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How new care models are (likely to be) making a difference to residents in care homes

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OPTIMAL TEAM

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Department of Health Disclaimer:
The views and opinions expressed therein are those of the authors and do not necessarily reflect those of the HS&DR, NIHR, NHS or the Department of Health.

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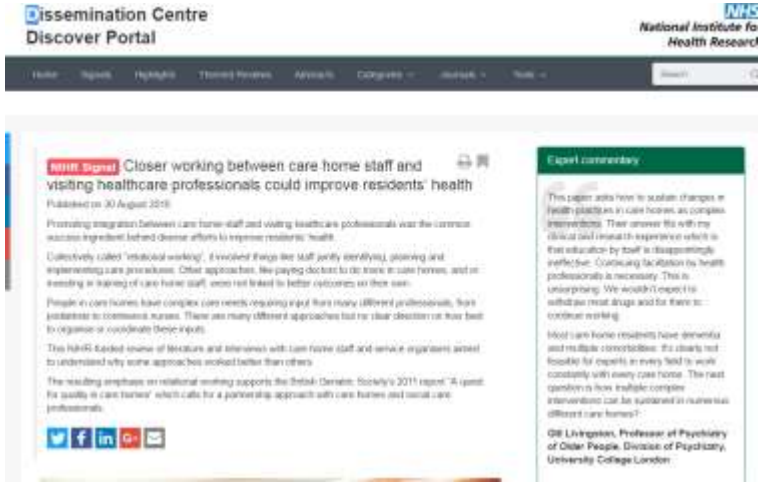
Phase one: Realist review

- Financial incentives or sanctions,
- Agreed protocols
- Clinical expertise
- Structured approaches to assessment and care planning

Of themselves likely to be **insufficient** to achieve change **if** they did not lead to NHS and care home staff working together to identify, plan and implement care home appropriate protocols



Optimal Phase 2

- 3 sites
- 12 care homes
- 239 residents
- 116 interviews
  - NHS and Care home staff
  - Residents & Relatives
  - Commissioners (including GP commissioners)
- 14 focus groups

Three sites similar aims different approach

Site 1 Care home specialist teams linked with other older people teams and Geriatricians

Site 2 linked care homes to specific GP practices + funding to support training of care home staff in complex care

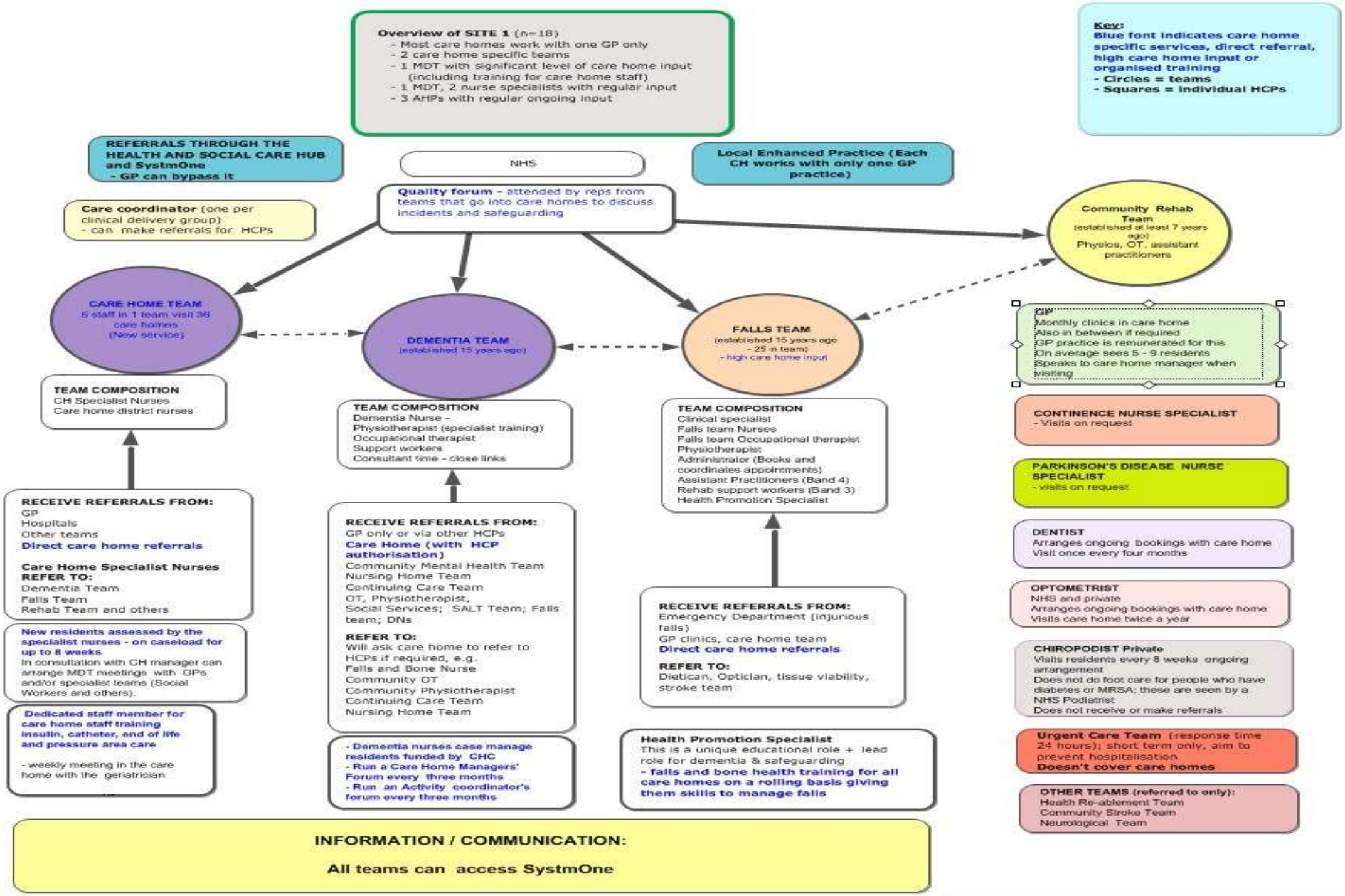
Site 3 Relied on GPs visiting individual residents with some extra nursing provision for care homes. Care home managers had all completed a **leadership programme**.

- Backdrop of reorganisation and changes to organisation of services
  - **New** NHS developed personalised care plans for care home residents
  - **Reorganisatio**n of community nursing services
  - Winter pressures **funding**
  - **Multiple** NHS trusts providing services to care homes
  - GP clinics introduced **then stopped**
  - Locum GPs replacing GPs who had retired were off sick **refusing** to visit care homes
  - Community dentists **stopped** visiting care homes
  - To **reduce need** for SALT community nurses trained in swallowing assessments
  - **Turnove**r of NHS staff working with care homes and care home managers


North Sea
Edinburgh
Glasgow
United Kingdom
Isle of Man
Leeds
Manchester
Dublin
Ireland
Liverpool
Birmingham
London
Amsterdam
Netherlands
Düsseldorf
Belgium
Cologne

Outcomes of interest

- Medication use
- Out-of-hours consultations
- Resident, carer and staff satisfaction
- Unplanned hospital admissions
- Length of hospital stay
- Costs of care to the NHS


Overview of SITE 1 (n=18)
- Most care homes work with one GP only
- 2 care home specific teams
- 1 MDT with significant level of care home input (including training for care home staff)
- 1 MDT, 2 nurse specialists with regular input
- 3 AHPs with regular ongoing input
Key:
Blue font indicates care home specific services, direct referral, high care home input or organised training
- Circles = teams
- Squares = individual HCPs
REFERRALS THROUGH THE HEALTH AND SOCIAL CARE HUB and SystmOne
- GP can bypass it
NHS
Local Enhanced Practice (Each CH works with only one GP practice)
Quality forum - attended by reps from teams that go into care homes to discuss incidents and safeguarding
Care coordinator (one per clinical delivery group)
- can make referrals for HCPs
Community Rehab Team
(established at least 7 years ago)
Physios, OT, assistant practitioners
CARE HOME TEAM
6 staff in 1 team visit 36 care homes
(New service)
DEMENTIA TEAM
(established 15 years ago)
FALLS TEAM
(established 15 years ago
- 25 in team)
- high care home input
GP
Monthly clinics in care home
Also in between if required
GP practice is remunerated for this
On average sees 5 - 9 residents
Speaks to care home manager when visiting
TEAM COMPOSITION
CH Specialist Nurses
Care home district nurses
TEAM COMPOSITION
Dementia Nurse -
Physiotherapist (specialist training)
Occupational therapist
Support workers
Consultant time - close links
TEAM COMPOSITION
Clinical specialist
Falls team Nurses
Falls team Occupational therapist
Physiotherapist
Administrator (Books and coordinates appointments)
Assistant Practitioners (Band 4)
Rehab support workers (Band 3)
Health Promotion Specialist
CONTINENCE NURSE SPECIALIST
- Visits on request
PARKINSON'S DISEASE NURSE SPECIALIST
- visits on request
DENTIST
Arranges ongoing bookings with care home
Visit once every four months
OPTOMETRIST
NHS and private
Arranges ongoing bookings with care home
Visits care home twice a year
CHIROPODIST Private
Visits residents every 8 weeks ongoing arrangement
Does not do foot care for people who have diabetes or MRSA; these are seen by a NHS Podiatrist
Does not receive or make referrals
Urgent Care Team (response time 24 hours); short term only, aim to prevent hospitalisation
Doesn't cover care homes
OTHER TEAMS (referred to only):
Health Re-ablement Team
Community Stroke Team
Neurological Team
RECEIVE REFERRALS FROM:
GP
Hospitals
Other teams
Direct care home referrals
Care Home Specialist Nurses REFER TO:
Dementia Team
Falls Team
Rehab Team and others
New residents assessed by the specialist nurses - on caseload for up to 8 weeks
In consultation with CH manager can arrange MDT meetings with GPs and/or specialist teams (Social Workers and others).
Dedicated staff member for care home staff training insulin, catheter, end of life and pressure area care
- weekly meeting in the care home with the geriatrician
RECEIVE REFERRALS FROM:
GP only or via other HCPs
Care Home (with HCP authorisation)
Community Mental Health Team
Nursing Home Team
Continuing Care Team
OT, Physiotherapist,
Social Services; SALT Team; Falls team; DNs
REFER TO:
Will ask care home to refer to HCPs if required, e.g.
Falls and Bone Nurse
Community OT
Community Physiotherapist
Continuing Care Team
Nursing Home Team
- Dementia nurses case manage residents funded by CHC
- Run a Care Home Managers' Forum every three months
- Run an Activity coordinator's forum every three months
RECEIVE REFERRALS FROM:
Emergency Department (injurious falls)
GP clinics, care home team
Direct care home referrals
REFER TO:
Dietican, Optician, tissue viability, stroke team
Health Promotion Specialist
This is a unique educational role + lead role for dementia & safeguarding
- falls and bone health training for all care homes on a rolling basis giving them skills to manage falls
INFORMATION / COMMUNICATION:
All teams can access SystmOne

REFERRALS THROUGH:
- **Majority through GP**
- Single point of access
- SystmOne

Overview of SITE 2 (n=9)
- care homes work with 1-3 GP practices
- 1 specialist practitioner dedicated to working with care homes only on eol care
- 2 specialist nurses, nursing and mental health teams, 2 AHPs visit on request

Named GPs receive additional payment to work with care homes
- (1-3 practices per care home)

KEY:
Blue font indicates care home specific services, direct referral, high care home input or organised training
- **Circles = teams**
- **Squares = individual HCPs**

NHS

COMMUNITY NURSING TEAM
- one team visits 6 care homes

TECHNICAL INSTRUCTOR for OT / PHYSIOTHERAPIST

6 trained nurses
3 HCAs staff in 1 team
(Integrated with the physiotherapists and OTs)

RECEIVE REFERRALS FROM:
GP
Hospitals
Social worker
Direct care home referrals for DNs but through GP for therapists apart from replacing equipment

EXTERNAL REFERRALS:
Tissue viability nurse specialist
GP
Continuing health care assessor
Social work care managers

Out of hours team covers nursing emergencies - from 5pm overnight

INFORMATION / COMMUNICATION:
Access SystmOne

PALLIATIVE CARE NURSE SPECIALIST
- based in the hospice team
- only works with care homes
- goes into 15 care homes in site 2
- active caseload of 5-10 residents
- regular joint visits and meetings with other HCPs

Works with hospice team
Specialist nurses
OT, SALT
physio
counselling
Consultant time

RECEIVE REFERRALS FROM:
Hospital - 20%
Direct referrals from care Homes - 75 % (including nursing homes)
Nurse specialist e.g. neurological MDT, heart failure NS, respiratory NS, family can also refer
REFER TO:

Other members of the hospice team, lymphoedema service, rapid response hospice at home, GP, DN, tissue viability NS, dietician, continuing nurse assessor

Regular training for care homes on end of life care. Topics requested by care home staff

INFORMATION / COMMUNICATION:
Paper light but uses different electronic system so not possible to share notes with other HCPs

TISSUE VIABILITY NURSE SPECIALIST

RECEIVE REFERRALS FROM:
GP
District nurses
Nursing home may refer direct

REFER TO:

GP for vascular team
District nurses for residential homes and nursing homes
Dietician

- Provides training to the top ten care home referrers CQUIN target
- Also provides training for care homes through sessions for care providers association

INTENSIVE MENTAL HEALTH TEAM
- co-location with team for older people (mental health)
- covers all care homes in site 2

TEAM COMPOSITION
Community Psychiatric Nurses
OTs
WORKS CLOSELY WITH:
- mental health team focusing on older people
- psychiatrist

RECEIVE REFERRALS FROM:
- mental health team
- GP
- hospital ward staff
- social worker
- memory service

Care homes have to refer via GP

REFER TO:
Older people's team, OT, dietician, SALT

INFORMATION / COMMUNICATION:

Access SystmOne

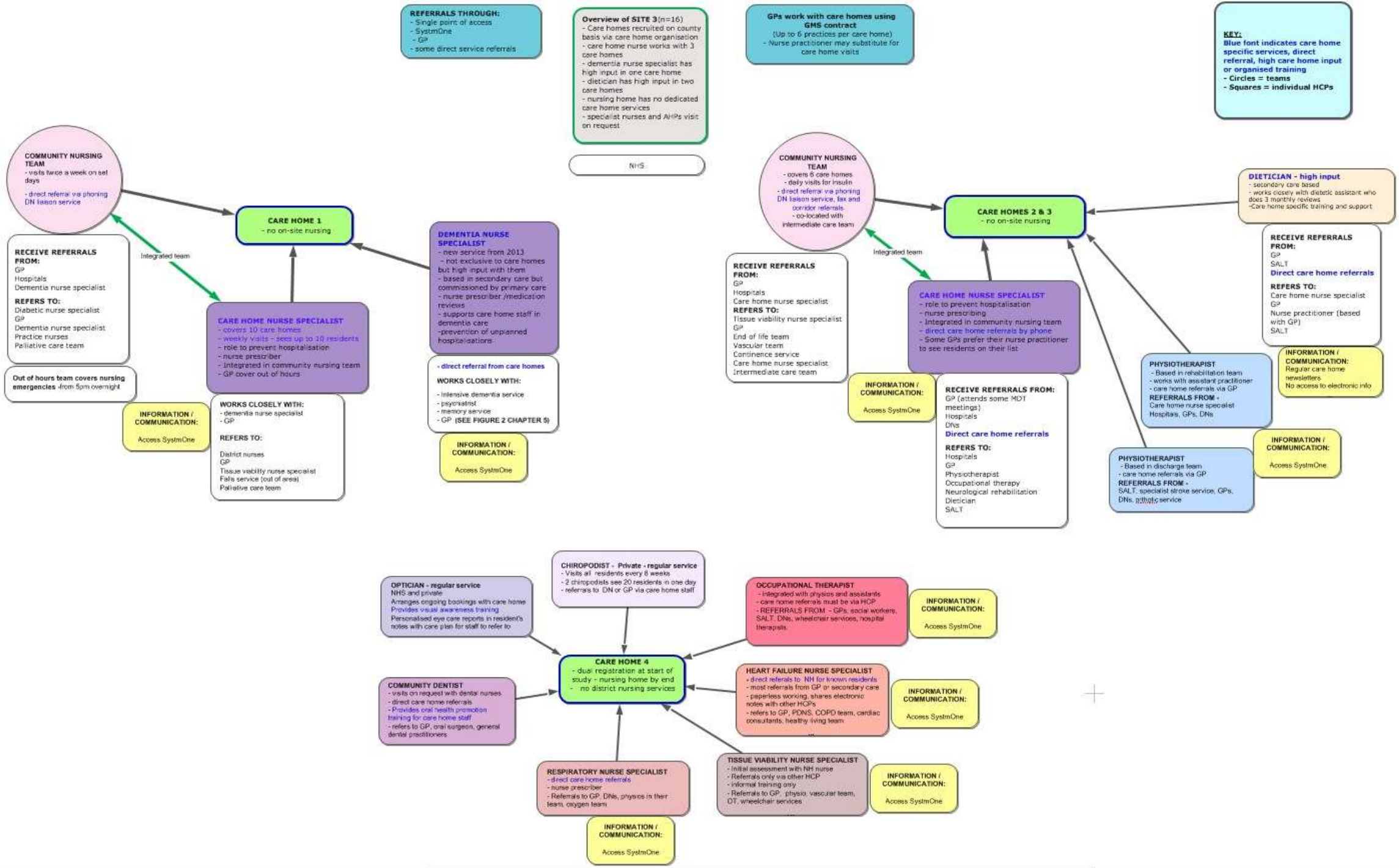
CONTINUING HEALTH CARE ASSESSOR
works for CCG and covers nursing homes
checks nursing needs are met and funding is appropriate
referrals to other services will be via the GP

GP
Weekly clinics in care homes
Also in between if required
GP practice is remunerated for this
Some care homes still have residents registered with GPs that visit on request

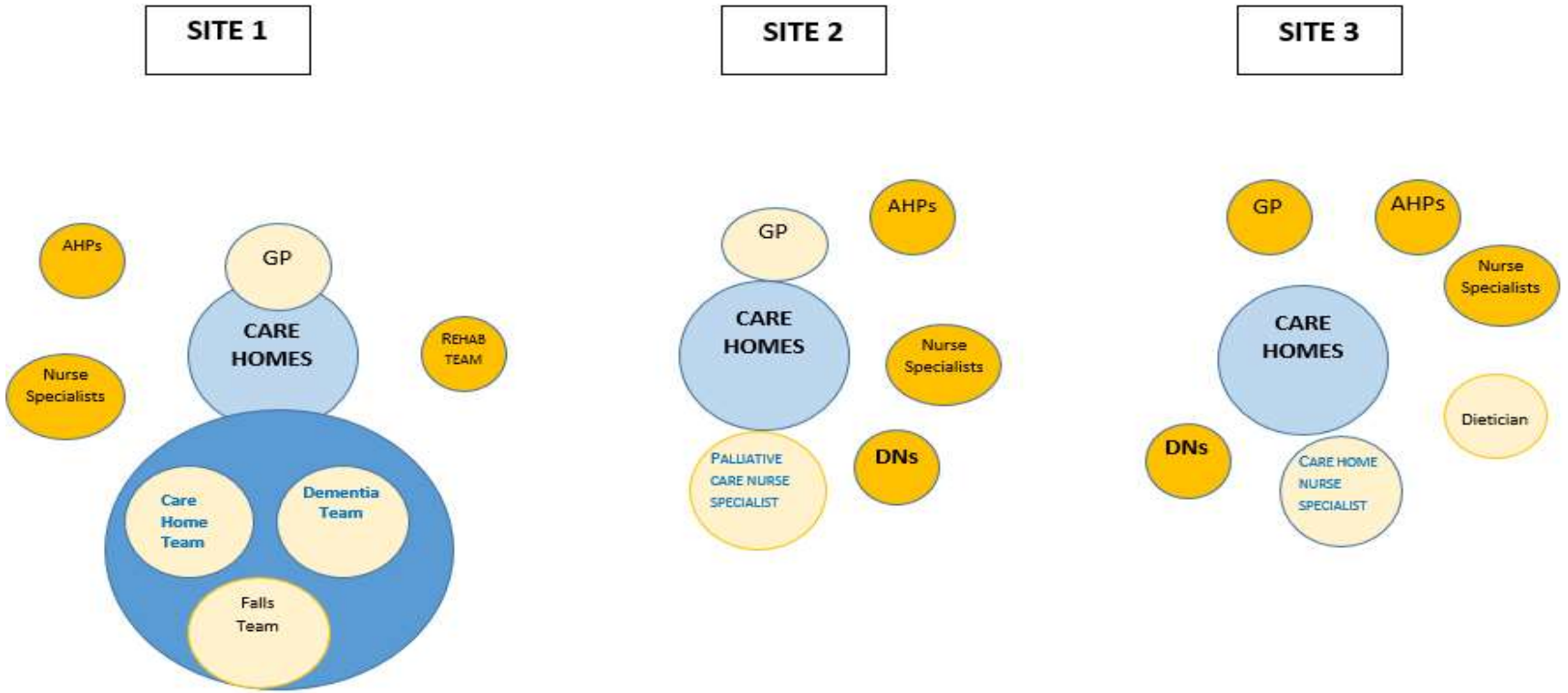
OPTICIAN
NHS and private
Arranges ongoing bookings with care home
Visits care home once a year
Personalised eye care reports in resident's notes with care plan for staff to refer to

CHIROPODIST Private
Visits residents every 6- 8 weeks ongoing arrangement
Any referrals are made through the care home staff e.g. DN

OTHER TEAMS (referred to only):
Neurological Team


REFERRALS THROUGH:
- Single point of access
- SystmOne
- GP
- some direct service referrals
Overview of SITE 3(n=16)
- Care homes recruited on county basis via care home organisation
- care home nurse works with 3 care homes
- dementia nurse specialist has high input in one care home
- dietician has high input in two care homes
- nursing home has no dedicated care home services
- specialist nurses and AHPs visit on request
NHS
GPs work with care homes using GMS contract
(Up to 6 practices per care home)
- Nurse practitioner may substitute for care home visits
KEY:
Blue font indicates care home specific services, direct referral, high care home input or organised training
- Circles = teams
- Squares = individual HCPs
COMMUNITY NURSING TEAM
- visits twice a week on set days
- direct referral via phoning DN liaison service
RECEIVE REFERRALS FROM:
GP
Hospitals
Dementia nurse specialist
REFERS TO:
Diabetic nurse specialist
GP
Dementia nurse specialist
Practice nurses
Palliative care team
Out of hours team covers nursing emergencies -from 5pm overnight
Integrated team
CARE HOME 1
- no on-site nursing
CARE HOME NURSE SPECIALIST
- covers 10 care homes
- weekly visits - sees up to 10 residents
- role to prevent hospitalisation
- nurse prescriber
- integrated in community nursing team
- GP cover out of hours
INFORMATION / COMMUNICATION:
Access SystmOne
WORKS CLOSELY WITH:
- dementia nurse specialist
- GP
REFERS TO:
District nurses
GP
Tissue viability nurse specialist
Falls service (out of area)
Palliative care team
DEMENTIA NURSE SPECIALIST
- new service from 2013
- not exclusive to care homes but high input with them
- based in secondary care but commissioned by primary care
- nurse prescriber /medication reviews
- supports care home staff in dementia care
-prevention of unplanned hospitalisations
- direct referral from care homes
WORKS CLOSELY WITH:
- Intensive dementia service
- psychiatrist
- memory service
- GP (SEE FIGURE 2 CHAPTER 5)
INFORMATION / COMMUNICATION:
Access SystmOne
COMMUNITY NURSING TEAM
- covers 6 care homes
- daily visits for insulin
- direct referral via phoning DN liaison service, fax and corridor referrals
- co-located with intermediate care team
RECEIVE REFERRALS FROM:
GP
Hospitals
Care home nurse specialist
REFERS TO:
Tissue viability nurse specialist
GP
End of life team
Vascular team
Continence service
Care home nurse specialist
Intermediate care team
Integrated team
CARE HOMES 2 & 3
- no on-site nursing
CARE HOME NURSE SPECIALIST
- role to prevent hospitalisation
- nurse prescribing
- Integrated in community nursing team
- direct care home referrals by phone
- Some GPs prefer their nurse practitioner to see residents on their list
INFORMATION / COMMUNICATION:
Access SystmOne
RECEIVE REFERRALS FROM:
GP (attends some MDT meetings)
Hospitals
DNs
Direct care home referrals
REFERS TO:
Hospitals
GP
Physiotherapist
Occupational therapy
Neurological rehabilitation
Dietician
SALT
DIETICIAN - high input
- secondary care based
- works closely with dietetic assistant who does 3 monthly reviews
-Care home specific training and support
RECEIVE REFERRALS FROM:
GP
SALT
Direct care home referrals
REFERS TO:
Care home nurse specialist
GP
Nurse practitioner (based with GP)
SALT
INFORMATION / COMMUNICATION:
Regular care home newsletters
No access to electronic info
PHYSIOTHERAPIST
- Based in rehabilitation team
- works with assistant practitioner
- care home referrals via GP
REFERRALS FROM -
Care home nurse specialist
Hospitals, GPs, DNs
INFORMATION / COMMUNICATION:
Access SystmOne
PHYSIOTHERAPIST
- Based in discharge team
- care home referrals via GP
REFERRALS FROM -
SALT, specialist stroke service, GPs, DNs, arthritis service
CHIROPODIST - Private - regular service
- Visits all residents every 8 weeks
- 2 chiropodists see 20 residents in one day
- referrals to DN or GP via care home staff
OPTICIAN - regular service
NHS and private
Arranges ongoing bookings with care home
Provides visual awareness training
Personalised eye care reports in resident's notes with care plan for staff to refer to
OCCUPATIONAL THERAPIST
- Integrated with physios and assistants
- care home referrals must be via HCP
- REFERRALS FROM - GPs, social workers, SALT, DNs, wheelchair services, hospital therapists.
INFORMATION / COMMUNICATION:
Access SystmOne
CARE HOME 4
- dual registration at start of study - nursing home by end
- no district nursing services
COMMUNITY DENTIST
- visits on request with dental nurses
- direct care home referrals
- Provides oral health promotion training for care home staff
- refers to GP, oral surgeon, general dental practitioners
HEART FAILURE NURSE SPECIALIST
- direct referrals to NH for known residents
- most referrals from GP or secondary care
- paperless working, shares electronic notes with other HCPs
- refers to GP, PDNS, COPD team, cardiac consultants, healthy living team
INFORMATION / COMMUNICATION:
Access SystmOne
RESPIRATORY NURSE SPECIALIST
- direct care home referrals
- nurse prescriber
- Referrals to GP, DNs, physios in their team, oxygen team
TISSUE VIABILITY NURSE SPECIALIST
- Initial assessment with NH nurse
- Referrals only via other HCP
- Informal training only
- Referrals to GP, physio, vascular team, OT, wheelchair services
INFORMATION / COMMUNICATION:
Access SystmOne
INFORMATION / COMMUNICATION:
Access SystmOne

Continuum of integration and referral systems



No difference in overall costs between sites (with caveats).

- Average total cost use, **per participant**, excluding hospital stays, was:

  Site 1 £634
  Site 2 £730
  Site 3 £880
  (With hospital admissions means rise to £1160, £1190 and £2096)

- **Site 1,** extra funding for formalised CH provision, not focussed around the GP **not more expensive**.
- **Site 2** GP costs were significantly higher , financial incentives mainstay of the service model to encourage increased GPs contact.
- **Site 3** Residents lower dependency **bu**t more secondary care non-admitted contacts, as well as a trend towards higher costs associated with hospital admissions. May suggest a tendency to refer residents into hospital, rather than provide care in-situ

Phase two: 3 sites

- Majority of residents were **low users** of NHS services
- Residents' (InterRAI data) pain, pressure ulcer prevalence, medication use and comorbidities predicted increased health service utilisation
- Prescribing profile similar to national picture
- GP most heavily utilised service (**but not in the same way**)
- **Different narratives** of how NHS work with care homes both **within** and across sites

Achieving common ground

- Supporting (incentivising) the right mix of people to be involved in the design of health care provision to care homes such as discussions before setting up a services, use of shared protocols and guidance and regular meetings (context)
- Prompts co-design and alignment of health care provision with the goals of care home staff and a shared view about what needs to be done (mechanism).
- Creates services credible to care home staff and relevant for residents, with the result that there is review and anticipation of residents' needs including medication and retaining residents with complex care needs in the care home (outcome).

Translation

- Ask care homes, including residents and relatives, what works for them.
- Consider that every care home will be different – avoid “one size fits all”.
- Consider care home readiness for change.

Learning and working

- When health care provision is funded to work with care homes on a regular basis and services have developed over time, and practitioners see this as a legitimate and manageable use of their time and skills (contexts)
- Staff and services are more likely to develop ways of working that seek to link residents with other NHS services and work with care home staff to resolve problems (mechanisms).
- This can lead to improved access to NHS services, crises avoided and care home staff and resident satisfaction with health care provision (outcomes)

Translation

- Find way to work with care homes at an institutional level, as well as engaging with individual resident.
- Consider how the organisational structure of the care home can support care delivery, including education and training, and audit.
- Consider badging jobs/services, or parts of them, as “care home specific”.

Working within a system of care: wrap around care for older people with frailty

- Commissioning several NHS services to work with care homes on a regular basis this creates a network of expertise in the care of older people (context)
- Increases NHS Staff and services' confidence and ability to refer residents and review care to adapt patterns of service delivery (mechanisms).
- This can improve residents' access to care and reduce demand on urgent and emergency care services (outcomes).

Translation

- Consider how care home staff trigger, refer to and interact with your service.
- Consider how services with care homes interconnect, make referrals, share observations and exchange ideas.
- You can’t write GPs out of service models – but you can make different (perhaps even better) use of their time.

Living and dying with dementia

- When NHS and care home staff have access to dementia expertise and *ongoing* training and support in dealing with residents' behaviours that they find challenging (context)
- They are likely to be confident using skills in providing dementia care and be proactive seeking support (mechanism)
- This reduces the need for antipsychotic prescribing and minimises the distress of residents (outcome).

Translation

- Whatever you choose to do needs to work for residents with dementia.

- And to link into dementia-specific care home services.

Conclusions

NHS services are more likely to work well with care homes when

- Payments and role specification endorse staff working with care homes at an institutional level as well as with individual residents.
- Activities that enable NHS staff and care home staff to co-design how they work together to improve residents' health care.
- Likely to require initiatives that focus on relationship building, and long term resource allocation by the NHS for working with and around care homes.

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OPTIMAL first look https://www.journalslibrary.nihr.ac.uk/programmes/hsdr/11102102/#/