Case study: East Kent NHS Foundation Trust/Ashford CCG – a systems approach to reducing hospital readmissions for frail older people

Background

In 2011 East Kent Hospitals University NHS Foundation Trust had been experiencing particularly **high readmission rates (within 30 days of discharge)** particularly in respect of **frail care home residents** admitted to hospital for unscheduled care. 35% of local readmissions were from care homes.

As a consequence, this vulnerable group were exposed to a range of risks, such as hospital-acquired infections, often leading to extended stays away from home. Readmission within 30 days of discharge is classified as a harm-event trigger and of particular interest to the Trust, which was committed to reducing harm events by 10% per annum.

In 2011 a team from East Kent Hospitals University NHS Foundation Trust started a project to **improve the quality of handover for older people being discharged back into care homes.** This was part of the Health Foundation's Safer Clinical Systems programme.

The team discovered that the actual problem lay with **a lack of communication between acute services and the care homes.** When the care homes did receive information it was written in medical language, making it hard to understand.

They also identified **a lack of specialist support for patients in the community**, both at discharge and during times of crisis, which often resulted in emergency readmission to hospital.

"The geriatrician project is all about promoting independence and providing access to a specialist opinion or treatment without the upheaval of care home residents having to go into hospital, which can be a stressful and distressing experience, particularly for people who may be confused or have dementia."

Dr Caroline Ruaux, Clinical Lead for the project

How it works:

Following discussions between Ashford Clinical Commissioning Group (CCG), Kent Community Health Trust (KCHT) and East Kent Hospitals University Foundation Trust (EKHUFT), it was agreed that they would pilot support to the care homes in the form of **a community matron and a consultant geriatrician** to help meet the gap in care. This approach aimed to reduce the number of readmissions and unnecessary trips to hospital, provide support for care home staff and improve care for clients. This new team was connected to GPs and care homes to ensure everyone was working together.

- The matron/geriatrician **case-manages patients within the care home**, acting as the first point of contact when a patient is discharged from hospital.
- Using a '**comprehensive geriatric assessment'** the community matron assesses all patients discharged from hospital to a care home setting within 48 hours, ensuring continuity of care and appropriate follow-up. This assessment is designed to assess an elderly patient's functional ability, physical and mental health, identifying any potential challenges and risks to them at the time of discharge, and considers how these can be managed.
- An **Anticipatory Care Plan** is generated which is normally no longer than 2 sides of A4. This plan includes concise information about residents transferred to hospital and a discharge summary.
- The community matron works with the care home to deliver the plan. The geriatrician supports the matron to develop Anticipatory Care Plans for complex cases or patients preparing for end of life.
- Since the majority of hospital readmissions were happening after 5pm, **matron hours were extended** to 8pm, and a 24-hour on-call information service was introduced.

Patients include new admissions to care homes, patients deemed at risk, high users of emergency services (care home or patients in their own home) and patients residing in care homes that initiate high A&E attendances and hospital admissions as identified through the use of a 'Care Home Dashboard'.

A Care Home Forum operates comprising representatives from care homes, the Acute Trust, Community Trust and Social Care. The agenda is set by care homes and the forum undertakes training and education and is a network and opportunity to share ideas

Impacts and outcomes

Previously, when a care home resident fell ill, they would often be taken to A&E by care home staff to be assessed and treated. Now, care homes can call the matron or geriatrician for advice and assistance. This means that residents can now be seen, assessed and treated without being moved for the majority of illnesses, and are only hospitalised when absolutely necessary.

Figures from Ashford CCG for 2014 indicated that in comparison to the previous year:

- A&E attendances from care homes in Ashford had decreased by 11.1%
- Emergency admissions from care homes in Ashford had decreased by 11% (figures from October 2014 – comparison with same period in previous year)
- Overall the new way of working has reduced readmissions by 38%

"I see this as an enabling initiative – helping older people stay in their place of choice… if they want to be in hospital, then the geriatrician will enable that. But many don't, they just want to be listened to." ***Michelle Amourdedieu (former programme manager)***

Other Outcomes

- Integrated working in practice - improved communication and relationships
- All teams feel supported – improved confidence in managing frail vulnerable residents
- Higher level of stakeholder engagement
- Good and bad practice information sharing
- Residents managed in their own home
- Holistic approach
- Won the award for 'efficiency in community service redesign' by the HSJ Efficiency Awards in 2013

"When planning a project like this, you think you can predict where your key pinch points are, but the diagnostic phase helps you realise there are other factors. The anticipatory care plan is something that care home providers can actually use, so that everyone understands the ceiling of treatment, and patients aren't forced into a cycle of readmission-discharge-readmission-discharge." ***Helen Goodwin, Deputy Director of Risk, Governance and Patient Safety East Kent Trust***

Next steps

- The sustainability of the project has been confirmed.
- The Care Home Forum will continue to ensure engagement with care home staff
- The project will continue to take forward care home led initiatives like the communications tool

Discussion points

- Do you have specific measures in place to reduce patient readmissions from this vulnerable group? If so how effective are these by comparison to the East Kent project?
- If you do not have measures in place do you think the East Kent approach should be considered by your CCG? How would you go about initiating a similar scheme?