Changing the culture of personalised care plans in care homes: The Bromley experiment

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Introduction

Care home residents are entering care homes later in life with increasing frailty and comorbidities, including increased prevalence of dementia. These people are vulnerable within the spectrum of their illnesses but are also subjected to variable (and often inequitable) access to integrated healthcare resulting in lack of continuity of care, polypharmacy, avoidable hospital admissions, increasing morbidity and poor patient experience.

Providing proactive care for people living in care homes is the goal of the Enhanced Health in Care Homes (EHCH) Framework. Multidisciplinary team (MDT) working is critical to the success of the EHCH model.

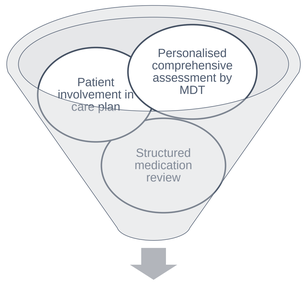

Figure 1. EHCH contractual elements 2024

Methodology

A pilot MDT intervention was delivered across eleven older peoples care settings with the most ambulance conveyances. MDT members were from general practice (including pharmacist), Gerontology, ambulance service, district nursing, Palliative and end-of-life care, Psychiatry, Social Care, Integrated Care Board and senior care home staff.

The intervention was refined iteratively over five months via a Plan-Do-Study-Act cycle. The MDT undertook comprehensive geriatric assessments, advance care planning and structured medication reviews for 69 of the most complex and multi-morbid patients. Outcomes were documented in personalised care and support plans (PCSP) using a digital platform (Universal Care Plan) used widely across London boroughs.

Figure 2. Multi-disciplinary conference in a care home supported by an engaged care home team

Results

- **Increased PCSP:** 100% MDT patients had a PCSP post-MDT. Resultant system culture change saw a three-fold increase in new PCSPs across all care settings.
- **Reduced 999 activity:** average monthly number of 999 calls reduced for 54% MDT patients across 8 settings.

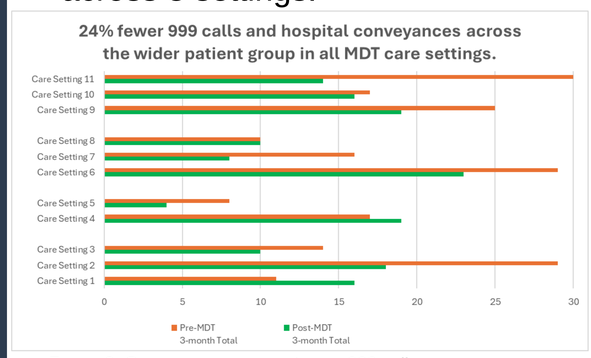

Figure 3. Graph showing reduction in 999 calls and conveyances for MDT care settings

- **Reduced polypharmacy**: on average, 1.2 medicines per patient were deprescribed. Presence of a pharmacist almost doubled deprescribing rate up to 1.5 (vs 0.8 without pharmacist)
- **MDT member satisfaction:** MDT professionals, including care home staff valued shared learning and shared clinical decision-making.

Conclusion

The care home MDT was an effective intervention, addressing health inequalities of frail, older patients with mLTCs, sharing decision making and clinical risk. Through proactive personalised care planning, it offered opportunities for more efficiency of diagnosis, treatment and effective prescribing with swifter recognition of phase of illness.

Future programmes of work will focus on:

- Mainstreaming an MDT model for the most complex care home residents *[complex dementia and severe frailty]*
- Further upskilling clinicians in areas of lessons learnt and developing AI powered clinical tools in this space.

Learning from this work demonstrates the power of cross-organisation working. The 25/26 strategy builds on this moving towards frailty integrated neighbourhood teams.

Acknowledgements

Figure 2. Photo provided by Jawa Group
Figure 3. Data sourced from London Ambulance Service