A description of the service or practice

In August 2010 GATNET - Gateshead's GP commissioning consortia - commissioned a year long pilot project to support the care home setting and attempt to reduce emergency admissions by implementing a preventative approach to healthcare delivery.

A nurse specialist was appointed by the provider to change the provision of care from reactive to proactive and work collaboratively with GPs and community teams providing care to patients in their own home. A joint working arrangement was also established between the nurse, a local GP with a Special Interest and the Community Geriatrician to provide regular Multi Disciplinary support.

The 5 care homes with the highest rates of emergency admissions were engaged and readily agreed to participate in the pilot. The following practice was subsequently developed and delivered to the participating care homes:

- Weekly 'ward rounds' were established in each of the five homes involved in the pilot and attended by the multi disciplinary team, care home staff and family members. Other practitioners such as pharmacists were also involved, as and when necessary.

- Comprehensive Geriatric Assessments were undertaken and personalised care/end of life plans developed for each patient during these ward rounds. This enabled effective case management to be undertaken by anyone subsequently involved in their care.

- Regular education, training and updates were also provided to care home staff to increase their skills and competencies, further improving patient care and raising standards.

- The promotion and enablement of other established community teams as an alternative to a hospital admission e.g. Urgent Care Team, Intermediate Care Team, Community Resource Team for Older People.

In order to be able to measure the success of the pilot programme, an audit was undertaken by the Nurse Specialist with the 5 care homes to establish a baseline of current practice in each of the homes to develop clinical practice and for a suitable training programme for all staff.

Drivers for developing the service or practice

One key setting was and still is placing a significant burden on the capacity and capability of local services to provide effective, quality and value for money healthcare in Gateshead; Care Homes. Locally a frail population in care homes is coupled with an increasing number of short stay acute admissions. During 2009-2010 the cost of admissions from care homes in

Gateshead was £3 million with a significant proportion being for inappropriate 0-1 day length of stays for falls and for end of life care where the patient would have actually been better supported in their residential setting.

It was also deemed appropriate that a specific programme of care was developed as the projected population aged 85 years and over in Gateshead will increase by up 35 % over the next 20 years, from 3,900 to 7,500 placing further pressures on the capacity of services to support older people and the settings in which they present.

Whilst there are a number of services who provide healthcare to this setting, prior to undertaking this pilot there was no comprehensive specialist provision apart from one Community Geriatrician for a population of over 40,000 people aged 65 and over and a number of individual contracts between a range of providers such as mental health services and Specialist Care Homes to provide bespoke support to individual cases.

Residents of Care Homes have complex healthcare needs, reflecting multiple long-term conditions, significant disability and frailty. In order to provide adequate healthcare support a structured, multi agency and proactive approach to care needed to be developed, with patients and relatives at the centre of decisions about care.

Key challenges faced

In terms of key challenges, the main challenge was the level of frailty of the care home residents, the subsequent complexity of their needs and the testing time faced in delivering safe high quality care. The level of frailty exceeded that ever seen previously by the Nurse Specialist, the community geriatrician and the lead GP. Indeed, one of the conclusions of the pilot programme was that the older people involved in the programme had more severe levels of frailty than the majority of patients being cared for in the acute medical ward of Gateshead's Queen Elisabeth Hospital. As the pilot progressed a much more robust multi-disciplinary approach was developed as other clinicians and professionals became involved once the initial impact of the pilot programme was recognised. There was also measurable improvement in collaborative working between health and social care providers with the discharge and re-ablement process being improved.

Accomplishments: outcomes or benefits of the service or practice to either the provider, the purchaser or the patient (evidence of outcome)

A clinical audit was undertaken to capture the impact of the work and demonstrated a reduction in hospital admissions of 45.5% when comparing admission data in the 12 months period prior to the pilot resulting in approximately 440 bed days being saved at a cost of £243,146.

This project improved health care for this population, improved collaborative working, coordinated care and improved communication between practitioners.

The pilot received over whelming support and very positive feedback from care home staff, patients, and families, assessed through a qualitative satisfaction survey.

In addition the project was favourably received by other colleagues such as GPs, social workers and other specialists who all worked collaboratively over the course of the pilot.

Specific patient benefits included:

- Dedicated support for the Care Home setting resulting in improved patient choice and quality of care
- Increased adherence to NICE guidelines and improved clinical effectiveness
- Improved planned care interventions including advanced care planning
- Increase in independence, confidence and mobility
- Reduction in the likelihood of social isolation due to poor mobility and fear of falling
- Reduction in health inequalities
- Equitable access to health care services for this target group.
- Reduction in the number of medication errors

The cost-benefit of the pilot was measured based on the numbers of hospital admissions over the 12 months pilot period compared with the previous 12 months for the 98 patients included in this pilot.

The success of the pilot has been celebrated and work is now underway to roll out the programme to all homes in Gateshead.

How you think your example differs from current practice elsewhere

At the outset, the pilot was innovative in that it sought to provide not only clinical care but also education and informal sharing of knowledge and skills with care home staff. It was also developed to measure the impact of a preventative approach in reducing a rising number of emergency admissions amongst this group. However as the pilot progressed a number of other benefits were being realised specifically effective inter-agency working between the local authority, primary and secondary care services as well as those in community health services [formerly PCT provider services].

A strong emphasis was also placed on involving patients, carers and their families in the planning of healthcare as well as utilising qualitative feedback to inform service provision and planning.

Future direction

This pilot has delivered a strong and robust evidence base from which to commission new and more effective services. Managing frail people in the community, especially in a care home requires ‘team work’, through a collaborative working arrangement across service providers and an integrated approach to management; It is apparent that healthcare for care home residents requires input from a multidisciplinary team of NHS healthcare professionals from the Acute Trust, Primary and Community Care working collaboratively with the nursing staff based in the Care Home to improve the quality of healthcare and provide more appropriate planned care in order to prevent unnecessary admissions to hospital for conditions which would have been better supported in their residential setting.

There is no doubt that this enriched understanding of local needs, underpinned by a wealth of clinical evidence provides the impetus for adopting a different approach with the aim of ensuring proactive care planning and long term condition management with training and education at it’s core.

As a result of the success of this programme, a number of new services/service models are being commissioned using the learning from this pilot:

- The provision of a specialist team of nurses to support the care of residents in care homes with nursing beds who will hold active caseloads of 150 - 200 patients, coordinating care in collaboration with specialist/wider team e.g. old age psychiatry, pharmacist, therapists, advocacy staff, continuing care.

- The development of a One GP Practice: One Care Home approach locally through the implementation of a Service Level Agreement with local practices as well as the revision of the current Local Enhanced Service [LES] for care home residents to provide much more effective anticipatory care planning.

- Improved access to learning and development opportunities for care home staff regarding the assessment and management of older people with frailty and complex needs.

- Review of current service delivery models of existing community nursing teams.

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September 2011