Draft:

The Central Manchester Care Home Service- Integrated care for older people with severe frailty

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Abstract Locating and managing care of the frail elderly, living in Care homes, in a Primary Care setting leads to better outcomes for patients with a 68% reduction in unplanned admissions and 75% deaths occurring in the care home. The additional cost of the service is only 47% of the savings made when compared with the preceding year 2012. In 2013 the Service produces a net gain of £370,000 using the Better Care Fund formula. Patients and families report greater satisfaction. Morale improves in participating practices and in care homes. Primary Care is strengthened as it demonstrates its ability to care for the most vulnerable frail elderly.

Introduction

Elsewhere the literature suggests there are several models (Donald, 2008) for delivering a care home service, ranging from a secondary care Geriatrician led service through to a virtual GP Care Home practice. Others have suggested a variety of interventions to improve Care home medicine (Burns, 2013). More recently the RCGP and BGS (2016) have published, "Integrated care for older people with frailty", illustrating the diverse methods various groups, across the country, have developed to address care for the frail elderly. Local circumstances seem to dictate locally tailored solutions, and we offer ours.

Our experience in central Manchester, stemming from an 18 month action research project (SHINE) in 2012(ref) led by 2 senior community nurses was that Primary Care could deliver dramatic improvements in quality of life for patients, and improved professional job satisfaction, with marked decrease in unplanned admissions and most deaths occurring in the Homes. This was ascribed to two factors-good proactive care and anticipatory planning for death but, as importantly, an emphasis on team building to improve morale, develop trust and improve confidence in clinical care.

Why locate the service in General Practice?

GPs are generalists and, like their patients, value continuity. As patients get older they and their relatives value relationship-a doctor they know and can trust, over "anonymous" experts, realising implicitly that life is finite and quality of final years important. They want a doctor they trust, who knows them well, to advise and make nuanced decisions about treatment options. They want to be accompanied in their last illness and see their doctor as a witness to their lives. The current government's aspiration that each person over 75 should have a named doctor has hit a chord.

It is likely that doctors who are able to spend time getting to know patients and their relatives before they enter the final days or weeks of their lives, especially if demented, will have a better relationship and be more compassionate and in turn provide "better" care. Doctors also will benefit from the personal satisfaction and professional reward of caring for patients they know better.

The reality is that GPs are conflicted, with competing demands from patients, politicians and the way GP is financed. Des Spence has commented that QOF has focused doctors on measuring and manipulating patients' biochemistry and echoes Iona Heath complaint that we are focussed on biomedical asymptomatic disease rather than on caring for people who have illnesses with all the attendant fears and concerns. We've forgotten Hippocrates imperative "Cure sometimes, treat often, comfort always".

Furthermore there is a significant shift to provide medical care in the community, and recognition that as GPs we should be focusing on the 20% of the population with long-term conditions, complex co-morbidity and those approaching death. This requires attitudinal change but also increased time and resource. Currently we do busy surgeries and then "fit in" visits to nursing homes/ dying patients at lunchtime rather than seeing this as central and core work.

All these factors mean that dedicated time is needed for GPs and nurses to get to know patients and their relatives and that creating services, based in GP practices, delivering integrated care is preferable to bolt on services and the fragmentation of stand alone services.

Project development

In 2013 the convergence of a number of factors led to a proposal to provide a comprehensive service for our CCG. The central Manchester GP federation (NHS England, 2016) had been formed 2-3yrs previously and encouraged by the CCG was developing a number of GP projects. The NHS Better Care Fund (2017) provided a source of funding and there was the opportunity to collaborate with the community arm of the local hospital trust facilitated by previous joint working on the SHINE project.

The GP federation lead worked with CCG and community services leads to agree service specifications, budgets and structures to run the project. Baseline data for 2011-12 was collected and a jointly written bid document was submitted to the Better Care Fund bid process and approved.

GP practices were recruited to the project based on their pre-existing involvement in care homes to minimise the disruption of residents changing GPs. 8 practices were recruited with support from a clinical lead and supported by a dedicated nursing service, the Care Home support team(CHST) and medicines optimisation pharmacists. The community services arm of the local hospital recruits and employs the nursing and medicines optimisation staff under a subcontract from the GP federation which is the lead provider. The providers and leads meet monthly as a steering group to manage and shape the project as we proceed.

Project aims

1. Through better team working and regular education sessions, improve morale, develop trust and improve confidence in clinical care, in turn impacting on the following:
2. Improve quality of life for residents, and reduce iatrogenic harm, through proactive medical care and review
3. Improve medicines optimisation utilising pharmacy support
4. Reduce inappropriate unplanned admissions-known to have adverse outcomes
5. Allow most residents to die at home
6. Demonstrate cost savings to justify ongoing funding

Proposed Design and Rationale

At the time there was poor uptake of a LES to support Care home work, thought to be due to lack of financial resources, but also because there was a lack of clinical leadership and the absence of an appealing vision and a coherent strategy.

What is apparent is that patients and nursing home staff value regular contact with their doctor, and a practice that is both proactive and responsive to crises and a change in a patient's condition. It seems evident from SHINE (see above), that advanced care planning COMBINED with significant team building led to a reduction in both admissions and ensured most deaths occurred in the home. Subsequent experience was that after the intervention finished and with a change in staff, particularly at senior level, there was a return to previous behaviour with failure to use ACPs, rising anxiety among staff and an increase in unplanned admissions. This is only combated by ongoing relationship building with staff, careful analysis of significant events-eg deaths and admissions. Trust and confidence are built through frequent contact, both for patients and staff alike. Interestingly the work for doctors can be very rewarding with improved morale among staff, comforted patients and grateful relatives, along with professional satisfaction of managing complex clinical and ethically challenging problems.

Our assertion is that once yearly medical reviews, even if combined with ACPs, will not lead, per se, to better outcomes for patients or reduce inappropriate admissions. This is particularly the case if the doctor is not part of the team that provides normal reactive care.

One home is linked to one practice, bringing the benefits of consistency and developing long-term professional relationships. We feel that while there will be a lead GP within each practice that the whole practice should be involved to provide cover, but also professional support. We also recognise that there might be a critical mass in terms of number of patients, to allow the development of expertise and to maintain skills. While it seemed more efficient if all residents were registered with the same practice, we recognised some patients may wish to stay with their existing GP and we have allowed this to happen but we have seen care homes staff and relatives increasingly choosing to register with the practice with whom that care home has a special relationship.

Our experience is that a medium to large practice can manage up to 100 patients, but only if very enthusiastic and willing to commit a substantial resource. On average we think it requires 2-3 sessions per week to look after a 35 bed home with an annual throughput of circa 50 patients. We feel this can be achieved by one doctor and a deputy and is ideally suited to training practices as

there are excellent training opportunities and the trainees have a lot to offer the patients and the practices. From personal experience it feels comfortable to manage this workload, and still retain all the other elements of a varied and diverse generalist role.

We knew from discussion with practices that the LES was not taken up due to poor funding, poor support and a failure to help practices see how they could make it work as an enjoyable, satisfying part of the week. We therefore used a mentoring/educational model to provide support both through formal educational meetings but also informally on shared visits, discussion of cases and significant events eg of admissions and deaths. More experienced practitioners, both ACMs and GPs could partner with practices and NH to offer this support.

Evidence suggests that pharmacy input, reviewing medication and improving Care home systems can lead to significant cost savings, reduced GP callouts, admissions, falls and hip fractures (ref).

Two senior community nurses at ACM/ANP level were already providing some support to care homes, through managing minor illness, prescribing and advanced care planning, supporting and complementing GP work. We added 2 additional nurses to the team to expand the coverage to residential beds too.

Recruitment

- 361 patients registered with central Manchester GPs in 12 care homes supported by 8 practices
- A flexible matching of practices and different sized homes, based on the loose principle that 1 practice will wish to look after c 35-40 beds with a turnover of 50 pts/year
- Patients will be encouraged to register with the linked practice (with exceptions)
- Flexibility about registration of patients to accommodate small numbers who will wish to stay with own GP

The Contract

Practices subcontracted by the GP Federation:

- 1-2 sessions/week for proactive work-annual review; medication review and advanced care planning (lead GP). Practices are paid £380 per occupied bed per year and are encouraged to look after numbers of patients that fund sessions per week ie a minimum critical mass of approx. 30 patients.
- For Ad-hoc reactive care as required during the rest of the week (All practice team)
- SEA meetings as deemed necessary

For nurses and pharmacists from the foundation trust subcontracted by the GP federation:

- The Care Home Support Team of community nurses was expanded to a team of 4, c£108Kpa.
- A part time pharmacist to carry out medication reviews, and improve CH systems £20Kpa.

For GPs, senior community nurses and pharmacist:

- Regular attendance at a monthly educational/service development meeting organised by clinical lead

Leadership function

Systems change or Organisation Development (Wikipedia, 2017), requires a number of drivers: good clinical leadership from respected peers; adequate financial and human resources; a robust vision and a clear implementation strategy.

An iterative approach: The nature of participatory or action research is that there is no overarching template or complex plan; but that by an incremental process of trial and error, by testing hypotheses and trialling ideas we can see what works, modify it if necessary before rolling out to others. We know the general direction of travel and a vague destination, but not yet the detailed means or the final goal.
The benefit of this incremental approach, which relies on frequent reflection and analysis, is that we quickly realise when we are making mistakes and need to change direction before making costly changes.

Close collaboration between the authors, both senior GPs, was important. One of us (JH) is a GP director of the federation and manages the project, liaising with commissioners, writing bids, measuring outcomes etc while the other (TG) is an experienced educator and experienced in Care Home work and palliative care, taking on the role of clinical leadership and service development through team building, education and audit.

The GP managerial lead is responsible for:
Managing the budget
Liaising with subcontractors
Compliance with the contract
Collating quarterly KPIs
Liaising with practices to ensure they feel supported and stay part of the service

The clinical lead is responsible for:

- Developing and refining the service
- Support practice teams
- Provide educational support

Jointly:

- Peer mentoring
- liaise with stakeholders eg GP federation, CCG, Local Authority, Hospital trust, home owners, participating GP practices, ACMs, nursing home managers and staff, family/carers and patients
- Providing reports etc

Outcomes

- Key Metrics: 62% reduction in admissions compared with 2012 data- the year before the service started; 75% of deaths occurred in the care homes to third quarter 2016/7; financial savings depend on the formula used: using 'Better Care Fund' agreed calculations, savings of approximately £700,000 against costs of circa £330,000.
- Good anticipatory care leading to "good deaths" *see box: Case study*
- Greater job satisfaction for GPs, CHST and care home teams *see box: Teaching and teamwork*
- Improved morale
- Recognition from outside bodies that important and valuable work
- Use of SEA tool leading to increased confidence, changing attitudes, new skills

Case study

For the last few years, collectively we have been working to deliver a more kindly and compassionate palliative care for the very frail elderly, moving away from curative life prolonging care at all costs, to a position where we allow patients a natural and peaceful death when the time seems right. Of course one aims to achieve consensus, but sometimes this is not always possible, and a difficult ethical decision has to be made.

By way of illustration, we recently looked after a patient with mild dementia and a stroke, who had long wanted to join her dead husband and in an ACP had told us she didn't want resuscitation or admission to hospital. She had a further stroke, and was completely unable to swallow. With her, we agreed palliative care in the Home and gave her midazolam for her fear. Unfortunately her next of kin, a niece, who understood her wishes, was abroad, and other relatives who rarely visited, then insisted she be admitted. Kindly but firmly we explained that wasn't in her interests, especially with ACP, but we took advice from colleagues including the duty AMU consultant, and kept to our plan. Overnight the relatives contacted the police, saying their aunt was being neglected. Fortunately the police along with ambulance service and OOH GP service concurred with our plan. The returning niece was very grateful to us and she died peacefully after a week.

This episode had impacted widely on the Care Home, but also the practice team, and we debriefed with the whole practice, allowing them to share their feelings. One of the older receptionists, a thoughtful and devoutly Christian woman, commented we'd done a good job, and recounted how her husband had had a similar stroke, but against his wishes had been admitted for a drip. He died 2 weeks later, and she said it had been an awful experience. Her account was very salutary.

Our experience both in the Care Homes and talking more widely to the general public is that they value this deeply human approach to death, and would have wished it for their relatives.

Teaching and team working

Regular debriefing about deaths and unplanned admissions using Significant Event Analysis(SEA) is a powerful tool to promote effective team working, clinical effectiveness and better outcomes for patients.
Some comments from team members:

- We should all develop a fuller understanding of our residents as people-this applies as much to the doctors as to the care home team!
- Nurses could be more assertive in their opinions and in turn doctors pay heed to nurses concerns.
- We should have more of these meetings. They are very useful and we learn a lot from them. Talking about real cases is often more valuable than "formal" training. We should invite other nurses and carers to the next SEA meeting.
- We all learnt a lot about how systems can be improved and fine tuned to help our patients die with dignity and in familiar surroundings. We also learnt that it can be very rewarding to look after our residents from the time of admission through to their death, and to feel we had done a good job. It is really good to see how few patients are admitted and how patients are being allowed to die peacefully in the Home.
- I found real benefit in the regular meetings that you have facilitated, in allowing us to discuss our experiences whether good or bad and to look at any learning needs. I particularly found the SEAs which you facilitated particularly useful in improving patient care and allowing positive feedback to the care homes.

Difficulties to overcome/lessons learnt

- CH demand expands as practice and CHST becomes more accessible. CH staff can ask for advice about minor problems they might previously have managed themselves. *Solution*: Using the SBAR tool to help staff present their concerns logically; to save minor problems for a weekly round; to use CHST for minor problems; to have honest feedback-CH staff increasingly feel confident to point out practices' failings!
- OOH services undermining ACP and admissions avoidance work. Call handlers and triage teams may advise 999 calls rather than visit; Both CH nurses and visiting GPs can fail to follow care plans and admit. *Solution:* robust care plans and protocols shared with OOH; use of electronic record; closer liaison w OOH managers; Behavioural and attitudinal change through SEA and case studies
- Need to improve Geriatric liaison; Poor communication between acute medical teams and practices; delays in discharge-partly due to CH needing to reassess admitted patients and for CHC funding to be agreed. *Solution:* Developing dialogue to improve trust and confidence between GPs and consultants; shared educational meetings etc

Future plans

- Raise quality of OOH care to that of Care home service –closer working w OOH providers
- Closer collaboration with Geriatricians-see recent joint RCGP/BGS paper "Integrated care for older people with frailty"
- Further work to improve experiential quality of life for residents-use of non medical models/ asset based approaches and collaboration with the voluntary sector
- Work w less frail older people to carry out more holistic care planning while at same time incorporating life coaching to improve quality of life of final years

Key messages
Support for long term funding from commissioners
Management located in Primary care
An iterative approach to management
Good clinical/ educational leadership
Developing close partnership working between practice and care home
Validation and praise of Care home staff through case studies and significant event analysis of deaths and admissions
The whole practice benefits from professional challenge of complex care, from a sense of pride in providing patient centred care and good end of life care. GP Registrars find the work challenging but ultimately rewarding-teaching clinical, managerial and leadership skills
Better outcomes for patients: improved relationship with clinicians, reduced inappropriate admissions and more compassionate end of life care

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