SEaRCH

SOUTH EASTERN SYDNEY RESEARCH COLLABORATION HUB

EVALUATION REPORT

Peer Led Collaborative

NSW GOVERNMENT Health
South Eastern Sydney
Local Health District

UNSW SYDNEY

EVALUATION REPORT:

Peer Led Collaborative

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ABOUT SEaRCH

The South Eastern Sydney Research Collaboration Hub (SEaRCH) is a partnership between the UNSW Sydney Centre for Primary Health Care and Equity (CPHCE) and the South Eastern Sydney Local Health District (SESLHD).

CPHCE is a research centre within the Faculty of Medicine, UNSW Sydney, that has been undertaking primary health care since 1996. SESLHD is a statutory authority responsible for 8 public hospitals and a range of community-based health services covering a culturally and linguistically diverse population of over 850,000 people.

SEaRCH's role is to strengthen the planning and delivery of evidence-based primary health and integrated care. We undertake research, evaluation and capacity building activities to strengthen primary health care and address health inequities, with the aim of contributing to better, fairer health in the community.

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INTRODUCTION

This evaluation report outlines the findings from the Peer Led Collaborative (PLC) small group learning sessions with Practice Nurses (PNs) and Clinical Nurse Consultants (CNCs) over a six-month period in 2019.

Background

The PLC is a partnership between Central and Eastern Sydney PHN (CESPHN), South Eastern Sydney Local Health District (SESLHD) and South Eastern Sydney Research Collaboration Hub (SEaRCH) at University of New South Wales (UNSW) that brought together health care professionals in the St George locality. The model built on the learnings of the St George Division of General Practice and CESPHN's 'Small Group Learning' (SGL) program which is an established model of education primarily for General Practitioners. Similar international models demonstrate benefits not only for participants, but also to practices and patients.

The model aimed to build relationships and strengthen networks between primary care and the hospital sector and by proxy improve health outcomes aligned with the quadruple aims (reduced costs, patient experience, staff experience and population health) in the long term. The project was an initiative of the Integrated Care strategy in SESLHD.

Target group/eligibility

This project aimed to target health care workers who have an interest in sharing ideas and group learning around chronic disease and to build and understand each other's capability and capacity in this area. The pilot targeted CNCs working within St George Hospital Medical subspecialties and PNs from primary care practices located within the District.

Aims

The aims of the PLC were to create a social (learning) network and improve the knowledge exchange between the participants in both the primary care and hospital sectors around the management and referral pathways for those with chronic complex conditions. The longer term the goal was to utilise the learnings from this pilot to create self-sustaining PLC groups across SESLHD.

Strategies

A small group of healthcare workers were brought together to form a PLC group aiming for equal numbers of medical CNCs and local PNs. In the initial meeting group, self-governance and PLC goals were established with specific learning needs identified. Five additional meetings focused on self-determined topics with the group working collaboratively to meet joint learning needs.

Project Team

- Sonia Van Gessel (SESLHD project lead)
- Jan Sadler (CESPHN project lead)
- Cathy O'Callaghan, SEaRCH, UNSW
- Anna McGlynn, Health Pathways
- Brendon McDougall, Integrated Care, SESLHD
- Sandy Johnston, Integrated Care CNC, SESLHD
- Australian Practice Nurse Association (APNA) representative

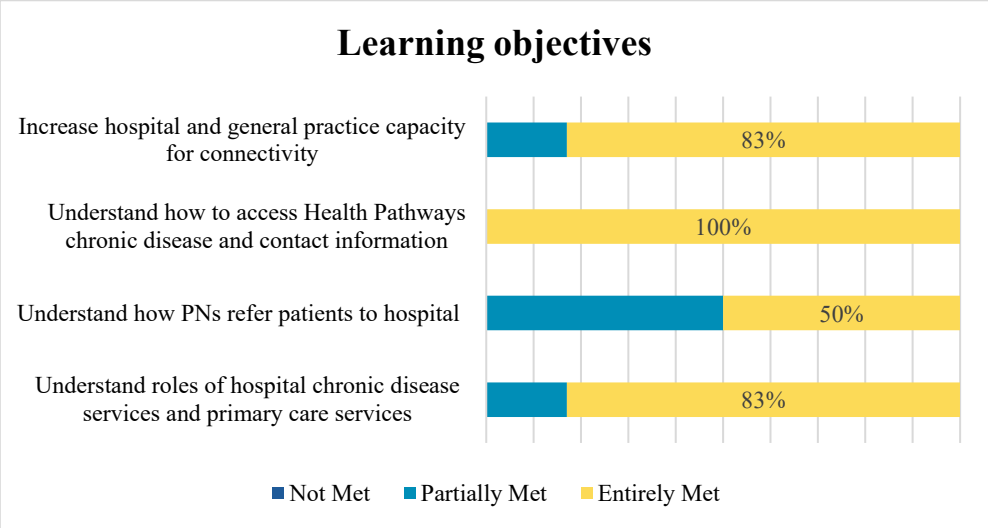
Deliverables and Scheduling

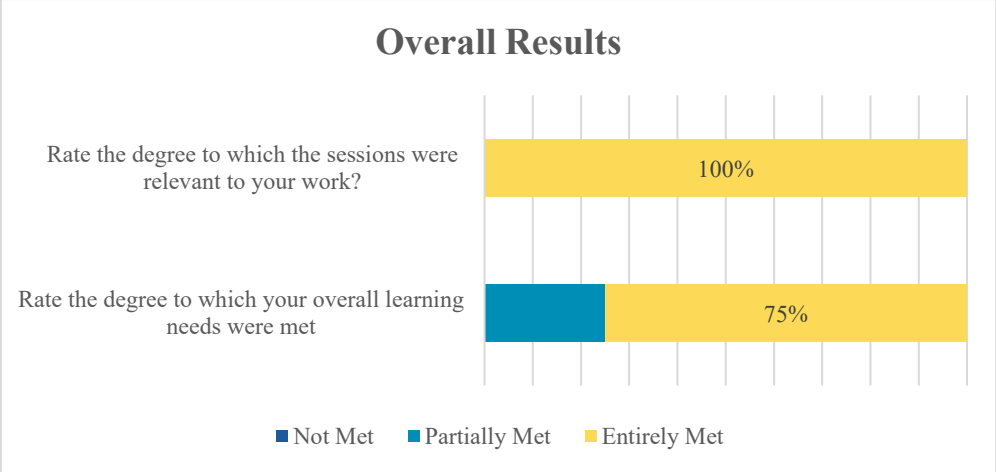
The six sessions consisted of 6 short 45 minutes to 1-hour breakfast meetings held monthly at St George Research and Education Centre.

Meeting	Date	Topic
1	25 July	Learning objectives set
2	22 August	Accessing Health Pathways
3	19 September	Transfer of care from primary health care to hospital
4	17 October	Communication between hospital and primary care services
5	14 November	Referring to Extended Community Care
6	12 December	Future directions

EVALUATION OF PLC SESSIONS

An evaluation occurred prior to and at the first meeting where all participants submitted then discussed their learning objectives. At the end of the six sessions, participants were also asked to complete an evaluation form using a combination of likert scales and open-ended questions. Of the attendees, 50% completed an evaluation form. The results have been collated and reported below. All participants met the learning objectives as outlined at the beginning of the sessions.





Assessment of delivery of PLC sessions

Overall participants found the sessions well run and facilitated. The interaction and relationship building between PNs and CNCs was highlighted as being of primary importance. The flexibility and tailoring of content to the needs and feedback of PNs were paramount to the design of the sessions and collaboration across the tertiary and primary health sectors. The sessions could be improved by more PNs attending.

Practical changes implemented in the workplace

> It has helped me in my role [to understand] the importance of building relationships with general practice to better care for chronic disease patients. CNC

For CNCs:

- Understanding the role of PNs and their work constraints
- More commitment to liaise with PN for better health care
- Relationship building and networking opportunities
- Better care for patients with complex needs and relationships with community

For PNs:

- Better understanding and use of Health Pathways
- Understanding of available services and how to refer to them
- Informed doctors of partnerships and learnings from attending PLC

Connectivity between hospital services and primary health care

Benefits gained through being a member of the PLC group and interacting with other health professionals included:

CNCs:

- Knowing about services offered by other CNCs
- Understanding the isolating environment for PNs and their needs
- Network with community and understanding their perspective
- Awareness of PHN and Health Pathways initiatives

PNs:

- Gained a better understanding of the services provided; how they are accessed, and how to refer patients from primary care
- Built links with CNCs

"I am now aware that we are not working in isolation but that hospital staff are willing and interested in working together" PN

Future networking

The importance of future activities to develop the relationship between hospital based chronic disease and primary services was discussed. The following regular PN/CNC networking opportunities could be developed:

- Educational evenings
- Clinical walk arounds/open days
- Small group learnings

Future topics could include:

- Better understanding of general practice business models and how they function
- Best practice models of chronic disease management involving CNCs and PNs
- New projects and research
- Referring patients to hospital specialty areas (eg. ambulatory care, mental health outpatients etc)

Participants also stressed the need for more development and support for PNs in their role including mentoring new PNs. A core group of skilled and experienced PNs working in clinical care with CNCs could disseminate information and be a 'hands on' resource for PNs to ensure safe practices. Critical to success and sustainability is the involvement of the Primary Health Network (PHN) and APNA to embed the practice of CNCs and PNs working together on integrated care initiatives.

Reflection from providers

The organisers had the opportunity to reflect on how they thought the sessions were conducted and how they could be improved.

THE MOST SIGNIFICANT CHANGE AS THE RESULT OF THE PLC?

- Getting to know the work environment of PNs and CNCs
- Enabling networking and knowledge sharing
- Establishing the first step in the direction of future work and practice change
- Using Health Pathways (as an outlet for getting PHN involvement and important for prioritising local referral pathways)
- Highlighting difficulties in being able to integrate hospital and primary services and the need to build CPD and social networks for PNs in CESPHN due to a lack of current support
- Utilising other formats for future networking eg. CNCs present every year and hospital tours encouraged

WHAT WORKED WELL?

- Simple CNC presentations, tours and insights into Health Pathways and available services
- Flexibity of approach, inclusiveness with participants deciding on topics, opportunities to discuss and ability of participants to ask questions, participants inviting others to give opinions, as well as casual learning environment and some formal content.
- Establishing working relationships between CNCs and PNs

- Facilitation and organisation of sessions by SESLHD

DIFFICULTIES?

- Timing and low attendance of PNs
- Dfiferent priorities, scope and learning needs of PNs
- Inconsistent group attendance which impacted on group cohesion, ability to progress on action items and the ability of the group to be self facilitated as it was dependent on the organisers to follow up.
- Lack of staffing resources from primary care to support PNs

HOW COULD THIS BE IMPROVED IN THE FUTURE?

- More support is needed from SESLHD and the PHN
- To be self directed, participants need to take on more responsibillity and practice changes. Unfortunately they lack the capacity to do so.
- Future research projects between SESLHD, SEaRCH, PHN and APNA could include a:
  - Mapping project to understand the number of PN FTEs, their locations, scope, range of practice and supports
  - Local project of mentoring the clinical competency of PNs in different clusters which could link into the care cordinator preventable hospital admission program

CONCLUSIONS

Overall the PLC sessions were very successful. All participants agreed their learning objectives were either entirely or partially met. The format, structure and content of the forum was well received with participants setting the direction of the sessions and having joint learning objectives. Most useful was understanding the roles of PNs and CNCs, networks and relationship building, small group collaborative learning of services and referral pathways. The sessions also enabled understanding of the work constraints of PNs and how they could be assisted in the future.

The initial aim was to start with one PLC group which could be self-sustaining in the future. The comments by participants and providers highlighted that this would be difficult with the lack of support and broad scope of practice for PNs. Future initiatives could map the needs and locations of PNs, work with PN clusters to ensure competencies and continue to facilitate joint networking and small learning opportunities.