Case Study: Community Geriatrician Project

Dr Caroline Ruaux – GP and Long Term Conditions Lead, Ashford CCG
Need for change

- Frail older people with comorbidities have high health and social care requirements that require detailed assessments. Such individuals are at risk of unplanned admission and readmission to hospital.

- Care home population identified as high users (35% of local readmissions were from care homes).

- Lack of access to urgent support for care homes – only option A&E.

- Lack of access to clinical advice out of hours.

- Lack of anticipatory care planning.
Need for Change
What did we do?

• Implementation of Community Geriatrician and Matron Service

• Team:
  ➢ Community Matron working extended hours - 8am to 8pm 7 days a week and a 24hr on call system
  ➢ Community Geriatrician
  ➢ Clinical Nurse Specialist (Care Homes) – service specification altered

• Aim: To provide an assessment diagnosis and treatment service for patients with complex long term care needs either living within a care home or within their own home living within the Ashford CCG boundaries, supporting admission avoidance.
Model of Care

**Identifying Patients**
- New admissions to care homes
- Identification of patients who are deemed at risk
- High users of emergency services – care home or patients in their own home
- Care Home Dashboard – A&E attendances & admissions from Care Homes

**Pathway**
- Clients are assessed by the Community Matron in the first instance to screen and identify need
- Clients will be assessed in the care home/home environment
- Comprehensive assessment of health and care needs with completion of Anticipatory Care Plans
- Complex patients referred to Community Geriatrician
- Ward rounds
- Weekly MDT meetings
Supporting Work Streams

Care Home Forum
- Representation from Care Homes, Acute Trust, Community Trust, Social Care
- Training, education, networking and opportunity to share ideas
- Agenda setting – care home led

Communications Tool
- Issues -
  - Documentation lengthy & lost in transfer
  - Frequent telephone calls to care homes
  - Lack of information to homes on discharge
- Solution –
  - A&E staff and care homes worked together to design the ‘communications tool’
  - Communications tool – 2 sides A4, pink paper
  - Concise information about residents transferred to hospital
  - Discharge summary included on reverse
Outcomes

• A&E attendances:
  ➢ 169 A&E attendances from Care homes in Ashford up to Month 4 of 2014/15, a 11.1% decrease on the same period last year.
  ➢ Estimated 10% reduction on 2013/14 FOT

• Emergency admissions:
  ➢ 138 Emergency admissions from Care homes in Ashford up to Month 4 of 2014/15, a 11% decrease on the same period last year.
  ➢ Estimated 10% reduction on 2013/14 FOT

• Residents managed in their own home
• Holistic approach
• Improved communication and relationships
• Integrated working in practice
• All teams feel supported – improved confidence in managing frail vulnerable residents
Challenges

- Recruitment issues – impact on admission avoidance
- Difficulty in obtaining care home data to support monitoring due to changes in level of information CCGs can access
- Engagement – care homes and GPs
Next Steps

• 2nd stage of pilot ongoing (outreach clinics, GP referrals for complex patients)

• Sustainability confirmed

• Continue with care home forums and engagement with care home staff

• Continue to take forward care home led initiatives e.g. communications tool

• Share model with other Health Providers locally and nationally
Thank you