NHS England

Prime Minister's Challenge Fund (PMCF): Improving Access to General Practice

Innovation Showcase Series

Enhanced use of specialist nursing staff to reduce pressure on GPs

December 2015: Showcase Eight

About PMCF

In October 2013, the Prime Minister announced a **£50 million Challenge Fund** to help improve access to general practice and stimulate innovative ways of providing primary care services. The first wave of 20 pilots was announced in April 2014; covering 1,100 general practices and 7.5 million patients.

In September 2014, a further £100m of funding was announced by the Prime Minister for a second wave. Following a selection process, 37 pilot schemes covering 1,417 practices and 10.6million patients were chosen to participate. The fund will also support GPs to play an even stronger role at the heart of more integrated out-of-hospital services that deliver better health outcomes, more personalised care and excellent patient experience.

In total, the two cohorts cover over **18 million patients** in over **2,500 practices**.

There are core objectives of the programme. These are:

- To provide additional hours of GP appointment time
- To improve patient and staff satisfaction with access to general practice
- To increase the range of contact modes

Innovation showcases

This paper is the eighth in a series of 'innovation showcases' designed to highlight the successes of the **wave one pilots**.

This paper focuses on pilots which are making enhanced use of specialist nursing staff. The pilots featured are Herefordshire; Derbyshire and Nottinghamshire and Workington.

Key messages

How have pilots managed to successfully deliver their schemes?

Links with the wider health network: nurses skillsets can be used to relieve pressure elsewhere in the wider health network.

Practice-based care: nurses can also be used to provide additional access to primary care to registered patients in their local practice, ultimately relieving pressure on GP time.

Specialisms relating to local health needs: recruiting nurses or Advanced Nurse Practitioners (ANPs) with specialist experience relevant to local health needs allows specific patient population to be targeted by the pilot.

Key recommendations to consider

Recruitment: this can be a cause of delay so remaining flexible, considering internal upskilling and commencing with recruitment plans as soon as possible can reduce the negative impact of possible delays.

Sustainability: undertaking an exercise to scope out the local health needs of the pilot area informs the choice of specialism for the recruitment and usage of the specilaist nursing initiative.

Stakeholder engagement: in order to maintain buy-in from key stakeholders, a consistent engagement strategy to accurately explain the nature of the pilot initiative and the rationale behind it can be beneficial.

Evidencing success: in order for specialist nursing initiatives to be commissioned in the future by the CCG, evidence is needed to support the business case for continuation.

Evidence of success

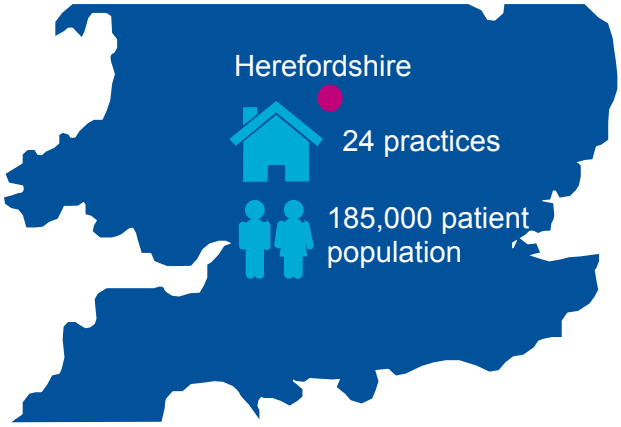
"The CCG has agreed that you should appoint to the link nurse posts on a permanent basis"
Herefordshire CCG

Since it was set up the care homes nurse and the frail elderly multi-disciplinary team has seen over 250 patients and is averaging 40 referrals per month, the pilot is positive that this is preventing some hospital admissions.
Workington pilot

Taurus Healthcare, Herefordshire

Key elements of the initiative

In Herefordshire a link nurse has been recruited to work at the interface between a GP practice, the hospital and social services. The purpose of this work stream is to ensure patients discharged from hospital are quickly and appropriately followed up and supported in primary care. Discharged patients are contacted by the link nurse to ensure care plans are in place, medications are being reviewed to dovetail with pre-admission primary care records and services recommended.



- The pilot recognises that if patients with existing conditions stayed longer than necessary in hospitals, it led to:
  - fragmented communications between the hospital and the patient's practice,
  - a delayed care plan originally agreed by social services, and
  - in many cases exacerbation of patient's conditions.
- An ANP has been recruited and seconded to a practice to track patients from primary to secondary care. This link nurse aims to visit the hospital within 24 hours of the patient arriving there in order to discuss the plan for them to be discharged.
- The link nurse contacts social services to try to ensure that the patient's care package remains active until they are discharged (if they have a care package already in place).
- The initiative is now part of the wider Clinical Commissioning Group (CCG) commissioned Integrated Care Service across Herefordshire, with multiple link nurses planned to be rolled out throughout the CCG area, led by the current ANP link nurse.

Recommendations

- It was originally intended for two link nurses to work collaboratively, however due to recruitment constraints the project progressed with one ANP as a link nurse. Pilots should remain flexible to change in order to overcome challenges.
- It is important to ensure that staff from all three providers, primary, secondary and social care, are engaged and talking to each other as soon as possible to generate buy in and support.
- The success of this pilot is strongly credited to the prior experience and enthusiasm of the link nurse. Recruiting experienced and dedicated staff is key to successful delivery.
- By collecting patient feedback data and the number of patients impacted by this scheme, the pilot was able to provide the necessary evidence to CCG to commission future provision of the service.

Impacts

The Link Nurse input a total of 32 clinic days to this project. This translated to 41 patients being seen, of which 38 patients received a post discharge review once discharged from hospital. 25 of these patient consultations prevented immediate GP review, therefore saving expensive GP resources.

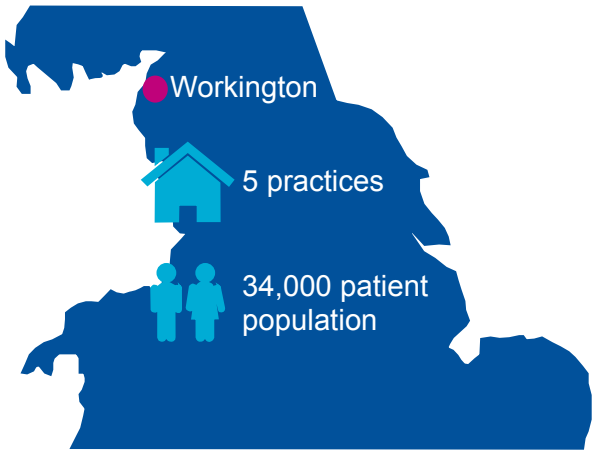
"The link nurse has been acting as a link between my father, our family, the GP surgery in Belmont and Hereford County Hospital. It has been really helpful to have someone who appears to be thinking about the whole picture concerning my father and his cancer as well as my mother and her difficulties."

Patient's son

Working better together, Workington

Key elements of the initiative

In Workington there are three specialist nursing posts for care homes, chronic obstructive pulmonary disease (COPD) and diabetes working on a town-wide basis on behalf of the five practice to offer patients home visits or appointments.



Delivery

- The care homes nurse (an experienced community matron) leads the pilot's frail and elderly multi-disciplinary team (MDT) to improve the care of the elderly and vulnerable in care homes and the community. Each local care home has an assigned nurse contact (from one of the three nursing posts in the MDT).
- The COPD nurse is clinic based, where patients regularly attend appointments to continue and proactively manage their condition. The nurse focuses on patients requiring a COPD review, ensuring that the review they receive meets the gold standard framework.
- The diabetes nurse has targeted those patients moving from oral to injectable insulin, hosting two clinics per week at the Workington Primary Care Centre.

Governance

- The care homes nurse plays a role in the governance of the federation, for example by assisting the administrative staff in refreshing the 'lone working' and 'working in the community' policies. She also represents the federation at various clinical forums when required.
- The COPD and diabetes nurses are generally operationally focused, but link in with other services such as the Community Respiratory team, and the Cumbria Diabetes team.

Recommendations

- The pilot took time to review the local health needs to identify the interventions the specialist nurses should focus on; the care homes nurse was employed because the number of residents over 85 in Workington is predicted to grow by 130% over the next 20 years, high levels of deprivation in Workington justified the need for a specialist COPD nurse; whilst the diabetes nurse was hired as the local areas has a higher incidence of recorded diabetes and the existing local Cumbria Diabetes team was under strain.
- A core challenge encountered was in ensuring other organisations understood the roles of the nursing posts. Diabetes Cumbria and Cumbria Specialist Respiratory Team needed reassurance that the Workington pilot nurses were not overlapping with their service offering; therefore a consistent stakeholder engagement strategy was necessary to prevent negativity around the pilot.
- The pilot struggled with recruiting to the diabetes post; the role was not filled until February 2015, five months after it was first advertised. The pilot recommended commencing recruitment process as soon as possible.

Impacts

The care homes nurse and the frail elderly MDT are seen to have had a positive impact with a reduction noted in practices of GP visits to care homes. Since it was set up the team has seen over 250 patients and is averaging 40 referrals per month, the pilot is positive that this is preventing some hospital admissions

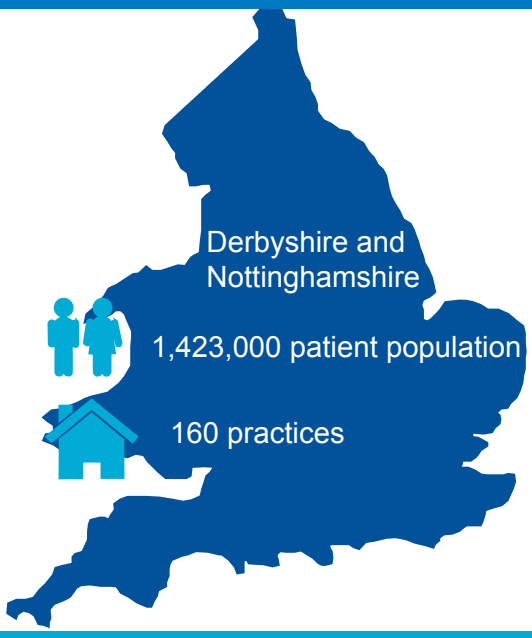
Workington pilot

Transforming Primary Care in Derbyshire and Nottinghamshire

Key elements of collaboration

Derbyshire and Nottinghamshire have implemented a number of different specialist nursing interventions across some of the eight CCGs involved in this pilot, including:

- Appointments with an ANP one to four times a week.
- GP-led telephone triage supported by ANPs.
- ANP visits to care homes.
- Involvement from ANPs in the delivery of weekend urgent primary care services from a hub.
- The pilot was designed as a portfolio of interventions to allow CCGs to trial interventions they considered to be appropriate to their own locality. This gave the pilot the opportunity to learn which interventions were most successful under which conditions and then roll these out more broadly across Derbyshire and Nottinghamshire.
- In Nottingham North East (NNE) the intervention began with a practice offering appointments with an ANP one day per week from April 2014. This was later increased to three days per week. Another practice began offering appointments with an ANP across four days of the week from June 2014. Alongside the ANP appointments this CCG tested a new triage model where ANPs and GPs administered telephone assessments of urgent same day care patients to assess whether visits to the practice were necessary. The practice extended this service as it demonstrated that urgent same day calls were being dealt with appropriately without involving visits to the practice.
- Erewash provided ANP care to patients in care homes: ANPs visited care homes in the locality to deal with primary care complaints for residents.
- In Rushcliffe ANPs were involved in the delivery of a weekend urgent care primary care service from a hub. ANPs helped to staff the hub alongside GPs and non-medical staff from the local practices.



Recommendations

- Recruiting additional ANPs has been a challenge for the pilot. This needs to be considered as a possible delay to delivering ANP- related interventions. Internal staff development may be one approach to getting appropriate staff but the time to train them up needs to be factored into a delivery plan.
- The extended use of ANPs represents a change in the way primary care is delivered in some areas. Telephone triage may be completely new to some practices and not all GPs and ANPs are comfortable with delivering triage without a face to face consultation. Proper engagement, involvement in design and training is important to successful delivery of these models.
- In the NNE CCG, an audit of calls to two practices showed that around 50% of patients did not need to be seen by a GP. This evidence provided justification for the intervention and contributed to the accurate mapping of demand in the local health economy.

Impacts

Erewash's care home workstream has generated a high degree of positive feedback from all involved. The service has yielded savings through using appropriate staff to care for patients in their usual place of residence, thus effectively paying for itself. This has enabled the pilot service to be mainstreamed.

How have they done it? Common success factors

Links with the wider health network

Each of the pilots covered in this showcase utilised nursing skillsets to relieve pressure elsewhere in the wider health network so as to reduce pressure on primary care and ultimately GPs' time. Both Derbyshire and Nottinghamshire and the Workington pilot incorporated nurses into care homes, a common cause of primary care appointments in the area, whilst Herefordshire placed ANPs at the interface of primary care and urgent and social health care.

Specialisms relating to the local health needs

Each pilot scoped the local health needs in their area and, based on this, recruited nurses with relevant specialist experience.

Derbyshire and Nottingham, Workington and Herefordshire each undertook a scoping exercise to inform the choice of specialism for the recruitment and usage of their nursing initiative. By involving local health stakeholders in this process early on it allows shared ownership and clinicians to be more enthusiastic about the project as it develops. An additional benefit is the increased likelihood that the initiative the pilot chooses to implement will accurately meet the needs of the local health community, therefore resulting in high utilisation and a successful pilot.

Evidencing success

In order to generate the evidence required for future service delivery pilots collected data. The Herefordshire pilot chose to record the outcomes and patient feedback associated with the link nurse intervention from the beginning of the project, in order to present the impacts of the scheme to the CCG. The initiative is now part of the wider CCG commissioned Integrated Care Service across Herefordshire.

Recruitment

Each of the three pilots identified recruitment as a key challenge to their original plans, reflecting a national shortage of nurses, and specifically ANPs. Herefordshire and Derbyshire and Nottinghamshire both recommended remaining flexible and considering internal upskilling in order to adapt plans when faced with recruitment barriers; whilst Workington recommended commencing with recruitment plans as soon as possible so as to reduce the negative impact of possible delays.

The National Evaluation

In summer 2014, NHS England commissioned Mott MacDonald, an independent organisation, to undertake an evaluation of the wave one programme. The evaluation team is working alongside the pilots as they deliver their projects, working with them to learn and share delivery lessons. The evaluation involves a multi-methods approach including:

- Interviews with pilot leaders and those involved in implementation during the programme.
- Interviews with pilot partners and stakeholders involved in delivery.
- Engagement with a selection of practices and patients.
- Assessment of the impacts and outcomes measured against nine national metrics.
- Identifying, examining and sharing good practice.

Mott MacDonald