Clinical Support To Care Homes & Nursing Homes

Examples Of Innovation In The West Midlands

QIPP Development Team
NHS West Midlands
September 2011 V1
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7. Care Home Review Team Sandwell PCT
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13. Clinical Case Manager Report Heart Of Birmingham TPCT
15. Nursing Home Support Service: South Staffordshire
18. The In-Reach To Care Homes Service - Worcester
20. Virtual Team Of Health Care Professionals For Care Homes With Nursing
22. “Feel It On A Friday” Shropshire And Staffordshire Heart And Stroke Network
24. Summerhill Surgery Care Homes Division
26. Harms Project: Shropshire County PCT
This compendium brings together the work that was presented at the quarterly event for care homes and nursing homes in July 2011. The event was designed to showcase clinical interventions in residential settings and was part of the NHS West Midlands QIPP (Quality, Innovation, Productivity and Prevention) workstream. The feedback from the event was that a written version of the information presented would be well received, both for those who attended and those who could not be accommodated on the day.

Executive Summary

There is a substantial body of evidence that considerable savings can be made when the NHS works more closely with care homes and nursing homes. The impact on quality and patient safety is also significant. The evidence base that has been gathered in the West Midlands will be presented at our Autumn event and will be made available to commissioning colleagues by the end of the year.

The model of intervention that is recommended by the QIPP workstream is an enhanced primary care service supported by an In Reach service. The successful enhanced primary care service has three components;

● Weekly ‘ward rounds’. As well as giving every resident weekly access to primary care, the ward rounds encourage all residents to choose the attendant practitioner as their GP.
● Good Out-of-Hours services. Evidence shows that a significant proportion of avoidable admissions from care homes and nursing homes occur out of hours.
● Single Point of Contact. Anecdotally we know that care home managers (and the cultures they propagate) are the most significant factor in the decision to call an ambulance. Timely access to a known clinician allows care home managers to take a more balanced approach to risk, and gives them the knowledge and support to make a clinically informed decision. There are a wide variety of In Reach teams and services operating in the West Midlands. There is insufficient comparative evidence to disaggregate the successful components of these services at present.

● Common sense suggests that a well resourced multidisciplinary team will cover all those areas that are needed to support residential settings.
● Cost effectiveness is improved by using In Reach staff to up-skill carers and nurses to provide clinical interventions themselves.
● There are compelling arguments that In Reach services should be located in primary care settings due to their close working relationship with primary care practitioners. However, the quality of partnership working across the health economy and the ability to build supportive relationships with homes appears to be the key to success rather than location.
● There are exciting innovations under way in the acute sector, both in terms of diversionary activity and Outreach into the community. We hope to be able to report on these innovations when evaluation is available.

The eleven contributors to this compendium have kindly offered to act as the contact for their service. The two pages that they have submitted for this report are a distillation of the literature they have available. We hope that commissioners will use these contact details to facilitate the commissioning of similar services in their own localities.

Acknowledgements

The NHS West Midlands QIPP development team wish to thank contributors, both for their time in hosting the networking and knowledge sharing event, and for the content for this compendium. Our thanks go to Linda Simcock and Dave Jefferson, Stuart Hutchinson, Shirley Mallon, Karen George, Caroline Wescott, Gillian Rudge, Sally Williams, Linda Pritchett, Jenny Sears-Brown, Carol Jones and Ceri Wright.
The Care Home Liaison Team (CHLT) came into existence on 1st April 2008, and is staffed by two band 7 RMN’s only. There are 4 psychogeriatricians in North Staffordshire, and each of the practitioner’s works with 2 each: Linda Simcock works with Dr. Woods (Staffordshire Moorlands) and Dr. Adeyemo (North Stoke), and Dave Jefferson works with Dr. Udeze (Staffordshire, Newcastle) and Dr. Negi (South Stoke). This report gives provides a statistical breakdown of our activity during the period from April 2008 to April 2011.

1) Referrals Into Service –

<table>
<thead>
<tr>
<th>Total</th>
<th>Gp Refs</th>
<th>Other Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>1303</td>
<td>1184 (91%)</td>
<td>119 (9%)</td>
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</table>

<table>
<thead>
<tr>
<th>Practitioner</th>
<th>Nursing</th>
<th>Residential</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Linda Simcock</td>
<td>394 (61%)</td>
<td>256 (39%)</td>
<td>650</td>
</tr>
<tr>
<td>David Jefferson</td>
<td>274 (42%)</td>
<td>379 (58%)</td>
<td>653</td>
</tr>
<tr>
<td>Total</td>
<td>668 (51%)</td>
<td>635 (49%)</td>
<td>1303</td>
</tr>
</tbody>
</table>

2) TOTAL CONTACTS –

3173 contacts in total, average of 2.4 contacts per patient. 3) WAITING LIST TIMES –

average length of time on waiting list is 24 days.

4) ADMISSIONS INTO COMBINED HEALTHCARE IN-PATIENT BEDS FROM CHLT:

Total of 31 admissions (2.3% of total number of referrals), of these 31 admissions, 30 admitted for Behavioural and Psychological Symptoms of Dementia (BPSD), the other for depression. We are currently reviewing the focus of the team in the light of the requests for training as it is acknowledged that the training can play an invaluable part in equipping care home staff with the skills they need to keep “residents in residence”, particularly in the light of the currently drive to reduce antipsychotic use for people with dementia.
TABLE 1 – TRAINING PROVIDED 2008.

<table>
<thead>
<tr>
<th>DATE</th>
<th>VENUE/CARE HOME ATTENDED</th>
<th>NUMBER OF STAFF IN ATTENDANCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.7.08</td>
<td>St. Georges Hospital, Stafford – various homes</td>
<td>20</td>
</tr>
<tr>
<td>14.7.08</td>
<td>As above</td>
<td>18</td>
</tr>
<tr>
<td>19.9.08</td>
<td>Harplands Hospital - various</td>
<td>19</td>
</tr>
<tr>
<td>3.10.11</td>
<td>As above</td>
<td>20</td>
</tr>
<tr>
<td>6.11.08</td>
<td>Ladydale Residential home</td>
<td>12</td>
</tr>
<tr>
<td>7.11.08</td>
<td>Harplands Hospital - various</td>
<td>21</td>
</tr>
<tr>
<td>18.11.08</td>
<td>Weston Coyney Support Unit social service staff</td>
<td>15</td>
</tr>
<tr>
<td>20.11.08</td>
<td>Weston Coyney Support Unit</td>
<td>15</td>
</tr>
<tr>
<td>24.11.08</td>
<td>Weston Coyney Support Unit</td>
<td>15</td>
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<td></td>
<td><strong>TOTAL - 152</strong></td>
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TABLE 2 – TRAINING PROVIDED 2009.

<table>
<thead>
<tr>
<th>DATE</th>
<th>VENUE/CARE HOME ATTENDED</th>
<th>NUMBER OF STAFF IN ATTENDANCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>26.1.09</td>
<td>Weston Coyney Support unit - various</td>
<td>15</td>
</tr>
<tr>
<td>3.2.09</td>
<td>As above</td>
<td>15</td>
</tr>
<tr>
<td>17.2.09</td>
<td>Stafford – social service</td>
<td>17</td>
</tr>
<tr>
<td>24.2.09</td>
<td>As above</td>
<td>20</td>
</tr>
<tr>
<td>20.3.09</td>
<td>As above</td>
<td>25</td>
</tr>
<tr>
<td>24.3.09</td>
<td>As above</td>
<td>18</td>
</tr>
<tr>
<td>31.3.09</td>
<td>Weston Coyney – social service staff</td>
<td>15</td>
</tr>
<tr>
<td>6.4.09</td>
<td>As above</td>
<td>15</td>
</tr>
<tr>
<td>8.4.09</td>
<td>Stafford – social service staff</td>
<td>21</td>
</tr>
<tr>
<td>17.4.09</td>
<td>As above</td>
<td>20</td>
</tr>
<tr>
<td>20.4.09</td>
<td>Weston Coyney Support Unit – social service staff</td>
<td>15</td>
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<tr>
<td>21.4.09</td>
<td>As above</td>
<td>14</td>
</tr>
<tr>
<td>27.4.09</td>
<td>Harplands Hospital - various</td>
<td>20</td>
</tr>
<tr>
<td>29.4.09</td>
<td>Stafford – social service staff</td>
<td>25</td>
</tr>
<tr>
<td>11-12.5.09</td>
<td>Weston coyney – social service staff</td>
<td>16</td>
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<td>28.5.09</td>
<td>Ladydale Residential Home</td>
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</tr>
<tr>
<td>8.6.09</td>
<td>Tamworth – social service staff</td>
<td>40 (x2 sessions)</td>
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<td>22-23.6.09</td>
<td>Weston coyney – social service staff</td>
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<td>21-22.9.09</td>
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<td>15</td>
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<td>29.9.09</td>
<td>Harplands hospital - various</td>
<td>20</td>
</tr>
<tr>
<td>5-6.10.09</td>
<td>Weston coyney – social service staff</td>
<td>15</td>
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<tr>
<td>26.10.09</td>
<td>Harplands Hospital - various</td>
<td>25</td>
</tr>
<tr>
<td>29-30.10.09</td>
<td>Weston Coyney – social service staff</td>
<td>14</td>
</tr>
<tr>
<td>2-3.11.09</td>
<td>As above</td>
<td>15</td>
</tr>
<tr>
<td>23-24.11.09</td>
<td>As above</td>
<td>15</td>
</tr>
<tr>
<td>17.12.09</td>
<td>Lyme Valley house residential home</td>
<td>10</td>
</tr>
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<td></td>
<td><strong>TOTAL - 464</strong></td>
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## TABLE 3 – TRAINING PROVIDED 2010.

<table>
<thead>
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<th>DATE</th>
<th>VENUE/CARE HOME ATTENDED</th>
<th>NUMBER OF STAFF IN ATTENDANCE</th>
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<tbody>
<tr>
<td>13.1.10</td>
<td>Lyme Valley House</td>
<td>10</td>
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<tr>
<td>25.1.10</td>
<td>Hampsalls Hall</td>
<td>12</td>
</tr>
<tr>
<td>1.2.10</td>
<td>As above</td>
<td>15</td>
</tr>
<tr>
<td>15.2.10</td>
<td>As above</td>
<td>13</td>
</tr>
<tr>
<td>23.2.10</td>
<td>Goldendale Residential Home</td>
<td>15</td>
</tr>
<tr>
<td>10.5.10</td>
<td>Guardian Care</td>
<td>25</td>
</tr>
<tr>
<td>25.5.10</td>
<td>Hempstalls Hall</td>
<td>12</td>
</tr>
<tr>
<td>22.6.10</td>
<td>Harplands Hospital - various</td>
<td>20</td>
</tr>
<tr>
<td>7.9.10</td>
<td>As above</td>
<td>20</td>
</tr>
<tr>
<td>14.9.10</td>
<td>The Farmhouse Residential home</td>
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<td>20.9.10</td>
<td>Guardian Care</td>
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<td>4.10.10</td>
<td>The Maples</td>
<td>12</td>
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<tr>
<td>6.10.10</td>
<td>The Poplars</td>
<td>15</td>
</tr>
<tr>
<td>8.11.10</td>
<td>Hilltop Manor</td>
<td>15</td>
</tr>
<tr>
<td>15.11.10</td>
<td>As above</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td><strong>TOTAL - 241</strong></td>
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## TABLE 4 – TRAINING PROVIDED 2011 (TO END OF MAY)

<table>
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<th>DATE</th>
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<th>NUMBER OF STAFF IN ATTENDANCE</th>
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</thead>
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<td>17.1.11</td>
<td>Borough Arms Hotel – various</td>
<td>20</td>
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<tr>
<td>24.1.11</td>
<td>The Beeches</td>
<td>14</td>
</tr>
<tr>
<td>24.1.11</td>
<td>Dresden House</td>
<td>12</td>
</tr>
<tr>
<td>14.2.11</td>
<td>Moorland House, Leek - various</td>
<td>10</td>
</tr>
<tr>
<td>21.2.11</td>
<td>Hilltop Manor</td>
<td>25</td>
</tr>
<tr>
<td>28.2.11</td>
<td>Borough Arms hotel</td>
<td>30</td>
</tr>
<tr>
<td>14.3.11</td>
<td>The Beeches</td>
<td>15</td>
</tr>
<tr>
<td>14.3.11</td>
<td>Dresden House</td>
<td>14</td>
</tr>
<tr>
<td>21.3.11</td>
<td>Moorland House</td>
<td>12</td>
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<tr>
<td>28.3.11</td>
<td>New Milton Nursing home</td>
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<td>5.4.11</td>
<td>Harplands Hospital</td>
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<td>11.4.11</td>
<td>Ravenswood</td>
<td>12</td>
</tr>
<tr>
<td>18.4.11</td>
<td>Newpark House</td>
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<tr>
<td>18.4.11</td>
<td>The Limes</td>
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</tr>
<tr>
<td>15.6.11</td>
<td>Harplands Hospital - various</td>
<td>21</td>
</tr>
<tr>
<td></td>
<td><strong>TOTAL - 242</strong></td>
<td></td>
</tr>
</tbody>
</table>
Summary Of Chlt Activity, April 2008-End May 2011:

The service has received 1303 referrals to date, made 3173 contacts and trained 1106 care home staff throughout the county.

The training we provide focus's upon using non-pharmacological interventions, based on the Newcastle Model, for BPSD and also aspects of functional mental illnesses.

We are presently being inundated with requests for our training from private care home as part of the national and local reduction in the use of antipsychotic medication in people with dementia initiative. However, due to the high level of referrals into the service, we are currently unable to meet this demand.

Quotes from Trainees

“An enjoyable course, with lots of information, but done so we could understand, and not using lots of technical terms”

“Most enjoyable, and presented in a way that you can understand, nice relaxed atmosphere”

“Thank you for an enjoyable couple of days. Just what we needed! Very good skills and knowledge that can be taken back into the workplace”

Contact: lindam.simcock@northstaffs.nhs.uk or davida.jefferson@northstaffs.nhs.uk
The Care Home Review Team consists of a Consultant Geriatrician, a nurse and a pharmacist. The aim of the team is to review all residents in Nursing Homes in the Oldbury and Smethwick areas of Sandwell. This consists of 5 nursing homes with 260 beds.

The remit of the team is:

- Undertake health checks on residents in care homes, which is holistic and multidisciplinary and where necessary carry out physical examinations and take bloods where necessary.
- Undertake full medication reviews
- Review Nursing care plans/risk assessments/nursing interventions.
- Appropriate referrals including liaison and clarification
- Provide prompt written summaries for each resident to the care home, to the GP, community pharmacy linked to the home, and where appropriate, to the mental health team or other teams.
- Provide a summative report to the Cluster and the care home at end of each home visit
- Support staff in caring for residents, give advice and identify training needs.
- Conduct a medicines audit

GP's in the area invited the team to review residents under their care, and sent medical summaries to the team before the team visited.

Each review of a resident generated a review which was shared with the nursing home, the GP, and the team. Reviews were sent by fax or secure e-mail as soon as the visit had ended. At the end of each period of visiting a summary report was generated. Again, this was shared with the Nursing Home, the GP and the PCT governance section.

Results

In the first year of operation, medication savings of £30 090 were identified, or £406 per resident reviewed. Savings were identified in a number of areas

1) Ensuring that the correct amount of medication is ordered by the home from the GP

2) Ensuring that medication is being given regularly, and that when medication is being given as required that waste is kept to a minimum.

3) Reducing and stopping unnecessary medication, particularly secondary prevention

4) Changing medication to appropriate formulation or to comply with the Sandwell formulary. A particular area of interest was anti-psychotic medication. We were able to stop in some cases, or strongly recommend that mental health services were involved for those who had ongoing requirements for this class of medication.
Qualitative changes were also made.

Care plans were improved, and two of the homes which CQC had graded at one star (adequate) were graded as two stars (good) after inspections during the year.

We also identified areas of poor care, including tip back chairs which had been made by sawing 15cm off the rear legs of standard chairs. We raised 15 clinical incidents and 2 adult safeguarding during the course of the first year.

We were able to improve liaison with other services, particularly tissue viability and dietician services.

This led to better pressure care and wound management, and appropriate use of dietary supplements. We were able to promote a policy where there was no prescription of dietary supplements without a review by a dietician. We actively promoted end of life discussions between the nursing home staff, the GP and the resident or their relatives.

Admissions.

We were unable to show any definite effect on admissions, although we were able to identify to the commissioners factors which would need to be addressed if admissions avoidance schemes were to be successful.
Birmingham East And North GP Locally Enhanced Service

REDUCING HOSPITAL ADMISSIONS OF CARE HOME RESIDENTS

GP Local Enhanced Agreement for proactive medical support to care homes with nursing

BACKGROUND:

NHS BEN is responsible for 27 care homes with nursing, 26 of which specialise in older people’s care and one is dedicated to adults with learning disabilities; a total of 991 beds. In addition, there are 47 care homes without nursing with 1,052 beds.

An analysis of emergency admissions to the Heart of England NHS Foundation Trust (HoEFT) hospitals of over 65’s from care homes both with and without nursing in the year 2007-8 showed 1,314 admissions at a total cost of £3.59m (See Table 1).

- 649 admissions at a cost of £1.8m came from care homes with nursing.

It is acknowledged that data accuracy was problematic given that hospitals do not record the main residency as a named care home only the address and postcode. There will therefore be some errors through picking up admissions from people living in domestic homes in the immediate vicinity of care homes. Independent appraisal of patient records by a clinician found 30% to be either preventable or avoidable – a potential saving of £1m although it was accepted that only 70% of this was achievable in practice, a potential saving of £700k. Much of this involved basic nursing practice such as nutrition and hydration, positioning, management of diabetes and End of Life Care rather than complex nursing tasks.

Many homes feared negative criticism by the Inspectorate for failure to refer to medical services and tended to default to use of hospitals rather than community health services.

It was decided to start with care homes with nursing as their target cohort has the greatest instability of health needs as seen in the Funded Nursing Care determinations. Care homes with nursing already received proactive visits at least monthly from a complex care nurse to review the Funded Nursing Care determinations of residents and provide advice on health care management. In many homes it was found that suggested improvements in the health management of individual residents were not generalised to the working practices of the home.

The GP LES

GPs provide health care to their registered patient populations through their General Medical Services (GMS) contract with the NHS. Within this contract, they can obtain additional payments for specified health checks done in accordance with the Quality Outcomes Framework (QOF).

PCTs have the facility to purchase GP services over and above the GMS through Enhanced Service Agreements, most of which are locally determined with others being nationally determined.

Local GPs across NHS Birmingham East and North were offered the opportunity to take up a Locally Enhanced Service agreement to work with specified care homes with nursing and the visiting complex care nurses to improve health care in their designated care homes with nursing with a view to reducing the level of emergency admissions.
The LES agreement gives details of the role of the GP and the care home with nursing and other supports available to assist in the task.

In particular, GPs on a LES agree to:

- Provide a health review of all new admissions to their designated care home with nursing of people registered with their practice
- Monthly health reviews of residents registered with their practice
- At least weekly planned visits to the Home with additional emergency call outs where appropriate
- Track general trends in the Home and identify areas of improvement in the working practices of the Home for referral to supporting services

Although residents retain the facility to choose their own GP, many are found to like the proactive nature of the LES GP arrangement and opt to transfer registration.

IMPACT OF THE LES

The impact of the GPs is evaluated once a year through:

- Joint meetings with the Care Home manager, the GP and commissioners
- Refresh of the data on the use of hospitals by care homes

Between the years 2007/8 and 2009/10 there were significant reductions in emergency admissions to HoEFT hospitals from all types of care homes in Birmingham East and North.

The parallel fall in the residential care home control group shows that not all the reductions in emergency admissions can be attributed to the impact of the GP LES. However the table does show a significantly greater reduction in emergency admissions from the sector served by a GP LES so it is therefore concluded that it is a cost effective approach.

Other issues:

Audit interviews assisted both the GP LES practice and the nursing home manager to identify the improvements made in working practices in the financial year of the LES and those planned for subsequent years.

Many care home with nursing managers reported a greater sense of confidence in their judgement about selection of residents for referral to the GP, community health services and hospitals and improvement in their working practices as a result of a trusted relationship with a visiting GP.

Most GPs confirmed improvements in the judgements of care home managers in identifying people who warranted GP attention and improvements in ordering repeat prescriptions, thereby reducing medicine waste. However, GPs covering 4 homes reported intractable chaotic working practices that will be taken up at a strategic level with the parent company.

Contact: Shirley.Mallon@benpct.nhs.uk

<table>
<thead>
<tr>
<th>Type of Home</th>
<th>2007-2008</th>
<th>2009-2010</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total emergency admissions 2007/08</td>
<td>Cost of emergency admissions 2007/08</td>
<td>Total emergency admissions 2009/10</td>
</tr>
<tr>
<td>Care homes with nursing</td>
<td>649</td>
<td>£1.80m</td>
<td>220</td>
</tr>
<tr>
<td>Care homes without nursing</td>
<td>665</td>
<td>£1.79m</td>
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<tr>
<td>All</td>
<td>1,314</td>
<td>£3.59m</td>
<td>658</td>
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</tbody>
</table>

Birmingham East And North GP Locally Enhanced Service
Shropshire Partners in Care (SPIC) is an umbrella organisation; its purpose is to support the development of a high quality social care sector in the areas of Shropshire and Telford & Wrekin.

Core Values

- Excellence – SPIC promotes the best possible practice among care providers and also wishes to be seen as an exemplary employer
- Value for Money – SPIC provides services to members (and others who work in or use the care sector) that are efficient and add value to the delivery and use of care services
- Ethical – SPIC works in a way that safeguards the human rights of all those who may need or use care services and supports its members to deliver services that place service user rights at the centre of their decision making.
- Partnership Working – SPIC works in partnership with all stakeholders who share the same mission and values

Core Activities

Training – to provide affordable and good quality courses for SPIC members that ensure high standards across the care sector.

Information/Advice – to provide an accurate, relevant and up to date information service and a responsive advice service to SPIC members and other stakeholders in the care sector.

CRB Checks – to provide an efficient and affordable service for members that ensures that all staff seeking to work in the care sector are checked in line with current statutory requirements.

 Representation – to ensure that care providers’ views and expertise help to inform local statutory planning, decision making and commissioning.

Spic deliver, collaborate and commission training from a number of their partners:

- Infection Control Team
- Primary Care Trusts
- Hospice
- South Staffordshire & Shropshire Healthcare NHS Foundation Trust
- Shropshire Council
- Telford Council
- Skills for Care
- Clinical Nurse Advisor

The post of Clinical Nurse Advisor/ Independent sector (CNA) was set up with Shropshire Partners in Care (SPIC) initially to facilitate continuing professional development of Registered Nurses and Care workers in the independent sector across Shropshire. The purpose of the post is to identify education and development needs of the independent sector workforce to ensure they provide evidence based quality care which meets standards set by the Quality Care Commission.

Purpose of the Post:

- Assist with the identification of educational, training and development needs within Shropshire Care Homes and domiciliary care agencies.
- Support clinicians within the Independent Sector to work within clinical governance and care standards framework
- Ensure future workforce development requirements within IS are met.
Clinical Nurse Advisor / Independent Sector
Shropshire Partners in Care

- Offer advice and information regarding the provision of training and development programmes to meet identified needs.
- Provide, facilitate and evaluate programmes of training delivered to the IS.
- Assist practitioners to continually raise standards of care within the Independent Sector.
- Ensure that the education provided is fit for purpose and meets both personal and organisational requirements.
- To act as a point of contact for clinical advice and support for practitioners in the IS.
- To widen professional links and support mechanisms for nurses working in the IS.
- Facilitate and maintain a culture of lifelong learning
- To work with clinicians to prevent hospital admissions from Independent sector by championing proactive management of residents.
- Influence healthy and productive relationships between Primary, Secondary care and the Independent sector. Particularly focussing on discharge planning.

Recent initiative

Following the examination of West Midland Ambulance Data, it was identified that a Residential Home in Shropshire had had a total of 117 ambulance call outs to the home from January to October an average of 11 ambulances per month. This was significantly higher than any other home in Shropshire at that time. Following a discussion with the home we were able to establish the possible cause. The home had a policy in place which stated that if a resident had a fall or bumped their head the carers had to call 999. We worked with carers, trained them to manage head injuries in the home using NICE Guidance, Worked with the home owners to change their policy to reflect NICE Guidance. The result of this initiative has seen a reduction in ambulances attendance to an average of 3 per month.

Contact: Karen.George@telfordpct.nhs.uk
Clinical Case Manager Report Heart Of Birmingham TPCT

Clinical Case Manager (Nursing Homes)

Heart of Birmingham tpc (Birmingham Community Healthcare NHS Trust from Dec 2010)
This role commenced in January 2010.

The case manager (CM) is an experienced nurse with prescribing skills and a varied nursing background including extensive work with care homes. She works with 127 residents in St Clements Nursing Home (37 beds) and 3 units of Perry Locks Nursing Home (90 beds). Anticipated benefits of the role during the first year. These were based on the expectations of the Strategic Health Authority Clinical Support to Nursing Homes QUIPP project and included:

- Improved clinical support to nursing homes.
- Reduced number of emergency admissions to hospital from care homes with nursing by 25%
- Reduced number of deaths in hospital by 20%.
- Increased number of expected deaths occurring in care home by 25%.

Method of working

- The CM is on call to nursing home staff, acting as first point of contact
- Visits homes where possible on a daily basis, or at least makes telephone contact.
- Provides short term intervention to any resident as needed. E.g. prompt assessment and treatment of residents with urinary tract infection, chest infection, cellulitis, fungal skin infection, conjunctivitis etc.
- Proactively coordinates care for residents, concentrating most on those with more complex needs, particularly those at the end of life.
- Participates in weekly “ward rounds” with GPs at each home and monthly palliative care meetings at St Clements surgery.

Figure 1

![Hospital admissions Lawrence House](chart.png)
Outcomes – hospital admissions

In 2009 there were 22 admissions to hospital from Lawrence House (a 30 bedded unit of Perry Locks), while in 2010 there were 11. (Figure 1). This represents a 50% reduction, the greatest impact being over the later part of the year.

Outcomes – Place of death

In St Clements Nursing Home the percentage of people dying in hospital dropped from 50% in 2009 to less than 18% in 2010, despite significantly more deaths occurring. (Figure 2)
There was no change in place of death at Perry Locks Nursing Home, the percentage of people dying in the home remaining at 58%.

Conclusion

The CM role has been positively received by residents and their relatives, nursing home staff, GPs and other clinical staff. Measurable effects have occurred at least in terms of hospital admissions from Lawrence House and end of life care at St Clements Nursing Home. GPs support the role because it greatly reduces the number of times they are called out while improving continuity of care.

Contact: linda.pritchett@bhamcommunity.nhs.uk
The Nursing Home Support Service was commissioned by 5 Consortia in South Staffordshire PCT subsequent to 6 months piloting to establish if clinical theories were indeed correct and could be translated to patients. This is a highly innovative model of delivering healthcare.

The word innovate is derived from a Latin word which means to renew or change. For an improvement to take place it is necessary for people to change the way they make decisions, or make choices outside of their norm. With this premise the service lead and team leader tested and challenged current thinking with regard to nursing home support to achieve the following aims –

- To provide specialist clinical support in the care of elderly people in nursing homes
- To provide a link to other professionals in the local health economy to support the care of people in nursing homes
- To assure GP’s, Commissioners and regulatory bodies that quality care is being delivered in nursing homes.
- To enable elderly people to remain at home and not be admitted to hospital unnecessarily.

The team is multidisciplinary, including 2 dieticians, 2 continence nurses, 2 EoL nurses, a pharmacist and a pharmacy technician, 2 tissue viability nurses, 1.5 infection control nurses, a discharge liaison nurse, a project manager, a team leader and a team administrator.

Consortia and practice managers meetings have been attended and local nursing home managers meetings. Within the nursing homes there is local engagement with relatives groups to promote the message of supporting quality care.
The views of the local health care community have been positive. One GP provided the following testimonial after the intervention of the Dieticians:

“I was keen to reduce my prescribing costs of supplements but didn’t really know how to go about it. This service was fantastic. Virtually no work from me (just cancelling the feeds no longer required, 15 mins max) and I will save + £20k!

Also, the people who need the feeds are now on the correct one e.g. with protein. It’s a no brainer” Pat Staite – GP – Sandy Lane Surgery

The service covers 66 Nursing Homes and supports 5 Consortia’s – Stafford and Surrounds (SAS), Seisdon, East Staffs, Cannock and South East Staffordshire (SES). The distribution of nursing homes patients is evidence in table 1.

The map below illustrates the scale of the challenge to provide specialist clinical support to such a large geographical area. The homes are all marked.

Graph 1 details the savings achieved per home following audit of oral nutritional supplements (ONS) in each Nursing Home. The data shows prescribing costs pre audit and prescribing costs post audit. The audit process also includes the implementation of the MUST tool training and initiation of the Malnutrition matters Care Pathway to ensure that the Nursing Homes understand the process required before patients are commenced upon ONS.

The clinical theories tested during the pilot and investigation stage were two fold.

- Direct clinical specialist support could have an impact on appropriate prescribing and achieve savings. Graphs 1 and 2 below illustrate the savings achieved through the clinical review of patients on Oral Nutritional Supplements (ONS) in 6 nursing homes taken from the QIPP project Pilot studies 2010. Findings showed that 52% of patients were being inappropriately prescribed which means a waste of health care resources and no benefit for patients. This correlates with the CHUMS report (Care Home Use of Medicines review) which evidenced that there were 1.9 prescribing errors per patient in nursing homes.
Nursing Home Support Service: South Staffordshire

Graph 2

Graph 2 details the projected prescribing cost savings annually which can only be sustained with the implementation of active training around nutritional support within the Nursing Homes.

Similar work was done around the treatment of pressure ulcers and significant savings were identified.

The generic outcomes are:

- To facilitate standardisation of care within nursing homes across South Staffordshire to help achieve and maintain quality.
- To see a reduction in unplanned admissions to acute providers from nursing homes.
- To see efficiencies achieved with prescribing particularly with oral nutritional supplements, wound care and medicines management.
- To facilitate an improvement in the knowledge and skill base of staff in nursing homes.
- To devise clinical pathways and train nursing home staff to follow these pathways in partnership with health care professionals and all stakeholders.
- To provide assurance to GP’s and commissioners and regulatory bodies such as the CQC regarding health care delivery to nursing homes.

Our vision for the future is:

“To ensure residents in nursing homes are valued and cared for as they deserve through productive partnerships which raise the standards of care across South Staffordshire.”

www.nhsnhs.co.uk
Contact: Gillian.rudge@southstaffspct.nhs.uk
The In-Reach to Care Homes Service - Worcester

Background

- 50 – 74% of care home residents will have some form of cognitive impairment 1,2,3
- 40% of people living in care homes will have a diagnosis of depression according to Age Concern
- Cognitive impairment increases the risk of hospital admission, is associated with the prescription of anti-psychotic medication and increases the risk of falling 1,2,3,5
- Cost of dementia in England, £17.03 billion, accommodation approx £7 billion of this6.
- Currently 138 care/nursing homes in Worcestershire, 67 in the south.

Referral Route

- Referrals accepted from the CMHT’s and Inpatient areas from Care Co-ordinators or Lead Professionals.
- First line interventions need to have been suggested to the care home and reviewed.
- If CMHT interventions not working and intensive support is required referral to In Reach can be made.
- Care Co-ordinator/Lead Professional remain case holders during IR interventions.
- IR and CC/LP discuss discharge plans.

Objectives

1. Prevent crisis through early and intensive intervention.
2. Avoid unnecessary moves and admissions into hospitals.
3. Support transfers from home, inappropriate care homes or hospital into suitable care homes.
4. Promote quality of care, to raise standards and residents health and well-being using a person centred approach and training.
5. Improve person centred risk management & inappropriate use of anti-psychotic medication
6. Support and potentially reduce the workload of the CMHT’s.
7. Family support and signposting.
8. In Reach also undertake intensive work to facilitate successful transfers to care homes from hospital, in cases where people have complex needs and there is high risk of re-admission. There are obvious cost savings in these cases.
9. Occupancy levels on Berkeley ward have fallen significantly in the last 3 months.

Quality

- Life story – informing activities and memory boxes
- Person centred interventions and care planning
- Involving families
- Personalisation of bedrooms
- Activities and meaningful occupation
- Training for staff around person centred care and dignity issues
The In-Reach to Care Homes Service-Worcester

What we did in our first six months

<table>
<thead>
<tr>
<th>Service</th>
<th>Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supporting transfers</td>
<td>11</td>
</tr>
<tr>
<td>Avoiding moves/admissions</td>
<td>12</td>
</tr>
<tr>
<td>Crisis prevention/early intervention</td>
<td>15</td>
</tr>
<tr>
<td>Person centred risk management/medication review</td>
<td>18</td>
</tr>
<tr>
<td>Family support &amp; signposting</td>
<td>34</td>
</tr>
<tr>
<td>Care quality interventions</td>
<td>46</td>
</tr>
</tbody>
</table>

Savings in Inpatient Spend

- IRCHT believe 12 people may have been admitted to inpatient care without their intervention. Using the Trust ‘average’ inpatient stay as a basis for costing, the potential savings are:
  - £137,340 if all were admitted to Berkeley
  - £321,768 if all were admitted to Athelon

The Future

- Great steps have been made since In Reach commenced in July 2010.
- We are told by the Care Services Quality Team and the CMHT’s that there is great unmet need in the North.
- Residential/ Nursing home forums also tell us that they need our service.
- We need to extend the team and increase our skill mix. OT input has fantastic possibilities in a larger team.

Contact: sally.williams@worcsmhpnhs.uk
Purpose / Aims:

To raise standards of Health care in Care Homes with Nursing ensuring the best possible levels of care for residents of NHS Birmingham East and North.

Objectives:

To assign named members of the multi disciplinary community health services to each care home with nursing to form Virtual Teams attached to each Home:

- To facilitate appropriate and timely referral by Homes
- To facilitate the appropriate use of the range of community health services
- To ensure that effective inter-professional communication occurs on all issues affecting individual residents and individual Care Homes with Nursing, in the NHS BEN catchment area.
- Each care home, including the home manager, owners, key workers, patients and their families will know who and how to contact members of the MDT team to ensure that the best possible care is delivered, to prevent unnecessary hospital admissions and to help support early discharges

Organisational

A Virtual team to be assigned to each home across NHS Birmingham East and North

Each Care Home with nursing to be provided with an assigned Virtual Team under the co ordination of the Continuing Care Manager

Leadership

Each Virtual Team to have an identified lead person normally the Continuing Care Manager

- Clear roles and responsibilities of each professional member of the Virtual Team to be defined and shared across the Virtual Team
- All community health services commissioned by NHS Birmingham East and North to be represented in the Virtual Team.
- The numbers of Homes covered by each member of staff will vary in accordance with the size of their community health service.
- One member of each of the professional groups to be allocated to one or more nursing home

Virtual Team:

The group of community health care professionals who ordinarily visit Care Homes with Nursing either to attend to named residents as required or who visit regularly to provide overall support with working practices
Virtual Team of Health Care Professionals for Care Homes with Nursing

Quality Outcomes

- Preventing deterioration in health
- Preventing avoidable admissions to hospital
- Preventing unnecessary unplanned admissions to hospital, and if this did happen
- To help speed up discharge back to the nursing home.
- To link with supportive developments in acute hospitals
- To enable the multi disciplinary team members to share issues and concerns
- To enable the multi disciplinary team to share evidence of good practice
- To enable each home to build a positive relationship with the nominated professionals

Membership

Continuing Care Manager, Continuing Health Care team, Tissue Viability, Continence, Dietetics, Speech and Language therapy, Mental Health team, Medicines Management, GPs, Physiotherapy, Occupational Therapy.

Reporting

To provide evidence to NHS and local authority commissioning bodies and other agencies of quality monitoring through a balanced score card approach that includes data on:

- incidence of hospital attendances and admissions and agree action plans to address areas of concern
- infection rates, incidence and location of planned and unplanned deaths, Tissue viability incidents, falls and safeguarding concerns and agree actions

Contact: Caroline.wescott@benpct.nhs.uk
"Feel it on a Friday"
Shropshire and Staffordshire Heart and Stroke Network

Authors:
Jenny Sears- Brown and Rachel Redgrave
Service Improvement Managers - Shropshire and Staffordshire Heart & Stroke Network

Our Working Environment:
Shropshire and Staffordshire Heart & Stroke Network facilitate local healthcare providers to deliver safe quality effective patient care in line with national and local drivers. The network crosses all clinical boundaries and healthcare providers and works with independent, public, NHS, social care and voluntary agencies.

The focus of our work:
The project basically enables care workers to detect irregular pulses and refer to the most appropriate health care professional for further treatment. This was achieved by delivering a 60 minute training programme composing of the following content, firstly raising the awareness of the recognition of stroke / TIA emphasising the need to treat this situation as a medical emergency through a DVD and discussion. The second aspect of the training contained a very basic overview of the pathophysiological changes of an irregular heart beat and how this can go on to contribute towards a formation of a clot and lead to a thromboembolic cerebral event, followed by a practical skill teaching session for performing manual radial pulse checks.

Two sites where chosen for a pilot due to them being identified as having higher than average ambulance responses and hospital attendances. Shropshire Partners in Care along with Telford & Wrekin PCT enhanced community nursing care team allocated a specific case manager to work with the care staff and this project was included as part of the overall enhanced educational programme service in order to detect early signs of illness etc. However it should mentioned that the training programme could be delivered as part of a stand alone educational programme.
“Feel it on a Friday”
Shropshire and Staffordshire
Heart and Stroke Network

Project summary:

- Residential / nursing home care workers are trained in the early recognition of stroke and TIA.
- Residential / nursing home staff are trained in performing manual radial pulse checks.
- Pulses are recorded on a weekly basis or if the patient feels or appears unwell or has fallen.
- All pulses are documented on a data collection tool.
- Where an irregular pulse is detected and the resident of the nursing home appears well they are referred to the case manager / emergency care practitioner and an ECG if performed to confirm the presence of an arrhythmia and referral to appropriate health care provider.
- If a irregular pulse is detected and the patient appears unwell 999 call for further assessment.

What is novel of innovative?

“Feel it on a Friday” is a simple idea that can be applied to a range of settings. It has the potential to reduce the number of strokes, reduce the associated costs to the NHS and stroke survivors themselves along with their families.

The idea can be applied to any health and social economy across the country, it may also appeal to a range of other sectors e.g. charitable day centres, home scheme managers etc.

Feedback: Structured interview with Area Manager and Deputy Manager

Overall impression

Very worthwhile; senior staff have more support, more knowledge and more confidence dealing with day to day duties

What went well

Training - Friendly, fun, liked practical aspects the best; really enjoyed ‘feeling pulses’ and putting theory into practice on the same day. 60 mins is the right amount of time to dedicate to it because it prevents boredom and staff can be released for an hour within their working day.

All staff (even cleaners and kitchen staff) benefitted from having awareness training

Multi-professional relations have definitely improved with Rapid Response. Rapid response very knowledgeable and always explain things clearly in a way that is easy to understand

Staff feel more professional when speaking with GP and asking for patients to be reviewed

Areas to be improved

Certificates to be issued on the day would be good
Wish Rapid Response could not only provide a day but specify a time to visit although staff do recognise pressures on Rapid Response Team

Good ideas
1. Introduced a pulse check book which is completed weekly – better than separate bits of paper
2. Introduced weekly pulse check on Friday because case manager always visits on Friday and things get actioned immediately and not forgotten
3. Delegated ‘weekly pulse checks’ to a few senior support workers who undertake pulse checks together

Contact: Jenny.sears-brown@nhs.net
Practice Manager: Carol Jones  
Office Manager: Alison Lilley  
Receptionists: Shirley Mantle, Jenny Owen, Joanne Wallett, Linda Haycock, Shirley New  
Care Home Prescriptions: Angela Fellows  
Scanning: Pam Thorneycroft  
Nursing Admin: Lynn Jones  
Medical Records: Shirley New  
Medical Secretary: Julie Brooks

Who Are We?

A self-contained division of Summerhill Surgery- a long-established family practice. We have Three GPs, 2 Nurse Practitioners, a Health care Assistant and a staff member manning the prescription line. They are supported by the practice admin team and our integrated nursing team.

Dr Nick Plant
A Birmingham graduate (1974), he has worked in Kingswinford in his family’s practice for nearly 30 years. He has looked after the residents of Care Homes for over 20 years. He now divides his time between Care Homes and GP Commissioning.

Dr Sue Hocking
A Sheffield graduate (1971), Sue is an experienced GP who has worked in Aberdeen and Devon before moving here.

Dr Sukhdev Sihra
A London Graduate (2002), Suk joined the Practice in March having worked in London and Sandwell. He has a keen interest in Geriatric Medicine and is currently studying for a Masters Degree in Gerontology.

Serena Hewitt
Serena is a Nurse Practitioner. She is a qualified nurse prescriber and is studying for a Masters degree as an Advanced Nurse Practitioner.

Jane Smith
Jane is a Nurse Practitioner. She is a qualified nurse prescriber and is studying for a Masters degree as an Advanced Nurse Practitioner.

The Way We Work

We are very aware that the residents in Care Homes are amongst the sickest people in the community, but they often have very poor access to medical care. Furthermore, the care staff who look after them can be very unsupported, especially out of hours.

We believe in offering structured care with regular weekly visits.

We are available at the end of the telephone to offer support and advice.

We are available for support or to visit, 24 hours a day, 365 days of the year.

We believe that a Care Home is the resident’s home. We will do our very best to ensure that they are not admitted to hospital unless there is a problem that can be sorted out only in hospital. We will arrange for specialists to visit at the home where possible. We arrange for blood tests to be done at the home.
Weekly Visits

We visit each home on a weekly basis. We try to ensure that this is the same day/time every week to give continuity and to allow relatives to meet us. We ask the home to have a round book with details of each resident we will discuss or see. We review their medication on a quarterly basis. We also keep disease registers and ensure that we monitor long-term conditions.

Clinics at Summerhill

Blood Tests – Monday and Wednesdays 12.00pm – 3.00pm
Smoking Cessation – Ask at reception
Warfarin Clinic Tuesday 10.00am to 11.30am
Daily consultation slots in the late afternoon for those that can attend the surgery. These are conveniently timed for those who attend college or day centres. Relatives can also make appointments at these times.

Access to Patient Information

All patient information is treated as strictly confidential and will adhere to the Data Protection Act 1998. No information will be passed to a third party without the written consent of patients or their representatives.

Out of Hours

All out of hours are carried out by the practice- no emergency service is used.
We also provide out of hours cover for Intermediate Care beds and the Ridge Hill Learning Disability Unit.

Comments / Complaints

We aim to offer the highest standard of service. Should you have any comment or complaint to make regarding the service you have received please contact Dr Nick Plant or the Practice Manager, Carol Jones.

Records

We keep a computerized record at the surgery and scanned letters. We use a handheld computer to take this information to the homes. We keep the paper originals at the home and take all letters to the homes to keep nursing and care staff fully informed.
We have an admission procedure for each new resident with a proforma of essential information that is faxed to the practice.

Contact: carol.jones2@dudley.nhs.uk
HARMS Project:
Shropshire County PCT

Abbreviations:

CHUMS - Care Homes Use of Medicines Study
HARMs - Hospital Admissions Relating to Medicines
HART - HARMs assessment report template
(MCAP - Medicines Care Action Plan
(REview data collection form)
MAR - Medicines Administration Record
MMT - Medicines Management Team
PBP - Practice-based Pharmacist

Background

The overall incidence of hospitals admissions related to medicines (HARMs) is around 4.9% to 5.3% and these account for 3.7% to 4.3% of all hospital admissions. Data from the Strategic Health Authority suggests that there were 78,000 such admissions last year in the West Midlands, of which 52,260 were potentially preventable. This means:

- There are potentially more than 418,080 bed days lost due to HARMs.
- The average cost of an admission is approximately £1,400 in the West Midlands.
- This indicates that the financial impact of potentially avoidable HARMs is over £72 million each year.

Initial funding for a pilot project was obtained via a SHA Emergency Threshold bid, which was then submitted to the PEC and the Prioritisation Committee for approval. The original project proposed various initiatives to identify patients at risk of HARMs, namely:

- Those having had 3 or more unplanned medical admissions in a year
- Patients in community hospitals
- Patients attending monthly ‘falls’ clinics
- Patients being reviewed by community matrons
- Patients in care homes
- All patients over 75 under the care of their GP who are taking higher-HARMs risks medicines, or who are on four or more medicines.

Pilot Project

Scoping the need for a HARMs service was determined through a pilot project. The SHA had identified a list of which medicines are more likely to be implicated in HARMs and these were incorporated into a reporting template (HART) which PBPs used while reviewing patient records. The PBP would assess each patient for potential problems which could be linked to a possible or actual admission to hospital. All interventions proposed by the PBP were ranked as red (urgent action required), orange (timely review/action required) or green (no intervention required). Interventions were then either documented on a MCAP for consideration by the patient’s GP at their convenience or discussed with the GP in a face-to-face meeting.

The main focus of the pilot project was to determine the feasibility and reproducibility of conducting in-depth medicines reviews by pharmacists in the Care Home Setting, as recommended by the CHUMS report. Four Care Homes were targeted in the pilot project and two approaches were adopted (Appendix 1). Three pharmacists and one pharmacy technician were recruited on a part-time basis for the pilot project. The work was conducted between November 2010 and March 2011. The key findings are summarised in Appendices 4 and 5.
Interim results from the pilot project were submitted to the PCT to secure future funding for the HARMs initiative. Current funding for the project stands at 1.4 WTE Band 8A Pharmacist and 0.4 WTE Band 5 Pharmacy technician time. To date 17.5 hours pharmacist’s time has been secured.

Current Scoping

A research paper published by the King’s Fund examined a number of issues relating to avoiding hospitals admissions. It concluded that there is a lack of clear evidence in both identifying patients at risk of emergency admissions and interventions to prevent them. Therefore, a broad methodology that seeks to address some of the factors that are known to contribute to hospital admissions would appear to be the most pragmatic approach until clear and robust evidence emerges.

The following HARMs initiatives will be explored in the next phase of the project. A simplified HARMs Intervention Template has been developed from the HART and MCAP for intervention recording across all settings.

1) Medication Reviews in Care Homes
2) Referrals from Falls Clinics
3) Community Hospitals - improved discharge data (CQUINs target)
   - identification of vulnerable patients to follow up post discharge
4) Links with Secondary Care (SaTH), eg
   - interfacing with secondary care pharmacists to identify vulnerable patients for follow up post discharge
   - improved discharge data (CQUINs target)

References


Contact: ceri.wright@nhs.net