used to fund existing practice staff. In this case Linda has been working on a pilot programme which we would like to continue and develop further. Linda is a Practice Nurse Prescriber post and has been working with our nursing homes and care homes, visiting regularly (weekly) to opportunistically help with problems as they arrive. This post is wholly based in the community to manage patients in Care and Nursing Homes by providing treatment, preventative care, screening and patient education and to act as practice liaison and support for staff in Care and Nursing homes. We would like to develop her role further in terms of educating our care homes about common problems and how to prevent them escalating such as UTIs and pneumonia. She also visits some patients at home and reviews care plans when they are on our Care Register. Linda has developed working relationships with the St Catherine's Hospice clinical nurse specialists supporting care homes and we feel this will improve management of palliative care patients, in particular Linda has had training in syringe driver management to enable her to support nurses in nursing homes. Linda will discuss advanced care planning with relatives with the appropriate consent. See attached Job Description for the post.
- One of our current Respiratory Practice Nurses is keen to do her nurse prescribing training and we in the process of planning this as we feel this would greatly enhance the service and would meet our aim for all our practice nurses outreaching in to the community to be nurse prescribers with the ability to optimize patient management.

Background

- Our patient list size is 14,371. We have 239 patients in Care or Nursing Homes or Sheltered Accommodation or private convent homes. We have 240 patients on our Care Register. We have 700 patients on our diabetes register, 23 of whom live in care and nursing homes. We have 367 patients on our COPD register.
- We undertook a nursing skills analysis of each of the five locality GP practices' nursing teams and also with the Community Nursing Team.
- Our proposal has taken in to account better integration and expansion of our own practice nursing team and how this integrates with the current District Nursing Community Team and

the nurses working in our Care Homes. As we are a large practice there is enough workload within our practice for an extra nurse's time to be spent on seeing housebound patients in the community rather than sharing a nurse between ourselves and another practice, which would then mean we didn't have enough time to see all our patients.

- See attached skills audit. We particularly identified a gap of chronic disease management in the community for patients who are unable to attend the surgery based clinics. We have experienced practice nurses who could be freed up by an additional nursing post to enable them to deliver care to patients in their homes or nursing and care homes.
- We have identified with our Community Locality Manager Sue Milner that these posts will fill a true gap in service rather than free up District Nursing time. We feel this will allow us and the District Nursing team to become more patient focussed.
- We have identified and agreed our skills gaps we would like to concentrate on:-
    - Diabetes and the need for succession planning
    - Need for further Practice Nurse Prescribers
    - Need for further mentoring
- We have completed the Primary Care Toolkit for all nursing and healthcare assistant staff and submitted our workforce profile to the Federation
- We have held an evening educational event with Care and Nursing Home staff and discussed our plans.
- We have given an initial overview of our plan to a member of our PPG and our bid will be discussed at our full PPG meeting in October.
- Use of new technologies:-
    - we currently run RAIDr software monthly to identify patients at risk. We are using this software to identify patients with diabetes or COPD who have emergency hospital admissions. While we have one of the lower rates in North Yorkshire practices of emergency admissions, we do recognise that our emergency admissions are rising. See attached the latest summary of COPD admissions, which have risen by 11 admissions compared to the previous year.
    - we have registered and are in the process of recruiting diabetic patients to Vitrucare patient self-management system. We have particularly concentrated on Diabetic patients as we are aware of the rising numbers of diabetic patients and the need to increase management of this group of patients (QOF).
- We had a meeting 27th July with the Nurse/Manager at Ashbourne concerning diabetes nurse training which we feel could be of benefit to some staff already in post – initial half or full day with Ashbourne providing specialist diabetic nurse mentoring support for our new Practice Nurse / existing staff by sitting in x number of clinics over a period of time – details to be confirmed. We have three Diabetes Training Modules booked during September and with the additional funding for nurse time we could hold additional clinics for the new nurse in training with a Nurse Mentor from Ashbourne. This would free up our current diabetic nurses to be able to continue to see patients normally as the new nurse would be mentored and aid with a quicker / smoother induction meaning that we do not have to reduce the number of patients throughput in the surgery setting.
- We have enrolled our current Treatment Suite nurse on the course Diabetes Management in Primary Care (CPD Certified) which started on 2.9.15 and which will take 6 months to complete (250 hours notional study time) with 4,000 word case study. This will be completed through additional time to her current role while recruitment takes place.
- We will be recruiting to replace our Treatment Suite nurse – for information only / not part of any funding in this plan

- The plan will be further developed with local practices and members of our Patient Participation Group (PPG). We have discussed our plans at a meeting with a representative of our PPG who was very supportive of the aims of the bid.

Financial Implications

- Ashbourne diabetes training – the training is free - we are not fully aware of the training time / back fill time required – we met on 27.7.15 and are aware of three half day modular training sessions. Two of our nurses have attended the first training session on diabetes – done within practice time. For the future two sessions we will require backfill and the cost to the practice will be 12 hours of nursing time - £222.56.
- Diabetes Management in Primary Care – Training is funded so free to the practice. This will involve nurse backfill for 4 workshop full days plus home study - estimated cost of workshop days to be £ 13.89 x 9 hrs in day x 4 days plus employer's on costs = £ 625-05.
- Mentoring training – not yet clarified. We have confirmed that we will get free mentoring from Ashbourne specialist Diabetic Nurses for the new Practice Nurse post holder in training and this will be inclusive of her normal working hours and pay. We will also seek respiratory nurse mentoring for our new nurse – we have no costing for this currently.
- Nurse Prescribing training – to clarify.
- Appointment of a new Practice Nurse for the project – at 29 hours per week – currently based on our practice nursing grade F / Year 1 £21,003-72 pa plus an estimated employer's additional costs for superannuation and NI gives a total cost of = £26,254 pa.
- Our existing Practice Nurse undertaking the Nurse Prescriber Training works 18 ¾ hours per week. A difference of approx. £430 per year plus employer's costs making a total of £538 per year additional costs.
- Fund the Outreach Nurse Pilot Post – 17 ½ hours per = £ 20,143 pa
- Total costs for the practice in one year = £ 47,782 plus training backfill:-
    - Post 1 = £ 26,254
    - Post 2 = £ 20,143
    - Change to existing staff salary for nurse prescribing - £ 538
    - Diabetes modules training backfill / Diabetes Diploma training backfill = £ 847
- We realise that funding will not stretch to this, but feel there would be great value in employing a Pharmacist to do medication reviews for housebound patients – a Pharmacist could be employed by a group of practices.

Teaching and Training

- Our Pilot Nurse and one of our Lead GPs – Dr Martin Linton - are also doing teaching and training for care homes and have already done an evening session on UTIs, Certifying Death and the Pilot Nurse role plus we had an invited speaker - Consultant in Care of the Elderly, Dr J Snape - who did a presentation on "Treating the Elderly". We have further sessions planned throughout the year and following discussion with local practices will also include nursing staff from other local GP Practices and the Community. Care and nursing home staff have also requested future sessions to look at diabetes and circulatory conditions, heart/stroke. We have discussed that eventually each practice will share in the responsibility for facilitating these meetings. We plan to have the next session on reducing falls as 50% of admissions are related to falls and plan to have another session on chest infections and pneumonia. In anticipation of this meeting we will be contacting Andrea Cowlin who is the link for the frailty model being implemented in the community.

- The teaching session we have already had and ones we will offer on falls prevention and pneumonia collaborate with the local care home staff and the District Nursing Community Team. This benefits the other practices too who will share the District Nursing Community team and who also have patients in the same care homes.

- We have regular meetings once a month with our current practice nursing team. On discussion with Sue Milner, our local Community Manager we have agreed that every 3 months this will be a purely educational meeting which the Community District Nurses from across the region will be invited too. It will be an integrated nurse meeting and the Heart Failure, Respiratory and Palliative Community nurses will also be invited. This will encourage greater peer support and peer review. It will also be an opportunity to discuss patient's being seen to improve integration of care.

Evaluation of the Project

- We will look at patient outcomes through QOF scores (such as HBA1c levels), reviewing diabetic and COPD patients who have not responded to practice invitations for monitoring and by analysis of our diabetes and respiratory related emergency admissions, including ambulatory admissions for conditions with a primary secondary care coding of pneumonia. We will also look at rates of GP visits to these patients and the use of the Out of Hours Service. We will look at this data every 3 months and report back to the project team.
- The Vitrucare Project will have an inbuilt patient evaluation as part of the project
- For the Outreach Nurse Pilot we plan to evaluate using key performance indicators. These are QOF scores, number of GP visits and the number of admissions from care homes during the pilot period to see whether they have decreased or not. If the pilot is successful then we will continue this and share our learning with other practices.
- Additionally for our Outreach Nurse Pilot Dr Linda Carter will do a qualitative evaluation of the Nurse Pilot with nursing and care homes towards the end of our 12 month pilot. A questionnaire is in the process of being designed between Dr Carter and Linda Bennison to look qualitatively at whether the nursing homes and care homes feel that the care of patients has improved and whether they feel better supported and educated.

Timeline

- Recruit a new nurse to free up senior nurse time to visit housebound patients – recruitment required – start October and in post by November / December 15
- Existing nurse increase in hours to do diabetic training and mentoring – immediate
- Training a current nurse in diabetes – start September 15 and complete by end February 2016
- Arrange nurse prescribing training for an existing nurse - ? start January 16 for 26 weeks
- Ongoing evaluation of Nurse Pilot – review after February 2016 (after 12 months)
- Teaching sessions to the locality primary care nursing teams, district nursing team and care and nursing home staff – Dr Martin Linton and Linda Bennison (nurse) – the next session in November 2015 and quarterly thereafter.
- The proposals will be discussed at our next PPG meeting – October 2015
- The project team will meet again in November 2015 and again in January 2016 to evaluate progress so far. After this time we envisage that we will evaluate our progress every 3 month