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Enhanced health in care homes – learning from the vanguards and primary care homes

William Roberts, Head of Health and Social Care, Innovation Unit and former National Lead, Enhanced health in care homes vanguards, NHS England, Lesley Bainbridge, Clinical Lead, North East and North Cumbria Frailty Network, Newcastle Gateshead Clinical Commissioning Group and Dr Jeremy Carter, GP and Lead, Herne Bay Primary Care Home

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Innovation Unit
New solutions
for thriving societies

The Enhanced Health in Care Home Vanguards Primary Care

William Roberts
Head of Health and Social Care

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The Care Home Vanguards

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Why

- Care homes residents are a frail, vulnerable population with increasingly complex needs & dependency with variable access to NHS services
- Hospital-based interventions have limited effectiveness for this population

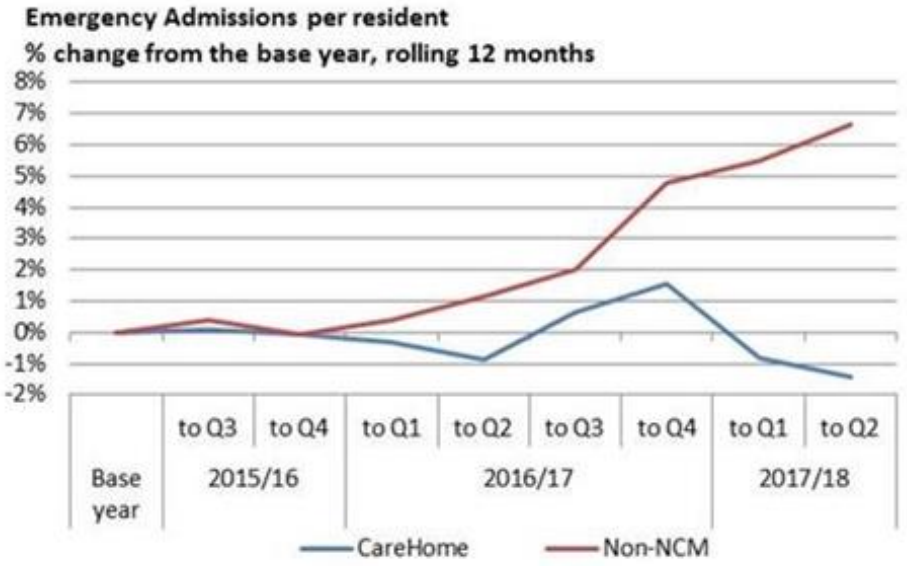
What

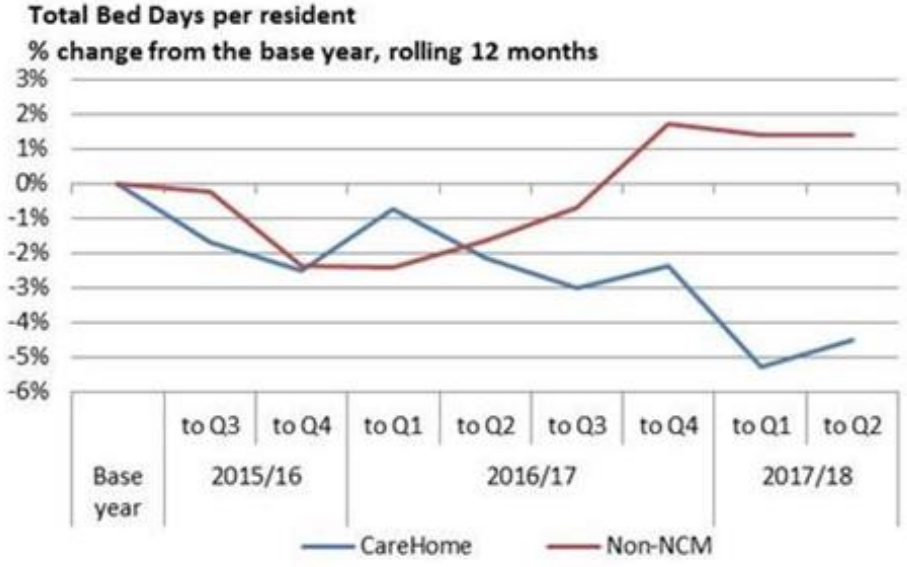
- 6 exemplar sites across the country
- These 6 sites are providing joined-up primary, community and secondary, social care to residents of care/ nursing homes and Extra care Living Schemes

How

- Co-production- top-bottom
- With not to
- Whole system, multiple changes, coordinated

Performance from baseline





There has been a consistent and sustained trend in the performance of care home vanguards

		Care Home Vanguards	Non-NCM
Change from baseline	Emergency Admissions	**-1.4%**	**6.7%**
	Bed Days	**-4.5%**	**1.4%**

Average ROI- 52%

NHS ENGLAND ORE team

The Impact

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Better relationships between commissioners and providers

Staff more engaged and enthused

Improved access to NHS services for care home residents

Financial savings

What have we learned

- Person centred approach essential and focus on the populations health and needs
- Implementing evidence based care important
- Care homes critical partner in the work at all stages
- Not one change that makes a difference, requires a coordinated approach to improvement as isolated initiatives may create unwanted consequences
- Great work goes on all over the country, but it needs building upon and coordinating
- Primary Care Networks offer a real opportunity to embed great care for specific populations
- Relationships take time and compromise

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Lesley Bainbridge, Clinical Lead, North East and North Cumbria Frailty Network, Newcastle Gateshead Clinical Commissioning Group

NHS
Newcastle Gateshead
Clinical Commissioning Group

ENHANCED HEALTH in CARE HOMES

learning from the Vanguards: Newcastle Gateshead

Lesley Bainbridge, Clinical Lead, North East and North Cumbria Clinical Frailty Network

October 2019

The sharing: model and metrics

- Care home partnership
- Link practice
- Lead GP
- Ward round
- Nurse Specialists
- Virtual ward

	OUR CCG	Vanguard 5 Care Homes	Non V Care Homes
Emergenc	-3.2%	-1.4%	6.7%

SAVINGS	
Reduction Emergency Admissions Bed Days	£8,942,731
Ir	£ 1897,268

Andrew McCarthy, Joanne Gray,
Health and Life Sciences,
Northumbria University

The learning: real stuff

- Sustainable change takes time
- Know your population
- Use the evidence base
- Even with a proactive model reactive care is needed
- Developing the workforce is key
- Move with the times
- Specialists out of hospitals
- Ask questions of the data
- Don’t shout too early
- Find your clinical engagement superstars

NHS
Newcastle Gateshead
Clinical Commissioning Group

Thank You

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Enhanced health in care homes – learning from the vanguards and primary care homes

Dr Jeremy Carter, GP and Lead, Herne Bay Primary Care Home

Herne Bay PCH Care Home Pilot

- Herne Bay Demographic
  - Population (PHE 2018/2019) : 40718
  - >75yr 11.7% (7.8%), >85yr 3.8%(2.3%)
  - Care Home Beds 514 = 1.3% : Nursing Home 1.0% (0.5%)
- Herne Bay Practices working together 10+ years
- Herne Bay Health Care Ltd (HBHC)
- Care Home Plan
  - EHCH Framework
  - CCG / East Kent Care Home Group : ‘can it work at PCH level?’
  - Winter Pressures & Development Scheme funds
  - Pilot : Herne Bay

Care Home Pilot Detail

- Multidisciplinary / Multi-organisational Care Home support focussing on Advanced Care Planning
- Clinical Team
  - HBHC
    - 3 GP's, 2 Paramedic Practitioners, 1 Advanced Nurse Practitioner
    - Leadership for Project from 2 GP Frailty Leads
  - Kent Community Health NHS Foundation Trust (KCHFT)
    - Consultant HCOOP,
    - 1 Consultant Advanced Clinical Practitioners in Frailty
    - 1 Advanced Clinical Practitioners in Frailty
- 6 Care Homes
- Other stakeholders involved
  - Canterbury & Coastal CCG, South East Coast Ambulance (SECAmb), Kent County Council (KCC), CQC

Results

- Pilot for 9 months
- Metric outcome : Hospital Attendance (vs Admissions)
- Non Elective Hospital Attendances from the 6 care homes reduced by 27% compared to previous year : significant reduction ($p<0.042$)
- Qualitative Outcome : Care Home staff felt more confident to refer to Care Plans, and felt had other options than to call 999
- Some variance between care plan quality was identified

Lessons

- Positives
  - Demonstrated the PCH/PCN footprint can deliver this service with good outcomes
  - Good collaborative working between GP's & KCHFT
  - Strong Commissioning
  - Linking with SECAmb + KCC
- Further Development
  - Understanding the different outcomes between care homes
  - Possible Differences in Care Plans : standardising
  - Roll out to wider Care Home population
  - Involving Care Homes more in the PCN?
  - Could the model be adapted beyond Care Homes?
  - Can we build on the relationships to expand wider collaborative work?

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