NCL LONG TERM CONDITION LOCALLY COMMISSIONED SERVICE

CASE STUDY - PCN COLLABORATIVE WORKING

Following the NHS Long Term Plan in 2019, Primary Care Networks (PCNs) were formed to collaborate healthcare services. The aim of PCNs was to alleviate the strain on healthcare staff, allowing them to work together to deliver primary care services. A PCN which consisted of five practices in NCL came together to consider how a PCN collaborative approach could improve the quality and consistency of their LTC recall and management pathways.

The previous year, one practice within the PCN had adopted and been successful in rolling out a new Multimorbidity month of birth recall pathway. The aims were to:

- Promote multimorbidity reviewing of patients for all long-term conditions.
- Reduce the total number of appointments patients attend throughout the year.
- Reduce replication of work, for example blood tests, saving both time and money.
- Longer appointment times to promote self-management of LTC's and improve health outcomes.
- Reduce GP demand through risk stratification.
- Holistic approach, patient centred care looking at the whole patient and not an individual condition.
- Increase uptake of LTC annual reviews.
- Structured approach to recalling patients with LTC's.

Two ways of working were rolled out across the PCN to support this model of care and are detailed below.

Design a Common Process to Streamline LTC Recalls Supported by a PCN-Employed Care Co-Ordinator

The ARRS Care Coordinator role has been given to PCNs to improve the health outcomes of patients. The PCN decided one project which the care coordinator would lead was to reach out to patients and engage them holistically. The aim was to improve patient care for those with long term conditions and the care coordinator would be involved in the whole patient journey in an administrative way. This includes contacting patients to book them into appointments via telephone call, identifying needs and signposting them to relevant services such as social prescribing and weight management.

Process

- Employed PCN Care Co-ordinator through ARRS funding.
- Monthly PCN meeting attended by representatives from each practice appointed a Project Lead who would be responsible managing and training of care coordinator.
- Encouraged all 5 practices to follow common LTC recall pathway followed by Care Coordinator
- 5 Practices in PCN, 1 day per week allocated to each practice with timetable drafted by PM's.
- Encouraged each practice to promote month of birth recall for all patients with any LTC using Ardens month of birth searches.
- Patients with single condition of COPD or asthma are sent ACT/CAT questionnaire and all other patients are called by care coordinator.
- Care coordinator discussed with patients the new process of LTC recall and pathway and offers patient a 30minute check and test appointment with HCA/NA.
- Care coordinator booked appointment or feeds back to practice any declines.
- Care coordinator coded invitation for LTC and documents outcome.

- Care coordinator also used this contact to record some QOF required data and identify needs for further referral.
- Work alongside clinicians and the MDT, act as a point of contact between the patients, clinicians, and other members of the community team.

How PCN Collaboration Occurred

- One practice manager in the PCN was appointed care co-ordinator project lead. This involved training, facilitating meetings and connections with MDT.
- Weekly meetings were in place so that PCN Lead Nurse, Lead Practice Manager, Care Coordinator, Lead pharmacist and Clinical Director could discuss and emerging issues, projects, progress and how the PCN role can evolve and be adapted.
- There are ad-hoc meetings with the social prescribing team as well as the SMI nurse. The CC is also invited to some practice clinical meetings.
- The care coordinator was invited to relevant PCN MDT meetings to feedback progress.

Benefits for Patients

- Appointment booking is easier
- No waiting on telephone queues to book appointments
- Improved continuity and point of contact
- Addresses inequality with patients who are unable to use online technology to book appointments.
- Patients are less likely to 'slip through the net'
- More personalised approach with informed choice

Benefits for Practices

- Less telephone traffic to book LTC appointments
- Common recall system
- Improved communication and coordination
- More efficient and appropriate use of appointments
- More admin staff capacity

Feedback from Care Co-ordinator

The care coordinator felt that she had more direction with recalls from some practices more than others based on their individual recall pathway.

> *'I find working from a month of birth spreadsheet is very helpful as is a shared document and is very straight forward i.e., has clear instruction on what needs to be booked for the patient. I also find the month of birth spreadsheet works well as I am able to view what activity has taken place by other team members, we are able to leave notes for each other making it a smooth process'.*

Learning and Challenges

- The PCN have learnt a lot from this and feel they have a lot more insight into how other roles that involve working across multiple practices can be approached with success.

- The PCN recognised the importance of role clarity, training, and boundaries. The exact role of the care coordinator will differ with the individual needs of the PCN and practices within it.
- Since the Care Coordinator is a relatively new role and workforce, recruitment was difficult. This was a new role for practices to embed and was a pilot for 1 year. The PCN were able to offer the role to one person who then had to quickly adapt to working with five different practices in multiple sites who all work in different ways and have different skill mix.
- The new Care Coordinator had no background in general practice and the PCN was still figuring out this new role.
- Another similar challenge has been establishing clear lines of hierarchy and responsibility when someone is not employed directly by the practices or the PCN.
- Onboarding all 5 practices to new LTC recall pathway, this was more successful in some practices than others.
- Some practices used the Care coordinator role for other types of recall other than LTC, one of example of this was flu season recalls.

Impact

One practice within the PCN audited the impact of a personalised, holistic, multimorbidity approach in calling patients to book for LTC review and found a 44% increase in patients attending their multi condition reviews. In one practice with a total list size of 11799 patients, on average 155 patients are called per month for LTC multimorbidity review.

ARRS-Employed Nurse Associate Trained to Perform Holistic LTC Check and Test Appointments

There was recognition that the PCN would benefit from extra nursing capacity. The Nursing Associate (NA) role bridges the gap between health support workers and registered nurses to help deliver hands on, person centred as part of the nursing team.

Process

- Advertised and recruited a qualified Nurse Associate. PCN Nurse Lead and one practice manager conducted interviews.
- Identified members of the nursing team within the PCN who have capacity to train, support, and mentor the new NA.
- NA employed full time using ARRS funding.
- Decision made at PCN monthly meeting with representatives from each practice that the NA should start working between 2 practices initially.
- PCN Nurse Lead identified a nurse in each practice who had capacity and was keen to support and mentor this new member of the team.
- PCN Nurse Lead created induction pack and competency framework.
- Fortnightly meetings were arranged for both mentors to meet to discuss progress and plan educational session.
- The NA was trained on LTC pathway.
- Practices agreed that a priority should be to train the NA in check and testing for LTC.

- Inhouse, online and F2F training was attended by the NA.
- The NA had check and test clinics set up in each practice every day.

How PCN Collaboration Occurred

- The PCN Nurse Lead was the clinical lead that was responsible for the NA.
- Both practice managers in the practices the NA worked in were responsible for managing the NA.
- NA was part of the PCN nursing team education and support session which happened once per month for 4 hours.
- Monthly PCN meetings allowed the PCN Nurse Lead and PM's to report progress and next steps to keep all practices informed.

Benefits

- The role has built capacity of the nursing workforce within the PCN.
- Supports the delivery of high-quality care.
- The NA can perform more complex tasks than some healthcare support workers.
- This has enabled GPNs and pharmacists within practices to focus on more complex clinical work.
- Practices who do not have nursing capacity to train new nursing team members benefited from training done in neighbouring practices.

Learning and Challenges

- Started working within two practices was more manageable and allowed a settling-in period and continuity for the new member of the team.
- It was apparent how important communication was between the teams hosting the NA. Regular meetings to discuss progress and address any concerns meant that problems could be dealt with as a team.
- Fully qualified Nursing Associates who have no experience in primary care and have trained in secondary care only may need more training and support than those with previous primary care experience. This signified to us the lack of specific primary care training within the current NA training and qualification.
- Not every practice had the nursing capacity to provide clinical supervision, education, and support for the NA.
- The NA was new to primary care and therefore this was a huge change and meant a greater need and time for training and support. The nurses supporting the NA found the teaching rewarding however this did reduce their clinical capacity for the period of training.
- The NA had to adapt to the different ways of working in each practice although both practices did work in very similar ways. The NA found initially working between 2 practices a challenge however this got easier with time and experience. The NA would now be happy to work between more practices.

Impact

- Created an extra 132 nursing appointments to offer patients per week.
- Currently performing 34 30-minute check and test appointments per week for 2 practices.
- Releasing nurses to perform more complex LTC Discussion reviews.
- Increased GP capacity to perform high risk LTC discussion appointments.

Next Steps

- It took one year to fully embed the NA and to gain confidence in own ability. Plan for the NA to increase the number of practices within the PCN that works in with the aim for all 5 practices to have allocated time for check and test appointments.
- There is the possibility for this model to be replicated if the PCN decides to employ another NA through the ARRS funding.