Health and Wellbeing Reviews:

Evaluation Report of a nine month pilot in Sutton Nursing Homes
Programme: Sutton Homes Of Care Vanguard 14th November 2016

Contents

1. Executive summary ........................................... Page 1
2. Background to the pilot ........................................ 2
3. The model of health and wellbeing reviews ............... 3
4. Identified outcomes from the pilot ......................... 3
   4.1. Individual care planning and reviews ................. 3
   4.2. Reducing avoidable resident admissions to hospital 4
   4.3. Effective working relationships ....................... 7
   4.4. Other outcomes ........................................ 8
5. Financial costs and benefits of implementing the pilot .. 8
6. Key learning from the pilot .................................. 9
7. Conclusion ..................................................... 10
8. Next steps ..................................................... 11
9. References ..................................................... 11
10. Appendices .................................................... 13
    A. Development of the model ......................... 13
    B. Care coordinator role outline ................. 15
    C. Referrals to other services ................... 18
    D. Impact metrics .................................... 19
    E. Qualitative report on the care coordinator role 21
    F. Observational study of the model in action .... 37

1.0 Executive summary

Residents of care homes are becoming increasingly frail, with complex healthcare needs that require proactive management in order to maximise quality of life. A pilot of a new model of care was set up in six nursing care homes. The study, over nine months established weekly Health and Wellbeing Reviews (HWBR). The pilot delivered dedicated, proactive general practitioner (GP) input to residents and provided support for the GP from a care coordinator (registered nurse) in the home.

The model was effective in driving up quality, particularly around the management of and care planning for acute and chronic health conditions, enabling conversations with residents and their families, advanced care planning around end of life care and residents achieving their preferred place of death. It significantly enhanced shared decision-making and team work between the care coordinator and GP, and a streamlined process enabled a more efficient and effective service for the residents. Development of nurses in the home to become care coordinators was crucial to achieving all these positive outcomes. There were marginal changes to A&E attendance, non-elective admissions and ambulance activity across the pilot sites; however the nursing home that previously received only a reactive service from general practice
demonstrated the greatest improvements. It is important to note that the nursing homes involved had been exposed to a number of initiatives to support them to provide better care over an 18-month period prior to the pilot. This has possibly affected the demonstrable impact of this model to date. Further research will be carried out.

2.0 Background to the pilot

It has long been evidenced that residents of care homes have complex healthcare needs, reflecting multiple long-term conditions, significant disability and advanced frailty (British Geriatric Society 2015). As our population continues to age and grow, it is imperative that new models of care are developed to support in the management of the increasing pressures this population may place on the acute sector, as well as advancing the quality of care provided to residents, allowing them to enjoy life in the care home without becoming over-medicalised in their ongoing living situation. Smith et al (2015) note that emergency admissions are higher for those aged 75 from geographical areas with higher numbers of care home residents. With 6 per cent of Sutton residents aged 75 and older residing in a care home, the population sits above the national average of 4 per cent (Institute of Public Care 2015), putting the area at high risk of increased pressure on the acute sector.

Whilst it is recognised that hospital admission can cause high levels of anxiety and confusion in care home residents, as well as pose greater risk of nosocomial infection and deterioration in physical condition (NHS England 2015), unnecessary hospital admissions are still extremely common. Some studies estimate that this population may account for up to 66 per cent of all non-elective admissions of the over 75 population (Smith et al 2015). There has been little research investigating alternatives to prevent and reduce hospital admissions from this population group, however a number of pilots have demonstrated that significant reductions in acute admissions and improved quality of life indicators can be achieved through upskilling care home staff and providing an Enhanced Primary and Community Care service (Garden 2013, Griffin 2013, Whitehead 2012, University of York 2014). Other clinical commissioning groups (CCG) have demonstrated significant impacts on resident outcomes through enhanced support to care homes. The Newcastle Gateshead CCG model has achieved remarkable results to date, including a reduction of non-elective admissions (NELs) by 14.5 per cent compared to their baseline year of 2011/12. Financial savings have also been demonstrated elsewhere across the country through the provision of dedicated weekly proactive primary care and the subsequent reduction in non-elective hospital admissions, for example Sheffield CCG used a locally enhanced service, Stockport CCG utilised primary care development funding and both areas independently achieved a 9% reduction in NELs from care homes. Interestingly a pilot by Lincolnshire hospitals managed to reduce NELs by 37% in their first year by enhancing the coordination of advanced care planning through regular primary care in-reach and care home staff training.

Considering this evidence, the aims of the Health and Wellbeing Review pilot are:

1. To ensure that every resident in the pilot care homes has an individual holistic care plan which has been co-produced with the resident, their family, GP and Care Co-ordinator.
2. To provide preventative and proactive healthcare working as part of a multi-disciplinary team, including a formal review of the residents’ care plan every six months.
3. To reduce avoidable admissions to secondary care and inappropriate/unnecessary use of emergency and urgent care services by care home staff
4. To develop effective working relationships between the GP and care co-ordinators in the home and to support multidisciplinary decision-making regarding residents’ care.

Health and Wellbeing Reviews (HWBR) were established to deliver dedicated proactive general practitioner (GP) input to nursing home residents and to provide support to the linked GP from a registered nurse in the home. The HWBR visit is coordinated by the registered nurse from the home who has received additional
training to develop their leadership skills and take on the role of ‘care co-ordinator’. This model meets two core elements of the enhanced health in care homes framework (NHS England, 2016), namely enhanced primary care support and workforce development.

Sutton is an outer London borough with a population of 198,134 (2014, Joint Strategic Needs Assessment). Sutton has 80 care homes, of which 18 are nursing homes, 11 are residential homes and the remainder are for those with learning disabilities or mental health needs. There are a total of 1213 beds, of which approximately 30 per cent are funded through statutory provision by health or social care and the remainder are funded privately. Sutton has been working in partnership with local care homes since April 2014 and various initiatives have been implemented during the last 2 years including, sign-posting and education packages, care home manager forums and bespoke training from in-reach community nursing. Within the first year of this work, Sutton saw a reduction in non-elective admissions from care homes across the area of between 10-14 per cent. Sutton was awarded Vanguard status in spring 2015 based on these achievements.

3.0 The model of health and wellbeing reviews

The link GP visits her/his nursing home at the same time each week to undertake the Health and Wellbeing Review. In preparation for the visit, the care co-ordinator will have identified residents to be seen with an acute need, for example an infection, and appropriate nursing actions will have been taken, for example collecting a specimen. Following the visit, the care co-ordinator will update the residents’ notes and nursing care plans and begin any required referrals that they are able to make to other services. The GP will update the residents’ primary care notes, making any referrals that only she/he can make.

During the visit in the preceding week, one or two residents will have been identified for a full Health and Wellbeing Review. This holistic, proactive review involves assessing the resident’s physical and psychological health needs based on the comprehensive geriatric assessment, in addition to considering overall wellbeing, social and multidisciplinary needs. During this review, consideration will also be given to advanced care planning for potential health crisis management and end of life care needs. The GP and care coordinator will make preparations ahead of this discussion to ensure it captures the most up to date information regarding that individual, for example recent observations and blood results. A specific form, developed by a GP to capture the holistic nature of the review can be found in appendix A. The care co-ordinator is supernumerary during the HWBR to enable time to prepare for the round and taking any subsequent actions.

This model was piloted in six nursing care homes in Sutton. The home had to meet the following criteria: two registered nurses in substantive posts to become care co-ordinators and compliance with Care Quality Commission regulations. Five of the homes already had a named GP and for the sixth, this was enabled through the CCG. This model was developed by vanguard partners and is based on a similar model introduced in Newcastle-Gateshead CCG in 2009. Development of the model can be found in Appendix A and the role outline for the care coordinator can be found in Appendix B.

4.0 Identified Outcomes

At the beginning of the pilot, the six nursing homes had a combined bed capacity of 192 beds (range 16-39) and the pilot ran for nine months from November 2015 to July 2016, covering a total of 39 weeks. Self-reported activity data from each pilot site has been analysed, alongside non-elective emergency admissions, accident and emergency attendances, length of hospital stay and ambulance activity data. This data is received directly from the acute trust and ambulance service and is continually being refined to
ensure accurate reporting of outcomes. Minor discrepancies between ambulance conveyance and hospital admission suggest a small number of residents are conveyed to other local acute trusts. At the end of March a mid-point evaluation workshop was held to gain qualitative feedback from the GPs, care co-ordinators and care home managers in each of the six nursing homes. Data was analysed in relation to the four aims of the pilot cited above.

4.1 Individual care planning and reviews

In total there were 2,529 episodes where residents were reviewed by the GP from November 2015 to July 2016. Of these 51 per cent were for an acute need, 35 per cent were a follow-up from a previous concern and 14 per cent were health and wellbeing reviews (HWBR). The high proportion of reviews required for residents’ acute needs highlights the overall frailty of this population group. Using this data, on average each resident was reviewed fifteen times during the nine months (range 11 to 19), again highlighting the level of frailty and complexity. In four of the six homes, every resident had at least one HWBR during the nine months and in two nursing homes, the HWBR was carried out more frequently than every six months due to the changing needs of the resident (end of life care).

During the pilot, there were 159 referrals to other services which are presented in Appendix C. Referrals were made to a total of 27 different services - 18 community-based services (84 per cent of referrals) and 9 secondary care-based services (7 per cent of referrals). Eleven referrals were unspecified (7 per cent). As anticipated, the majority of the 159 referrals were to dietetics (21 per cent), the challenging behaviour team (17 per cent) and speech and language therapy (16 per cent). It is assumed that earlier intervention from other services will enhance preventative care, for example safer management of dysphagia should reduce risk of unplanned admission due to aspiration pneumonia. In some instances, the care co-ordinator was able to involve these named professionals in their residents' holistic reviews.

4.2 Reducing avoidable resident admissions to hospital

Surveys of the GPs, care co-ordinators and managers showed that they ‘agreed’ or ‘strongly agreed’ that the Health and Wellbeing Review had enabled them to be more proactive and reduce unnecessary admissions. Those who ‘agreed’ stated that this was because their care home had been using a similar approach prior to the pilot. Reasons cited for reduced patient admissions were:

- Better access to the wider multidisciplinary team (MDT)
- A more holistic approach to residents’ care and disease management
- A systematic approach to ensuring that all residents get a medical review regularly, not just those in crisis
- Fewer crisis issues to deal with as these were being prevented through proactive management
- More opportunity to reduce anxiety of family members through discussion with the GP, care co-ordinators and wider multidisciplinary team
- More proactive medicines management ensuring residents were on optimal doses of the right medicines
- Earlier use of appropriate medications to support good end of life care
- Improved care co-ordinator confidence to make referrals to the wider MDT as a result of training
- Better team working as professionals, with time to discuss cases and agree an approach

Accident and emergency (A&E) attendance and non-elective emergency admissions

Overall changes to A&E attendance and non-elective admissions during the nine months showed a mixed effect. Comparison of hospital data for both A&E attendance and non-elective admissions from each home shows marginal changes between 2014/15 and 2015/16 over the same nine-month period. For both of these outcome measures, some homes improved, some remained unchanged and some demonstrated increased activity, as shown in table 1 and illustrated in charts 1 and 2 below.
Table 1: Change in care home activity (actual change) from November 2014 to July 2015 (pre-pilot comparator) and November 2015 to July 2016 (pilot).

<table>
<thead>
<tr>
<th>Nursing Home</th>
<th>Performance indicators (direction of travel and actual change in number of residents from 2014/15 to 2015/16 for pilot months only):</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A&amp;E attendance</td>
</tr>
<tr>
<td>1</td>
<td>↑ 1</td>
</tr>
<tr>
<td>2</td>
<td>↓ 3</td>
</tr>
<tr>
<td>3</td>
<td>↓ 1</td>
</tr>
<tr>
<td>4</td>
<td>unchanged</td>
</tr>
<tr>
<td>5</td>
<td>↓ 1</td>
</tr>
<tr>
<td>6</td>
<td>↑ 1</td>
</tr>
</tbody>
</table>

Source: Epsom and St Helier NHS Trust, St Helier only data; London Ambulance Service

Although all care homes thought that they had reduced unnecessary admissions, the data does not support this consistently. Any interpretation of the data should be approached with caution as the actual numbers are small and there are several factors to be considered that could account for variation. The care home population is not static and residents change over time therefore the pre-pilot comparator is not an exact match. The nursing homes who participated in the pilot may not be a representative sample as they were self-selected and the majority already had a visiting linked GP.

In three homes, the residents who were admitted had been reviewed with the GP during the preceding week, suggesting their condition had deteriorated and hospital admission was necessary. In two homes, most admissions had been reviewed during the HWBR the previous week however in one home just under half of the residents admitted to hospital had not been reviewed during the previous week. Although residents who had been admitted to hospital were reviewed on the HWBR following their discharge, pilot sites were not asked to classify whether the admission was clinically necessary or could have been avoided. Analysis of the reason for hospital admission (coded primary diagnosis from hospital data) from the pilot homes has revealed a noticeable reduction in admissions resulting from disorders of the respiratory tract and urinary tract. This suggests that common infections are being recognised earlier and managed effectively in the care home. There has also been a reduction in the number of admissions due to injuries and fractures.
Length of stay in hospital

It was anticipated that the HWBR would have an impact on residents’ length of stay in hospital (LOS) due to the care co-ordinator actively supporting discharge back to the care home and the ability to manage more complex conditions and treatment requirements due to formalised GP support. Analysis of LOS data from the hospital suggests this was the case in only two homes where LOS was obviously shorter when compared to the same nine months of the previous year. The same two homes had reduced non-elective admissions overall, suggesting less residents were being admitted and staying a shorter amount of time in hospital. Hospital LOS analysis broadly highlights that less residents are being admitted for short-stays of <3 days, implying that the homes are now managing some conditions without the need for hospitalisation.

Use of emergency services (ambulance)

Comparison of the London Ambulance Service’s (LAS) activity data for each home for the pilot’s nine months against the same nine months the previous year showed that two homes reduced LAS activity by about a third, two homes had similar numbers between the two periods, whilst two homes almost doubled activity. This is represented as actual numbers in table 1 above and illustrated as a trend over time in charts 3 and 4 below. When comparing LAS call-outs and conveyances, more 999 calls have resulted in conveyances, suggesting that emergency calls are being made more appropriately.

Comparison against peers

It was anticipated that comparison of the six homes using the HWBR against another nursing home matched by resident need and bed capacity would illustrate differences with A&E attendance, non-elective admissions and ambulance activity during the pilot period. Data analysed from November 2015 to March 2016, did not identify any patterns and variation between homes could be influenced by a number of different factors, for example a change in home manager, how much the home utilise other support services and primary care involvement through other means.

A different analysis of pilot and non-pilot homes identified some patterns in activity. Charts 5 and 6 below demonstrate how the six pilot sites compare against all 12 non-pilot nursing homes over the last three years (complete financial years) and it can be seen that there is a steady downwards trend in non-elective admissions. Changes to A&E activity have been more variable.
The pilot sites demonstrated a significant fall in non-elective admissions from 2013/14 to 2014/15 but an overall negligible reduction during the pilot. The initial reduction in admissions correlates with the start of the CCG’s work with care homes and the introduction of a number of interventions aimed at reducing unnecessary admissions. The effect of earlier interventions also demonstrates reductions in urgent activity across all Sutton nursing homes as demonstrated in chart 7 below.

Further analysis of the impact metrics for the pilot nursing homes is presented in Appendix D.

### 4.3 Effective working relationships

Workshops were held at the beginning of the pilot and at the mid-point in March 2016, to collect qualitative feedback from care coordinators, GPs and care home managers regarding the impact of the pilot. The care co-ordinators overall confidence in communicating with GPs and emergency services increased by nearly a quarter (23 per cent improvement) and confidence to communicate with relatives in critical situations has nearly doubled (44 per cent improvement). For four individuals, their self-reported confidence had doubled and further discussion of the care coordinators’ enhanced confidence is presented qualitatively in Appendix E. At the beginning of the pilot, care co-ordinators hoped that training provided by the Vanguard would support them to develop new skills and confidence which would enable them to provide better care for their residents. All care co-ordinators reported they had been able to develop new skills and confidence and this was enabling them to provide better care. Care co-ordinators reported they had a better understanding of their residents needs and highly valued being part of a team.

GPs felt that they now had more confidence in all staff at the care home as a result of the HWBR model and they found that care had shifted to become more proactive allowing them to work with the nurses to...
prevent problems developing and to reduce the amount of unmet need. They appreciated the opportunity to work with trained care co-ordinators as a team.

Care Home Managers hoped that the HWBR would improve the quality of services they were able to offer and improve the confidence, skills and job satisfaction of their staff. In practice they felt that the HWBR had created a much more open culture and improved relationships with GPs and the wider multidisciplinary team (MDT). They were pleased to see their nurses making more referrals and having the confidence to be assertive in advocating for residents' needs which has resulted in greater input from the wider MDT.

With one exception all care home teams either agreed or strongly agreed that communication and team working between the care home and GPs had improved as a result of the HWBR. The care home that disagreed simply said that they had always had good communication and team working and that the model had provided them with more resources to support the good work they had always been doing. One care home team specifically highlighted that communications with the wider MDT had improved and felt this was associated with improved clinical skills and assertiveness in their care co-ordinators as a result of the leadership training. One care home felt strongly that improved communication had created a sense of team working that had not been present prior to the pilot.

4.4 Other outcomes

In addition to the anticipated outcomes from this model, there were unexpected outcomes identified that have not been formally measured but represent a collective opinion from the six sites.

Time

The amount of time required to complete a HWBR is not formalised and care co-ordinators were asked to record how much time they spent preparing for and completing the HWBR and addressing subsequent actions. On average, the amount of time care co-ordinators spent per week on the HWBR was just over 3 hours which equates to an average of 5 hours per resident across the 9 month period (range 3-8.5).

The GPs were not asked to record the time they spent on the HWBR and any associated activities. However, GPs found that just as they had hoped prior to undertaking the pilot, they had more time to talk to residents and their families and this proved particularly important in supporting a richer and more holistic understanding of residents and their needs. Having additional time proved invaluable in supporting chronic disease management and in helping residents and their families understand and plan end of life care. Care home residents have access to community specialist palliative care nurses and during the pilot period, 57 residents were supported to pass away in the pilot care homes as their preferred place of death, compared to 7 who were admitted to hospital and did not achieve their preference. This enhanced quality of care and experience was enabled through closer, more coordinated working between the care home, GP and specialist nurses, partly facilitated through the HWBR. In addition to having more time for residents and families, the GPs reported time efficiencies during the week through having a more systematic way of working with the care home, particularly a reduction in telephone calls from the nursing home. For some sites, the HWBR also changed the way the care home worked with the GP practice staff, enabling a more streamlined and effective service for the home and its residents and more efficient use of practice staff time.

Enhancing the quality of care

During the mid-point evaluation event, all pilot sites reported their quality of end of life care provision had improved, as illustrated above but were unsure of demonstrable changes to other indicators. By looking at the pan-London continuing healthcare quality dashboard, four homes reported a reduction in the number of falls, urinary tract infections and healthcare-associated infections (HCAI) during the pilot months, compared to the equivalent time period the previous year. One home remained the same for all indicators and one home had a significant reduction in HCAIs but an increase in falls and urinary tract infections. The care coordinators’ perception of improvements to quality is further explored in appendix E.
Impact on care home staff

The care home managers generally felt more supported by the HWBR model and were pleased that their residents were regularly being medically reviewed in a systematic way and as a result, individual care plans were being updated in a more proactive and holistic way. Managers also reported enhanced confidence and feeling more empowered in their role.

The care coordinators reported several benefits to the HWBR model and being part of a networked community of nurses and within the wider healthcare community. They valued opportunities to learn from each other, share experiences and develop peer relationships which they reported enhanced their confidence, value and self-worth. Care coordinators also reported learning from other professionals and developing enhanced relationships with MDT colleagues. They felt this enabled more joined-up services to give a better resident experience, for example one arranged for the dietician and speech and language therapist to join the HWBR with the GP to discuss care plans for their residents with dysphagia.

5.0 Financial costs and benefits of implementing the pilot

For six nursing homes, over nine months, the total cost has been £69,780.

The GP elements cost:

- Annual retainer fee - £4000 per ‘link’ care home with up to 25 beds. An additional £1000 for each 10 beds (pro rata)
- £100 for each resident Health and Wellbeing formal review with a care plan made (limit of two payments per year)

The care co-ordinator elements cost:

- £480 each month (£20 an hour for four hours each week and four weeks in a month) for weekly care co-ordinator role as part of HWBR
- £160 each month (£20 an hour for eight hours a month) for associated activities, e.g. study days, care co-ordinator network meetings, evaluation events
- Additional cost for leadership training (not included in above)

It was anticipated that the pilot would enable financial savings due to a reduction in acute and unplanned activity. As discussed above, the overall reduction in non-elective and A&E activity is marginal, however savings can still be identified based on actual activity. Overall, three A&E attendances (£265 per episode) and seven admissions were avoided (£3170 per admission) which indicates gross savings of £23K.

Although not directly attributable to the HWBR, the number of residents who achieved their preferred place of death in the pilot nursing homes due to a combination of community specialist palliative care and enhanced GP involvement represents an estimated saving of £195K in unplanned hospital activity.

6.0 Key learning from the pilot

Several lessons have been learnt during the pilot, particularly relating to key requirements for the model to be effective, methodology of conducting a pilot and opportunities for further development. Further observations regarding the model in action can be found in appendix F.
Key requirements for effectiveness:

- Protected time for both GP and care co-ordinator: proactive care requires additional time
- GP and care co-ordinator to agree local process and structure for weekly visits and residents’ 6-month Health and Wellbeing Reviews
- Equal responsibility for preparation for round
  - Care coordinator to prioritise who needs to be seen and why, observations and evidence to support concerns (e.g. behaviour chart, wound swab)
  - GP to review medical notes and medications for residents identified to be seen
- Equal recognition of need for and taking responsibility for 6/12 reviews
  - GP reviewing medical notes, last documented screening, ordering bloods etc.
  - Care coordinator assessing resident’s health and wellbeing trends since last review e.g. observations, number of falls, chronic disease control
- Both GP and care coordinator to consider multidisciplinary needs, psychological health and social situation
- Continuity of person is important to enable the GP and care co-ordinator to develop an effective working relationship and ensure clear roles, responsibilities and expectations of each other
- Need for a comprehensive, standardised tool to systematically record the 6-month holistic review and capture the complexity of residents’ needs

Undertaking a pilot and measuring impact:

- Identifying baseline data to demonstrate changes in activity in core measurable outcomes
- The project manager to regularly attend the HWBR in the first few months after launch to support implementation and ensure a degree of standardisation of process and documentation
- Whilst recognising competing priorities, ensure a robust process for GPs and care coordinators to submit their monitoring data and identify ways to encourage timely submission
- The need for a method to collect evidence of time-efficiencies and to capture avoided admissions or ambulance activity

Avenues for development of the model:

- Greater opportunities and modalities for GPs and care coordinators to come together to reflect on their experiences and practice and to share learning
- Potential to use primary care READ coding to develop further understanding of the needs of the care home population and thus tailor the model to address unmet need and provide an avenue to capture care home-based activity
- Enabling resident’s documented six-month health and wellbeing review to be accessed by out of hours services thus enhancing decision-making

7.0 Conclusion

The pilot of Health and Wellbeing Reviews (HWBR) in six nursing homes achieved three of the four original aims. These were:

1. To ensure that every resident in the pilot care homes has an individual holistic care plan which has been co-produced with the resident, their family, GP and Care Co-ordinator.
2. To provide preventative and proactive healthcare working as part of a multi-disciplinary team, including a formal review of the residents’ care plan every six months.
3. To develop effective working relationships between the GP and care co-ordinators in the home and to support multidisciplinary decision-making regarding residents’ care.

The aim to reduce emergency activity from care homes was not consistently demonstrated, apart from one home in which the HWBR model was completely new. The care home who had previously received a
purely reactive service from primary care demonstrated the greatest change. This suggests that the model is effective and could release system-wide financial savings with care homes that do not currently have proactive primary care interventions. For the other five homes, the changes were marginal which indicates that regular, planned in-reach from primary care is effective to maintain a steady level of unplanned activity. Residents’ unplanned admissions to hospital are multifactorial and due to the frailty and complexity of many residents, an amount of urgent activity is to be expected and cannot automatically be attributed to a failure of care.

Although the cost to benefit ratio of this model could not be evidenced during the pilot, based on similar initiatives it is expected that implementing the HWBR across all care homes would yield financial benefits to the health and social care system.

The HWBR enables a more systematic process to review residents’ acute and future health needs and clearly demonstrated improvements in the quality of care provided to residents, particularly around proactive care planning and enabling conversations with residents and family to address their needs and wishes. The HWBR model enables primary care to meet best practice guidelines for managing frailty and long term conditions, such as recommendations from the British Geriatrics Society (2014) and to meet national targets on reducing unplanned hospital admissions in the frail elderly (Lyndon & Stevens, 2014). Leadership development of nursing home clinical staff as part of the care co-ordinator role has facilitated time efficiencies through better planning, ensuring the HWBR is focussed on the right residents and enabled greater collaborative team working, thus enhancing the nursing homes provision of a quality service for their residents.

8.0 Next steps

As part of the ongoing Sutton Homes of Care Vanguard programme, the impact of the HWBRs in nursing homes will continue to be evaluated. During the pilot there has been anecdotal evidence of increased resident and family satisfaction and this element will also be further explored. The care co-ordinator role appears to be a unique feature of this model compared to other enhanced primary care in care homes models across the country and the impact of the care coordinator role on both residents and staff warrants further investigation.

Caroline Pollington, Lead Nurse Sutton Homes of Care Vanguard, 14th November 2016.
Sutccg.carehomevanguard@nhs.net

9.0 References


Garden, J. 2013. Impact of training and advance care planning for care home residents with dementia on hospital admission and place of death. United Lincolnshire Hospitals Trust. HSJ awards.


NHS England, South. 2014. Safe, compassionate care for frail older people using an integrated care pathway: practical guidance for commissioners, providers and nursing, medical and allied health professional leaders.


University of York. 2014. Interventions to reduce unplanned admissions from care home settings.
Appendix A  Development of the model

A task and finish group was held, comprising cross-partner representation to design and agree the new model of care. This resulted in formulation of the health and wellbeing reviews by a care coordinator from the nursing home and linked general practitioner. The following outcomes were agreed:

- Primary care specification, outlining expectations of activity, details of payment and additional remuneration for completing 6-monthly proactive resident health and wellbeing reviews
- Identification of the care coordinator role components through shared examples from partner organisations. The final role outline can be found in appendix B
- Selection criteria for nursing homes; to be compliant with the care quality commission registration requirements and have two substantive nurses willing to undertake care coordinator role and associated personal development
- Identification of impact measures

Initiation process and launch

An email was sent out to all nursing homes in Sutton CCG asking for expressions of interest. Due to the timeframes associated with programme milestones, it was anticipated that nursing homes that had a linked GP practice would be optimal. Through this process, five nursing homes were identified. A further home had both the interest and staffing but no dedicated, named GP. For this home, the quality assurance manager from the CCG discussed the pilot with the practice where their residents are registered and agreement was reached. Following this process, a launch date was set and confirmatory letters were sent to the pilot homes and their respective GP. The launch date coincided with the first care coordinator training day which included comprehensive assessment of the older person, assertiveness and confident-communication skills training and how to develop networks and support mechanisms.

Developments during the pilot

The data collection template was developed by the Vanguard project team based on anticipated activity and effects. Early in the pilot, it became apparent that there was a need to standardise what elements of health and wellbeing were discussed during the residents 6-month review. One of the GPs developed the health and wellbeing review document which is sufficiently comprehensive to capture all potential elements for this client group. These are outlined overleaf.

The vanguard partners who were involved in development of the model are:

- Quality Assurance Manager- Sutton Clinical Commissioning Group
- Older Persons Lead Nurse - Epsom and St Helier University Hospitals NHS Trust
- Care Home Support Team Nurse - Sutton Community Health Services
- GP Clinical Lead for the Vanguard Programme
- A local GP who looks after care homes
- Care home managers as sector representatives
- Local team leader from London Ambulance Service NHS Trust
- Senior representative from local branch of Alzheimer’s Society
- Senior representative from local branch of Age UK
- Senior representative from Adult social Services from the London Borough of Sutton
Data collection template (completed by care coordinator)

<table>
<thead>
<tr>
<th>Number of resident reviews</th>
<th>Acute need</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Follow-up</td>
</tr>
<tr>
<td></td>
<td>6/12 holistic</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Number of community service referrals*</th>
<th></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Number of GP call-outs</th>
<th></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Number of 999 call-outs</th>
<th></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Hospital admissions</th>
<th>Number of admissions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>seen by GP in previous 7 days?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Average time spent on MHWR (hours)</th>
<th></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Nursing time to complete associated activities (hours)</th>
<th></th>
</tr>
</thead>
</table>

| Estimated GP time to complete associated activities | |

Template for 6-month review (completed collaboratively by care coordinator and GP)

**HEALTH PROFESSIONAL VISIT – SIX MONTH HEALTH AND WELLBEING REVIEW**

**NAME OF SERVICE USER:** ________________________________

**VITAL SIGNS:**
- Blood pressure – 
- Temperature – 
- Respiratory rate – 
- Pulse– 
- O2 Sats- 
- Blood sugar- 
- Weight-

**URGENT ADMISSIONS IN LAST 6/12:**

**MEDICATION:**

**PAST MEDICAL HISTORY:**

- **Chronic Disease Optimisation:**
  - Exercise/Mobility (incl. falls)
  - Social/Mood (incl. vision and hearing):
  - Behaviour/Cognition/Dementia:
  - DOLS?
  - Eating & Drinking (incl. swallow and teeth)
  - Skin integrity & Continence:
  - Advanced care planning/decision-making:
  - DNAR?
  - CMC?

**MDT’S / DOCTOR’S NAME & SIGNATURE:** ________________________________

**NURSE’S NAME & SIGNATURE:** ________________________________

**DATE:** ________________________________
Appendix B  Care coordinator role outline

Position:  Care Co-ordinator
Responsible to:  Home Manager
Accountable to:  Home Manager

ROLE SUMMARY
- To provide leadership within the care home to continuously improve the standards of care and quality of life for all residents within the home.
- To be actively involved in the Vanguard programme new models of care, including attendance and participation in any training and evaluation relevant to the role (internal or external providers).

ROLE DESCRIPTION
- To be available (supernumary) on the day of the GP ward round review.
- To proactively identify residents of concern for GP review, including the completion of any necessary assessments required prior to review, e.g. urinalysis, patient observations, wound assessment.
- To be a key liaison and the named point of contact for the GP and other health and social care professionals (HCP).
- To ensure communications received from the GP and other HCP are documented and shared with the care home manager and other staff as appropriate.
- To ensure the resident is involved in all discussions around their care and treatment and the plan of care is updated following review from the GP or other HCP.
- To ensure the residents' next of kin is aware of any concerns regarding their relative's health and is kept informed of the plan of care to address this concern.
- To minimise the need for hospital admission by proactively utilising resources identified in the ‘Concerned about a resident’ poster, e.g. CPAT.
- To ensure that the ‘red bag protocol’ is adhered to if a resident requires admission to hospital.
- To minimise the hospital length of stay by reviewing residents within 48 hours of admission and liaising with the treating team to determine the earliest discharge date. Following this assessment, any changes to the residents needs are taken into consideration and a plan of care is put in place to address these.
- To be able to identify when a HCP referral would be appropriate and initiate the referral process e.g. dietician.
- To undertake the role of Medicines Champion in close liaison with the Care Home pharmacist.
- To be able to identify when a health needs assessment may be appropriate and take responsibility for ensuring this is completed in a timely manner.
- To develop an effective working relationship with all community teams who support the provision of individualised care for residents within the home.
• To demonstrate a comprehensive awareness of services available in the local community to support health and wellbeing and how residents may access these services. This may include voluntary and charitable agencies.

• To be actively involved in the Care Home Network and Care Co-ordinators network across the borough to enable peer support, the sharing of best practice and evaluation of the role.

• To be responsible for initial and ongoing holistic assessments to address the resident’s physical, psychological, spiritual, social, emotional and cultural health and wellbeing needs, ensuring a multidisciplinary approach to their care is initiated, planned and implemented.

• To develop effective working relationships with the care home staff and be involved continuing personal and professional development.

• To supervise care staff to ensure that the care delivered meets the personal care needs of the residents in a way that respects the dignity of the individual and promotes independence.

• To work closely with the care home manager to coordinate the working day effectively, ensuring any identified issues are resolved.

• To optimise the residents and family’s positive experience of care within the home.

• To help and support residents to be able to continue the expression of their cultural and spiritual needs and values, recognising what is important to them as individuals.

• To ensure that residents reaching the end of life have a plan of care that will meet their clinical and personal needs and is aligned with their wishes, underpinned by the 5 core principles of end of life care.

PERSON SPECIFICATION

Essential

• An experienced nurse in the care home.

• Genuine interest in the maximisation of health, wellbeing and independence in the older person and the ability to advocate effectively.

• Evidence of enhanced skills in the following areas of care:
  o Physical assessment
  o Tissue viability and pressure ulcer prevention and management
  o Hydration and nutrition
  o End of Life Care
  o Dementia expertise, specifically managing challenging behaviour
  o Continence and urinary catheter management
  o Bowel care and management
  o Management of home oxygen

• Excellent verbal and written communication skills
Desirable

- A recognised mentorship qualification to support the development of others.
- The ability to critically reflect on situations to identify learning.
- Evidence of enhanced skills in the following areas of care:
  - Administration of intravenous fluids and antibiotics
  - Tracheostomy care and management
- Evidence of previous experience in comprehensive physical assessment and managing long term conditions.
# Appendix C  Referrals to other services

The table below outlines the range of acute and community-based services that residents were referred to as a result of the health and wellbeing reviews.

<table>
<thead>
<tr>
<th>Community-based service</th>
<th>Number of referrals during 9-month period</th>
<th>Percentage of overall referrals (total 159)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dietician</td>
<td>34</td>
<td>21.4</td>
</tr>
<tr>
<td>Challenging behaviour team</td>
<td>27</td>
<td>16.9</td>
</tr>
<tr>
<td>Speech and language therapy</td>
<td>25</td>
<td>15.7</td>
</tr>
<tr>
<td>Physiotherapy</td>
<td>11</td>
<td>6.9</td>
</tr>
<tr>
<td>Tissue viability nurse specialist</td>
<td>6</td>
<td>3.7</td>
</tr>
<tr>
<td>Specialist palliative care (hospice)</td>
<td>6</td>
<td>3.7</td>
</tr>
<tr>
<td>Neuro-rehabilitation team</td>
<td>4</td>
<td>2.5</td>
</tr>
<tr>
<td>Podiatry</td>
<td>4</td>
<td>2.5</td>
</tr>
<tr>
<td>Care home pharmacist</td>
<td>3</td>
<td>1.8</td>
</tr>
<tr>
<td>Respiratory clinical nurse specialist</td>
<td>2</td>
<td>1.2</td>
</tr>
<tr>
<td>Community mental health team</td>
<td>2</td>
<td>1.2</td>
</tr>
<tr>
<td>Diabetes clinical nurse specialist</td>
<td>2</td>
<td>1.2</td>
</tr>
<tr>
<td>General practice (second opinion)</td>
<td>2</td>
<td>1.2</td>
</tr>
<tr>
<td>Parkinson's disease clinical nurse specialist</td>
<td>1</td>
<td>0.6</td>
</tr>
<tr>
<td>Low vision clinic</td>
<td>1</td>
<td>0.6</td>
</tr>
<tr>
<td>Falls prevention team</td>
<td>1</td>
<td>0.6</td>
</tr>
<tr>
<td>Social worker</td>
<td>1</td>
<td>0.6</td>
</tr>
<tr>
<td>Social services Deprivation of Liberty Safeguards team</td>
<td>1</td>
<td>0.6</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Secondary care service</th>
<th>Number of referrals during 9 month period</th>
<th>Percentage of overall referrals (total 159)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dermatology (secondary care)</td>
<td>2</td>
<td>1.2</td>
</tr>
<tr>
<td>Pain clinic (secondary care)</td>
<td>2</td>
<td>1.2</td>
</tr>
<tr>
<td>Neurology (secondary care)</td>
<td>2</td>
<td>1.2</td>
</tr>
<tr>
<td>Stroke clinic (secondary care)</td>
<td>2</td>
<td>1.2</td>
</tr>
<tr>
<td>Spasticity clinic (secondary care)</td>
<td>2</td>
<td>1.2</td>
</tr>
<tr>
<td>Radiology (secondary care)</td>
<td>1</td>
<td>0.6</td>
</tr>
<tr>
<td>Haematology (secondary care)</td>
<td>1</td>
<td>0.6</td>
</tr>
<tr>
<td>Oncology (secondary care)</td>
<td>1</td>
<td>0.6</td>
</tr>
<tr>
<td>Urology (secondary care)</td>
<td>1</td>
<td>0.6</td>
</tr>
<tr>
<td>Parkinson's disease clinical nurse specialist</td>
<td>1</td>
<td>0.6</td>
</tr>
<tr>
<td>Unspecified</td>
<td>11</td>
<td>6.9</td>
</tr>
</tbody>
</table>
Appendix D  Impact metrics

The statistical process control charts presented below demonstrate the activity trends for the six nursing homes involved in the pilot since April 2013. This data is received directly from the acute trust and ambulance service and is continually being refined to ensure accurate reporting of outcomes. Minor discrepancies between ambulance conveyance and hospital admission suggest a small number of residents are conveyed to other local acute trusts.

The control limits (green lines) and the mean (red line) are determined from the baseline data. Any month (dot) that falls outside of the upper or lower limits warrants further investigation to understand why performance is not as expected. If there are seven consecutive months (dots) lower than mean (red line), this indicates enhanced and sustained performance.
Appendix E  Qualitative report on the care coordinator role.

Care Coordinators at the Core of a New Model of Care in Nursing Homes: Trusted Resources, Guardians of Quality and Inspiring Leaders

Report prepared for the Sutton Clinical Commissioning Group Vanguard Programme by Dr Stephanie Fade PhD, Director at What Matters Cubed, August 2016.

Contents

Summary
Background and Introduction
What is this report about?
Who might find it useful?
What did we do?
What did we find?
Do others support these perspectives?
What relevance does this have for the sector?
Next Steps
References
Annex 1: Semi-structured interview schedule
Annex 2: Summary of the findings of the March Evaluation Workshop
Summary

This report describes the impact of a Care Coordinator role implemented at the six Nursing Homes in the Sutton Clinical Commissioning Group (CCG) vanguard programme. This programme was a partnership of Nursing Homes supported by the CCG and NHS England to implement new models of care to improve care quality and efficiency. Specifically the Sutton Vanguard programme sought to:

- Improve resident, carer and staff experience
- Provide a replicable and sustainable model for other health and care systems
- Deliver reductions in
  - Avoidable conditions such as UTIs, Falls and Pressure sores
  - 999 calls and Ambulance attendances
  - A+E attendances
  - Non Elective Admissions
  - Length of stay in the acute care setting
  - Out of Hours GP service demand, releasing capacity for other vital activity

The findings in this report are of relevance to nurses, nurse educators, student nurses, care home owners and managers, GPs, commissioners, policy-makers and the general public, particularly older people, their relatives and anyone considering a career in nursing.

In an era where Care/Nursing Homes are often only heard of in the context of scandal and heart-wrenching stories of poor care and even abuse, it is refreshing to be able to report the experiences of senior nurses who were prepared to take on an extended role in nursing homes, stretching themselves to support the residents they serve.

Given the dramatic increase forecast in the older population with complex healthcare needs over the next 5-10 years and an increase in demand for care, it is crucial that nursing home residents are treated with compassion, empathy, respect and a thorough understanding of their physical, mental, and emotional needs. This report makes a compelling case for a defined Care Coordinator role in Nursing and other Homes as part of the strategy to deliver this. The Sutton experience has revealed benefits associated with the role for residents and their carers, care home staff and the wider multidisciplinary team. Recommendations have been included for making the benefits sustainable within current funds and for spreading the benefits to other boroughs and parts of the care sector.

Background and Introduction

The Vanguard Programme

In October 2014 the NHS published its 5 Year Forward View. This document set out a clear direction for the NHS highlighting the necessity, amongst other things, for more work around patient centred care and forging stronger partnerships between health and social care. The document described a vision to support the development, evaluation and where it made sense, the adoption and spread of radical new care delivery options including those designed to improve care for people in care/nursing homes.

In January 2015, as part of this vision the NHS invited individual organisations and partnerships to apply to become ‘Vanguard’ sites for the new care models programme. In March following a rigorous application process the Sutton Vanguard was among the first 29 sites chosen to develop new care models to act as blueprints for the NHS moving forward and to provide inspiration to the rest of the health and care system.

Specifically the Sutton Vanguard Programme sought to achieve the following objectives:

- Improve resident, carer and staff experience
- Provide a replicable and sustainable model for other health and care systems
- Deliver reductions in
  - Avoidable conditions such as UTIs, Falls and Pressure sores
  - 999 calls and Ambulance attendances
What Pharmacist. Home evaluation

Given interview

What and find GPs offers

The useful Care

Who Vanguard A

networking.

personal clinical

A took wellbeing

take the

The care.

narrative
tailored

describing

This decision

report made

other Care, Vanguard

training

are

together

took responsibility for systematic review of all residents’ needs through a holistic weekly health and wellbeing round at the home.

A tailored training and education programme was developed to support the Care Coordinators and included clinical updates in key areas such as Catheter Care, Medicines Management and Continence Care and personal and professional skills training to support confident communication and effective professional networking.

What is this report about?

This report is about how the Care Coordinator role supported delivery of the Sutton Vanguard objectives. The focus of this report is the experiences of the senior nurses who took on the Care Coordinator role. The report explores the care coordinators’ reservations and motivations around taking on the role and presents a narrative describing their journey in the role.

A decision was made to explore the Care Coordinator role in more depth, as it is unique to the Sutton Vanguard programme and core to delivering all its objectives.

Who might find it useful?

This report provides information for Sutton CCG about key elements of the Vanguard experience that the Care Coordinators are passionate to see sustained and secured for the future. Such information will also be useful to other parts of the country considering approaches to enhancing care, efficiency and productivity in nursing and other types of residential home where there are complex needs.

The report also provides an insight into day-to-day life as a senior nurse in a nursing home and as such it offers useful information to nurses, student nurses and nurse educators.

GPs and the wider multidisciplinary team including residents, relatives and other care home staff may also find inspiration in the “art of the possible” as described by these nurses in relation to the benefits of a strong and wide community of practice supporting care in nursing homes.

What did we do?

A convenience sample of 3 Care Coordinators from 3 different homes were interviewed. A semi-structured interview schedule was developed and can be found in annex 1.

Given that only 3 Care Coordinators could be interviewed the findings were checked against those from an evaluation workshop carried out four months earlier. The evaluation workshop was attended by GPs, Care Home owners and managers, Care Coordinators, CCG Vanguard Team members and the Vanguard Pharmacist. A summary of the findings from this workshop can be found at annex 2.

What did we find?

The Rewards of Nursing Home Careers

The nurses interviewed spanned the generations as follows; 20’s (n=1), 30’s (n=1), 60’s (n=1.) From a career perspective none of them had started out with a career in nursing homes in mind. They had either
“fallen into” nursing home nursing or had experiences as a student that made them think about it as a possibility.

Of the two nurses who had not thought about nursing homes initially it was necessity that led them to the nursing home roles they took on. For example:

“When I started I did a variety of jobs via an agency in the acute sector. There weren’t many jobs in the hospitals and I saw a role in a home and though I’d give it a try. Now I love it. You get to really spend time with people and develop proper relationships. It’s what so many nurses miss you know just talking to people. In the hospitals you know it’s all sitting at the nursing station and paperwork. I mean there is paperwork here but the job is more personal.”

“I needed to get my NMC PIN so that I could work in this country and I saw this carer role and thought I could get my experience there. Once I was here I loved it. I mean you have the responsibility and you can develop responsibility. The other staff are great, we are a team.”

“The place was a big mess you know they really needed staff so I just thought ‘let’s do it’. It wasn’t my plan it was just there.”

The nurse who had been inspired to take the path into nursing homes spoke passionately about the importance of exposure to nursing home roles as a student.

“In my 3rd year I did a 17 week placement in District Nursing. I was going into the homes of elderly people and realised I was often the only person they saw in days. I learnt a lot about long-term conditions in that placement. We were flagging up safeguarding issues, these people could not take care of themselves and we were getting them places in homes. It made me think how elderly people need nurses. You just get to see the bad stuff you know on the news. But I thought these homes they are good places, doing a good job.”

These comments are interesting given the current difficulties that Nursing Homes face recruiting staff. They highlight the importance of getting the messages out about the benefits of working in the care sector and perhaps working to overcome the barriers to offering more students exposure to Nursing Homes as part of their training.

Lack of confidence

All of the nurses interviewed had to be persuaded to take on the Care Coordinator role. All 3 had concerns at the outset about the additional demands of the role and their ability to cope with the extra work and the increased responsibility. The role was funded to make the position supernumerary but despite this one nurse reported that she felt as though she was doing 2 jobs. This seemed to be due to difficulties recruiting in suitable staff for backfill, once again highlighting the importance of making working in nursing homes more attractive and publicising the benefits.

“I didn’t want to do it. I suppose because I knew it would create more work and I’m already stretched. My manager just said ‘come on you’ve got to do it.’ I know there’s this money to support the role but it was hard to use it for getting other people in. It’s just so hard to recruit. We’re just starting to get there now but it’s hard. So I suppose I was reluctant. I also thought I’m going to go to this training and I’m going to be the only dumb one. Everyone else will know all the clinical stuff and I’m just going to look like an idiot. So I wasn’t enthusiastic.”
“Our proprietor she encouraged me. You know she said ‘you’ll be good.’ I wasn’t so sure you know you think everyone will be better than you. You think you’ll just look stupid.”

“I was keen for the responsibility. I just thought how am I going to get them (other staff) to trust me?”

Despite these initial reservations it was clear from the interviews that all the nurses thought that they had grown into the role over the course of the Vanguard Programme and that they believed that they had made a real and significant difference in the role.

**Making a difference**

The diagram below shows the ways in which the Care Coordinators developed in their role, the sources of support that helped them and the benefits that they perceived for residents and the wider health and care system as a result. It was clear from the interviews that as the Care Coordinators began to observe the impact they were having their confidence and enthusiasm grew.

**Care Coordinator Competencies**

**Sources of Development Support**
1. Training
2. GP Partner
3. The Vanguard Community

**Resultant Improvements**
1. Improved Care
2. Better information for professionals
3. Advice and Guidance for wider Care Home Staff

**Figure 1:** How and Where the Care Coordinator Role Made a Difference

**Trusted Resource**

Despite their initial lack of confidence the Care Coordinators soon found that they became a trusted resource. All the Care Coordinators spoke about this and were clearly surprised and pleased. Examples were given relating to being a resource for different parts of the Nursing Home community.
Care Coordinators talked about being a trusted resource for other professionals and this boosted their confidence and had a positive impact in terms of the relationship with the wider multidisciplinary team and the support that the home was able to get from other professionals. For example:

“I was able to give my clinical judgment, speaking to other professionals and our GP. Our GP really seems to respect me now because of my new knowledge of medication. I get asked for my opinion and I’m confident to give it and then I see how that helps. I just think wow I did that.”

“I feel like we are able to get a quicker response from the multidisciplinary team because I can explain exactly why we need them. You know I understand more and I can explain it confidently. They ask me questions and I know the answers because I really know all the residents. You feel great because you get the residents help more quickly and sometimes the person does not even have to come in. They can just advise and they trust me to get it done and do the monitoring and feed it all back.”

“With Vanguard you really feel part of something - everyone knows the Vanguard, if you say you’re a Care Coordinator to a nurse in the hospital they see you differently now they know we are working with hospitals. They know the skills you have and what you’re trying to achieve. They ask me questions now, before they didn’t seem to ask.”

The nurses also talked about the way that relatives grew to trust them as a source of advice and support.

“I am able to explain clinical things to the residents’ relatives now and you know they trust me and they ask my advice. I never thought I could do that.”

“I definitely think my Care Coordinator role pushed me. Now I see I am able to manage to get trust from people who don’t know me. Now I am like a reference point for the family, the role pushed me and gave me more confidence.”

All three sources of development support shown in figure 1 seemed to have a role to play in enabling the Care Coordinators to become a trusted resource.

“Working with our GP was great. I could ask her things and she would really explain and take the time. I learnt so much about medicines and end of life. It was amazing.”

“That training we had on how to speak with relatives and professionals and how to feel confident. It was great to have theory then the chance to have a go in a safe space, taking it in turns and all helping each other. It made such a difference. I just got back afterwards and thought ‘wow I can do this, I can have difficult conversations, I know I can because I’ve done it and I’ve got these tools.’ ”

“When I go to the meetings with all the 6 Care Coordinators we all seem more positive. We all have similar problems and we are able to be open honest and share. We give each other advice and recommendations.”

“Before I joined Vanguard I didn’t know anyone outside the home. Now I know I can pick up the phone to you the Marsden, the pharmacist, the SLT (Speech and Language Therapist.) We’re like one big community. I never knew there was so much support out there. You’re not on your own. Even on the night shift. It really helps you learn. I’ve learnt so much.”
Guardians of Quality

The Care Coordinators were all passionate about doing a good job and helping the residents. It was clear from speaking to them that they enjoyed using their new knowledge and skills to drive quality improvement. The Care Coordinators gave examples relating to improving residents’ experiences, saving money and following clinical and safeguarding guidelines.

“Sometimes you notice that something is not being done very well but it’s your responsibility to be calm, to remind the other staff of the things you expect them to do properly. You remind them about really important things like safeguarding so the staff are staff of quality.”

“If you notice they are not taking their medications, you can get that reviewed. So you make good use of money and make sure the resident has the right care. It’s our responsibility, you don’t just say ‘oh it’s not my patient’ like they do on the wards. You make sure things are being done right.”

“If a resident dies, different cultures they have different ways of looking at this. So you know you can help the carers understand. He had this religion and this is what needs to be done. You can help them, help their development so things are better for the residents.”

“You can make time to talk to the residents and help others learn how to be with people who have dementia. They still notice things and they deserve to have the best quality of life. They’ve been through so much, through wars and they should get the respect. It’s about talking, being with them, giving comfort.”

The Care Coordinators also talked about how having an official leadership role made it easier for them to drive quality up.

“I always want to do a good job but you feel like it’s not your business talking to others about how they do things. But now I have the role I feel like I can. I enjoy the responsibility because I can make a difference and see that difference.”

Inspiring Leader

The Care Coordinators were all keen to share their new and developing knowledge and skills with others at the home. They were confident to lead training sessions themselves, to work alongside and mentor other staff and to allow staff to shadow, observe and ask questions. They took pride in this work and talked about the positive feedback they’d had from others.

“Cascade training is so important. I’ve had the benefit and I want to pass it on. I also offer to give people 1:1 help afterwards to get them going and build their confidence. They say they find that really helpful. You know it’s ok hearing about it and using models but in real life you need some support.”

“After the training I like to let people shadow me so they can see the new ways I am doing things and ask questions.”

Two of the Care Coordinators talked about succession planning and working to inspire other senior nurse to take on the Care Coordinator role and to feel proud of working in a Nursing Home:

“I have a lead nurse who I have encouraged and given her confidence so when I go they will have the opportunity. Empowering others is very very important. What I found coming into nursing homes is a lot of people had lost their confidence. I think that’s because of the negative feedback from hospitals. They would
say 'why are you working in a nursing home there's not a lot going on there.' What I’ve done is lifted the nurses. I used to feel awkward saying I was from a nursing home but now I feel proud.”

“Once we've employed more staff I want to empower them. We need younger people coming up so we can then pass on our knowledge and get them networked in and give them the confidence. The only exposure people get is bad through the media. Until people come in and see then we can inspire, empower and give confidence.”

Do others support these perspectives?

This piece of work reports the perspectives of the Care Coordinators themselves and of course they may have a biased view. However an evaluation workshop attended by GPs, Nursing Home owners and managers, members of the CCG Vanguard Programme Team and the Vanguard Pharmacist provided evidence to support the findings. A full summary can be found at annex 2.

At this workshop GPs reported that they appreciated the opportunity to work with trained care coordinators and they felt that they now had more confidence in all staff at the care home as a result of working closely with the Care Coordinators during their weekly visits to the homes. They reported that care had shifted to become more proactive allowing them to work with the nurses to prevent problems developing and to reduce the amount of unmet need. The ability to work with the care coordinators to develop clear care plans was key to this.

It is interesting that the GPs commented that they now had more confidence in staff throughout the Care Homes and this is likely to reflect the impact of the leadership role that the Care Coordinators reported taking on and the way that they took responsibility for quality and for nurturing and developing other staff in the home.

Managers and owners were pleased to see their nurses making more referrals and having the confidence to be assertive in advocating for residents’ needs and felt that this had resulted in greater input from the wider MDT. They were pleased with the training provided via the Vanguard for their staff as they could see that it had up-skilled the Care Coordinators clinically and in relation to leadership skills around communication and assertiveness. Managers and owners hoped that the Vanguard network would continue to offer opportunities for staff to share and spread good practice.

What relevance does this have for the sector?

Improving quality

Commissioners, home owners and managers, staff and the general public all have a shared interest in improving the quality of care in the residential care sector.

Many Nursing Homes have established mechanisms to support close working between GPs and Nursing Home Staff. The Sutton Vanguard Care Coordinator role goes beyond this and is an innovative approach to ensuring that residents with ever more complex needs get the care and intervention they need in an efficient and timely way.

Nursing staff in Nursing Homes often report feeling isolated and under-valued which decreases their confidence and job satisfaction (Owen et al 2006.) This reflects the opinions of the nurses in this study before they took on the Care Coordinator role. By contrast the data showed that once established and supported in their new roles the Care Coordinators felt able to make a real and positive difference to residents’ lives. A named role with appropriate support behind it to enable nurses to develop clinically and professionally has the potential to be an effective catalyst for change and improvement in the sector.
A report by the Joseph Rowntree Foundation (Wild, Szczepura and Nelson 2010) highlighted the need for more clinical development opportunities for staff in homes for older people and for more incentives and career opportunities to encourage and support staff development and quality of care in the sector.

Whilst formal training was clearly important to the Care Coordinators, learning within a rich and inspiring community of practice was also powerful. Close relationships with GPs linked with the home were critical and Care Coordinators also drew on each other and on the wider network of experts that they were introduced to. This reflects the findings of a recent Royal College of Nursing literature review (Spilsbury K, Hanratty B and McCaughan D 2015) which stressed that creative approaches to learning and development would be necessary to meet the learning needs of care home staff and to overcome some of the barriers of access and attendance. In addition the report emphasised that professional development should be more than a ‘one-off’ training events and should particularly support those working night shifts.

The Care Coordinators had much to say about the importance of the Vanguard community and this is interesting in relation to Communities of Practice (CoP) theory (Lave and Wenger 1991.) What drives a CoP is a challenge or set of challenges (known as the Domain) that need to be resolved in order to make a real difference in terms of outcomes. Membership implies a commitment to this Domain, and a shared competence that distinguishes the members from people outside the Community. Through regular interaction, communication and support people in CoPs develop relationships based on respect and trust. This is very much what the Care Coordinators reported. Members of a CoP share a passion for developing the best practices they can whilst sharing a range of resources: experiences, stories, tools and ways of addressing recurring problems.

NHS Education for Scotland has gone a step further supporting the joining together of CoPs as Managed Knowledge Networks. These are extended, national groups of health and social care staff that cross discipline, organisational and sector boundaries and are linked by a common need to access and share information. Some are supported by a community website.

It would seem important to support and encourage the maintenance of the Sutton Vanguard CoP and wider networks across the sector as a means of driving continual quality improvement and as a source of ongoing development support for all staff in the sector whatever their profession or shift arrangements.

**Tackling recruitment difficulties**

There are issues for nurse educators around both the preparation of nurses for nursing home roles and their exposure during their formal education to positive experiences of work in the sector (Stevens 2011 and Spilsbury et al 2015). Placement opportunities in the sector are few and far between due to the difficulties associated with offering placements in small, over-stretched, privately owned businesses.

Recruitment difficulties in the care sector are hampering attempts at quality improvement but the Sutton Care Coordinator role offers a replicable model, which drives job satisfaction for individuals in the role and supports a more vibrant and appealing work environment.

The Care Coordinators were concerned about the poor image of the sector and it is interesting that only one of them had a deliberate plan at the outset of their career to work in the sector.

The current increasing demand for student nursing placement opportunities creates a burning platform for action to find new and innovative placement settings. Exposure to the vibrant and inspiring work environment supported by the Care Coordinator role would give students a more positive view of the sector and support their development was specific reference to the needs of nursing home residents. This may support recruitment going forward. Clearly there are barriers to be overcome to open up these private businesses to nursing students but this could be a valuable area for the nursing profession and nurse educators to explore.
Next Steps

Funding to support the supernumerary nature of the Care Coordinator role and the weekly proactive GP visits has now come to an end. Despite this there is much scope for embedding the benefits of the Care Coordinator role and creating a sustainable future.

Two key actions are suggested for further exploration:

1. Support the development of networks and communities of practice for the care sector

Communities of Practice and Managed Knowledge Networks can have a significant impact on job satisfaction and quality of care. There is now the opportunity for the Nursing Homes across the CCG area to join together to create a vibrant and powerful CoP led by senior nurses acting as named Care Coordinators. Replicating this model in other boroughs and other parts of the care sector could facilitate the development of a wider Managed Knowledge Network to support quality improvement further.

CoPs and Managed Knowledge Networks offer a powerful and potentially low cost route to supporting staff across the sector. However it will be important to offer resources to cultivate and nurture CoPs in the sector. For example funding the development and maintenance of community and network websites or forums and running regular face-to-face events to keep the momentum going.

2. Work with nurse educators to develop pre-registration training to support recruitment into the care sector

The pre-registration curriculum is already full of elements that would support the development of the knowledge, attitudes and skills required by the sector. For example students already cover poly-pharmacy, managing patients with complex long-terms conditions, dementia, nutrition, tissue viability and continence care. However with the absence of placement opportunities students may not be making the link fully between what they are learning and the needs of residents. Furthermore students who take on paid work as carers in the care sector may not be seeing the best quality practice where they work.

The Department of Health (2009) has previously published guidance on supporting placements in small and privately run organisations as follows:

- Engage with relevant staff to develop appropriate simulation training
- Make use of appropriately supervised peer learning. This is where students are placed in groups and carry out tasks under supervision initially drawing on each other to solve problems and develop strategies, checking these with qualified staff before taking action and working together to reflect on their learning (Baldry-Currens and Bithell 2003.)
- Work with potential providers to discuss and manage insurance issues.

A care sector placement summit could bring together expert stakeholders from across the sector to discuss and resolve barriers.

Universities could also work together to publicise employment opportunities in exemplary care providers to enable their students to gain valuable employment whilst studying.
References


Annex 1: Semi-structured interview schedule

- Interviewee code

- Age 20’s 30’s 40’s 50’s 60’s

- Number of years qualified as a nurse at the start of the Vanguard pilot:

- Time at the Care Home at the start of the Vanguard pilot

- Time in previous Care Home nursing roles

- Time in other Care Home roles

- Please can you tell be about how you first came to nursing as a career? When. What attracted them? Hopes for their career

- Please can you tell me about how you came to be working in a Nursing Home? When. What circumstances surrounded their application. What attracted them

- Please tell me about the circumstances surrounding your taking on the Care Coordinator role. How did they become aware? What were their initial thoughts? Any reservations? Any hopes?

- What elements of the Vanguard programme were most helpful to them in their role? People. Workshops. Experiences

- Please can you describe in more detail how these things impacted your practice and/or the work of others in the home?

- What elements of the role did you most enjoy

- Tell me a bit about your career aspirations. Before Vanguard. After Vanguard

- Please tell me about any specific next steps you have in mind for your career.
Annex 2: Summary of the findings of the March Evaluation Workshop

This information has been derived from feedback obtained at an evaluation workshop attended by GPs, care coordinators, the CCG Vanguard team and the Vanguard pharmacist.

There are 3 core elements:

- Information about how the hopes and fears of the different professional groups had played out in practice.
- Key themes from the case studies presented by the Care Home teams.
- Feedback relating to 2 key questions about the benefits of the Health and Wellbeing Review

How the Hopes and Fears of the Different Professional Groups Played out in Practice

The different professional groups expressed specific hopes and fears before and during the pilot and feedback was given on how these played out in practice over the course of the pilot as follows.

GPs

At the core of the GPs motivation to be involved in the pilot was an aspiration for better care for residents and their families. GPs found that just as they had hoped they had more time to talk to residents and their families and this proved particularly important in supporting a richer and more holistic understanding of residents and their needs. This proved invaluable in supporting chronic disease management and in helping residents and their families understand and plan end of life care. GPs had concerns at the outset about sustainability but having experienced the approach they feel that as long as funding is in place to release the time it should be sustainable from their perspective. They had wondered if the Care Homes might struggle to staff the approach adequately but in practice this was not an issue. They appreciated the opportunity to work with trained care coordinators as a team and again hoped that ongoing funding would be available to train nurses and maintain and grow the pool of nurses with care coordinator skills. They felt that they now had more confidence in all staff at the care home as a result of the HWBR model and they found that care had shifted to become more proactive allowing them to work with the nurses to prevent problems developing and to reduce the amount of unmet need. The ability to work with the care coordinators to develop care plans was key to this.

GPs initially wondered if the paperwork might be burdensome but in practice found that it was manageable in terms of the time required and that they were able to write notes up in a timely way because they had funded time to do this. They felt that a remote access solution i.e. EMIS would have helped them to be even more efficient and effective with their records. At the outset they wondered if the Health and Wellbeing Review (HWBR) might result in such high numbers of multidisciplinary team (MDT) referrals that the wider system might not be able to cope. In practice they found that adequate MDT support was available albeit that consultations were not always available within a timeframe that would offer best care for the residents.

GPs valued the enhanced pharmacy support available as a result of the model as this allowed for more rigorous medicines review. This resulted in unnecessary medication being stopped and appropriate medication being started or re-started.

Care Home Managers and Owners

At the outset Care Home Managers and owners hoped that the HWBR would improve the quality of services they were able to offer and improve the confidence, skills and job satisfaction of their staff. In practice they felt that the HWBR had created a much more open culture and improved relationships with GPs and the wider MDT. They were pleased to see their nurses making more referrals and having the confidence to be assertive in advocating for residents’ needs. This has resulted in greater input from the wider MDT. They were pleased with the ongoing training provided via the Vanguard for their staff which has had a significant impact in terms of up-skilling them clinically and in relation to leadership skills around
communication and assertiveness. Managers and owners hoped that the Vanguard network would continue to offer opportunities for staff to share and spread good practice.

They were also pleased that their residents were being reviewed medically in a systematic way on a regular basis and that care plans were being updated in a more proactive and holistic way as a result. As they had hoped the increased pharmacy input had enabled them to reduce the wastage of medicines and sip feeds and ensure that residents were on the most appropriate and helpful drugs.

A significant concern at the outset had been a worry that the nurses who took on the care coordinator role might not be able to manage the increased workload. In practice they found that ensuring that the care coordinators were supernumerary enabled them to manage the workload associated with the role effectively.

Care coordinators

Care coordinators were pleased that as they had hoped they had been able to develop new skills and confidence as a result of the Vanguard training which was enabling them to provide better care for their residents. They are aware that they need additional and ongoing clinical skills training in order to equip themselves to improve care even more.

They are pleased that they are getting more timely support from the GPs and the MDT and that this is enabling them to reduce unnecessary hospital admissions. They had been concerned at the outset about the volume of paperwork involved. They do find that they struggle to complete the red bag paperwork in an emergency but they also find that the red bag method reduces the time they spend talking to acute care staff if a resident is admitted and makes the process of discharging the resident from hospital back to the vcare home more efficient and effective. In order to manage this challenge they now try to anticipate admissions earlier and complete as much of the red bag paperwork as possible in advance so that once the need to be admitted is confirmed they can complete the remaining paperwork without needing to rush.

Case Studies Shared by the Care Home Teams

Having worked in professional groups to discuss how their hopes and fears at the outset of the project had played out in practice the workshop participants shared their experiences in care home teams. The manager, care coordinator and GP from each care home had worked together to develop and present their experiences. Listening to the presentations it was clear that all the Care Homes teams felt proud to be a part of the Vanguard and sensed that what they were part of was an evolving community of practice that was wider than the team in each care home.

Key themes from each Care Home are shown in the table below.

<table>
<thead>
<tr>
<th>Reduced admissions</th>
<th>Better care</th>
<th>Better disease management</th>
<th>Team-working</th>
<th>On-going training needs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lady with Parkinsonian syndrome in final days of life able to stay in care home because staff and family were supported by GP and palliative care team to understand changes in nutritional and hydration needs at the end of life</td>
<td>More time to talk to residents and families</td>
<td>All patients seen by the GP systematically every 6 weeks in order to be proactive rather than reactive</td>
<td>Manager feeling more supported and more confident to challenge wider MDT in relation to their contractual responsibilities</td>
<td>Administering zoladex injections Fortification of foods and nutrient dense diets</td>
</tr>
</tbody>
</table>
## Reduced admissions

Care plans clear and updated regularly empowers care home staff to support residents without the need for admissions.

## Better care

GP and Care Coordinators had time to talk to daughters of a lady with challenging behaviour about her behavioural triggers. This enabled them to reduce challenging episodes whilst also keeping medication to a minimum.

## Better disease management

In-depth input from Vanguard pharmacist has enabled at least 20 unnecessary medications to be stopped and others modified to improve effectiveness.

## Team-working

In-going training needs

## On-going training needs

Giving flu vaccinations

<table>
<thead>
<tr>
<th>Resident with urinary catheter in situ, which became blocked. With Darzi Fellow’s support managed to identify someone who was able to visit the home and support the nurses to change the Catheter</th>
<th>Care home staff better able to fortify everyday foods and reduce reliance on sip feeds following training from Dietitian</th>
<th>Ear syringing Catheter insertion and removal</th>
</tr>
</thead>
<tbody>
<tr>
<td>81 year old patient with vascular dementia and Parkinson’s Disease. Had a lesion, which looked like a cut on his head. Anticipated that he might have MRSA, which was confirmed and treated. GP able to liaise with colleague at the surgery with a special interest in dermatology. Possible Squamous Cell Carcinoma identified. GP able to arrange biopsy last on the list and a phone call from the hospital when they were ready for him to reduce the time required waiting at the hospital.</td>
<td></td>
<td>End of life</td>
</tr>
</tbody>
</table>

All Care Homes agreed or strongly agreed that the HWBR had enabled them to be more proactive and reduce unnecessary admissions. Those that simply agreed stated that this was because their Care Home
had been using a similar approach prior to the Vanguard implementation. Reasons cited for reduced patient admissions were:

- Better access to the wider MDT
- A more holistic approach to residents’ care and disease management
- A systematic approach to ensuring that all residents get a medical review regularly not just those in crisis
- Fewer crisis issues to deal with week by week as these were being prevented through proactive management
- Earlier use of appropriate medications to support good end of life care
- More opportunity to reduce anxiety of family members through discussion with the GP, care coordinators and wider multidisciplinary team
- More proactive medicines management ensuring residents were on optimal doses of the right medicines
- Improved care coordinator confidence to make referrals to the wider MDT as a result of training
- Better team working as professionals have time to discuss cases and agree an approach

With one exception all care home teams either agreed or strongly agreed that communication between the care home and GPs had improved as a result of the Vanguard. The Care Home that disagreed simply said that they had always had good communication and the Vanguard had provided them with more resources to support the good work they had always been doing. One Care Home team specifically highlighted that communications with the wider MDT had improved and felt this was associated with improved clinical skills and assertiveness in their care coordinators as a result of the Vanguard training. One team highlighted the important role of written communication and stressed the benefits of having better quality notes as a result of the Vanguard pilot. Some teams expressed a wish for the improvements in communication to extend beyond the care coordinators and named GP to the whole GP practice and all care home staff. Training for GP receptionists was also raised as an important issue with Care Homes reporting variable experiences when trying to access GP support via the practice receptionist. One Care Home wanted to make the particular point that improved communication had created a sense of team working that had not been present prior to the Vanguard pilot.
Appendix F  Observational study of the model in action

Throughout the pilot, the Lead nurse from the Vanguard project team visited pilot sites to observe the model in action, identify and discuss any challenges encountered and identify areas of good practice. Whilst differences are to be expected, the impact these may have on the effectiveness of the HWBR from the perspective of the resident, care coordinator and general practitioner warrants further exploration. Observations have been broadly categorised under the headings of practical aspects, working relationships and decision-making and wider system considerations. From these observations, key learning has been identified as presented in section 7 above with recommendations for best practice.

Practical aspects

Variation was seen with respect to communicating the ‘residents to be seen’ list with the GP ahead of the HWBR. Some homes did not present this information until the GP arrived in the home however others communicated this ahead of time via secure email or fax. A couple of homes utilised this communication to also highlight any prescription issues which the GP would the address prior to attending the home. There was no obvious correlation between the size of the home and the practice they adopted. Where the GP received information ahead of the visit, time efficiencies were apparent. The process for identification of residents due a 6 month holistic review was variable and flexible to meet the residents’ needs however a systematic process is required to ensure residents are not accidentally missed. The availability of physical assessment equipment for the GP to utilise was variable and in general, each GP brought their own clinical equipment.

Working relationships and decision-making

For each of the sites, the dynamics of the working relationship between care coordinators and GPs changed over time, presumably as they developed a closer relationship over time. The care coordinators varied in their confidence and ability to provide specific individual context and appropriate clinical challenge during the decision-making process. There was no obvious correlation between this and the nurses’ years of experience. Only two of the care coordinators completed their nurse training in the UK and it would be interesting to explore the potential influence of cultural norms and behaviour of the development of an effective working relationship. Occasionally a GP trainee would complete the HWBR however in this circumstance the decision-making and subsequent actions were less timely for the residents as advice was sought from the link GP. With this in mind, the HWBR model provides an excellent platform for developing skills

Considerations for the wider healthcare system

Written and verbal communication from both community and hospital-based services was variable in terms of both quality and timeliness. Pockets of extremely poor practice were observed that had implications for providing continuity of care, resident safety and effective decision-making.

One GP had remote access to the primary-care record in the nursing home which enabled time efficiencies and accurate and timely record-keeping. One limitation to this was limited functionality for prescribing and ordering investigations such as blood tests which were completed back at the practice. The ability to utilise shared care records will undoubtedly enhance effectiveness of communication in this model. Apart from financial investment, a limitation with regards harnessing technology and promoting wider adoption is the information technology capabilities of the home, which were considerably variable.

The HWBR model enabled greater team working and enhanced communication and could easily be applied to other disciplines.