NAPC | National Association of Primary Care

NPCN National Primary Care Network

The development of nursing within new models of care

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Introduction

The National Primary Care Network (NPCN) was created in 2009 for the Department of Health to facilitate better clinical engagement in commissioning. The network is now hosted by the National Association of Primary Care (NAPC) and provides a forum to ensure clinical thinking, presence and leadership are central to the NHS reform agenda. It is representative of the wider clinical community working in the NHS and highlights key information from the large networks from which the NPCN is drawn. The network has a particular interest in service development.

Foreword by Dr James Kingsland OBE, President, NAPC

I am delighted to introduce the latest report in the series of meetings of the NPCN.

This report aims to provide a summary of our meeting in September 2017, capturing the energy and enthusiasm of the participants and speakers, as well as the important debates stimulated by the meeting.

The focus was on nursing development within new models of care, such as primary care homes, and the issues surrounding it.

In attendance:

- Dr James Kingsland OBE, *President, NAPC*
- Elaine Biscoe, *Executive Member, NAPC*
- Dr Crystal Oldman CBE, *Chief Executive, Queen's Nursing Institute (QNI)*
- Sam Sherrington, *Executive Member, NAPC*
- Julie Bolus, *Executive Member, NAPC*
- Moira Auchterlonie, *Chief Executive Officer, Family Doctor Association*
- Rhian Last, *Education Lead, Education for Health*
- Kate Howie, *Chief Nurse, Optum*
- Jeremy Stokes, *Strategic Marketing and Compliance Director, Fittleworth Medical Limited*
- Natalie Beswetherick, *Director of Practice and Development, Chartered Society of Physiotherapy*
- Dr Liz Butterfield, *Board Member, Royal Pharmaceutical Society*
- Rachel Newton, *Head of Policy, Chartered Society of Physiotherapy*
- Zoe Richmond, *Commissioning Lead, Local Optical Committee Support Unit (LOCSU)*
- Dr Vijay Rawal, *Medical Director, Havistock Healthcare*
- Wendy Majewska, *Richmond PCH*

Value of multidisciplinary working within a primary care home

Primary care home – current position

There was a discussion outlining the current position of the primary care home (PCH) programme. The key points are summarised below.

- The PCH model, is predicated on working in a multi-professional way that is not focused specifically on a GP practice. It is based on first contact care; care that's not based on a medical model alone, but health and social care. It looks at early detection and prevention, rather than waiting for people to get ill and then treating them.

- One in seven people in England are now being supported by 191 developing PCHs*. However, even with the vanguards, many of the developing models are not easily transferable to other locations, because of differences in funding, location, personnel and other resources.

- One of the other challenges of PCH is how to scale up beyond the GP practice to general population health management without losing the personalised, local, responsive, continual care that people have enjoyed through registration with a practice. At the same time, the workforce of a PCH needs to be large enough to deal with a bigger population, take on a budget and risk manage it, yet still be small enough to feel like one team – one in which the staff feel like they have ownership of the model. Evidence suggests a general population size of between 30,000 – 50,000 achieves this balance. Nevertheless, other issues remain, such as recruitment, training and role delineation.

Primary care workforce – summary of discussion

There was a discussion about primary care workforce and in particular, primary care nurses.

- There is a desire to put together a strategy for the network to look at how to take forward national strategies such as the 10 point action plan for General Practice Nursing for proper funding of the primary care workforce, *General Practice – Developing confidence, capability and capacity*, and the Care Quality Commission's *State of Care in General Practice 2014-2017*. This report in particular found that the best-rated practices had highly-effective nursing teams which were given the freedom to be effective, through time and support.

- There is acknowledgement that too frequently decisions are made about nurses without the input of nurses or those who fully understand the issues. Nurses are often represented by GPs.

- There was a discussion about four regional boards, developed as part of the 10 point action plan which would meet to distribute finance for projects. The network felt it was important there was a voice for general practice nurses, particularly those engaged in new models of care on the boards.

** number of PCH sites as of September 2017, now more than 200 across England*

- Training is seen as another concern after the CQC inspection of general practice highlighted cases of nurses being pressured to provide unsafe care beyond their scope of practice. It should be more consistent and more trained primary care nurses need to be available. In particular, student nurses need a sign-off mentor, which most practices don't have. There is a perceived lack of competency guidelines. It was suggested that this was something the NAPC could consider helping with.

- It was highlighted that if detailed standards were written down and mapped to Nursing and Midwifery Council (NMC) standards, there would a qualification, which would raise standards across the country. This would help mitigate concerns that the regional boards may start to set their own standards unless national standards were developed.

- There could also be scope for improved multidisciplinary training to enable each profession to improve understanding of what others do and to ensure good practice across a base set of skills. However, it should also be acknowledged that some professionals already find the curricula is "jam packed". If nurses were to decide to do more, such as learn pharmacology skills, they may also have to decide what they should no longer do.

Nursing recruitment

There was a discussion about recruitment of nurses to primary care and many expressed concern.

- While to some extent the issue mirrors challenges around the recruitment of nurses in general, primary care faces additional concerns.

- It was suggested that there should be more focus on promoting the positives of nursing in primary care and encouraging nurses unhappy in the acute sector to consider making a move into primary care. The benefits of being a generalist over specialising in one area also need to be better highlighted. Generalising can be seen by some as a backward step.

- Career progression for nurses in primary care needs to be addressed. It was felt that the usual model, in which GPs employ nurses, makes career progression and moving into a leadership role more difficult for nurses in primary care. This impacts on a nurse's ability to affect organisational culture. It is historically rare to have nurse partners in practices or nurses who want to become partners.

- The primary care home model could offer opportunities as it was suggested that 'charismatic leadership' is vital to success and in many cases it could potentially be nurses taking the lead. It was suggested that fewer GPs are keen to be leaders and instead portfolio careers are becoming more attractive.

- Changing culture is seen as fundamental to reform. This means change at all levels from leadership to first contact care otherwise everything will continue as it always has.

Nursing within a multidisciplinary team (MDT)

Leadership

The session was dedicated to looking at what nurses offered multidisciplinary teams in primary care.

- It was highlighted that there are few senior nursing leaders with backgrounds in primary care. There is also a perceived hierarchy in directors of nursing, at the top of which are those with a background in acute care. This might put off ambitious nurses from coming into primary care.

- It was observed that historically, primary care could be seen as a 'dead end – something you did at the end of your career to fit in with the kids as it had better hours'.

- The limitations in terms of the size of organisation in primary care were also discussed. Even bigger practices are still relatively small organisations, so a framework for career progression is hard to see, whereas acute care has a much clearer pathway, which makes it more appealing for many. For example, nurse leads at GP practices often might only have two staff working for them, while a nurse lead at a foundation trust might have thousands. It is, therefore, harder for a general practice nurse to progress to more senior roles without leaving primary care.

- The recruitment issue in primary care nursing is a particularly important issue as primary care is where the majority of people access care. There was a discussion about how recruitment could be boosted. Suggestions included: finding out what current practice nurses enjoy about their jobs, clarifying myths around poor pensions and setting an ambition to have a primary care nurse as Chief Nurse by 2030.

- It was also highlighted that there were problems with pay parity, with primary care offering something similar to Agenda for Change (AfC) but which is not AfC and this being a significant barrier to secondary care nurses wanting to come into primary care. AfC is seen as safer. It was also noted that in some cases community nurses can have greater responsibility and autonomy but are paid less than their peers in other care sectors.

Training

The discussion about leadership was followed by a discussion about training more widely.

- The challenges of developing talent in primary care were highlighted and difficulties of releasing nurses for five or 10 days for training. It was felt that perhaps the length of courses was too long and that costs could be too high for practices to authorise them.

- However, it was felt that training was important as the demographics of the workforce change and general practice ensures that it has the skills it needs for the future.

- There was a suggestion that there could be a general practice nurse facilitator/educator role in every clinical commissioning group (CCG) to lead.

Who is a practice nurse?

There was considerable debate about the perception of a practice nurse and how that affected recruitment. In particular, it was felt that the perception that practice nurses were older and at the end of their careers was incorrect and needed to change.

- Career progression was again highlighted as a major barrier to attracting ambitious nurses. However, it was acknowledged that, for many, general practice offered the opportunity to deliver care to patients, in some cases over generations and that this was what some nurses wanted, rather than step away from their patients to become leaders.

- In conclusion, space for leaders needs to be created and there should be more noise around the joy of primary care and the opportunities it offers. There also needs to be some focus on dispelling myths.

Examples of best practice within primary care homes

There was a session in which exemplars of best practice shared their work.

- The extent of existing PCH sites around England was shown, highlighting that most were around conurbations and there were gaps in the south west around Bristol.

- In Norfolk, there are PCHs spanning several CCGs, with patients regularly crossing borders. For example, one district nurse who had put herself forward to take the lead on developing a PCH had now gone from the periphery to managing the project, using business and planning skills.

The main presentation was by Wendy Majewska, Richmond PCH, one of the rapid test sites. Located in the wealthy London Borough of Richmond upon Thames and covering a population of 59,000, the PCH provides integrated 'everything-except-hospital' care, particularly since Richmond has no acute hospitals.

The voluntary sector was fully integrated with primary care and very important for both resilience and prevention.

The key points of the presentation were:

- People needed to understand why change was needed – the aim is a 'complete care community'. In particular they needed to feel involved in the decision making. This means sharing information and making people aware of the cost implications of what the service does.

- Understanding that not everyone wants to lead and appreciating the challenges of recruiting GPs to become partners in the PCH as some view the seniority as a 'hassle'.

- There had been issues persuading other healthcare professionals of the merits of PCH and of understanding the benefit of spending money on the costs of establishing something new rather than more staff. This was helped by running workshops and showing they were listening.

- The PCH also explained to stakeholders that what it was doing was ‘locality working’ because people understood this . However, it was also important to get people to understand the PCH model and the inclusive multiprofessional teams.

- Local ownership was seen as vital. Building coalitions of the willing is hard work and requires people to believe in what they are doing if they are going to encourage other people to join them. It is also important to help people to understand that they can influence the agenda.

- The first thing the site did was to hold a multidisciplinary learning workshop to find out what staff thought was working well, what needed strengthening and where there were gaps. There was also an online staff survey. The workshops had pharmacists, voluntary sector colleagues, community matrons, district nurses, practice nurses, GPs and a commissioner in attendance.

- They also talked to patients and potential patients about what they wanted. A good example is one older lady who was seen as ‘very demanding’. The team met with her and discovered she was frustrated, but everything she said was valid.

- Based on that research, different workstreams were developed. Active signposting training has been rolled out to other areas and involves 10 high-end actions that staff need to know, including pharmacists and GPs, so they can proactively signpost people to services. Eight workshops were used to train staff, and identify patients who would benefit.

- Follow-ups four months later with staff sought to understand whether the training had been put into practice, learn the problems with implementation and whether additional resources were needed. Getting senior staff on board was seen as very important.

- Having a local college offering a health and social care course, the PCH was able to target a particular demographic for training with a six-week course, supporting those who were unsure how to find out about the fantastic opportunities for working in care and helping people.

- In conclusion, not all problems faced by PCHs are easily solvable so it is important to focus on the successes. It was also advised that it is important to enlist the help of ‘champions’, even if they’re not directly related to the project, but who understand the importance of what is being done and spread the word. Above all, it is vital for everyone to have a common vision of who they are providing services for, and what they want, so they could move in the same direction together.

Conclusion and next steps

There was a discussion about whether it would be beneficial to publish examples of best practice before Dr James Kingsland, NAPC President, concluded the day.

Final thoughts included:

- There were a few common issues such as career development and training that applied to a number of different professions. Various initiatives could possibly be brought together.
- PCH sites should take the opportunity to share learning with the rest of the system on how financial barriers in funding can be overcome.
- There are some very enthusiastic commissioners already, but it was harder when money was being redirected as there was resistance to that.
- No organisation wants to see its current model destabilised. Although it would be good to see investment in change management, particularly at first point of contact, it was felt that the same barriers would remain a problem. This ultimately leads to ending up with more or less the same model as before, but with revisions. However, the strength of primary care was that it was united so there was the capability to do almost everything that needs to be done, beyond that which required specialist equipment.
- It is important to keep asking what is working well.

Conclusion

Dr Kingsland then summarised the areas he felt had emerged from the day as priorities for advancing the PCH model:

- nurse leadership, as a style of practice and something deserving recognition within the community;
- career progression, parity of esteem, and strengthening of nursing in a multidisciplinary service;
- the framework of standards and competencies mapped to current principles and standards but specific to new ways of working;
- the consideration of assurance and accreditation;
- education and training;
- the consideration of generic versus specialist working in a multidisciplinary environment;
- thinking about what good looks like; and
- how to operate at the top of your licence with all the checks and measures that provide good guidance but with the appetite to remain independent.

He also suggested an additional area that hadn't been covered, but which was also important was the risk appetite to be involved at the organisational level. He highlighted that the PCH as it matures will need to take on a form and will need an organisational model, with potentially 100-200 people working within that model. Whatever the shape, it was necessary to understand the appetite for nursing to take ownership, not only in deciding the agenda but also not asking for permission to develop their roles within the organisation. If nurses helped to design the model, they would also need to take some accountability for it, he argued.

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