BARNSLEY PRIMARY CARE FORUM

OFFER TO SUPPORT PRACTICES

SHOW CASING THE WORK ADDITIONAL ROLES CAN DO TO BE DELIVERED BY THE PCN TEAM AT BEST

- Nurse Associates
- Trainee Nurse Associates
- Physician Associates
- Care Coordinators
- Health and Wellbeing Coaches
- Mobile Health and Wellbeing Coaches
- Social Prescribing Link Workers
- Mental Health Practitioners

TRAINEE NURSING ASSOCIATE

To begin training as a Nursing Associate, you'll need GCSEs grade 9 to 4 (A to C) in maths and English, or Functional Skills Level 2 in maths and English. Some employers will also ask for a level 3 qualification.

You'll also need to show that you can study for a foundation degree level and complete the Nursing Associate Apprenticeship programme.

Trainee Nurse Associates combine learning in action in their base placement with University lectures and additional placement areas, to develop expertise, across all areas of nursing.

NURSE ASSOCIATES

Nurse Associates bridge the gap between unregulated health care assistants and registered nurses.

The Nurse Associate (NA) must work under the direction of the Registered Nurse from the first day in practice onwards. Registered Nurses will support to train and develop the Nurse Associate, identifying any areas for further development.

Nurse Associates are NMC registrants, but unable to assess patients this must be undertaken by Registered Nurses.

PHYSICIAN ASSOCIATES

- Physician Associates are healthcare professionals trained in a medical model to provide permanent mid-level medical care to patients
- A PA works in the assessment, diagnosis, and management of a patient under the supervision of a doctor
- PA can not prescribe medication

As an integral part of the multidisciplinary team, the PA can perform the following:

- Take medical histories from patients
- carry out physical examinations
- see patients with long-term chronic conditions
- formulate differential diagnoses and management plans
- Carry out diagnostic and therapeutic procedures
- develop and deliver appropriate treatment and management plans
- request and interpret diagnostic studies
- provide health promotion and disease prevention advice for patients
- Annual Health Reviews for SMI/LD patients

CARE COORDINATORS

Care Home work

- First point of contact
- Work closely with community nurses to arrange MDT / ward rounds meetings
- Take any onward referrals/tasks from MDT/ward rounds were possible
- Develop PCP with community nurses – Community Nurses provided training to Care Coordinators or

Cancer work

- Monitor C - signs
- Ensure referrals on two wait have all inform included
- Be first point of contact for patient on cancer pathway
- Work with Health and well being coaches on cancer reviews
- Contact non attenders screening

Learning disabilities

- LD bowel screening pilot
- LD Nurses in SWYPT provided training to CC on script used in LD pilot
- If Patients need further support CC referring into LD Nurses
- Contacting people on LD register encourage patient come annual Health review
- Work with other ARRS to run LD clinics

Severe Mental Illness

- SMI champions in practice – SWYPT provided training
- Encourage patients on SMI to come for annual health

Other work

- Encouraging people to attend flu /covid vaccines
- Case find Social prescribers
- Work with clinicians to encourage pts to come Long term conditions review
- Dementia Reviews
- Personalised care plans on house bound patients
- Work with frequent attenders
- Offer support for Carers

HEALTH AND WELLBEING COACHES

Health coaching is a partnership between health and care practitioners and people

It guides and prompts people to change their behaviour so they can make health care choices based on what matters to them

It also supports them to become more active in their behaviour so they can make health care choices based on what matter to them

It also supports them to become more active in their health and care

Healthy diet – work to understand why the patients diet may need to be healthier and help identify and implement changes

Weight Management – work to understand reason for needing to manage weight and help identify small realistic sustainable changes make onward referral to weight management where needed

Increasing physical activity –Identify barriers to physical activity and consider alternatives that fit into a patients lifestyle

Low mood stress anxiety –Help to indentify ways that a patient can improve their mental health and overcome barriers that have prevented this

Help understood and manage health conditions –supporting clinical teams to support patients in implementing health advice they have been given

Monitor blood pressure

Group sessions such as Diabetes , healthy eating, menopause

MOBILE HEALTH AND WELLBEING COACHES

Physical Health assessment on LD& SMI patients using blue boxes in community on none engages

These send a coded consultation to GP clinical system Action plan is emailed to practice Safe Haven email

Deliver LD and SMI annual Health reviews clinics in practice

SOCIAL PRESCRIBING LINK WORKER

The role of the Social Prescribing Link Worker is

- **To take referrals from GP practices and from a wide range of agencies, including pharmacies, wider multi-disciplinary teams, hospital discharge teams, allied health professionals, fire service, police, job centres, social care services, housing associations, and voluntary, community and social enterprise (VCSE) organisations (list not exhaustive)**
- **% of all social prescribing referrals received from SWYPT services**

  April 15%

  May 26%

  June 46%
- **Provide personalised support to individuals, their families and carers to take control of their health and wellbeing, live independently and improve their health access and outcomes, as a key member of the PCN multi-disciplinary team .**
- **After initial assessment, our Link Workers work with a patient for around 12 weeks however each patient is different so the length of support can vary.**
- **Link Workers undertake weekly check ins with patients/family.**
- **Link Workers will chase any onward referrals to ensure our patients are receiving the support they need, when they need it.**
- **Although our Link Workers have direct access to clinical systems, its important that GP's are update on any changes or progress – this is ensured through attending MDT meetings, where possible.**
- **ONS4 assessments are completed before closing a case and at 3, 6 and 12 months to ensure progress.**

MENTAL HEALTH PRACTITIONERS

- The aim of the Brief Interventions Service is to bridge the gap between primary and secondary care services and allow access to intervention in a timely manner and enhance the patient journey
- Referrals are received by assessment services and discussed in the MDT
- Practitioners manage their own caseloads, devise a plan of care in partnership with the patient and work with individuals for a period of up to 10 weeks in length

Interventions include:

- Work around understanding anxiety and anxiety management;
- Understanding and managing depression;
- Emotional regulation and distress tolerance;
- Building self-esteem and confidence;
- Building resilience;
- Goal setting;
- Safety planning; Perform and record clinical observations including blood pressure, temperature, respirations, pulse.
- Undertake clinical tasks including cannulation, venepuncture, ECGs
- Accurately record nutritional and fluid intake.
- Develop understanding of caring for individuals with dementia, mental illness, learning disabilities etc.
- B12 Injections
- Vaccinations
- Hypertension Reviews
- Phlebotomy
- Pulse Checks
- Following completion of the Foundation course, the NA can undertake Chronic Disease Management: COPD, Asthma, Diabetes Care
- On completion of the NEPSEC Cytology Training, the NA can undertake Cervical Screening

LMC TOP TIPS REGARDING HOW BEST TO MANAGE PRACTICE WORKLOAD

The new GMS regulations require practices to make an assessment of need and offer an appointment or **signpost** to an appropriate service.

Care Navigation/non-clinical triage really important.

Need to consider how many contacts is 'safe' widely accepted as around 25 appointments or up to 35 clinical contacts per day.

The regulations do not preclude signposting to other services including A&E, or 111 (important if practices are unable to safely clinically triage).

Fully Utilise CPS, First contact Physio, Home visiting service, self referral to IAPT/TADs.

Remember ACC-08 as a target is worth 25p per patient.

LMC

Move Workload to the most appropriate member of practice team

- Admin filing letters
- Upskill Nurses to file chronic disease bloods using a protocol
- Maximise utilisation of Nurse time to manage Chronic Disease, and simple problems via protocol- consider increasing Nurse prescribing
- Maximise NA and HCA skills, they can do majority of injections, smears and many Reviews

Consider stopping unfunded work- Phlebotomy, Spirometry, Follow-up PSA/haematology, Nursing activities such as wound care or ear syringing.

Please tell the LMC about all contract breeches- the hospital is obliged to give MED3s, Prescribe medications , order and follow up their own tests.

LMC can help with applications to close lists.

TRAINING TO BE PROVIDED FOR ADDITIONAL ROLES

Such as undertaking chronic disease reviews.

MONTHLY SESSIONS TO BE PROVIDED BY LMC AND BEST FOR PRACTICE MANAGERS.

- BEST provides 8 afternoon sessions a year for GP, ANP's and PA's and AHP. The GP session are clinically based education session which are also open to AHP's, PA's and Clinical Pharmacist's working in Barnsley practices.
- There are also 8 sessions provided for PN's, HCA's and AHP's which are added value sessions to provide additional training and information above what the clinical and update training that is already available to them.
- Additionally 6 sessions are provided which are dedicated updates / training for community pharmacy and open to all staff working within the pharmacy including Pharmacists, ACTs, dispensers and counter staff.
- BEST provided a series of practice manager leadership development training sessions which built into a series to provide management and leadership training for upcoming and aspiring practice managers. This training has series has now completed. Specific training to support Practice Managers in their job roles has also been offered, things like having a specialist come and talk / advise on employment policies, estates, fire checks etc.
- The BEST website is part of the training offer and provides resources for all staff working in Barnsley, the website provides local clinical information as well as dedicated areas of information for different groups eg Pharmacists, Nurses, general practice staff etc.
- LMC willing to attend Practice Mangers and BEST to clarify any contractual concerns about new contract and also to take any concerns queries back to other provider(such as hospital), NHSE or the ICB.

TRAINING TO BE IMPLEMENTED FOR RECEPTION AND ADMINISTRATION STAFF TO ASSIST THEM IN COMPLETING BACK-OFFICE FUNCTIONS

- **Care Navigation**
- **Filing routine letter**
- **Coding training**
- **Utilising First Contact Physios**
- **Utilising Home Visitors**
- **Utilising Extended Hours**

CARE NAVIGATION

Benefits for Practice –

Reduced GP Appointments – estimated at 1,046 per year for a 10,000 patient practice.

Make more appropriate time of each team member's skills.

Reduce internal referrals.

Respond to changing patient needs.

Staff satisfaction – Receptionists feel they're doing a better job for patients and making bigger contribution to the practice.

FILING ROUTINE LETTER

The LMC can share example protocols for admin filing letters.

Consider allowing all letters without actions to be coded and filed.

Letters with actions or around safeguarding to go to most appropriate clinical team member.

CODING TRAINING

This will vary from practice to practice

Formal coding training is avaliable from????? to ensure all administrators are able to do this effectively

Consider having a coding protocol to ensure that appropriate codes are always in place.

UTILISING FIRST CONTACT PHYSIOS

Our FCP are highly skilled regulated MSK practitioners from SWYPT's MSK service

Patients can book into this service via their GP Receptionist the FCP

FCP are seeing patients at first appointment

MSK assessment

Triage patients

Treatment plans

Refer for on going investigations

UTILISING HOME VISITORS

The home visiting service is intended for the following patients:

- House bound patients with an **acute** medical need
- Vulnerable patients from the age of 19
- Care Home Based patients

How Home visiting works

- Our admin/clinical staff review the referral form
- Once the referral has been reviewed it will be passed on to a practitioner to complete the visit
- A copy of the consultation will be sent via the safehaven email for your records

Advanced clinical practitioners between the hours of 10:00-20:00

- **Capacity for 26+referrals daily**
- Ease the pressure for GP surgeries and free up their time for other appointments/Tasks
- They can make referrals via Rightcare for hospitalisation or further treatment
- If they feel the patient requires GP intervention, they will contact the GP for further advice and discussion.

Unfortunately, we are unable to accept the following:

- Medication reviews
- Palliative care reviews/decision for end-of-life care
- Falls check/injuries
- Non housebound patients
- Patients declining hospital admissions
- Pain management review
- Internal vaginal examinations
- Verification of death
- Mental Health

How your practice can help us:

- An up-to-date **EGFR**
- Providing Bypass Numbers
- Number for on call GP
- **Key Safe** Numbers
- Patient Alerts
- Attaching on the Day Clinical triage.

UTILISING EXTENDED HOURS

Call: I Heart 01226 242419

- Designed to help patients access same day appointments during the evening and weekends.
- The service has created additional appointments enabling patients to receive medical advice outside of standard GP surgery opening times.
- Consultation Reports will be sent automatically to practices as per OoH reports
- Appointments available with GP'S ANP/ACP and Nurses
- Smear Clinics available for practices to refer patients.

Our phone lines are open

- Monday to Friday 4:00pm – 6:00pm
- Saturday, Sunday and Bank Holidays 8:00am – 9:30am

Our appointments are based at several sites these include

- Woodlands Drive Medical Cetnre
- Chapelfield Medical Centre
- Oaks Park Primary Care Centre