NHS Lanarkshire

Evaluation of Local Enhanced Services (LES) for the Provision of General Medical Services to Care Homes

August 2010
# INDEX

1. **Background** 3
2. **Project Aim** 4
3. **Project Objectives** 4
4. **Methodology** 4
5. **Questionnaire Results** 5-25
   5.1 GP 5
   5.2 Practice Manager 11
   5.3 Care Home Manager 15
   5.4 Pharmacy 20
   5.5 Carer/Relatives 24
6. **Structured Interviews** 26-28
   6.1 GP Interview Results 26
   6.2 Social Work 27
   6.3 Care Home Manager 28
7. **The Impact** 28-32
   7.1 Hospital Admissions 28
   7.2 A&E Attendances 29
   7.3 OOH (Out of Hours Service) 31
   7.4 ACP (Anticipatory Care Plan) 31
   7.5 Care Home Residents 32
   7.6 On Families 32
   7.7 On Clinical Practice 32
8. **Finance** 32-34
9. **Conclusion** 34-35

**Appendices**
1. Specification of Services
2. Contract Document

**References**

**Acknowledgements**
1. Background

1.1 It was recognised that the care needs of residents in Care Homes had increased significantly over recent years. Information published recently identified that in 2004, 47% of Care Home residents were aged 85+. This figure rose to 51% in 2009. Over the same period, there had been a 38% increase in the numbers of residents who fell into the top 4 high dependency groups (31% - 43%). This rise highlights the growing complexity of needs within Care Home residents (SCRUGS, 2009). Indeed, many patients in care homes would now meet the criteria for continuing hospital in-patient care. Additionally, it was also recognised that provision of General Medical Services to care home residents was predominantly re-active and variable. Accordingly, a scheme to provide enhanced services under a Local Enhanced Service (LES) was devised. This scheme would be for both nursing and residential homes.

1.2 Following a detailed process of negotiation and consultation with key parties, a specification of service Appendix 1 and contract Appendix 2 was agreed. In April 2008, agreement was reached on the provision of enhanced General Medical Services to Care Homes in NHS Lanarkshire. There are currently 4256 care home beds in NHS Lanarkshire. The LES was developed on the basis of a single general practice being provided with additional funding to provide an enhanced general medical service to one or more care homes in its locality with approximately 90 patients (or more). On the basis of 90 beds, the practice would undertake to visit twice per week as a minimum on days to suit both GP and care home. Medical records would be held in the care home and the practice would maintain an electronic register for this patient group. NHS Lanarkshire had to be reassured that the practice had the proper experience/training in managing elderly patients with significant care needs before awarding the contract.

1.3 This Local Enhanced Service (LES) was introduced initially in the East Kilbride Locality, thereafter in Clydesdale and Motherwell, leading onto NHS Lanarkshire-wide adoption. In those Localities in the latter cohort, there were varying numbers of homes for which none of the local GP practices were interested in providing the LES. Accordingly, there were a number of practices which agreed to take on homes out with their immediate area. This process was completed in January 2009. Notwithstanding, the Coatbridge area continues to have a number of care homes not covered by the LES.

1.4 Since then, work has been undertaken in seeking to identify both quantitative and qualitative data to measure the impact the service was having and where there maybe further areas which could be improved upon. In addition, the nGMC Contract Monitoring Group has established a mechanism to allow monitoring of the actual service provision by the practice which holds the contract with the respective home.

---

1
2. Project Aim

2.1 This Evaluation is aimed at assessing the impact of the new LES service to Care Homes and how it has been received across NHS Lanarkshire. It aims to gather views from a range of stakeholders both in a quantitative and qualitative manner. It also sets out areas where scope for improvement/enhancement may exist.

3. Objectives of the LES

3.1 The objectives of the LES were to:-

- Improve GMS input to Care Home Residents
- Increase proactive care for Care Home Residents
- Reduce levels of unscheduled visits by GPs
- Reduce levels of unscheduled admissions to acute hospitals
- Increase provision and subsequent maintenance of evidence-based protocols for consistent care provision to Care Home Residents
- Improved management of prescribing in the Care Home setting

4. Methodology

A variety of methods were used to gather data for the evaluation. Firstly, individual questionnaires were designed for GP’s, Practice Managers, Care Home Managers, Pharmacy and Carer/Relatives to gather their views on the impact of the introduction of this service.

Secondly, a number of interviews were carried out among GP’s from both North and South Lanarkshire CHPs. These interviews were carried out using a set of structured questions. Further interviews were undertaken with representatives of acute geriatricians, Social Work and care home matrons.
5. Questionnaires

5.1 GP Results

5.1.1 1. How beneficial do you think the Care Homes Project has been to your service?

- Very beneficial: 65%
- Not beneficial: 22%
- No change: 13%

Common Themes
- Workload has increased but is now centralised
- Less fragmented care for patients

5.1.2 2. Has it made a difference to unscheduled visits?

- Yes: 90%
- No: 10%

Common Themes
- Less unscheduled visits but there is still a degree of inappropriate requests.
- Still receive unscheduled visit requests but at least they’re all to the one home. Time is not spent travelling from one home to the next.
• Reduction in unscheduled visits but this counterbalances the increased number of scheduled visits we have to do.

5.1.3

3. Compared to the time spent at Care Homes before April 2008, how much time are you now spending?

Common Themes
• Slightly more time is now spent on record keeping, summarising notes and QOF areas.
• Now have more patients than before so overall more time is spent.
• Much better structure and proactive care compared to having to fire fight.

5.1.4

4. Compared to travel time spent visiting Care Homes before the care home project began, has there been an impact on your travel time?

Common Themes
• Reduction by 90%.
• A lot less travel time is now required.
5.1.5

5. In your view, has the Care Homes Project led to any improvements in clinical practice?

- Yes: 81%
- No: 14%
- Don't know: 5%

If possible, please comment on areas such as -

- Continuity of care: 100%
- Anticipatory Care: 69%
- Chronic Disease Management: 94%
- End of Life Care: 81%
- Admissions: 88%
- Palliative Care: 81%

Perceived improvement in the various areas of care identified above are significant.
5.1.6

6. Overall, has the Care Homes Project made an impact on your workload?

- 60% Increased workload
- 25% Reduced workload
- 15% No change

Common Themes
- Increased workload due to taking on additional patients.
- Slight increase in workload but it is a better quality workload.
- Increase in workload due to prescribing issues.

5.1.7

7. Have you noticed any changes in the pattern of prescribing?

- 50% Yes
- 50% No
5.1.7a

7a. Have you noticed any changes in efficiency around repeat prescribing?

- Yes: 55%
- No: 45%

5.1.7b

7b. Have you noticed any changes in efficiency of acute prescribing?

- Yes: 50%
- No: 50%
8. Communication between Practice and other stakeholders since April 2008

<table>
<thead>
<tr>
<th></th>
<th>Worse</th>
<th>Improved</th>
<th>No change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care Home Staff</td>
<td>3</td>
<td>15</td>
<td>2</td>
</tr>
<tr>
<td>Pharmacy Services</td>
<td>5</td>
<td>13</td>
<td>11</td>
</tr>
<tr>
<td>Care Home Liaison</td>
<td>10</td>
<td>8</td>
<td>0</td>
</tr>
<tr>
<td>Relatives / Carers</td>
<td>13</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>Community Staff</td>
<td>6</td>
<td>14</td>
<td>0</td>
</tr>
</tbody>
</table>

5.1.9

9. What is your view on the use of I.T. systems and support offered as part of the Care Homes Project?

Common Themes
- Inadequate, I find myself writing notes and then processing them back at the practice.
- IT support has been inadequate, our care home does not have a computer terminal though which we can access out patient details.
- Pocket Gpass is worse than normal. I tend not to use the laptop.

5.1.10 Key Messages - GPs

Overall, the introduction of this service has proved beneficial. It has also led to many improvements in clinical practice, particularly around continuity of care, anticipatory care, chronic disease management, end of life care, admissions and palliative care. It has also reduced unscheduled visits and reduced time spent travelling between care homes. However, work is still required around prescribing and IT in order to reduce time and medicine wastage.
5.2 Practice Manager Results

5.2.1

1. How beneficial do you think the Care Homes Project has been to your service?

- Very beneficial: 46%
- Not beneficial: 9%
- No change: 45%

Common Themes
- It has been beneficial in the fact that we are only dealing with one or two care homes.

5.2.2

2. In relation to time, has the Care Homes Project had an impact on the amount of time spent dealing with prescriptions errors/queries?

- More time: 25%
- Less time: 33%
- No change: 42%

Common Themes
- More time spent initially when dealing with scripts and setting up a system to deal with them. Less time is now spent on scripts as they are done automatically.
- We need a full time receptionist to deal with scripts on a daily basis. This has caused problems.
5.2.3

3. Has the Care Homes Project had an effect on the amount of house calls made?

- 25% More house calls
- 25% Less house calls
- 50% No change

Common Themes
- We rarely require a visit at other times.
- Reduction in unnecessary house calls due to good relationships with the care home.

5.2.4

4. In your view, has the Care Homes Project led to a change in the amount of phone calls received by the practice regarding care home patients?

- 58% More phone calls
- 42% Less phone calls
- 0% No change

Common Themes
- A good relationship with the care home has resulted in less calls regarding care home patients.
5.2.5

5. In general, has the Care Homes Project had an impact on your workload?

Common Themes
- Workload has increased due to the time the GP spends at the care home and also speaking with patient relatives.
- Workload increased significantly at the beginning but now the glitches have been ironed out things are more manageable.

5.2.6

6. Has the Care Homes Project made a significant difference to the practices financial position?
5.2.7

7. Communication between Practice and other stakeholders since the care home project began?

- Care Home Staff: 9 - 6 - 1
- Pharmacy Services: 5
- Care Home Liaison Staff: 6
- Relatives / Carers: 4 - 7 - 10
- Locality Staff: 0

Common Themes
- Difficult to carry laptop around home.
- We do not have pocket emis.

5.2.8

8. Does the Practice use the Care Homes Project laptop when visiting the Care Home?

- Yes: 45%
- No: 46%
- Occasionally: 9%

Common Themes
- Difficult to carry laptop around home.
- We do not have pocket emis.

5.2.9

9. What is your view of the IT systems and support offered as part of the Care Homes Project?
Common Themes

- Laptops are not adequate for the number of patients seen. Work is generally hand written and then brought back to the practice to be processed.
- Installing remote access to our clinical systems from the home would be much more beneficial than a laptop.

5.2.10 Key Messages – Practice Managers

The introduction of this service has proved beneficial to practice managers as there has been a significant reduction in house calls, a reduction in the amount of calls regarding patients and an improvement in communication between stakeholders. Areas, such as repeat prescribing, acute prescribing and IT still require some work in order to improve the service further.

5.3 Care Home Manager Results

5.3.1

1. How beneficial do you think the Care Homes Project has been to your service?

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>80%</td>
<td>Very beneficial</td>
</tr>
<tr>
<td>20%</td>
<td>Not beneficial</td>
</tr>
<tr>
<td>0%</td>
<td>No change</td>
</tr>
</tbody>
</table>

Common Themes

- Some teething problems at the beginning but now the service is running smoothly it is extremely beneficial.
- It is now a personal service that has created better working relationships between the GP and care home staff. Resulting in continuity of care.
- Feels like GP’s now have more time for our service users.
5.3.2

2. Has there been a change to the amount of time spent calling pharmacies and dealing with prescriptions/errors?

- More time: 4%
- Less time: 44%
- No change: 52%

Common Themes
- Less time is spent but there are still a lot of errors especially around repeat prescriptions.
- Less time as only have to deal with one practice as opposed to several practices.
- Communication between GP surgery and Pharmacy can be problematic.

5.3.3

3. Has there been a change to the amount of telephone calls made to GPs?

- More calls: 31%
- Less calls: 4%
- No change: 65%
Common Themes
- The service is much more streamlined which has reduced the amount of telephone calls.
- Less calls are required as communication has improved now that we deal regularly with the same people.
- Regular visits make it easier to deal with routine queries, therefore reducing calls.

4. Has there been a change to the amount of visits made by GPs

Common Themes
- Most calls can wait until regular weekly visit, only emergency calls now made.
- As staff know when GP is due they can plan for scheduled visits which reduce unscheduled visits.

5.3.5

5. How many GP visits do you get each week?
Common themes
- When we entered into the agreement we were told we would have 2 visits per week. However, we are only getting one visit per week.
- As of July 2010 our visits are being reduced to 1 visit per week.
- Have 2 visits per week which are on set days.

5.3.5a

<table>
<thead>
<tr>
<th>5a. Are GP annual reviews carried out, and if so how many?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Common Themes</td>
</tr>
<tr>
<td>- Yes all service users are reviewed annually.</td>
</tr>
<tr>
<td>- The practice nurse carries out reviews.</td>
</tr>
<tr>
<td>- Hardly any reviews carried out.</td>
</tr>
</tbody>
</table>

5.3.6

6. Has your workload changed?

- 29% Yes
- 71% No

Common Themes
- Dealing with one practice has significantly reduced my workload.
- More time now spent on reviews, ordering prescriptions, specimens etc.
- Workload has reduced as we have 2 weekly visits which have reduced our number of call outs.
5.3.7

7. Communication between Care Home staff and other stakeholders since the care home project began?

<table>
<thead>
<tr>
<th></th>
<th>Worse</th>
<th>Improved</th>
<th>No change</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP Practice</td>
<td>10</td>
<td>37</td>
<td>0</td>
</tr>
<tr>
<td>Pharmacy Services</td>
<td>23</td>
<td>22</td>
<td>0</td>
</tr>
<tr>
<td>Care Home Liaison</td>
<td>21</td>
<td>26</td>
<td>0</td>
</tr>
<tr>
<td>Relatives / Carers</td>
<td>23</td>
<td>24</td>
<td>0</td>
</tr>
</tbody>
</table>

5.3.8

8. Have you identified any staff training needs directly relating to the Care Homes Project?

- Yes: 30%
- No: 70%

Common Themes
- Additional training required around areas such as DNAR, LCP and wound pain management.
- Care Home Liaison staff have been very supportive and beneficial.
- GP’s need to be more aware of the legislation that surrounds care homes.

5.3.9

9. In order to improve this service further, what recommendations/suggestions would you make?

Common Themes
- It may be beneficial for the GP to have a dedicated room with IT facilities within the unit.
- A more proactive approach with reviews and annual checks for chronic conditions being planned by GP and not just visits to deal with acute illness.
- Overall I am satisfied with the service that I receive.

5.3.10 Key Messages – Care Home Managers

Care Home Managers have benefited greatly from the introduction of this service. They have witnessed improvements in communication and workload as well as a reduction in the amount of time spent calling pharmacies and GP’s. However, there is some variation in the number of scheduled visits care homes are receiving. In reviewing this, it is worth noting that 63% of the homes said they were getting 2 or more scheduled visits per week from the practice. The original specification was based on circa 90 patients in the home and the subsequent proposal of 2 scheduled visits per week. It is worth noting therefore that there are 49% of care homes with 45 or less beds, i.e. half the notional 90 beds.

5.4 Pharmacy Results

5.4.1

1. How beneficial do you think the Care Homes Project has been to your service?

- 100% Beneficial
- 0% Not beneficial
- 0% No change

Common Theme
- It has been great only dealing with one GP practice.
5.4.2

2. Communication between Pharmacy staff and other stakeholders since the care home project began?

![Bar Chart]

- Care Home Staff: 1 (Improved), 2 (No change)
- GP Practice(s): 1 (Improved), 2 (No change)

5.4.3

3. Compared to staff time spent dealing with Care Home prescriptions/queries prior to the care home project, how much time is now being spent?

![Pie Chart]

- 67% Less
- 33% No change

Common Theme
- The GP is very efficient at passing on information
4. In your view, has it made a difference to medicine wastage?

- Less waste: 67%
- More waste: 33%
- No change: 0%

5. Has there been a change in the accuracy of information on GP10?

- Improved: 67%
- Worse: 33%
- No change: 0%
6. In your view, has the Care Homes Project had an impact on notification of prescription changes?

Common Themes
- It is much easier as we are only dealing with one surgery
5.4.8

8. Have you noticed a change in your ability to identify missing prescriptions?

- Improved: 67%
- Worse: 33%
- No change: 0%

5.4.9

9. What is your view on the use of IT systems to support prescribing in Care Homes?

Common Themes
- We use IT systems to print MAR sheets

5.4.10 Key Messages - Pharmacies

Pharmacy identified improvements in communication with stakeholders and accuracy of information, as well as a reduction in time spent on dealing with prescriptions.

5.5 Carers/Relatives Results

5.5.1

How aware were you about the changes to your relatives GP service?

- Fully aware: 86%
- Reasonably aware: 14%
- Not aware: 0%
5.5.2

Was the reason for changing the GP service explained to you?

- 90% Yes Reason given
- 5% Minimal Reason given
- 5% No reason given

5.5.3

How would you rate the service provided by the GP?

- 57% Excellent
- 43% Acceptable
- 0% Unsure

5.5.4

In order to improve this service further what recommendations / suggestions would you make?

Common Themes
- No suggestion as I am very happy with the service.
- Better communication between GP’s.

5.5.5 Key Messages – Carers/Relatives

Carers and relatives appear satisfied with the service that is currently provided and generally point to improved communication with the GP.
6. Structured Interviews

6.1 GP Interviews

6.1.1 IT

It was found that there was very little IT support available. Many practices were provided with laptops from NHSL but practices claim that they are of limited use when attending Care Homes.

Laptops were of minimal benefit as they were not initially encrypted and were not set up for remote access to NHSL.

Printer access within the home is extremely remote. The majority of practices document their visit to the care home using a dictaphone or pen and paper. This was then brought back to the practice and processed.

It was widely recognised that IT systems within NHS are complex. However, GP’s felt that it would be beneficial to have remote access to NHSL network along with a printer to allow local generation of prescriptions.

6.1.2 Guidelines

84% of GP practices that were interviewed were familiar with the guidelines that were prepared by the GP protocol group (see Section 7.7). All of these practices were able to access the guidelines.

Practices who were familiar with the guidelines found that they were beneficial, particularly when used in conjunction with training.

6.1.3 Training

50% of GP practices interviewed were aware of a training and education events that took place as part of the enhanced service. Other practices could not recall any events taking place.

All practices agreed that the best format for training was in small groups. Although it was suggested that alternative arrangements should be in place such as online modules for those who are unable to attend such training events.

6.1.4 Support Staff

Nurse Liaison – All practices agreed that they were aware of the nurse liaison but they were unclear on the remit of this service.

CPN Liaison – This appeared to be widely used throughout GP practices and Care Homes and was found to be very useful.
Physio Liaison – 66% of practices that were interviewed were unaware of any physio liaison. The remaining practices had heard of a physio liaison but were unclear of the remit of this service.

Pharmacy Support – All practices were unaware of any pharmacy support. They did feel that this would be beneficial, particularly to deal with poly pharmacy and medicine wastage.

6.1.5 Visits

66% of practices found that 2 scheduled visits per week were necessary to cope with demand. Any less than 2 visits would not be manageable. The remaining 34% highlighted that 2 visits were unnecessary as only 1 visit per week was required. Any additional visits can be arranged when needed.

In terms of unscheduled visits to the home all GP practices have witnessed a decline, particularly practices that cover several homes.

6.1.6 Care Home

The general consensus suggests that there is a perception that nursing cover is inadequate within the nursing homes. The majority of practices have witnessed an increase in usage of bank nurses as well as an increase in staff turnover.

Areas such as taking bloods, ACP and end of life care were all areas that appear to require training within care homes. GP’s feel that this is vitally important in improving patient care.

Difficulties due to language barriers appear to be on the increase. 33% of GP practices interviewed have come across communication problems as a result of foreign staff.

6.1.7 Acute Support

In terms of acute support, it appears that there was very minimal support available.

There was some suggestion that increased support from acute services e.g. named consultant geriatricians per group of care homes would be beneficial. Some practices also feel that documentation could be improved as information is not always received in a timely fashion.

6.2 Consultant Geriatrician

The introduction of the GP led service is an overall improvement to what was carried out previously, particularly around unplanned admissions. There has been a reduction in unplanned admissions from care homes to acute care. The most common cause of admission is sepsis, usually respiratory or urinary, delirium and dehydration leading to acute renal failure.
In order to improve the service further, there should be more Anticipatory Care Plans and more scrutiny of prescribed medications to remove medications which are no longer appropriate in light of comorbidities and life expectancy.

6.3 SLC – Adult and Older People Manager

The GP led service is a vast improvement compared to the way service users were managed before. The introduction of this service has streamlined services allowing for more proactive care for service users.

Both service users and staff have benefited greatly from the introduction of the GP led service. Staff morale and confidence has been boosted due to the twice weekly visits from the GP. This in turn has developed a strong relationship with GP’s which is particularly beneficial for staff when they are caring for service users who have recently been discharged from hospital.

In order to improve the service further, it would be beneficial if the use of laptops in the care home were fully utilised with access to GPASS and printers as this would benefit the care home in managing prescribing in accordance with the Care Home Commission regulations.

7.0 The Impact

7.1 A&E Attendances

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>April</td>
<td>238</td>
<td>228</td>
<td>249</td>
<td>200</td>
<td>-4.2</td>
<td>4.6</td>
<td>-16.0</td>
</tr>
<tr>
<td>May</td>
<td>235</td>
<td>248</td>
<td>231</td>
<td>217</td>
<td>5.5</td>
<td>-1.7</td>
<td>-7.7</td>
</tr>
<tr>
<td>June</td>
<td>222</td>
<td>220</td>
<td>212</td>
<td>237</td>
<td>-0.9</td>
<td>-4.5</td>
<td>6.8</td>
</tr>
<tr>
<td>July</td>
<td>208</td>
<td>197</td>
<td>224</td>
<td>204</td>
<td>-5.3</td>
<td>7.7</td>
<td>-1.9</td>
</tr>
<tr>
<td>August</td>
<td>218</td>
<td>191</td>
<td>226</td>
<td></td>
<td>-12.4</td>
<td>3.7</td>
<td></td>
</tr>
<tr>
<td>September</td>
<td>227</td>
<td>204</td>
<td>221</td>
<td></td>
<td>-10.1</td>
<td>-2.6</td>
<td></td>
</tr>
<tr>
<td>October</td>
<td>240</td>
<td>248</td>
<td>247</td>
<td></td>
<td>3.3</td>
<td>2.9</td>
<td></td>
</tr>
<tr>
<td>November</td>
<td>224</td>
<td>236</td>
<td>206</td>
<td></td>
<td>5.4</td>
<td>-8.0</td>
<td></td>
</tr>
<tr>
<td>December</td>
<td>257</td>
<td>283</td>
<td>224</td>
<td></td>
<td>10.1</td>
<td>-12.8</td>
<td></td>
</tr>
<tr>
<td>January</td>
<td>264</td>
<td>280</td>
<td>211</td>
<td></td>
<td>6.1</td>
<td>-20.1</td>
<td></td>
</tr>
<tr>
<td>February</td>
<td>235</td>
<td>191</td>
<td>214</td>
<td></td>
<td>-18.7</td>
<td>-8.9</td>
<td></td>
</tr>
<tr>
<td>March</td>
<td>273</td>
<td>258</td>
<td>201</td>
<td></td>
<td>-5.5</td>
<td>-26.4</td>
<td></td>
</tr>
<tr>
<td>Total for financial year</td>
<td>2841</td>
<td>2784</td>
<td>2666</td>
<td>-2.0</td>
<td>-6.2</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The above table details the most up to date figures of A&E attendances for Lanarkshire Care Home residents. From this it will be noted that despite an increasing number of older people in care homes and complexity of resident’s needs, A&E attendances reduced by 6.2%. This figure also includes Coatbridge Locality which has experienced many difficulties as they were the last locality to introduce the LES. They have also experienced difficulties with coverage as some care homes have no coverage. If Coatbridge Locality is excluded from the calculation a 9.83% reduction would have been achieved in Lanarkshire’s A&E attendances. There has also been an increase in the number of care home beds in Coatbridge.

Under noted is the Locality breakdown for financial year 2009/10.

<table>
<thead>
<tr>
<th>Locality</th>
<th>% difference 2007/2008 to 2009/2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>North</td>
<td>4.3</td>
</tr>
<tr>
<td>Airdrie</td>
<td>-35.3</td>
</tr>
<tr>
<td>Coatbridge</td>
<td>29.0</td>
</tr>
<tr>
<td>Motherwell</td>
<td>-5.2</td>
</tr>
<tr>
<td>Wishaw</td>
<td>-8.6</td>
</tr>
<tr>
<td>Bellshill</td>
<td>-10.2</td>
</tr>
<tr>
<td>Hamilton</td>
<td>-11.8</td>
</tr>
<tr>
<td>East Kilbride</td>
<td>-4.5</td>
</tr>
<tr>
<td>Clydesdale</td>
<td>-10.4</td>
</tr>
</tbody>
</table>

### 7.2 Hospital Admissions

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>April</td>
<td>136</td>
<td>146</td>
<td>150</td>
<td>116</td>
<td>7.4</td>
<td>10.3</td>
</tr>
<tr>
<td>May</td>
<td>137</td>
<td>134</td>
<td>134</td>
<td>134</td>
<td>-2.2</td>
<td>-2.2</td>
</tr>
<tr>
<td>June</td>
<td>136</td>
<td>126</td>
<td>124</td>
<td>132</td>
<td>-7.4</td>
<td>-8.8</td>
</tr>
<tr>
<td>July</td>
<td>116</td>
<td>115</td>
<td>141</td>
<td>123</td>
<td>-0.9</td>
<td>21.6</td>
</tr>
<tr>
<td>August</td>
<td>127</td>
<td>111</td>
<td>120</td>
<td>120</td>
<td>-12.6</td>
<td>-5.5</td>
</tr>
<tr>
<td>September</td>
<td>129</td>
<td>123</td>
<td>129</td>
<td>129</td>
<td>-4.7</td>
<td>0.0</td>
</tr>
<tr>
<td>October</td>
<td>137</td>
<td>160</td>
<td>143</td>
<td>168</td>
<td>16.8</td>
<td>4.4</td>
</tr>
<tr>
<td>November</td>
<td>140</td>
<td>130</td>
<td>105</td>
<td>105</td>
<td>-7.1</td>
<td>-25.0</td>
</tr>
<tr>
<td>December</td>
<td>161</td>
<td>183</td>
<td>138</td>
<td>138</td>
<td>13.7</td>
<td>-14.3</td>
</tr>
<tr>
<td>January</td>
<td>173</td>
<td>194</td>
<td>129</td>
<td>129</td>
<td>12.1</td>
<td>-25.4</td>
</tr>
<tr>
<td>February</td>
<td>152</td>
<td>129</td>
<td>126</td>
<td>126</td>
<td>-15.1</td>
<td>-17.1</td>
</tr>
<tr>
<td>March</td>
<td>162</td>
<td>162</td>
<td>111</td>
<td>111</td>
<td>0.0</td>
<td>-31.5</td>
</tr>
</tbody>
</table>

Total for financial year: 1706 / 1713 / 1550 / 0.4 / -9.1
The above chart highlights the numbers of patients admitted to hospital following attendance at A&E. As such, if a similar trend exists in relation to Coatbridge, there remains further scope to improve the overall position.

The following chart is taken from the nationally published LTC Collaborative news briefings. It illustrates the number of emergency admissions from care homes from March 2009 to May 2010 (LTC Collaborative, May 2010) across a number of Scottish Health Board areas.

The chart below shows the percentage, where it has been provided, for the emergency admissions from Care Homes as a percentage of all registered care home places. (LTC Collaborative, May 2010) It will be noted that NHS Lanarkshire reports a 1% or less admissions figure.

As shown in the chart above, NHS Lanarkshire is performing very well in comparison with other healthboards. NHS Lanarkshire has one of the lowest percentages of emergency admissions from Care Homes. They have also witnessed a reduced number of emergency admissions from Care Homes since March 2009.

NHS Lanarkshire Information Services Staff have identified coding discrepancies across Scotland in this measure. As such, the assumption is that the tolerance levels are similar nationwide.
7.3 OOH

There has been a small reduction, -2.6%, in the demand on OOH services since the introduction of the OOH service. The under noted tables show the numbers of patients attending over previous years as well as the breakdown of those figures by Locality.

<table>
<thead>
<tr>
<th>OOH calls by Locality</th>
<th>% difference from 2007/08 to 2009/10</th>
</tr>
</thead>
<tbody>
<tr>
<td>North</td>
<td>14.5%</td>
</tr>
<tr>
<td>Aidrie</td>
<td>-51.7%</td>
</tr>
<tr>
<td>Coatbridge</td>
<td>60.5%</td>
</tr>
<tr>
<td>Motherwell</td>
<td>2.9%</td>
</tr>
<tr>
<td>Wishaw</td>
<td>-9.8%</td>
</tr>
<tr>
<td>Bellshill</td>
<td>-13.8%</td>
</tr>
<tr>
<td>Hamilton</td>
<td>1.1%</td>
</tr>
<tr>
<td>East Kilbride</td>
<td>-16.7%</td>
</tr>
<tr>
<td>Clydesdale</td>
<td>-4.7%</td>
</tr>
</tbody>
</table>

Again, these figures should be set against a backcloth of increasing dependency of residents in a care home setting. It is also worth considering the total numbers and subsequent rate of calls per patient. At 4,515 calls to OOH in the last year, this is very marginally over 1 call per care home bed (n4256).

Whilst the overall number of calls has shown a slight decrease, further work is required in understanding the increased demand in relation to home visits and increasingly complex patients.

7.4 Anticipatory Care Plans (ACPs)

The recent Anticipatory Care Plan Evaluation highlighted that the introduction of ACPs within the 9 care homes in the pilot has proved beneficial to Care Home staff, Care Home Residents and their families. As can be shown from the information below there has been a significant reduction in the number of A&E attendances, number of patients with an emergency inpatient admission, and a reduced total length of hospital stay following the introduction of an Anticipatory Care Plan.

<table>
<thead>
<tr>
<th>Dates of ACP</th>
<th>No of patients</th>
<th>No of months before and after analysed</th>
<th>No of A&amp;E attendances</th>
<th>No of patient with an emergency inpatient admission</th>
<th>No of emergency inpatient admission</th>
<th>Total hospital length of stay</th>
</tr>
</thead>
<tbody>
<tr>
<td>June – August</td>
<td>129</td>
<td>6</td>
<td>0.00</td>
<td>-29.17</td>
<td>-36.11</td>
<td>-50.79</td>
</tr>
<tr>
<td>September</td>
<td>37</td>
<td>5</td>
<td>-50.00</td>
<td>-50.00</td>
<td>-60.00</td>
<td>-2.94</td>
</tr>
<tr>
<td>October</td>
<td>33</td>
<td>4</td>
<td>-45.45</td>
<td>0.00</td>
<td>0.00</td>
<td>-91.80</td>
</tr>
</tbody>
</table>

% difference following introduction of ACP
Having dedicated general practices for each of the homes covered in the ACP pilot assisted in ensuring ownership of the process and effective communication with the respective patients and their relatives.

It is now planned for the introduction of Anticipatory Care Plans to be rolled out across all care homes in Lanarkshire.

**7.5 Care Home Residents**

Prior to the introduction of the LES, care home residents would normally be seen in a reactive ‘house call’ visit by their respective GP. Most practices operated a ‘house call’ rota meaning that it would often be a different GP who was seeing the patient on each occasion. Since the new LES, there is a greater consistency in the GP who visits and that they do so proactively - significantly improving continuity of care. Care Home residents now receive treatment from one single GP practice where the LES is in operation.

Similarly, a more efficient approach to annual reviews certifies that care home residents receive a holistic approach through coordinated care, including GP, family and other primary care service providers such as CPN liaison.

**7.6 Families**

Families of Care Home residents are now dealing with a single GP practice which allows them to build a strong relationship with the practice that is responsible for their family member’s care. In addition, they are also able to communicate with the GP practice much easier which assists in relieving any concerns that they may have.

**7.7 Clinical Practice**

In recognising the need to ensure consistent practice where possible, a Care Homes Protocols Group was established under the Chairmanship of Dr Sonthalia. The group subsequently ensured engagement with acute colleagues, care homes representatives, social work and key primary care individuals to share proposed protocols. These included administration of subcutaneous fluids, initial assessment and annual review, management of suspected lower UTI and review of anti dementia medication.

The protocols are based on evidence-based practice and should be consistent with acute and primary care processes e.g. drugs formulary, care pathways etc. They are also available on First Port – NHS Lanarkshire’s internal intra-net site, meaning that they can be accessed electronically as and when required.

**8. Finance**

8.1 The Care Home LES was funded using a combination of nGMS income which would be due to the practice through their practice list as well as a ‘top up’ to recognise that the service is expecting the respective practice to
provide a level of service which goes beyond that required as part of routine GMS (General Medical Services).

The top-up was based on the number of beds within the respective home as well as a fixed cost to recognise some of the additionality that would fall to the practice regardless of the size of the home.

The cost structure was based on an average sized home of 90 beds, which would require a routine twice a week visit by the GP/practice. The fixed cost element was £2,000, and subsequently adjusted to £1,500 or £2,500 depending on the size of the home. The ‘top-up’ element was £130 per bed.

The details of the costs are included in the contract with the practice, as per Appendix 2.

The funding envelope also included an increase in the number of Care Home Liaison staff from 2.0 wte to 3.0 wte as well as a physiotherapist and pharmacist.

The total funding package for the LES and supporting staff is £697k.

In looking at the value for money of this investment, the additionality in terms of time spent in the care homes by practices is well demonstrated in this evaluation as well as the various improvement measures identified. In addition, there are other comparators which it is useful to use, albeit as in virtually every initiative involving services for older people, it is very difficult to evidence that the respective improvement is the exclusive result of this single scheme. However, the data available for Coatbridge serves as a very useful measure of service provision where the LES has not been operating in full.

As highlighted in 7.1 A&E attendances from care homes have reduced by 6.2%, or 175 patients. Based on an average £259 per A&E attendance, this is potentially a saving of approximately £45,325. In reality, older people with complex needs take considerably more resource than the average A&E attendance and invariably are the type of patient that challenge the 4 hour target. As such, any reduction in this number is helpful.

Since the introduction of the service A&E admissions from care homes have also fell by 9.1%. This equates to 156 patients. Taking the average length of stay for geriatric assessment at 13 days, this equates to approximately 2028 bed days leading to a potential total saving of £661,128.

**Potential Savings from Introduction of ACP**

As highlighted at item 7.3, the introduction of the ACP process across 9 homes (covering 129 care home residents) led to a reduction of 192 hospital bed days in the 6 months following their ACP being established.

The ACP process is currently being rolled out across the remaining care homes in NHS Lanarkshire and the role of the GP LES in assisting in the delivery of this will be crucial.
Recognising that pilots have a tendency to evaluate better than subsequent mainstream roll-out, even allowing for a 50% impact, this still amounts to potential savings of 6000 bed days – or around £2 million (at £326 per geriatric assessment bed day). [Blue Book Costs]

9. Conclusion

The introduction of this Locally Enhanced Service is undoubtedly proving to have a positive impact on many parties. Many improvements have been made in areas such as patient care and communication between stakeholders.

The evaluation has demonstrated a high level of satisfaction as well as system efficiency across most of the key areas. 76% of GPs surveyed said they were now spending more time in care homes. Perhaps most telling of all is that 81% of them believed the new service had improved their clinical practice in the care being provided to this group of vulnerable elderly people. (The detail is provided at 5.1.5 across a range of key areas.)

Similarly, 80% of care home managers surveyed said that the new service had been ‘very beneficial’ to the care they provided. None said that it had not been beneficial. 73% of care home managers also agreed that GPs were now spending more time seeing patients in care homes.

There was universal consensus that communication across a range of areas had improved which in turn had led to greater efficiency in the provision of care.

As well as the qualitative evaluation, quantitative analysis identified a range of indicators which would suggest the LES has been a very successful initiative. Firstly, analysis of the age and needs of the care homes residents in Lanarkshire identified that both had increased, i.e. an increase of 4% in the number of over 85s – to 51% of all residents in 2009 and even more importantly, the numbers of those in the 4 highest dependency categories has increased by 38% in the last 5 years i.e. from 31% in 2004 to 43% in 2009. (SCRUGS 2009)

Set against these increases in the needs and vulnerability of the residents, there has been a full year (2009/10) impact of a 6.2% reduction in A&E attendances and a 9.1% reduction in admissions to hospital from A&E. The potential value of these reductions in terms of cost and bed days are set out in section 8.

It is also worth noting that during the course of the evaluation, disparity in the respective performance across the 9 Localities provided something of a ‘control-group’. Coatbridge was the area where most difficulty has been encountered in getting practices to provide the Care Homes LES, with a number of care homes still not covered. The breakdown of performance at 7.1 and 7.3 provides a stark comparator in outlining the variation against those Localities with full coverage. Whilst there was an increase in the number of Care Home Beds in Coatbridge during the period, this was nothing like the percentage variation in performance.
The benefits of the ACP process and the close investment of the GP providing the LES to the respective care home also offers significant further improvement in relation to continuity of care both in and out of hours. As well as providing patients with care pathways of their choosing, it will also reduce A&E attendances, admissions and subsequent ‘lengths of stay’ in hospital for this group of patients.

Undoubtedly, there are some areas that require further work in order to improve the service even further.

1. Better communication systems – linked to IT with OOH, should assist in more proactive care and reduced admissions.
2. Improved access to GP IT systems remotely from the practice – i.e. in the care home – featured constantly as part of the evaluation and has been flagged to Information Services colleagues.
3. Care Home Managers and GPs all pointed to potential improvements in prescribing practices and in particular, reducing medicines wastage. Much of the current practice – and subsequent perceived scope for wastage – is linked to Care Commission regulations and accordingly, having dedicated pharmacy support to pursue most efficient medicines usage may result in significant improvement.
4. A number of GPs also pointed to the potential to improve linkages with hospital based geriatrician colleagues.

The Care Homes LES was established to:

- Improve GMS input to Care Home Residents
- Increase proactive care for Care Home Residents
- Reduce levels of unscheduled visits by GPs
- Reduce levels of unscheduled admissions to acute hospitals
- Increase provision and subsequent maintenance of evidence-based protocols for consistent care provision to care home residents
- Improved management of prescribing in the Care Home setting

The foregoing evaluation demonstrates significant success in the first 5 of these with there being some room for improvement remaining around management of prescribing.
Acknowledgements

Vijay Sonthalia, Chair of Lanarkshire LMC
Iain Hathorn, Lead GP East Kilbride & Strathaven Area
Craig Cunningham, Head of Planning South CHP
Alison Cavinue, Care Home Liaison Team
Lynn Flannigan, Care Home Liaison Team
Hazel towers, Information Analyst
Janette Barrie, Nurse Consultant for Long Term Conditions
Brendan Martin, Consultant Care for the Elderly
Care Home Managers – Participating Care Homes
Practice Managers – Participating Practices
GP’s – Participating GP’s
Pharmacy – Participating Pharmacies
Marie Norton, CG Coordinator EK Locality
Gillian Airns, Clinical Quality Team Manager
Elaine Learmonth, Information Management
Jennifer Halyburton, PA South Lanarkshire CHP
Evelyn Devlin, Adult and Older People Manager SLC

References

LTC Collaborative, 2010
SCRUGS, 2009
ISD, 2010
Appendix 1

NHS Lanarkshire
South Lanarkshire CHP

Enhanced Service for the provision of General Medical Services to Care Home – 2007/08 – 2009/10

Specification of Service

1. Introduction

This specification details the service to be provided by a general medical practice to a care home (s) in a locality, through an enhanced service contract, agreed between the practice and NHS Lanarkshire.

This enhanced service specification is for an initial period of 3 years, and may be extended for a further period of 3 years in negotiation between NHS Lanarkshire and the participating practice.

2. Background

The strategic direction for services in NHS Scotland is for more care to be provided in community settings with less direct reliance on district general hospitals. As the demographics of Scotland change, with increasing numbers of people living longer, eventually requiring 24 hour care, the number of care homes to provide this function, are also increasing. The residents of these homes invariably have complex, multiple, long-term, medical problems which require regular monitoring and input from a variety of healthcare professionals. General medical practitioners are central to the provision of this care. A multi-disciplinary approach to delivering health care has, therefore, been developed in Lanarkshire, where general practitioners will be part of a ‘virtual’ team of professionals providing care to the people in care homes, and support for the care home staff in managing the health components of their residents.

3. Service Outline

This enhanced service will fund practices to provide the following:

**General Medical Care**

- Take full clinical responsibility for the patients under their care.
- Provide comprehensive on-call cover for all Patients within the Care Home between 8am and 6pm daily, Monday – Friday. (NHSL OOH service will cover periods outwith these times and at Public Holidays.)
• Examine all patients within 7 days of the day of their admission to the Care Home.
• Planned visits (Monday to Friday) to assess patients, arrange investigations, treatment and referrals to other services as required, liaising with appropriate sources of advice and supports. This will normally be no less than twice per week, at agreed times with the Matron/Manager or responsible officer of the Care Home, unless exceptional circumstances prevail.

Guidelines/referral protocols will be developed by a multidisciplinary group with representation from community nursing, OAP, specialists in care of the elderly, AHPs and general medical practitioners, to enable the conditions which cause the maximum number of admissions to acute services, namely, chest infections, dehydration and falls to be managed either in the community, or following assessment and discharge from acute assessment unit.

• Practices will be expected to review patients annually and more frequently when required, based on clinical need.

• Update and maintain adequate case records to a standard agreed with NHS Lanarkshire and provide a summary of patients’ medical records for inclusion in care home files. Appropriate discharge/transfer letters for patients will be provided where necessary.

• Afford patients and relatives an opportunity to discuss the management of their care, as appropriate and in accordance with best practice for patients in the community.

• Where required, certify death.

Health Improvement

• Practices will arrange for immunisations as appropriate, e.g. influenza, pneumococcal; and would liaise with public health re: communicable diseases

Anticipatory Care

• Patients will be pro-actively reviewed systematically in discussion with the senior staff of the Care Home. The review should include, for example:

  ➢ An assessment of new admissions in conjunction with care home staff
  ➢ Provision of Adult with Incapacity Certificates, when required
  ➢ Long term condition management
  ➢ End of life care planning
  ➢ Behavioural problems

One GP will be identified from the participating practice as the lead GP who will work with staff, supporting the implementation of multi-disciplinary
standards and clinical guidelines. The name of the lead GP will be provided to the Care Home Matron/Charge Nurse and the General Manager of the Locality.

The Practice will comply with NHS Policies & Procedures as are relevant to this Agreement. The Practice will also assist with enquiries in relation to any complaints by co-operating with the Procedures for Handling Complaints and meeting with patients as appropriate.

4. Monitoring and Evaluation

The provision of the service by the participating practices will be reviewed annually. An informal review will take place at six months with the responsible officer of the care home and the practice to address any issues which have emerged during the implementation phase.

The Locality General Manager will audit the service provided by the practices in terms of this agreement. Should the audit indicate that any variations to the Services provided is required, any such variation shall be subject to agreement by the NHS Board and participating practices.

The medical practitioners will assist the CHP, in collaboration and partnership with their NHS Lanarkshire colleagues at community, Out of Hours and hospital level, to meet its agreed targets in relation to:

- Delayed discharges
- Reducing repeat admissions
- Prescribing Action Plans

Where professional issues arise regarding the service provided and quality of care these will be referred to the Medical Director or nominated deputy for advice and guidance.

5. Care Home Responsibilities

It is generally assumed that patients coming from hospitals should be stable and have a clear description of their needs, including reviewed medication, on admission. Patients being admitted directly from the community should come with Single Shared Assessment information, although they may require medication review.

Initial assessment and regular general patient review should be part of the ongoing care planning system in care homes and is the responsibility of the care staff.

It is the responsibility of the person in charge of the Care Home to liaise with Specialist Nurses and AHP services and to alert the GP to new admissions requiring assessment and to those patients who require anticipatory care as described above.
Appendix 2

NHS LANARKSHIRE

ENHANCED SERVICE CONTRACT FOR SERVICES IN (Name of Care Home)

To ………… (Practice Name)

1. On behalf of NHS Lanarkshire I (Director of relevant CHP) am pleased to offer you a contract for the provision of the Enhanced General Medical Services at [Name of Care Home] commencing on __________2007.

This contract covers yourself and your partners in the General Practice [Name Each Individual Partner].

_________________________ GP
_________________________ GP
_________________________ GP
_________________________ GP
_________________________ GP
_________________________ GP
_________________________ GP
_________________________ GP
_________________________ GP

2. The duties and responsibilities required under this contract are summarised below. A copy of the ‘Specification of Service’ which will be shared with the Care Home(s) for which you will be providing the service is also attached.

2.1 The provision of clinical input to the assessment of patients admitted to the Care Home within one week of their admission. This assessment will contribute to the multidisciplinary care plan developed for each patient.

2.2 The provision of general medical services to each patient at a time agreed between the Care Home and the practice. The service provided should be equivalent to that provided for patients in the community. Care provided should be based on clinical or good practice guidelines, in line with NHS Lanarkshire policies and protocols and with NHS QIS Standards.

2.3 The practice will provide assessments/certification as required under the Adults with Incapacity Act where appropriate.

2.4 The practice should ensure that details of terminally ill patients are shared with the NHS Lanarkshire Primary Care OOH service.
2.5 Arrangements for requests for PLE (pronouncing life extinct)/certification of death to be agreed between Care Home/practice.

2.6 All practitioners who attend the home should be able to demonstrate evidence of continuous professional development (PGEA)/appraisal. (NHSL will arrange for regular training opportunities for participating practices.)

2.7 One or more of the general medical practitioners from the practice will be expected to participate in the educational programme, provided by NHS Lanarkshire, which may lead to accreditation as a GP with a special interest in care of the elderly.

2.8 The practice will be expected to participate in the evaluation of the project, including referrals to A&E and the Primary Care Out of Hours Service, over 65 readmissions, medicine management issues and patient and relative experience of the service.

3. The contract will continue while you and your partners remain principals in General Practice in the locality of the Care Home, but you will require to notify the employing authority of any change of status of your partners or yourself.

4. The terms of this Contract of Employment are subject to practices ensuring the appropriateness and safety of their partners and staff who will be involved in providing the service.

4.1 Should there be a change in the health status of any of the partners involved with the provision of service under this contract, which may affect their ability to safely undertake the duties of your post, you are required to inform the Occupational Health Department immediately.

4.2 Should any of the partners involved with the provision of service under this contract, be subject to any criminal proceedings during the course of your employment, you are required to inform the Medical Director immediately. Failure to do so may be dealt with under NHS Lanarkshire’s Disciplinary Procedure.

5. The contract will initially be for a period of 3 years, be subject to 6 months notice on either side and will be reviewed annually by both parties. Review process will include assessment of the patient and care home experience. Where it is evident that the service is not being delivered according to the contractual terms, the locality GM and lead GP will work with the practice to determine the underlying reasons for failure to provide the agreed service, and whether the practice has the capacity to continue to provide the service. If the outcome of the review suggests that the practice is not able to provide a service as detailed in the specification, the contract will be terminated.

6. All partners should be fully subscribed members of a recognised professional defence organisation.
7. The contract covers 52 weeks a year, providing comprehensive on-call cover for all patients within the Care Home between 8am and 6pm daily, Monday-Friday – excluding public holidays as agreed by NHSL. NHSL Out of Hours service will cover periods outwith these times.

8. The practice will receive an annual retainer of £1500 per cluster, plus £500 per home for the 2nd and subsequent homes within the cluster.

9. The practice will automatically receive the Global Sum Payment for each registered patient which amounts to approximately £55 per patient.

10. The practice will receive a fee of £130 per bed.

11. For the Financial year 2007/2008, there will be a ‘one-off’ non-recurring start up fee paid of £1000 per practice to enable the service to commence by 31st March 2008.

12. Either the NHS Board or the Lead GP may request by means of at least seven days written notice an extraordinary review meeting to be held to discuss any part of the service. The party requesting the meeting must give notice of the matter(s) to be disclosed.

If you agree to accept the contract on the terms specified above, please sign the form of acceptance and return it to me. A second copy of this letter is attached, which you should also sign and retain for reference.

Yours sincerely

Alan Lawrie
Executive Director
South Lanarkshire CHP
Form of Acceptance:

I/we hereby accept the offer of contract mentioned in the foregoing letter on the terms and subject to the conditions referred to in it.

Signed: _________________________________________________

______________________________________________________

______________________________________________________

______________________________________________________

______________________________________________________

______________________________________________________

Date: __________________________________________________

This offer, and acceptance of it, shall together constitute a Contract between the parties.