DRIFFIELD INTEGRATED NEIGHBOURHOOD TEAM (INT) CASE STUDY

Collaboration with Care Homes in Driffield

OVERVIEW

In May 2024, Driffield INT decided to prioritise Care Homes as a key area of focus. It was observed that both Driffield surgeries were handling a significant volume of inquiries from care homes, with the level of support varying between the two practices. It was recognised that improved communication with primary care could greatly benefit the care homes.

To address this, Driffield INT organised in-person workshops aimed at identifying the challenges that could be addressed to enhance care for residents.

As detailed on page 3, the outcomes of the project led to faster access to care and medications for residents, reduced duplication of tasks, and an improvement in the quality of communications between care homes and primary care.

DEFINING THE COHORT

The Parks Surgery triage system highlighted a large amount of contact from care homes, weekly care home ward rounds were over capacity and the surgery couldn't accommodate the number of visit requests.

From a care home perspective, it was felt that communication could be improved between primary care and care homes.

A deep dive audit of primary care data reviewed the volume of contacts, number of visit requests and nature of requests, and identified several themes:

- Visit purpose: Some visits were unnecessary
- Communication: Sometimes there was a lack of communication about a patient between professionals, resulting in multiple services being unnecessarily involved

Alongside insight from the district nursing teams and the bowel and bladder service, the INT felt that this was a valid piece of work to progress.

"Everyone felt that possibly things could work better in terms of demand on the system and the care that the patients are getting."

Case studies, where a primary care visit or support had been requested were reviewed, and the following themes were identified for care home patients:

- Constipation
- Urinary Tract Infection
- Incontinence
- Mobility issues such as falls
- Confusion
- Changes in behaviour

The INT identified training as an opportunity to support care home staff with these themes.

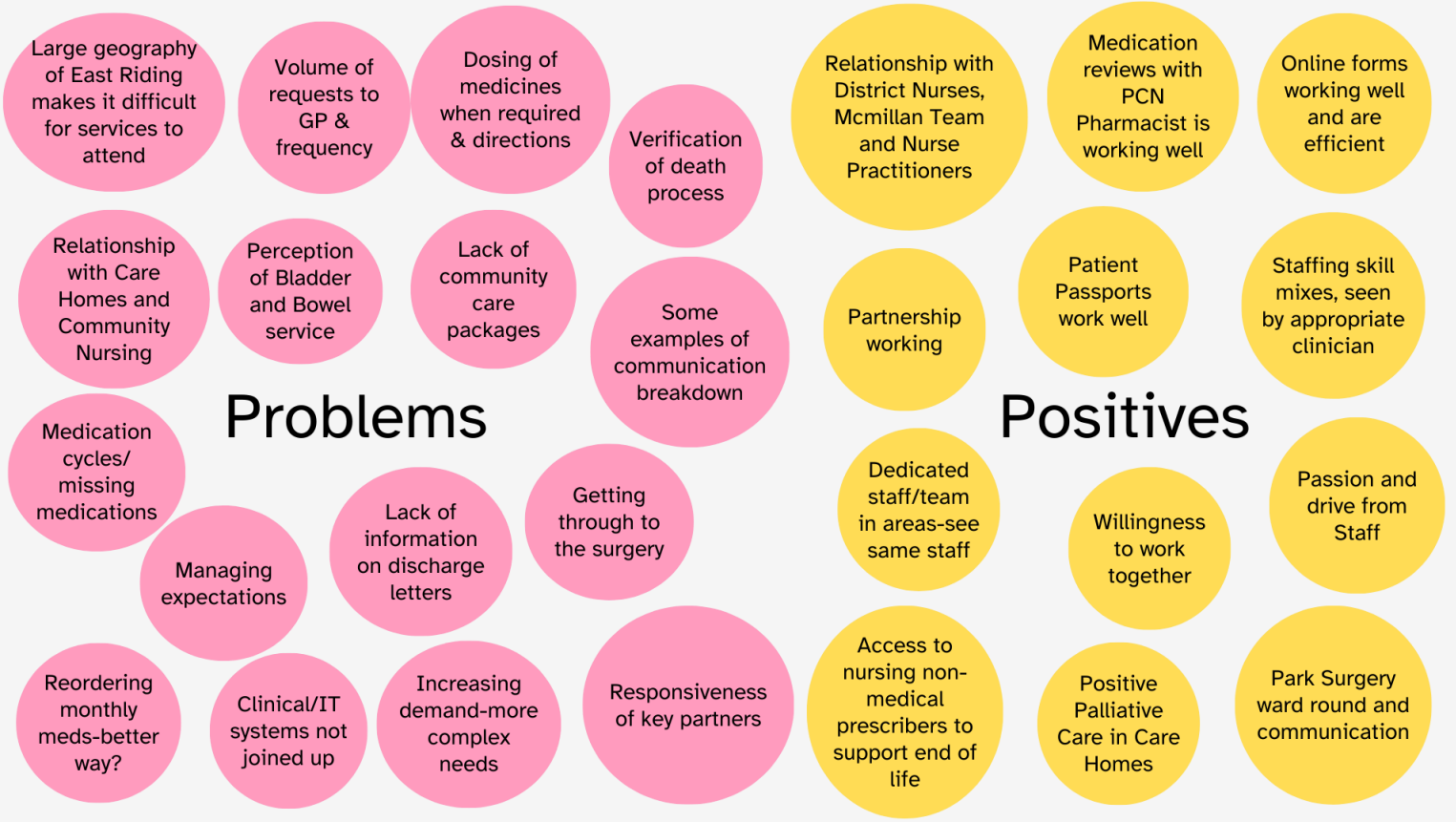
ENGAGING WITH PROVIDERS

An in-person deep dive session was held in July 2024, attended by three Driffield Care Homes, City Health Care Partnership (CHCP), Primary Care, Humber and North Yorkshire Integrated Care Board (HNY ICB) and North of England Care System Support (NECS).

Discussions facilitated by Yorkshire Health Partners, enabled all partners to contribute to topics such as what's going well, what's not working, how the INT can support the care homes, what can collectively be resolved. The session also included an element of training to encourage care home staff to be released to attend. All but one care home attended and have continued to engage.

KEY THEMES

The facilitated discussions identified key themes requring improvements, as illustrated below:



INTERVENTIONS

Following the facilitated discussion, joint interventions were planned and developed:

• Process mapping between General Practice (GP) and care homes – considered what to do before requesting a visit and sharing experiences of different things to try.

• A training programme for care home staff has been developed, based upon input from the care homes on what training they would benefit from. The training is delivered by system partners, aiming to empower and upskill staff in their knowledge and skills.

TRAINING PROVIDED

- ERYC - Dementia – misunderstanding of the variability in day-to-day behaviour and what is normal
- Dementia CIC – bespoke bitesize/ block training
- Frailty team – What the team do
- District nurses – Skin tear management
- GP - What does deterioration look like – when should surgery be called.
- Pharmacist/ GP - What observations are essential and why, how to take them (blood pressure, temperature, oxygen levels).
- CHCP – SBAR (situation, background, assessment, recommendation), contacting emergency services and handovers (to receptionists, out of hours etc)
- Sepsis
- Constipation, bladder & bowel – to be arranged

"You expect them to have this stuff but they don't, they're struggling."

OUTCOMES

Improving outcomes for residents:

- An increase in knowledge has enabled the care homes to manage some conditions without input from other services. For example, residents are now receiving more timely access to care for skin tears following training for care home staff. Previously, district nurses were visiting the homes to provide care every time a resident had a skin tear.

"We were ringing every single time someone had a little skin tear. Nine times out of ten it's healed so you don't actually need the district nurse input."

- Training in undertaking observations has increased staff confidence in the process. A care home that had already embedded this process shared their positive experience, and more care homes are now undertaking observations. The quality of information being shared has improved, making it easier for the surgery to triage medical requests, and giving care home residents more timely access to care.

"It saves time, our resident got an ambulance called straight away when we sent the obs into the GP."

“It’s an impact for both of us. Back and forth to the reception staff takes both their time and our time. When the information is sent upfront, they get one response, rather than back and forth”

Removing barriers to access:

- The opportunity to meet in-person has enabled relationships between organisations to develop, enabling a better understanding and appreciation of different roles.

“It's made everybody realise the challenges each job role has. It's given us a better understanding of what's happened or why things happen."

“There are many more providers we know more about, the frailty team, the bladder and bowel team, I know more about what services are on offer and how to refer, as do my colleagues, as do the care homes.”

- Reviewing processes has freed up capacity across the system, identifying processes that were not being utilised, and reviews being duplicated. Many of these findings were able to be resolved immediately, for example one home being unaware that a ward round existed, and another using the incorrect email address for contacting general practice. The Medical Centre is to reopen its dedicated care home line, following feedback from care home staff, and information is communicated more efficiently through the utilisation of patient summaries for residents with repeated health concerns.

“We didn't know that the frailty service were offering new patient reviews. So we were doing those and we didn't actually need to be.”

- Setting up care homes with proxy access to the NHS app is enabling time efficiencies. Some care homes didn’t know that this was available and are now utilising this process, reducing the waiting time for prescriptions and decreasing the number of calls to primary care and pharmacies. One care home felt that this was the biggest benefit of the project to date, creating time efficiencies and freeing up capacity in the care home. There is scope for this approach to be scaled-up across the region.

“This means the care homes have staff members who can access the app to order meds, check when it has been issued, and which pharmacy has it without having to call the GP or pharmacy.”

Experience of care:

- Connectivity between care homes within the local area has enabled peer support and the opportunity to work together.

"It's good to get different care homes together to speak about different cases and how we can help each other.”

- Improved connections between the care homes and hospital trusts have enabled conversations to ensure that hospital discharges are less disruptive to care home residents.

CHALLENGES

- The threshold of complexity that care homes are supporting is increasing
- Visit requests continue to increase nationally, from all sources
- One care home has not engaged in the project, possibly due to a recent change in management and staffing issues
- There is no budget for the INT, so availability for venue hire was very limited
- Some trainers pulled out at the last minute, so planned items were not able to go ahead
- Care homes struggled to release staff, and may benefit from training being brought to them
- Staff in different roles attended the training making peer support more challenging

"I don't think we are done now. It's an ongoing piece of work. We need to not see it as a finished project."

LEARNING

·**Building relationships takes the right environment:** In-person, friendly and informal meetings in neutral venues. Offering lunch encouraged attendance and gave space to get to know each other to build trust.
·**Relevant training:** Some training didn't meet the care homes' needs, dementia training focused on early-stage support not advanced care, which is more relevant.
·**Staff turnover needs to be managed carefully:** With high staff changes, good handovers are essential to avoid losing important information and experience.
·**Sharing knowledge:** There's a lot of experience within care homes, having the opportunity to come together and share knowledge as peers in similar roles is valued.
·**Understanding different perspectives:** Listening to both care home and primary care teams helps uncover real challenges and opportunities for improvement.
·**The frailty team is essential**: Most frail patients live in care homes, so the frailty team should play a central role.

NEXT STEPS

Due to continued demand for visits, the project will remain active with the training package delivered regularly to accommodate for staff turnover. Care homes have expressed an interest in accessing additional sessions with services including Bowel and Bladder, Dietetics, the Ambulance Service, and the Falls Team. The aim is to strengthen interprofessional relationships, enhance understanding of service pathways, and provide a forum to jointly explore challenges and identify opportunities for improvement.

This approach holds potential to be replicated in other areas, however its success is highly dependent on the specific context of each locality. While the model could be adopted in a like-for-like manner, the impact is likely to vary between care homes due to differing needs, cultures, and existing relationships. To be effective it is essential to invest time upfront in understanding the local landscape, identifying key issues, recurring themes, and service gaps. By grounding the approach in early insight, and co-producing solutions with stakeholders, the model becomes more relevant, sustainable, and impactful.

"It's definitely scalable, it's working here. It's very applicable to other areas."

CONCLUSION

While short-term benefits have been observed, it is anticipated that sustained delivery and enhanced collaboration will lead to continued long-term gains. The project has laid the foundation for strong professional relationships built on trust, respect, and a shared commitment to improving outcomes for residents. The ongoing support and engagement from INT members willing to offer training and guidance, has been key to the success of this work. Equally, the responsiveness and dedication of the care home staff, demonstrating their commitment to delivering the best possible care for their residents has been exceptional. This project has highlighted the positive outcomes that can be achieved when services come together with a common purpose and a collaborative mindset.

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