**Care Homes Case Study – Sheffield Locally Enhanced Service (LES)**

**Overview:**

GPs in Sheffield have been leading on the delivery of proactive, coordinated healthcare to care home residents through a Locally Enhanced Service (LES) first set up by NHS Sheffield in 2008. The initiative focuses on developing clear lines of communication between care homes and GPs and establishing effective access to community health services, including district nursing, specialist nursing and allied health professionals. The scheme has contributed to a reduction in hospital admissions in the area and has been popular with both residents and GPs, with 94 per cent of surveyed residents saying the service provides for their needs. Following its initial success the initiative has been expanded to cover all 85 residential care and nursing homes in Sheffield.

**Aims:**

- To enhance the level of GP care available to residents in care homes to help reduce avoidable hospital admissions
- To improve continuity of care, with a dedicated GP making a planned weekly visit to each care home
- To provide a proactive approach to developing residents’ healthcare goals via comprehensive assessments considering residents’ preferences, culture and decisions about end of life care
- To ensure clear access to community health services, including district nursing, specialist nursing and allied health professionals

**Context :**

There are over 400,000 people in the UK living in care homes. Many care home residents live with multiple health problems and have “End of Life” needs requiring care planning and support by integrated community teams. Despite this, they are often disadvantaged in their access to health and social care, which may lead to avoidable ill-health and unnecessary hospital admissions.

Prior to the introduction of the LES scheme a local bed usage survey by NHS Sheffield reported that:

- 25 per cent of admissions from care homes were avoidable
- Analysis of non-elective admissions data showed a nearly ten-fold difference in admission rates between homes.
Specific problems in Sheffield were identified as including:

- Inefficient systems and poor communication, with many care homes having residents registered with multiple practices
- Over-reliance on emergency services for crisis management in relation to care home residents
- A lack of pro-active care in managing chronic disease and medicines among care home residents and a lack of care planning, especially around end of life
- Uneven GP workload between practices and care homes, with a lack of resource or incentive for GPs to provide appropriate care

Key features:

Each care home taking part in the initiative was assigned one practice which accepted all residents who chose to register. A service agreement was set up between the home and the practice, with named GPs providing proactive care.

The project involved an annual medical review and care plans, copies of which were kept in the home and flagged on out of hours (OOH) databases to alert anybody on call out.

Provision was made for:

- A planned weekly surgery in the home with 6-monthly medication review
- Rapid access to a named community geriatrician
- Development of an event form to be completed for all emergency admissions by the care home manager and the GP to facilitate shared learning
- A monthly practice review of every emergency admission
- Additional payment to GPs based on the number and type of beds covered

Outcomes and results:

The introduction of this initiative has had a significant impact on helping to build effective relationships between practices and care homes for the benefit of patients. Outcomes from the scheme include:

- In year one of the scheme, there was a reverse in the trend of rising emergency visits from care homes, with a reduction in emergency admissions by six per 100 care home beds (approximately 9 per cent) compared with the previous year.

- This translated into gross savings of £145,000 in a single year for the 500 care home beds taking part in this small-scale pilot.

- A&E attendances fell by three per 100 care home beds (approximately 10 per cent) at a time when A&E attendances were rising in other areas.

- Monitoring data indicates that the number of hospital admissions from care homes in April – Oct 2011 showed a 15 per cent reduction compared to the same period in 2009

Key findings:

This initiative demonstrates that developing effective contracts and improved communication between GP practices and care homes can be a powerful tool in improving the level of care
provided to their residents. Local GPs have welcomed the initiative because it provided them with time to spend with residents and staff. Feedback for the pilot showed that for care home staff, 97 per cent agreed that their relationship with GPs had improved. In terms of family members, 97 per cent agreed that the person they cared for received better care as a result of the enhanced GP care to residents.

This case study demonstrates that investing in better incentives for practices and care homes to work more closely together (whether though an LES or by other means) can deliver significant improvements in the quality of care for this vulnerable group.