A new integrated model for Care Homes from Walsall CCG/Healthcare NHS Trust

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The Walsall Context

- Metropolitan Borough of Walsall population 269,323
- The borough is co-terminus with its local council and integrated healthcare trust
- No community hospital/community beds apart from NH beds
- Areas of severe post industrial deprivation: West/East divide
- 72 Care homes, 12 Nursing Homes - variations in quality
- Reacting to “Yo-Yoing” care provision and a waste of health & social care resources
- 2011/12 – The PCT/CCG and LA partners commenced an extensive joint quality approach to care home provision in Walsall.
- Throughout periods of change good engagement and commitment from Nursing Home sector managers
The Walsall Quality Improvement Story

• A common value base: safety, effectiveness, assurance and user engagement, with quality at the core
• Integrating Health & Social Care outcomes across agency boundaries
• A Quality dataset to inform interventions & demonstrate outcomes
• Coordination of a range of health and care activities
• Raising the confidence and leadership of the workforce
• Building in sustainability with providers by, ‘walking in their shoes’, yet reinforcing their accountability for quality
• Good governance and business management - more structured strategic board with links to the Walsall Partnership/HWBB
• Maximising engagement potential: Health watch, Ambulance service, enter and view schemes
Snapshot of Activities and Outcomes

- **Medical review pilot**: Consisted of 3 fundamental work streams, including hospital admission data review and meds management project with savings made and improved therapeutic outcomes for patients.

- **Improved data collection**: Standardised Self Assessment Tool for all nursing care homes in Walsall.

- **Development of a set of clinical protocols**: Extensive educational update for all care homes, free access to local clinical training, in line with local NHS provider.

- **Hospital admission and discharge task and finish group**: Improving relationships with hospital and care home staff. Improving arrangements for the transition of care for frail older patients.

- **Audits**: Programme of regular medicines management and infection control audits, with significant improvement evident.

- **Regional benchmarking**: led on development of Birmingham and Black Country benchmark reports on care home performance.
Enhanced Model for Care Homes

- Risk-stratification
- Preventative Care
- Good Discharge Planning
- Patient
- Care Planning
- Choice & Control at End of Life
- Rapid Response Care Closer to Home

Walsall Clinical Commissioning Group

Improving Health and Wellbeing for Walsall
Risk Stratification

• Identify and grade frailty- The Edmonton frail scale tool.

• Link to the frailty assessment, co-ordination, access to rapid support and diagnostics and person centred care planning.

• Enhanced support for older people with severe frailty in care homes.
Community Nursing In-reach

• Daily intelligence of admissions into A&E/wards
• Rapid assessment with home care knowledge
• Support reduced length of stay
• Support discharge planning/Transition of care.
• Rapid access for home follow up
• Prevention of avoidable readmission
Care Planning

- Proactive weekly ward rounds.
- Named GP practice team for care homes.
- Shared plan of care
- Emergency care plan
- Advance care planning
- MDT working
- Person centred care planning
- Virtual Ward
Choice, control and support towards end of life.

- Identifying people in the last year of life.
- Membership to the palliative care community steering group and operational group.
- Ensuring effective assessments i.e. advanced care planning and EOL care planning.
- Providing workforce training.
- Management of the dying phase.
- Supporting residents and their families to have choice and control at EOL.
Rapid Response Team

- Visits (2 hours) to sub-acutely ill patients who require rapid, intensive intervention to avoid hospital admission
- Referrals - GP’s, FEP/A&E, WMAS, 8.30am - 10.00pm, 7 days a week. Follow up 48 hours
- Work closely with therapies/social care reablement, step down to ICT, Community teams
- GP with specialist interest in frailty.
Outcomes

- Baseline Data: Sept 14 98, 999 calls made to WMAS from nursing homes.
- 68% reduction in 999 calls made to WMAS from nursing homes in Walsall.
- 78% reduction in the number of residents conveyed to hospital from 999 WMAS calls.
Improving Quality in Care Homes.

• 91% of patients receiving EOL care in nursing homes.
• Improved CQC Ratings.
• No Nursing Homes Suspended.
• Reduction in the number of avoidable pressure ulcers.
• 130 patients receiving enhanced support on the community virtual ward.
Nursing Home Manager Perspective

• Managing crisis and despair to a planned and coordinated delivery
• Avenues to choose – maximising patients and families choice
• Strengthening own accountability
• Cultural shift – blame culture
• Patient centred care is enhanced
• Pre-emptive care builds trust and confidence with staff, patients and their families
Benefits

- Patients receiving right care at the right time in their own home
- Staff feeling empowered and supported to make the right clinical decision
- Improved end of life care, more specifically non malignancy
- Bringing nursing homes in to the ‘community home’ enabling seamless care across the health and care environment
- Integrated approaches to care have realised real benefits for patients
Sustainability and Conclusion

• Now mainstreamed in line with community services review for Walsall
• Further Investment to enable the NH to implement the model of Improvement.
• Supporting staff with gaining the skills to measure and understand the safety culture in their home.
• Nursing Home forum to share practice
Improving Safety.

- Giving staff the tools and ability to measure and understand safety culture in their care home
- Care home staff will co-design service improvement training packages which are then could be actively used to drive service improvement
- Collecting data and using data to measure improvement interventions, exploring team safety and human factors in relation to safety
- Increasing understanding of clinical risk factors around harms and link these to improvement interventions
- Measure impact on safeguarding
- Additionally this programme will act as an enabler for Walsall CCG’s and LA priorities and work programmes e.g. BCF, Admission avoidance, Quality and Safety in Care Homes.
Any Questions?

Thank you for listening