Proactive Care in Independent Living Facilities – Reducing Unplanned Demand on the Health Economy

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Introduction

As the population ages local health services are under increasing pressure as there is an increasing demand for support and input. Health services are often reactive in nature and are sought in times of crisis for the individual requiring swift action to resolve.

Independent living facilities are generally sought by people who are finding it difficult to live independently, often due to an increasing frailty burden. It can be assumed therefore that there will be some increased need with physical and/ or cognitive tasks which may require a higher level of support than the general population. When reviewing our referrals over a 12-month period we noticed the demand on the FST (Frailty Support Team) was significantly greater in the independent living facilities than the general population.

Despite this increased demand there remains a disparity regarding primary care commissioning. Unlike nursing and residential homes there is no enhanced primary care provision.

We suspected that by adopting a proactive approach there is potential to reduce unplanned demand which in turn could save the wider NHS funds through identifying and mitigating risks prior to crisis.

Aim

The aim of this project was to see if a proactive approach to managing those with increasing care needs, for those residing in independent living facilities, could reduce the incidences of unplanned healthcare contact, including admission, on the local healthcare system.

This was to be achieved through a planned, holistic clinical assessment, a medication review aimed at reducing the burden of polypharmacy, an equipment/ environmental review to identify any physical risks/ provide equipment and the opportunity to discuss and complete do not resuscitate orders and advanced care plans.

We CARE through:

Compassion Accountability Respect Excellence

Methodology

All residents of a local independent living facility (who did not require specialist care) were invited to participate. Invitations were shared via letter delivered to the resident. Volunteer numbers were low and so all those who responded were invited to participate. Each participant had a 2 hour face-to-face (F2F) assessment in their own home. Participants were grouped according to care needs into low, medium and high groups:

'Low need'- residents not currently requiring any care.

Medium need'- those requiring OD/BD PoC.

'High need' those residents requiring a TDS or QDS package of care (PoC).

The 12-month period preceding the intervention was reviewed as well as six months post intervention.
Unplanned access to healthcare was defined as any patient-initiated contact and identified through the GP connect system. Unplanned contact was recorded as:

GP Triage Call

Telephone Consultation Primary Care

Home Visit Primary Care

111 Contact

999 Attendance

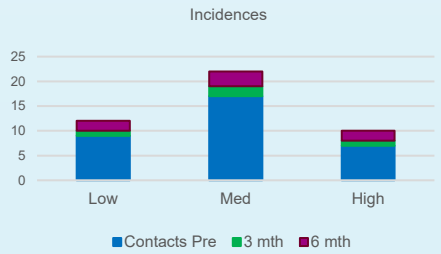
ED Admission

Number and type of unplanned healthcare access contacts were recorded with costings calculated for all contacts both before and after intervention. The costings and type of contact were then compared to understand if there was any changes noted.

Results

Participants	CFS	Contacts pre intervention	Contacts post intervention at 6 months	6 Month reduction in %	6 Month gross cost saving (£)	6 Month net cost saving (£)*
No PoC	4	9	3	66	464	393
Once/ twice PoC	6	17	5	61	573	502
Three/ four times daily PoC	7	7	5	29	256	185
Average	6	11	4	52	431	383

*Net savings allowed for 3 hours of Agenda for Change 23/24 mid band 7 pay



Initial F2F
3-month telephone review
6-month non-contact review of medical notes

F2F is the most effective at reducing incidents

Thanked for the time and support in getting the surgery to refer onto urology and ensuring that she was well set up.

Wife very thankful for all the support from the frailty team and stated that she that as a family they were in a better place to discuss the ACP and put forward planning in place, thanked again for taking time to support emotional needs of patient.

Conclusion

Every time a person experiences a crisis it has a significant impact on their physical and mental health as well as their support network.

As the population ages and life expectancy increases so does complexity and morbidity. This in turn exponentially stresses the healthcare systems. A crisis management approach is short-term, rarely individualised and carries significant negative unintended consequences for individuals such as loss of independence, undermined wellbeing, and diminished quality of life.

Investing in a proactive approach could reduce the burden on the local health services, in turn potentially saving significant amounts of resources by dealing with the problems before crisis. This could reduce the interventions required by GP's and free up resource thereby reducing the average wait time for primary care appointments.

Recommendations

The finding of this project suggest a longer and larger trial however, requires the investment to deliver and confirm if does have a positive change.

Acknowledgements

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