Case management makes savings

Bennett House, Telford and Wrekin

A pilot which used case management shows that the quality of care can be improved, whilst saving resources and reducing hospital admissions.

Skills for Health

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Background

Bennett House is a care home for older people in the West Midlands borough of Telford and Wrekin. Managed by Accord Housing Association, it is registered for up to 45 people over the age of 65 years. Up to 26 places at the home are for people with dementia.

The Bennett House case management project was initiated following an analysis of data collated by West Midland Ambulance Service (WMAS). Figures for ambulance requests and accident and emergency admissions were examined for part of 2010 and they showed that the ambulance attendances to Bennett House were significantly higher (nearly 50%) than other care homes with a similar care profile during the same period.

Aims and objectives

The aims of the project were to pilot the use of case managers to:

- reduce ambulance requests
- make savings on admissions to hospital
- reduce the number of hospital stays.

What was done?

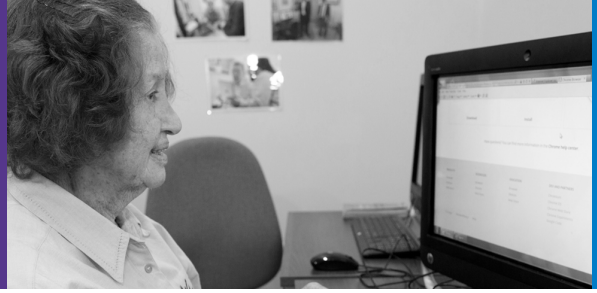
The plan was to approach the pilot in two ways and provide:

- a case manager, to work with Bennett House residents who required medical or nursing intervention
- the carers at Bennett House with a programme of training and development.

Case manager role

A case manager assists in reducing the number of admissions and inpatient bed days for residents living in their own homes. A case manger proactively manages people with long term conditions and is currently available throughout Telford and Wrekin. The outcome of proactively managing care home residents and providing timely care has the potential to prevent avoidable admissions to hospital and reduce the number of in-patient bed days.

Following discussions with commissioners and providers in NHS Telford and Wrekin, agreement was reached to pilot the case manager approach in Bennett House for three months. The appointed case manager was an Independent Prescriber and able to do comprehensive physical assessments of residents needing intervention, due to illness or care worker concern.



The training programme
The pilot training programme, see Appendix 1, was delivered by case managers and the clinical nurse advisor. The purpose of the training and development sessions was to:

- provide carers with the skills and confidence to enable them to recognise early signs and symptoms of illness
- empower carers to continue to offer quality care to their residents through a period of illness
- enable carers to deliver end of life care
- ensure carers are able to recognise when a resident needs medical intervention or to attend hospital.

The project team identified reasons for some of the high number of ambulance call outs to the organisation. Bennett House had operated an internal procedure which stated that all clients who sustain a head injury, however minor, should be referred to hospital. The project team considered that admission to hospital was not always necessary or appropriate for residents with head injury. Staff were trained to be confident in identifying when transfer to hospital, due to a head injury, was appropriate, and managing those not transferred appropriately and safely. National guidance relating to head injuries was used in the training. Staff managed head injuries differently (during the pilot, initially) using NICE guidance.

“We often sent our residents to hospital, knowing that they didn’t really need to go, especially someone who had bumped their head…after our training on head injuries we can now keep them here and monitor their condition. That’s got to be better for them.” **Carer.**

Outcomes

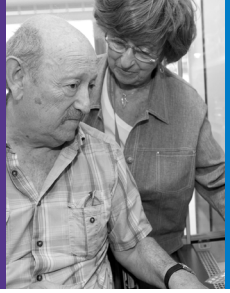
“The training programme has helped me to understand what to look out for with residents. I feel more confident in my role of carer.” **Carer.**

The project ran for a three month period commencing from December 2010 to February 2011. Winter is recognised by the health sector as a very challenging period. Using this period enabled the project team to demonstrate significant benefits to the residents of Bennett House, the Primary Care Trust, the acute Trust and WMAS. The project recorded a reduction in:

- ambulance attendances at Bennett House
- emergency admissions of residents to hospital
- attendances to the accident and emergency department
- the number of in-patient bed days of residents
- the number of GP contacts.

Carers received practical training on topics including blood pressure monitoring, urinalysis, blood glucose monitoring and pulse checks.

“I really enjoyed the pulse checks training. To think we can help prevent a stroke!” **Carer.**



Impact

Data from the pilot project shows:

- 268 client contacts were made by the case manager during the pilot period
- a 32% reduction in GP contacts
- the number of ambulance attendances prior to the pilot project averaged 11.6 per month, which were reduced to an average of 5.3 per month, during the project
- during 2010-11 there was a significant reduction in A & E attendances and hospital admissions, with a total cost saving of £67,332
- the cost of the case manager during the pilot period was £897.48
- the ongoing annual costs for a case manager are anticipated to be as little as £113.

Learning

Key learning from the pilot project is summarised below.

- Residents who attend hospital, particularly those with dementia, generally require someone to escort them, usually a care worker. Escorting residents to hospital can create a reduction in staffing levels within the organisation for several hours. Therefore the prevention of hospital attendance can benefit both the resident and the organisation.

- Carers would benefit from clarification about the role of the case manager, and how it differs from that of a district nurse. The case manager noted that a significant number of contacts could have been managed by a district nurse. However, it was recognised that as the case manager was visiting Bennett House three times per week it was reasonable for the carers to refer all residents needing attention, rather than calling on another service.

- The project helped managers plan the use of resources including the deployment of services and funding staff development.

- Residents have increased quality of care as a result of carers being empowered to undertake the management and monitoring of disease.

- There has been increased partnership working across health and social care and substantial savings gained by reducing hospital attendances, admissions and bed days.

Next steps

Following training with the Community Trust, a member of Bennett House staff has become a falls champion. They are running weekly exercise sessions in the home. This is a programme of gentle exercises that promotes good physical and cognitive function. It increases stamina and dexterity; improves balance; reduces cardiovascular risk; improves mood and independence—all whilst reducing the risk of falls.

Contacts

Accord Housing Association www.caldmoreaccordha.org.uk
Shropshire Community Health NHS Trust www.shropscommunityhealth.nhs.uk

Further information

For further information about the health and social care integration work between Skills for Health and Skills for Care please contact:
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