Confidential

NHS Newcastle Gateshead Clinical Commissioning Group

Review of case management approaches

January 2018
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1 Executive summary

1.1 Introduction

This report presents the findings of an independent review of three nurse-led case management approaches currently being taken to support older people, including those who are frail, in Newcastle and Gateshead. The review was commissioned by Newcastle Gateshead Clinical Commissioning Group. It was conducted by Cordis Bright, PPL and Cobic, a team of three independent research and consultancy organisations specialising in health and social care.

The review focuses in particular on three nurse-led case management approaches operating in Newcastle and Gateshead. These are: the community matron role, which was introduced in 2005-06; the older person nurse specialist role, which was introduced in 2012; and the practice frailty nurse role, which was introduced in 2015.

1.2 Context for case management approaches

The population of Newcastle Gateshead is ageing. This is likely to result in increased numbers of older people with complex health needs and a related increase in demand and delivery costs for health services. One method through which demand might be managed is case management.

Case management is outlined by Newcastle Gateshead CCG as one of the key elements of a needs-based approach to care, which is central to the local Enhanced Health in Care Homes model. However, there appears to be no locally-agreed definition of case management. There is also no single, nationally-recognised definition. It can be conceptualised either as a longer-term, proactive and holistic process to achieve broad outcomes with a patient, or as a short-term, intensive intervention to prevent escalation of need. The extent to which the nurse-led case management approaches for frail older people used in Newcastle Gateshead are aligned with one or other of these definitions is considered in chapter 5.

There was limited evidence of documented objectives and intended outcomes of case management approaches in Newcastle Gateshead, or of the specific case management roles considered in this review. Nevertheless, key objectives and intended outcomes were identified through stakeholder consultation and these were broadly consistent between stakeholders and roles.

Key identified objectives were:

- Ensuring that frail older people with multiple and complex needs receive holistic and well-coordinated multi-disciplinary care.
- Supporting the health and social care system to deliver efficient and cost-effective care.
The over-arching intended outcomes of the approaches associated with the three roles are also similar and fall into three main categories, which are:

- Improved health and wellbeing outcomes for frail older people.
- Improved quality of care for frail older people.
- Reduced unnecessary or inappropriate use of health and social care services.

The emphasis placed by stakeholders on different objectives and outcomes varied across roles.

The community matron role was introduced in 2005-06, coinciding with a national drive to introduce community matrons. The older person nurse specialist role was introduced in 2012 and the practice frailty nurse role was introduced in 2015. Both of these roles were piloted in Gateshead.

### 1.3 Key nurse-led case management approaches

The main characteristics of the teams delivering the three case management roles in Newcastle Gateshead are summarised in Figure 1.

In comparing these characteristics, key findings that emerge are:

- The cohorts of patients who are eligible for support from each of the three roles/approaches are relatively distinct but with some small areas of overlap which need to be carefully managed to ensure that the roles work together efficiently to form a case management system.

- There appear to be no detailed, documented eligibility criteria for the majority of case management roles. This makes it difficult to judge the extent to which these are common across different roles. It may also pose challenges for potential referrers to the services in terms of understanding which patients are eligible for referral. The broad eligibility criteria for the roles based in care homes (i.e. being resident in that care home) mean that case managers in these roles have no basis other than their professional judgement on which to prioritise patients and manage demand.

- Up-to-date activity data on patient profile were not available for the case management roles and teams. However, historic data and consultation with stakeholders suggest that co-morbidity and complexity are key reported characteristics of the patients case managed by all three roles. A proportion of staff in all three roles reported that they consider themselves to be case managing some older people who are not frail. Key differences in patient profile include the fact that community matrons work with patients who are aged 18-64 in addition to those aged 65+, and that long-term conditions rather than frailty are often the primary feature in community matrons’ caseloads.

- The teams delivering the three nurse-led case management approaches differ considerably in size, structure and composition. The community matrons and
older person nurse specialist teams in both Gateshead and Newcastle constitute teams are employed by the local hospital trust and are based in the community as a core element of community services. Meanwhile the practice frailty nurses operate only in Gateshead and are employed by the specific GP practices whose patients they support. The decision to employ a practice frailty nurse is at the discretion of the GP practice itself, rather than being mandated by the CCG or any other commissioning body.

- Caseload size is not consistent across the different roles involving case management for older people. Nor is it consistent within the same role. In addition, the way in which caseloads.

- Caseloads are conceptualised in different ways within the different roles. For instance, the caseloads older person nurse specialists and the practice frailty nurse working in a care home were described as the number of beds which were covered, whereas the caseloads for community matrons and practice frailty nurses working predominantly in patients’ own homes were described as the number of patients being worked with at any one time.
## Figure 1: Overview of nurse-led case management roles

<table>
<thead>
<tr>
<th>Role</th>
<th>Employer</th>
<th>Setting/Patient cohort</th>
<th>Eligibility criteria</th>
<th>Patient profile</th>
<th>Case load size¹</th>
<th>Team Structure and estimated cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gateshead community matron</td>
<td>Gateshead Health NHS Foundation Trust</td>
<td>Available across Gateshead. Predominantly working with patients living in their own homes.</td>
<td>Individuals aged 18+. Nominally individuals with 2 or more long-term conditions (LTCs), though there is some flexibility on this. Frail older people registered with GP practices without a practice frailty nurse.</td>
<td>Majority of caseload aged 65+. Majority of caseload living in own homes. Common presenting issues include: • LTCs such as respiratory disease, heart failure, diabetes, Parkinson’s Disease, cardiovascular disease. • Frailty. • Psychological/mental health issues. • Social needs.</td>
<td>Reported average caseload for FTE nurse was 45-60. Self-reported individual caseloads of between 26 and more than 50. 100% of caseload case managed.</td>
<td>15 FTE Band 7 nurses. Currently undergoing reorganisation. Moving from single team to split locality based teams. <strong>Estimated cost:</strong> £543,750</td>
</tr>
<tr>
<td>Newcastle community matron</td>
<td>Newcastle Upon Tyne Hospitals Trust</td>
<td>Available across Newcastle. Predominantly working with patients living in their own homes.</td>
<td>Documented eligibility criteria. Individuals aged 18+ with at least one LTC coupled with an additional issue or concern (see section 4.3.2).</td>
<td>Majority of caseload aged 65+ (at least 70%). Majority of caseload living in own homes (85%). Remainder in care homes (15%). Profile is increasingly complex. Common presenting issues include: • LTCs such as COPD, heart failure, diabetes, neurological conditions.</td>
<td>Combined caseload size of 238 (as at Nov 2017) Self-reported individual caseloads of between 30 and 78. (Varies by nurse due to work patterns and level of experience). 100% of caseload case managed.</td>
<td>3.9 FTE Band 7 nurses. (5 team members in total) Aligned to the community nursing clusters. <strong>Estimated cost:</strong> £141,375</td>
</tr>
</tbody>
</table>

¹ The reasons for different sources of data on caseload size are discussed in section 4.3.5
### Role: Gateshead Older Person Nurse Specialist

**Employer:** Gateshead Health NHS Foundation Trust

**Setting/Patient cohort:** Available to all residents in all older people’s care homes with nursing beds and two residential homes in Gateshead.

- 19 (61%) of 31 older people’s care homes
- 1158 (70%) of a total 1663 older people’s care home beds in Gateshead.

**Eligibility criteria:** Residents of linked care homes

**Patient profile:**
- Co-morbidities.
- Frailty.
- Frequent hospital attendance.

**Case load size:**
- Nurses aligned to 1-3 care homes each.
- Total beds in aligned homes varies per nurse from 60-220. Actively managing only a proportion of residents at any one time.

**Team Structure and estimated cost:**
- 8 FTE Band 7 nurses.
- (9 team members in total)
- Nurses are aligned to specific care homes.

**Estimated cost:** £290,000
<table>
<thead>
<tr>
<th>Role</th>
<th>Employer</th>
<th>Setting/ Patient cohort</th>
<th>Eligibility criteria</th>
<th>Patient profile</th>
<th>Case load size¹</th>
<th>Team Structure and estimated cost</th>
</tr>
</thead>
</table>
| Newcastle older person nurse specialist   | Newcastle Upon Tyne Hospitals Trust           | Available to all residents in 23 of 28 nursing or dual-registered older people’s care homes in Newcastle. Covering:  
- 23 (85%) of 27 older people’s care homes with nursing beds  
- 1235 (87%) of total 1423 beds in older people’s nursing or dual-registered homes. | Residents of linked care homes                                                                 | Varies between care homes. All patients are aged 65+. Common presenting issues include:  
- Frailty.  
- LTCs.  
- Degenerative conditions.  
- Dementia-related mental health issues and behaviour that challenges.  
- Frequent/recent falls.  
- Infections.  
- Pressure sores. | Nurses aligned to 1-4 care homes each.  
Total beds in aligned homes varies per nurse from 39-211. Actively managing only a proportion of residents at any one time. | 1 FTE Band 7 Team Leader  
8.8 FTE Band 6 nurses (13 team members in total).  
Nurses are aligned to specific care homes.  
Older person nurse specialists sit within the specialist care home support team, which also includes 0.8 FTE occupational therapist and 0.8 FTE palliative care nurse. | Estimated cost: £303,392 |
| Practice frailty nurse (Gateshead only)   | GP practices in Gateshead                     | Available to patients registered with specific Gateshead GP practices which have employed a practice frailty nurse. For patients living in their own homes, patients identified as moderately or severely frail.  
All residents in Springfield care home who are registered with Oxford Terrace GP practice. | For patients living in their own homes, common presenting issues include:  
- Frequent or recent falls  
- Respiratory and cardiac issues.  
- Social isolation.  
In Springfield care home, average patient is aged 90+. Common presenting issues include: | Varies for each Practice Frailty Nurse.  
For nurse in Springfield care home, 49 residents are currently registered with Oxford Terrace GP practice. Nurse does not actively case manage all residents at any one time. For nurse at Oxford | Oxford Terrace GP Practice: 1.0 FTE Band 7 nurse covering patients in their own homes and 0.4 FTE Band 7 nurse covering Springfield care home. | West Gateshead |
<table>
<thead>
<tr>
<th>Role</th>
<th>Employer</th>
<th>Setting/ Patient cohort</th>
<th>Eligibility criteria</th>
<th>Patient profile</th>
<th>Case load size(^1)</th>
<th>Team Structure and estimated cost</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Terrace working with patients in own home, patients are drawn from practice frailty register of approx. 220 people. Nurse does not consider herself to have a consistent caseload or to be actively case managing the majority of these patients at any one time. The nurse in West Gateshead locality has a caseload of 80-90 but it is not clear how many are case managed.</td>
<td>Acute health problems, such as chest infections and UTIs.</td>
<td>Terrace working with patients in own home, patients are drawn from practice frailty register of approx. 220 people. Nurse does not consider herself to have a consistent caseload or to be actively case managing the majority of these patients at any one time. The nurse in West Gateshead locality has a caseload of 80-90 but it is not clear how many are case managed.</td>
<td>locality: 1.0 FTE Band 7 nurse aligned to 3 GP practices and covering patients in their own homes. <strong>Estimated cost:</strong> £87,000</td>
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</table>
1.4 Implementation of case management approaches

Consultation with case managers suggested that the way they view their own case management responsibility varies across roles; some roles believed themselves to be case managing all patients on their caseload whereas other roles reported that they do not necessarily view themselves as case managers at all.

No outline of the core expected activities of case managers for older people in Newcastle Gateshead was evident in the documentation provided to the independent evaluation team for this review. However, the key activities reported by stakeholders as important to the roles and to case management were broadly consistent and could potentially be used as a basis for developing a model for local case management approaches. These can be categorised into the four stages of: comprehensive assessment; care planning and coordination; delivery of care; and monitoring and review.

There is one important function of the older person nurse specialist role in both Gateshead and Newcastle which is not directly connected to the case management of individual care home residents. This is training and support for care home staff. Whilst this was viewed as important by older person nurse specialists in both locations, it was outlined as a more significant component of the role by staff working in Newcastle.

Staff from each case management role reported that the time input required for the case management of patients varied significantly from patient to patient and also during different stages of work with individual patients. However, patients tended to fall into one of two broad categories: those requiring intensive support for a period of time, and those requiring lighter touch monitoring and review.

There is evidence from this review that the clarity of case management allocation for frail older people in Newcastle Gateshead could be strengthened. A minority of consulted staff in case management roles and wider stakeholders indicated that it is not always clear to them who is case managing a patient, or who should be.

Consultation with staff in case management roles and wider stakeholders suggested that partnership work with a range of services was improved by the existence of the case management roles, which have a clear focus on coordinating care through close communication with the different services involved in a patient’s care. The main groups of professionals with whom case managers reported experiencing challenges in partnership working were: secondary care staff, district nurses, care home staff and GPs.

There appears to be significant consistency in case management approaches across the three roles which are the focus of this review. However, a minority of consulted staff in case management roles and wider stakeholders reported that the approach taken by different staff members working in the same role may vary due to the different backgrounds, knowledge, skills and confidence levels of individual staff members.
The documentary evidence and consultation identified areas for improvement in the performance monitoring of case management approaches for older people. These are addressed in chapter 6.

1.5 Impact of case management approaches

This review considers quantitative evidence of outcomes, where this is available, but it is primarily based on evidence from qualitative consultation on the perceived outcomes of case management approaches and roles.

There is considerable consistency between the case management roles in respect of the outcomes that stakeholders report are being achieved, and these are broadly aligned with the objectives and intended outcomes of case management approaches.

Key patient outcomes which are perceived to be achieved by case management approaches relate to improvements in the health and wellbeing of patients and the quality of care delivered to them. Stakeholders identified that this begins with improved comprehensive assessment which results in a better understanding of patients’ needs and preferences, which then informs the planning and delivery of care.

The primary perceived outcomes of case management approaches for professionals are improved job satisfaction and improved partnership working. In addition, the stakeholders reported that the older person nurse specialist role impacts on the levels of understanding, skills and confidence of care home staff.

In terms of the health and social care system, the main outcomes to which case management approaches were reported to contribute are reducing unnecessary and inappropriate hospital admissions; improving care coordination to ensure that patients are referred to appropriate services and that tasks are allocated more efficiently, avoiding duplication; and reducing the input required from GPs for patients who are receiving case management.

The only case management role for which economic evaluation analysis was possible during this review is the community matrons in Newcastle. This analysis is based on the salary costs of the team and reported avoidance of hospital admissions over a four-month period. It suggests that the team could be responsible for contributing to a net saving on hospital admissions in the region of £153,000 per annum.

The outcomes data provided for this review have been limited. This has, in turn, restricted the level of analysis which could be conducted in relation to the outcomes achieved by case management approaches. This review therefore recommends a number of improvements to the performance monitoring of case management roles. Analysis was shared in relation to the older person nurse specialist role in Gateshead which indicates that work is underway to collate and analyse a wider range of outcomes data to understand the impact and outcomes of this role.
1.6 Future development of case management approaches

There is no national case management competences framework for frail older people. However, a competences framework for the care of people with long-term conditions was published by NHS England in 2005. The role descriptions of the different case manager roles have been compared to this competences framework. This revealed that the extent to which the competences are formalised in role descriptions varies across the different case management roles (from 8 of 9 competences well-referenced in the Gateshead community matron role description to 4 of 9 competences partially-referenced in the Newcastle community matron role description).

There were a number of key attributes of effective case managers which were commonly-identified by consulted case managers and wider stakeholders. In particular, in-depth knowledge of local services was seen as essential, as were advanced clinical skills. Experience in medicine for the elderly was also seen as important, although this was identified by a smaller majority of those consulted.

A number of key factors which support effective case management for frail older people were frequently identified by those consulted during this review. These included comprehensive assessment, access to MDT support and the alignment of case managers to GP practices and/or care homes.

Consultation conducted as part of this review identified several areas for potential improvement in the delivery of case management for frail older people in Newcastle Gateshead, which are not already discussed in previous sections of the report and related recommendations. These included:

- The roll-out of the case management role into all care homes.
- Improvements in the balance of reactive and proactive case management.
- Arrangements for caseload cover.

Four future challenges to effective case management for frail older people were highlighted by case managers and wider stakeholders during the consultation as part of this review. These were:

- Increasing levels of local need.
- Effective use of resources to meet future demand.
- Leadership for case managers.
- Lack of understanding of case management roles.

1.7 Recommendations

The recommendations resulting from this review are presented in It includes a description of the recommendation and lists the report sections from which it
emerges. Evidence for the recommendation is presented in the relevant report section.
**Figure 2: Recommendations for future development of case management approaches**

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Relevant report section(s)</th>
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<tbody>
<tr>
<td><strong>Strategic</strong></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>If a locally-agreed definition of frailty does not already exist, this should be developed. The existing or newly-developed definition should be promoted to all relevant stakeholders and included in all strategic and operational documentation relating to support for frail older people.</td>
</tr>
<tr>
<td>2</td>
<td>A local definition of case management should be developed and agreed by commissioners and providers. This definition should then be promoted to all stakeholders and applied to all services involving case management, including those for older people.</td>
</tr>
<tr>
<td>3</td>
<td>Following the agreement of a local definition of case management, commissioners and providers should agree a set of common objectives of case management, including (if applicable) specific objectives for the case management of older people. These objectives should then be promoted to all stakeholders and should form core objectives of all local services involving case management. This should ensure that case management services are all contributing towards the same objectives, and that there is a common understanding of these objectives amongst those commissioning and providing services.</td>
</tr>
<tr>
<td>4</td>
<td>Commissioners and providers should agree and document a local approach to case management for older people. This approach should be built-in to all roles and services involving case management. Again, this would contribute to a common vision of case management. It would also help to ensure that case management is being delivered consistently within and between different roles and teams. The approach could draw on evidence of the common understanding of case management approaches by local stakeholders, as identified by this review.</td>
</tr>
<tr>
<td>5</td>
<td>Alongside the agreement of common objectives for case management approaches, commissioners and providers should agree on a local approach to case management for older people. This approach should be built-in to all roles and services involving case management. Again, this would contribute to a common vision of case management. It would also help to ensure that case management is being delivered consistently within and between different roles and teams. The approach could draw on evidence of the common understanding of case management approaches by local stakeholders, as identified by this review.</td>
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^2 Feedback on this recommendation from key stakeholders indicates that it is already being taken forward and a definition is being developed via the frailty group.
providers should also agree a set of common intended outcomes which is specific to the case management of older people. Ideally these should be developed through a logic model approach. This should clearly articulate the inputs and activities, as well as SMART outputs, impacts and outcomes of case management. This would be beneficial in promoting a shared vision for case management and in ensuring that the expected impacts and outcomes are realistic in light of the resources available for case management. It would also be helpful in developing future performance monitoring arrangements for case management approaches.

This review recommends a number of improvements to ongoing collation and analysis of performance monitoring data. This should be based on a logic model approach that would facilitate more systematic collation and analysis of input, activity, output, impact and outcomes data. Clear metrics should then be determined to ensure that data can be captured in relation to the SMART outputs, impacts and outcomes, and therefore that performance against them can be monitored on an ongoing basis. It will be important to ensure that these metrics enable the monitoring of individual, person-centred impacts and outcomes for patients as well as system-level impacts and outcomes.

<table>
<thead>
<tr>
<th>Logic model element</th>
<th>Data requirements for outcomes analysis</th>
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| Inputs              | • Outline of budget allocated to case management, including breakdown of funding sources and areas of expenditure. This may be provided per case management team or as a total budget across Newcastle Gateshead.  
• Staffing details, including team structures, roles, FTE posts and salary bands.  
• Detail of any other resources required to deliver case management approaches, which are not directly funded by the budget (e.g. equipment, input from other non-funded staff teams) |

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3 It is recognised that the desired outcomes for individual older people will vary based on their circumstances, needs and preferences. It is entirely appropriate that these desired outcomes are person-centred and developed on an individual basis. However, an over-arching set of intended outcomes of case management approaches could be developed which would encompass these person-centred outcomes and therefore not preclude the use of case management to achieve individual outcomes with older people.

4 SMART stands for Specific, Measurable, Achievable, Relevant and Timebound.

5 Definitions of these key terms are presented in appendix D.
<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Relevant report section(s)</th>
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| Activities     | Description of the key activities delivered under case management, and the organisation/professional responsible for delivery. Examples include:  
- Referral pathways  
- Eligibility criteria  
- Comprehensive assessment  
- Care planning  
- Home visits  
- Liaison with family members  
- Checking records for medical history  
- Medication review  
- Prescribing  
- Diagnostics ordered  
- Onward referrals  
- Exit criteria | |
| Outputs        | As a minimum the following should be recorded for each case management service over the whole delivery period for case management and reported at regular intervals:  
- Numbers of patients referred  
- Referral sources for those referred (professional and (if applicable) care home at which patient resides)  
- Number of referrals accepted  
- Number of referrals not accepted and reasons for this  
- Profile of patients who access case management  
- Waiting times to access case management  
- Number of patients discharged.  
- Weekly caseload numbers, indicating how many are receiving case management and how many on the caseload but not being case managed by the service. |
### Recommendation

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<table>
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<td></td>
<td>Average length of time patients are only the caseload/case managed.</td>
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<tr>
<td></td>
<td>This data could be supplemented by outputs in relation to specific activities outlined in the logic model (such as, for example, numbers of patients receiving CGA, care plans, onward referrals to different services, etc. These data could also be used to provide the average number of tasks undertaken by case managers per patient).</td>
</tr>
</tbody>
</table>

### Impacts

<table>
<thead>
<tr>
<th></th>
<th>As a minimum the following should be recorded for each case management service over the whole delivery period for case management and reported at regular intervals:</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>Outcomes at review and (if applicable) discharge for all patients.</td>
</tr>
<tr>
<td></td>
<td>Indicators to enable assessment of clinical impact (from data already collected in the course of clinical work with patients). Examples include:</td>
</tr>
<tr>
<td></td>
<td>Patients’ care plan goals and whether these were achieved, to understand the numbers of patients who achieve some or all of their goals.</td>
</tr>
<tr>
<td></td>
<td>These could be supplemented by Patient Reported Outcome and Patient Reported Experience (PROMs &amp; PREMs) Measures, gathered through systematic and structured patient and family member feedback on work with case managers, quality of care, quality of life and/or health and wellbeing.</td>
</tr>
</tbody>
</table>

### Outcomes

|   | As a minimum, the following system-level data should be collated and reported for both Newcastle and Gateshead for the care home population and the general population of over 65s and analysed at regular intervals: |

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6 If up-to-date profile data is available for case management services, which suggests that they are working predominantly with people in a particular age group (e.g. over 80s), population-level data could be collated for patients in this age group rather than over 65s.
<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Relevant report section(s)</th>
</tr>
</thead>
</table>
| • Numbers of patients attending A&E  
• Numbers of patients admitted to the emergency department  
• Numbers of patients non-electively admitted to hospital  
• Average length of stay in hospital  
• Numbers of patients attending outpatient appointments  
• Numbers of patients dying in their preferred place of death (or, if preferred place of death is not known, numbers of residents dying in care homes or their own home)  
• Number of patients dying in hospital  
This could be supplemented by patient-level data for an agreed time period (e.g. 12-month prior to admission and a 12-month period following discharge) for residents who access case management. Examples include:  
• Secondary care service use.  
• Primary care service use. | |
| 7 In the future roles, teams and approaches involving case management should be clearly documented to provide clarity for both case managers and wider stakeholders. This includes documenting how the roles and their remits relate to each other to offer a systemic approach case management for older people in Newcastle Gateshead. This will ensure institutional knowledge is maintained with less reliance on personalities. | 4.1 |
| 8 The resourcing of the different case management approaches should be reviewed to ensure that case managers have sufficient capacity to manage both the reactive and proactive elements of their role. | 7.5.2 |
| 9 Commissioners and partners should collate and analyse more systematic quantitative data on the outcomes of nurse-led case management for care home residents, in order to determine whether this evidence supports the views of stakeholders that this case management approach should be introduced into all care homes in Newcastle Gateshead. This would be likely to require clinical audits or a resident data study, which might be supplemented by consultation with a sample of residents, family members, care home staff and GPs working | 7.5.1 |
## Recommendation

<table>
<thead>
<tr>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>with case managers in care homes⁷.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Relevant report section(s)</th>
</tr>
</thead>
</table>

| 10 | All future development of case management approaches for older people, or for roles involving case management, should maximise the possibility of care home and GP alignment for case managers and stipulate arrangements for case managers to access MDT input for patients. |
| 7.4.4 |

| 11 | Commissioners and providers should clarify, agree and document the balance in the older person nurse specialist role between delivering case management activities and delivering training and support to care home staff to support high-quality care and case management. |
| 5.6 |

### Operational

| 12 | Commissioners and providers should review the eligibility criteria for patients to receive support from the different case management roles and develop formal eligibility criteria for all roles. These should be clear and accessible to all staff delivering case management and to all potential referrers, as well as to strategic and operational managers and to commissioners. When developing the criteria, it will be important to consider how the different roles interact to create a local system of case management, and whether this can be further supported and clarified by ensuring effective eligibility criteria. |
| 4.3.2 |

| 13 | Those responsible for the allocation of caseloads should ensure that the caseload size for individual case managers in the same role is as equitable as possible, taking into account the number of hours worked by each staff member. The rationale for any differences in caseload size should be clearly articulated to all staff members. |
| 4.2.5 |

| 14 | For each role, the extent to which case management responsibility corresponds to caseload should be clarified. This should be clear to staff in the case management roles, and to other professionals working with them. If staff in these roles do not hold case management responsibility for any proportion of patients on their caseload who require case management then alternative case management arrangements should be in place and clear to all. |
| 5.3 |

---

⁷ Feedback on this recommendation from key stakeholders indicates that it is already being taken forward as part of the Community Services transformation in Gateshead.
<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Relevant report section(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>15</strong> The CCG, local authorities and NHS Trusts should consider how case management responsibility could be recorded on local systems and databases, to ensure that staff in all roles are able to determine whether a patient has a case manager and who this case manager is. This may include flags on a range of systems used by different healthcare professionals. It would need to include guidance on who is responsible for updating the systems with new case manager information, and how regularly.</td>
<td>5.7</td>
</tr>
<tr>
<td><strong>16</strong> Commissioners and providers should collectively decide whether CGA should be introduced in lieu of the current approach to comprehensive assessment. If a decision is taken to move from the current comprehensive assessment to CGA, resource implications will need to be addressed.</td>
<td>5.4.1</td>
</tr>
<tr>
<td><strong>17</strong> Whether the assessment is CGA or another form of comprehensive assessment, this should be common across all case management roles. A shared assessment tool should therefore be introduced for all roles and services involving the case management of older people. This would ensure consistency in assessment and also increase the likelihood that assessments performed by one service could be transferred to another service in the event of a patient’s case management being transferred.</td>
<td>5.4.1</td>
</tr>
<tr>
<td><strong>18</strong> Information available to professionals who might work alongside case managers should be improved in order to promote better understanding of case management and the specific case management services available. This might include producing clear and succinct leaflets about case management, the case management roles and remits, how they inter-relate and how to refer to them. It might also include ensuring that information about case management approaches and roles is included in workforce development and training. As a promotional tool, case studies could be produced about how case managers have worked with different partners previously to improve outcomes for patients and the system.</td>
<td>5.8.4</td>
</tr>
<tr>
<td><strong>19</strong> The CCG and partners should continue their work to develop and implement a workforce competency framework. This is a good example of local work to produce a system-wide approach to supporting older people through ensuring that professionals are appropriately qualified and that their continuous professional development is promoted. It would support standardisation and the development of transferable skills within and</td>
<td>5.9.2</td>
</tr>
<tr>
<td>Recommendation</td>
<td>Relevant report section(s)</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------------</td>
<td>---------------------------</td>
</tr>
<tr>
<td>20 Responsibility for recording and collating performance monitoring data should be clearly allocated to one or more staff member in each team. In allocating this, consideration must be made of the time/resource required to record and collate this data. If this cannot be absorbed by current staff members, further administrative resource may need to be identified.</td>
<td>6.5</td>
</tr>
<tr>
<td>21 The findings of performance monitoring should be shared with case managers and other professionals at regular intervals. This would enable any benefits of case management to be communicated to both case managers and other professionals. This might help to address concerns expressed by some stakeholder that the purpose and impact of their role is not always clear to them. It might also increase engagement with case management by other professionals.</td>
<td>6.5</td>
</tr>
<tr>
<td>22 In developing any future case management roles or job descriptions (included updated job descriptions for existing roles), consideration should be given as to whether it is appropriate to map the job description and person specification to NHS England’s Case management competences framework for the care of people with long term conditions.</td>
<td>7.3.1</td>
</tr>
<tr>
<td>23 Advanced clinical skills and experience in elderly medicine should be included as essential requirements in any future person specification for roles involving the case management of frail older people. Staff recruited to the role should also be provided with a comprehensive induction to ensure that they have adequate knowledge and understanding of local services.</td>
<td>7.3.2</td>
</tr>
<tr>
<td>24 Local commissioners and providers should conduct additional consultation to understand the extent to which prescribing skills allow case managers to more effectively manage the care of a patient. It is not clear based on the evidence of this review the extent to which prescribing is an important function of case management.</td>
<td>7.3.2</td>
</tr>
<tr>
<td>25 A more formalised hand-over period should be agreed and implemented between community matrons and older person nurse specialists for patients moving into care homes with an aligned older person nurse specialist. This should ensure that that handover is timely and structured, and provide patients and professionals with clarity</td>
<td>4.3.1</td>
</tr>
<tr>
<td>Recommendation</td>
<td>Relevant report section(s)</td>
</tr>
<tr>
<td>----------------</td>
<td>---------------------------</td>
</tr>
<tr>
<td>about who is case managing a resident during this settling-in period.</td>
<td></td>
</tr>
<tr>
<td>26 Formal arrangements should be made to cover case managers’ caseloads if they are absent from work and to ensure that teams have adequate resource in place to provide this cover. This would ensure that patients continue to receive case management support during staff absences.</td>
<td>7.5.3</td>
</tr>
</tbody>
</table>
2 Introduction

2.1 Overview

This report presents the findings of an independent review of three nurse-led case management approaches currently being taken to support older people, including those who are frail, in Newcastle and Gateshead. The review was commissioned by Newcastle Gateshead Clinical Commissioning Group. It was conducted by Cordis Bright, PPL and Cobic, a team of three independent research and consultancy organisations specialising in health and social care.

The review is part of the 2017-18 evaluation activity for the Enhanced Health in Care Homes Vanguard (the Vanguard) in Newcastle Gateshead. It was conducted between October 2017 and January 2018.

This report is accompanied by reviews of two other aspects of healthcare delivery for care home residents and frail older people in their own homes:

- Gateshead Virtual Ward
- Newcastle Gateshead step up/step down community beds.

Figure 3 presents all three aspects that have been reviewed.

The focus of this report is case management approaches.

These aspects of healthcare service delivery are not directly funded by the Vanguard but relate to the work of the Vanguard because they have been

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8 Definitions for key terms, such as frailty, are included at appendix D.
identified by the Newcastle Gateshead Pathway of Care group as important to the ongoing development and sustainability of enhanced health for care home residents in Newcastle Gateshead.

**What is the Pathway of Care group?**

The Pathway of Care group was brought together as part of the Vanguard. It is a multi-agency group of clinicians and other professionals from services supporting care home residents, which meets weekly to explore and develop clinical engagement and improvements in healthcare for care home residents. Clinicians attend as part of their normal work, although attending GPs and social workers receive funding from the Vanguard to backfill their posts and enable them to attend.

### 2.2 Description of key case management roles and approaches

This review focuses on nurse-led case management approaches associated with three different roles. These are:

- Community matron (CM).
- Older person nurse specialist (OPNS).
- Practice frailty nurse (PFN).

It is recognised that professionals in other roles might also be managing patients’ cases. This includes staff in both health and social care roles. The review considers the extent to which the three roles above might overlap with other roles, as well as the extent to which responsibility for case management is clear. However, other roles, outside the remit of this review are not described in detail in this report.

Figure 4 presents a summary description of each of the roles on which the review focuses. The roles differ in Gateshead and Newcastle so information is provided separately for each role in the locations in which it operates.
<table>
<thead>
<tr>
<th>Role</th>
<th>Working in…</th>
<th>Aligned to…</th>
<th>Core activities</th>
<th>Employer</th>
<th>Salary band of case managers</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Care homes</td>
<td>Patient's own homes</td>
<td>Clinical work</td>
<td>Staff training</td>
<td></td>
</tr>
<tr>
<td>Gateshead CM</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>Gateshead Health NHS Foundation Trust</td>
</tr>
<tr>
<td>Newcastle CM</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>Newcastle Upon Tyne Hospitals Trust</td>
</tr>
<tr>
<td>Gateshead OPNS</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>Gateshead Health NHS Foundation Trust</td>
</tr>
<tr>
<td>Newcastle OPNS</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>Newcastle Upon Tyne Hospitals Trust</td>
</tr>
<tr>
<td>PFN (Gateshead only)</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>GP practices in Gateshead</td>
</tr>
</tbody>
</table>

9 Gateshead community matrons are in the process of moving over to locality-based working. They were previously a single team.

10 The remits of the individual practice frailty nurses are different, so in fact one works exclusively in the community, one works exclusively in a single care home and one works predominantly in the community but also in care homes.
2.3 Review themes and questions

The review covers a range of themes and questions. These are summarised in Figure 5, which also indicates the section of the report in which the questions are addressed.
### Figure 5: Review themes and questions

<table>
<thead>
<tr>
<th>Theme</th>
<th>Questions</th>
<th>Report section</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local context and service landscape</td>
<td>What was the local context into which the three case management approaches were introduced? What change do they represent to previous arrangements?</td>
<td>Chapter 3 (all)</td>
</tr>
<tr>
<td>Objectives and intended outcomes</td>
<td>What are the objectives and intended outcomes of the case manager role for frail older people and for the three different case management approaches available locally?</td>
<td>3.5</td>
</tr>
<tr>
<td>Inputs</td>
<td>Which staff members are involved in delivering the three different case management approaches and who employs them?</td>
<td>4.2; 4.3.4</td>
</tr>
<tr>
<td></td>
<td>How much time do professionals spend in delivering the three different case management approaches (estimates per care home or per patient on caseload)?</td>
<td>4.3.5; 5.5</td>
</tr>
<tr>
<td></td>
<td>What are the costs associated with the three different case management approaches? Which organisations meet these costs? How much of this represents additional cost to previous arrangements and how much is diversion of resources which were already allocated to case management of primary care in care homes or for older people in their own homes?</td>
<td>4.3.4</td>
</tr>
<tr>
<td>Activities and outputs</td>
<td>Which care homes receive which of the three case management approach? How was this decision reached?</td>
<td>4.3</td>
</tr>
<tr>
<td></td>
<td>What is the profile of care homes and/or patients receiving each of the three approaches?</td>
<td>4.3.1; 4.3.2</td>
</tr>
<tr>
<td></td>
<td>What are the caseloads of the case managers delivering the three different approaches?</td>
<td>4.3.5</td>
</tr>
<tr>
<td></td>
<td>What are the key activities delivered under each of the three approaches? How do the approaches differ in delivery terms?</td>
<td>5.4</td>
</tr>
<tr>
<td>Impact and</td>
<td>What outcomes are achieved for residents as a result of the three different case management</td>
<td>Chapter 6</td>
</tr>
<tr>
<td>Theme</td>
<td>Questions</td>
<td>Report section</td>
</tr>
<tr>
<td>-------------------</td>
<td>---------------------------------------------------------------------------</td>
<td>----------------</td>
</tr>
<tr>
<td>outcomes</td>
<td>What outcomes are achieved for professionals working with residents as a result of the three different case management approaches?</td>
<td>6.3.2</td>
</tr>
</tbody>
</table>
|                   | What outcomes are achieved for the health and social care system as a result of the three different case management approaches? To include changes to rates of:  
|                   | a.) GP call-outs  
|                   | b.) A&E attendance  
|                   | c.) Non-elective admissions to hospital  
|                   | d.) Referrals to rapid response community nursing teams (i.e. UCT, RRIC, CRRT).  
<p>|                   | What costs are associated with these outcomes? | Chapter 6 (all) |
| Health economics  | What data is available to inform cost benefit and/or health economics analyses in relation to the three case management approaches? | 6.4; 6.5       |
|                   | What does analysis of the available data tell us about the cost benefit and/or health economic impact of the three case management approaches? | 6.4            |
|                   | Are there any gaps in this data? If so, how could these gaps be addressed locally in the future? | 6.5            |
| Staff experience  | What are the work experiences of staff delivering the three different case management approaches (and length of time they have been working with older people)? | 4.3.5; Chapter 5 (all) |
|                   | What are the work experiences of staff working alongside the three different case management approaches (e.g. GPs, care home staff, community/primary care teams, and secondary care teams)? | 5.8            |
| Process           | To what extent is it clear to all stakeholders which role should be case managing a patient? To what extent is it clear which role is case managing? Are all stakeholders able to distinguish between case | 5.7            |</p>
<table>
<thead>
<tr>
<th>Theme</th>
<th>Questions</th>
<th>Report section</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>managing a patient and having a patient on caseload?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>How well are case managers in the three roles working with other professionals involved with a patient?</td>
<td>5.8</td>
</tr>
<tr>
<td></td>
<td>To what extent are case managers in the same role managing cases in a standardised way? Do case managers in the three different roles manage in similar ways to each other?</td>
<td>5.9</td>
</tr>
<tr>
<td></td>
<td>What (if any) have been the past and current challenges to delivering the three case management approaches?</td>
<td>5.8; 7.6</td>
</tr>
<tr>
<td></td>
<td>What (if any) are the key future challenges to delivering the three case management approaches?</td>
<td>7.6</td>
</tr>
<tr>
<td></td>
<td>What are the key past and current successes in delivering the three case management approaches?</td>
<td>7.4</td>
</tr>
<tr>
<td>Future development</td>
<td>How might the design and delivery of the three case management approaches be improved in the future (if at all)?</td>
<td>7.5</td>
</tr>
<tr>
<td></td>
<td>Should one or more of the three case management approaches be rolled out more widely in the future? If so, what would roll-out look like? What would be the key resource implications, supporting factors and challenges to roll-out?</td>
<td>7.5.1</td>
</tr>
</tbody>
</table>
2.4 Review methodology

2.4.1 Summary of methodology

Figure 6 summarises the methodology for the review of case management approaches. This was developed by the independent evaluation team, in collaboration with the CCG, NECS and Pathway of Care group members. All approaches and tools were agreed with the CCG and NECS in advance of their use in the evaluation. Copies of all research tools are available at appendix A.

Figure 6: Methodology for review of case management approaches

Phase 1. Scoping report and evaluation framework (Oct 2017)
- Project launch
- Review of documentation
- Workshop with Pathway of Care group members
- Telephone interviews with key senior stakeholders
- Deliver draft evaluation framework and scoping report
- Circulate and receive feedback from CCG and NECS
- Evaluation framework and scoping report signed off

- Research tools developed and signed off by CCG and NECS
- Review of documentation and data
- 5 focus groups with case managers
- E-survey of case managers
- 6 telephone interviews with wider stakeholders
- Analysis and reporting
- Deliver draft final report
- Circulate and receive feedback from CCG, NECS and Pathway of Care group members
- Final report signed off

2.4.2 Phase 1 methodology

Phase 1 was conducted in October 2017.

Review of documentation

An initial review was conducted of a range of documentation relating to the Enhanced Health in Care Homes Vanguard, Pathway of Care group, case management approaches, step up step down community beds and Gateshead Virtual Ward. This was used to gather information to inform the scoping report and evaluation framework, as well as the preliminary approach to phase 2 of the evaluation.

Workshop with Pathway of Care group members

Two members of the evaluation team attended the weekly Pathway of Care meeting on 18 October 2017 and conducted a workshop with stakeholders in order to:
- Sense test our understanding of the information contained in documentation.
- Gather verbal information to build on this understanding and supplement the documented information.
- Discuss proposed approaches to phase 2 of the evaluation to understand what Pathway of Care group members believed to be the most practical and desirable methodology and to identify key contacts and stakeholders for different aspects of the three reviews.

**Telephone interviews with key senior stakeholders**

Telephone interviews were conducted with three key stakeholders with knowledge of the Enhanced Health in Care Homes Vanguard and of data which might be available to inform the evaluation. These were:

- Programme Manager at the CCG for the Enhanced Health in Care Homes Vanguard in Newcastle Gateshead.
- Lead Nurse at the CCG for the Enhanced Health in Care Homes Vanguard in Newcastle Gateshead.
- Principal Intelligence Analyst at NECS.

### 2.4.3 Methodology for phase 2

**Review of data and documentation relating to the case management approaches**

Based on the evaluation framework, the following data and documentary evidence was provided by review stakeholders to Cordis Bright, Cobic and PPL for review and analysed to inform this report.

**Figure 7 Summary of documentation for each case management role**

<table>
<thead>
<tr>
<th>Role</th>
<th>Documentation/data received</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gateshead CM</td>
<td>• Role description.</td>
</tr>
<tr>
<td></td>
<td>• Team structure and salary bands.</td>
</tr>
<tr>
<td>Newcastle CM</td>
<td>• Role description.</td>
</tr>
<tr>
<td></td>
<td>• Team structure and salary bands.</td>
</tr>
<tr>
<td></td>
<td>• Current combined caseload size.</td>
</tr>
<tr>
<td></td>
<td>• Eligibility criteria.</td>
</tr>
<tr>
<td>Gateshead OPSN</td>
<td>• Role description.</td>
</tr>
<tr>
<td></td>
<td>• Team structure and salary bands.</td>
</tr>
<tr>
<td></td>
<td>• Care home alignment and allocation, included numbers of beds in care homes.</td>
</tr>
</tbody>
</table>
### Role Documentation/data received

**Newcastle OPSN**
- Role description.
- Team structure and salary bands.
- Care home alignment and allocation, included numbers of beds in care homes.
- Service specification for specialist care home support team.
- Nursing home staff and resident feedback from consultation taking place in May-June 2016.

**Practice Frailty Nurse**
- Role description.
- Team structure and salary bands.
- Activity, outputs and outcomes data (Oct 13-Aug 14) from interim evaluation of practice frailty nurse pilot project.

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**Focus groups with staff members working in key case management roles**

Five focus groups were conducted in November 2017 with staff members working in the key case management roles which were the primary focus of the review. The numbers of staff who participated in each focus group are summarised in Figure 8.

**Figure 8: Participants in case management consultation by role**

<table>
<thead>
<tr>
<th>Case management role</th>
<th>Number of case managers in post</th>
<th>Focus group participants</th>
<th>E-survey respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Proportion of staff in role</td>
<td>Number</td>
</tr>
<tr>
<td>Gateshead CM</td>
<td>15</td>
<td>4</td>
<td>27%</td>
</tr>
<tr>
<td>Newcastle CM</td>
<td>3.9</td>
<td>3</td>
<td>60%</td>
</tr>
<tr>
<td>Gateshead OPNS</td>
<td>8</td>
<td>3</td>
<td>33%</td>
</tr>
<tr>
<td>Newcastle OPNS</td>
<td>9.8</td>
<td>4</td>
<td>27%</td>
</tr>
</tbody>
</table>
E-survey of staff members working in key case management roles

An E-survey was circulated by the evaluation team to lead contacts for each of the case management roles and localities with a request to circulate to all staff members in the role.

In total 20 staff members responded to the survey. However, two only included their job title and did not complete the remaining questions. These two responses were excluded from the overall analysis, meaning that in total 18 responses were analysed.

The numbers of staff in each case management role who responded to the E-survey are summarised in Figure 8.

Interviews with stakeholders with insight into local case management approaches

Six interviews were conducted with stakeholders not working in the role of community matron, older person nurse specialist or practice frailty nurse whose role provided them with insight into one or more of these roles and/or the case management of frail older people more generally. This included two GPs working alongside staff members in one or more of the case management roles, two staff members in strategic or senior operational roles in Newcastle Gateshead CCG, and two staff members in strategic and operational roles in Gateshead Health NHS Foundation Trust.

A note on reporting on consultation

When reporting on the findings from consultation we have distinguished between the different stakeholder groups as follows:

**Case managers** is used to denote consulted staff members in one of the three case management roles.

Wider stakeholders is used to denote staff members with insight into the case management roles, but who are not working in the roles as case managers.

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11 Practice frailty nurses operate only in Gateshead so, unlike the other roles, this is not sub-divided into Gateshead and Newcastle case managers.
2.4.4 Limitations of the review

There were a number of limitations to this review. Key limitations were:

- Systematic data on inputs, activity, outputs, impacts and outcomes of the case management approaches were not available to inform health economics analyses. As such, snapshot or other available data has been used where possible. These data have generally been drawn from previous clinical audits or internal evaluations (rather than access to any datasets) and therefore cannot be independently verified by the evaluation team. In addition, limitations in the data made analyses of longer-term patient and system outcomes of the case management approaches challenging.

- Documentation was available on elements of all approaches but this was not always directly comparable across approaches. There were also some gaps in the documentation, such as the absence of a formal job description or person specification for the practice frailty nurse role. Where documented evidence was not available, information was sought during qualitative consultation to address these gaps.

- The timescales for the review resulted in a two-month window to organise and conduct all field work, collate documentation/data from multiple stakeholders and complete the analysis and reporting. In particular, a longer field work window might have enabled more stakeholders to respond to the evaluation consultation.

2.5 Structure of the report

The remainder of this report is structured as follows:

- **Chapter 3** considers the context for case management approaches for frail older people in Newcastle Gateshead.

- **Chapter 4** provides an overview and comparison of the roles of community matron, older person nurse specialist and practice frailty nurse, which are three of the key roles in Newcastle Gateshead which involve nurse-led case management for frail older people.

- **Chapter 5** presents evidence on the implementation of nurse-led case management approaches for frail elderly people in Newcastle Gateshead, and the extent to which these are being delivered effectively.

- **Chapter 6** explores evidence on the impact of nurse-led case management approaches for frail older people in Newcastle Gateshead.

Stakeholders is used to denote a combination of case managers and wider stakeholders.
• **Chapter 7** summarises stakeholder views and evaluation findings in relation to the possible future development of local case management approaches for frail older people.

• **Chapter 8** presents the recommendations resulting from this review of local case management approaches.
3 Context for case management approaches in Newcastle Gateshead

3.1 Overview

This chapter presents findings on the definition of case management and on the need for case management for older people in Newcastle Gateshead. It considers the objectives and intended outcomes of case management approaches for frail older people in Newcastle Gateshead. It also summarises evidence on the local development of the three roles of community matrons, older person nurse specialist and practice frailty nurse, which are three local examples of nurse-led roles involving case management for frail older people. Chapter 4 then goes on to summarise the key characteristics of these roles and teams.

3.2 Key findings

The population of Newcastle Gateshead is ageing. This is likely to result in increased numbers of older people with complex health needs and a related increase in demand and delivery costs for health services. One method through which demand might be managed is case management.

Case management is outlined by Newcastle Gateshead CCG as one of the key elements of a needs-based approach to care, which is central to the local Enhanced Health in Care Homes model. However, there appears to be no locally-agreed definition of case management. There is also no single, nationally-recognised definition. It can be conceptualised either as a longer-term, proactive and holistic process to achieve broad outcomes with a patient, or as a short-term, intensive intervention to prevent escalation of need.

There was limited evidence of documented objectives and intended outcomes of case management approaches in Newcastle Gateshead, or of the specific case management roles considered in this review. Nevertheless, key objectives and intended outcomes were identified through stakeholder consultation and these were broadly consistent between stakeholders and roles.

Key identified objectives were:

- Ensuring that frail older people with multiple and complex needs receive holistic and well-coordinated multi-disciplinary care.
- Supporting the health and social care system to deliver efficient and cost-effective care.

The over-arching intended outcomes of the approaches associated with the three roles are also similar and fall into three main categories, which are:
- Improved health and wellbeing outcomes for frail older people.
- Improved quality of care for frail older people.
- Reduced unnecessary or inappropriate use of health and social care services.

The emphasis placed by stakeholders on different objectives and outcomes varied across roles.

The community matron role was introduced in 2005-06, coinciding with a national drive to introduce community matrons. The older person nurse specialist role was introduced in 2012 and the practice frailty nurse role was introduced in 2015. Both of these roles were piloted in Gateshead.

### 3.3 Population of Newcastle Gateshead

In the value proposition for the Enhanced Health in Care Homes Vanguard, Newcastle Gateshead CCG outlines some of the challenges to which the Enhanced Health in Care Homes Model seeks to respond\(^\text{12}\). These are summarised in Figure 9.

*Figure 9: Context for the Enhanced Health in Care Homes model in Newcastle Gateshead*

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\(^{12}\) Newcastle Gateshead CCG. *Newcastle Gateshead’s Vanguard (Enhanced Health in Care Homes) Value Proposition 2016-17.*
The population of Newcastle Gateshead, like the UK population overall, is ageing. Population segmentation work conducted by NECS indicates that in 2017 Newcastle Gateshead had a population of more than 79,000 people aged 65+. This is predicted to increase by 37% to more than 109,000 by 2037.

The average age of this population is also set to rise in the next 20 years. People aged 85+ currently make up 13% of the 65+ population in Newcastle Gateshead but by 2037 it is predicted that those aged 85+ will account for 18% of this population.

One consequence of the ageing population is that the proportion of the population with more complex health needs is also likely to increase over time. In fact, NECS projections estimate that the proportion of the population with severe health needs will increase by more than 3,700 (or 0.4%) by 2037, whilst the population with moderate health needs will increase by more than 27,000 (or 3.1%) in the same period. Severe health needs are defined as having 7 or more long-term conditions (LTCs), being housebound or in a care home, and/or being on the palliative care register. Moderate health needs are defined as having 4-6 LTCs.

In turn, increasing levels of complex health needs within the population is likely to lead to an increase in demand for health services, and to related increases in the costs of delivering these services. For example, people with severe health needs in Newcastle Gateshead required an average secondary care spend of £2,955 per person in 2015, whilst people with moderate health needs required an average spend of £1,736 in the same period. This compares to an average spend of £308 per head for the fit population.

In order to manage demand as effectively as possible and to ensure high-quality care is available to those who need it, health and social care commissioners and providers in Newcastle Gateshead have sought to develop approaches to deliver care which improves quality and supports system efficiencies. One such approach is case management of the healthcare of older people, and especially those who are frail and/or who have severe or moderate health needs. In fact, there is scope for this case management to work across health and social care. However, this review focuses primarily on healthcare because the review of documentation and consultation with stakeholders revealed that the roles under review generally case manage health but not also social care for older people.

3.4 Definition of case management

The King’s Fund identifies that there is not a universally-accepted definition of case management. In a 2011 review of case management it highlights that case management can be defined broadly as:

“A collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual’s and family’s comprehensive health needs”

through communication and available resources to promote quality cost-effective outcomes”\(^\text{14}\).

However it also reports that case management is often used in the NHS as a term to mean:

“An intensive, personalised and time-limited intervention aimed at preventing a specific occurrence or event – usually an emergency hospital admission”\(^\text{14}\).

These definitions indicate that the term case management can be conceptualised in two quite different ways, and therefore applied to a range of approaches. On the one hand case management is described as a holistic, long-term process of proactive activity aimed to achieve broad outcomes. But on the other hand it is described as a short-term and intensive intervention to prevent escalation of need.

In the documentation provided for this review, no locally-agreed definition of case management was provided and no definition from literature was cited. This may be because there is no clearly established common definition of case management nationally. However, without a locally-agreed definition it is difficult to ensure that local approaches and roles are applying a common definition and therefore inconsistencies in approaches may develop as a result of different interpretations of the term, particularly across roles.

**Recommendation:** A local definition of case management should be developed and agreed by commissioners and providers. This definition should then be promoted to all stakeholders and applied to all services involving case management, including those for older people.

As a result of the absence of a clear locally-agreed definition, this review considers how case management is conceptualised locally, as exemplified in the case management approaches in the three roles of community matron, older person nurse specialist and practice frailty nurse. It also explores the extent to which the understanding and application of case management approaches is consistent across these three roles and stakeholders who have insight into them, and what stakeholders consider to be the key elements and preferred approaches in case management for frail older people.

\(^{14}\) The King’s Fund (2011) "Case management: what it is and how it can be implemented" available: [https://www.kingsfund.org.uk/sites/default/files/Case-Management-paper-The-Kings-Fund-Paper-November-2011_0.pdf](https://www.kingsfund.org.uk/sites/default/files/Case-Management-paper-The-Kings-Fund-Paper-November-2011_0.pdf). The first definition is by The Case Management Society of America; the second is by The King’s Fund.
3.5 Objectives and intended outcomes of case management approaches

3.5.1 Key objectives

The role descriptions and other available documentation were reviewed to try to identify the aims and objectives of local case management approaches. For the majority of roles, aims and objectives were either not articulated or not described in any detail. However, they could be extrapolated from summaries of the purpose of the role. The review of role descriptions alongside consultation with stakeholders relating to the three case management roles, identified a primary objective across the roles to be ensuring that people with multiple and complex needs receive holistic and well-coordinated multi-disciplinary care. It was described as the central objective by the majority of stakeholders in the case management roles themselves, as well as the majority of wider stakeholders.

In addition to this primary objective, a second objective around supporting the health and social care system to deliver efficient and cost-effective care was implied by the job purpose outlined in each of the role descriptions and by the majority of consulted stakeholders.

Recommendation: Following the agreement of a local definition of case management, commissioners and providers should agree a set of common objectives of case management, including (if applicable) specific objectives for the case management of older people. These objectives should then be promoted to all stakeholders and should form core objectives of all local services involving case management. This should ensure that case management services are all contributing towards the same objectives, and that there is a common understanding of these objectives amongst those commissioning and providing services.

3.5.2 Intended outcomes

As with objectives, the intended outcomes of case management approaches were not generally clearly articulated in the available documentation, although some could be extrapolated from role descriptions. However, consulted stakeholders were able to identify a number of intended outcomes. For the majority of stakeholders, these related to the specific role in which they were working or with which they were most familiar. The intended outcomes outlined in relation to the different roles were broadly very similar and have therefore been used to build a picture of stakeholder-perceived intended outcomes of case management approaches, which is presented in Figure 10.

15 The exception was the older person nurse specialist role in Newcastle, which is the core role in the specialist care home support service, for which there was a detailed service specification.
Recommendation: Alongside the agreement of common objectives for case management approaches, commissioners and providers should also agree a set of common intended outcomes which is specific to the case management of older people\(^\text{16}\). Ideally these should be developed through a logic model approach. This should clearly articulate the inputs and activities, as well as SMART\(^{17}\) outputs, impacts and outcomes\(^{18}\) of case management. This would be beneficial in promoting a shared vision for case management and in ensuring that the expected impacts and outcomes are realistic in light of the resources available for case management. It would also be helpful in developing future performance monitoring arrangements for case management approaches (discussed in more detail in sections 5.10 and 6.5).

3.5.3 Consistency of objectives and intended outcomes across nurse-led case management roles

Although the objectives and intended outcomes identified by stakeholders across the case management roles were consistent, the emphasis placed on particular objectives and outcomes varied for different roles. For example, for the roles of community matrons and practice frailty nurses working with patients in their own home, the emphasis within improved health and wellbeing outcomes was on supporting patients to improve their self-management of health. This included improved self-management of long-term conditions, as well as improved understanding by patients of how changes to their environment and/or behaviour...
could improve their health or avoid future deterioration of their health. In contrast, the older person nurse specialist and practice frailty nurse roles which mainly involve working in a care home setting involved a greater emphasis on improved health outcomes which might result from changes to care practices, such as reduced rates of infection.

Similarly, reduced unnecessary admissions to secondary care and more efficient care coordination emerged as key intended outcomes for all three roles. However, the emphasis on additional intended outcomes for the use of health and social care services varied across the roles. For instance, appropriate reductions in GP time required to support frail older people was highlighted as a particularly important intended outcome for the practice frailty nurse role, although this was also referenced in relation to other roles.

An additional objective which is specific to the older person nurse specialist role is the delivery of training and support to care home staff to promote improved knowledge and skills, and therefore improved care practices. This is identified in the job description for the older person nurse specialist role in both Gateshead and Newcastle and was underlined as a key aim of the role in the focus groups with older person nurse specialists. This objective does not relate to the direct delivery of case management for frail older people, but activity linked to this objective has the capacity to contribute to the achievement of some of the same intended outcomes.

3.6 Development of case management approaches

Case management is outlined as one of three key elements of a needs-based approach to care delivery (alongside assessment, care and support planning; and self-care and self-management), which is defined as a core element of the Enhanced Health in Care Homes model in Newcastle Gateshead.

The historical development of the case management approaches for each of the three roles has differed considerably. To some extent, this has taken place organically as a result of particular pilots and initiatives, rather than being part of a systematic approach to introduce improved case management approaches for all older people, including those who are frail. While the role of the community matron has been in operation across Newcastle Gateshead since 2005-06, the older person nurse specialist and practice frailty nurse role have been introduced in the past four years.

3.6.1 Community matron

Stakeholders reported that the community matron role was established in 2005-06 in Newcastle Gateshead. This coincided with a national move towards introducing the role. It was originally an H grade nursing post (prior to the current NHS bands under the Agenda for Change) and was targeted to people who lived

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19 Newcastle Gateshead CCG. Newcastle Gateshead’s Vanguard (Enhanced Health in Care Homes) Value Proposition 2016-17.
in their own homes, and especially those with long-term conditions\(^{20}\) and complex needs. Stakeholders indicated that the target audience for the role was never formally altered to include frail older people but that over the course of delivering the service community matrons had begun to take referrals for frail patients (who did not necessarily have a long-term condition).

3.6.2 Older person nurse specialist

Stakeholder consultation and the internal evaluation of the older person nurse specialist role was piloted in Gateshead in 2009-10\(^{21}\). The pilot was led by South Tyneside NHS Foundation Trust, who were delivering community services in Gateshead at that time. It involved establishing a joint working arrangement between a nurse specialist for older people and a GP with an interest in geriatrics. They worked collaboratively with a proportion of residents in some of the local care homes with nursing beds. Activities delivered under the pilot included weekly ‘ward rounds’ resulting in more proactive care following assessment based on the principles of the Comprehensive Geriatric Assessment and the development of personalised care plans. Proactive care was also improved through regular multi-disciplinary team meetings and family forum meetings.

An internal evaluation of the pilot was carried out and reported that the pilot resulted in an estimated 56% reduction in hospital admissions for the 98 residents who participated in the pilot, when comparing their hospital use data during the pilot period to that in the 12-month period prior to the pilot\(^{22}\).

The OPNS role was introduced formally in Gateshead in 2012 and subsequently introduced in 2016 in Newcastle. Section 4.3.4 below demonstrates that the implementation of the OPNS in Newcastle and Gateshead has differed in terms of team structure. However, the broad aims and objectives of the role are the same in both locations.

3.6.3 Practice frailty nurse

Stakeholder consultation and the internal evaluation of the practice frailty nurse pilot shows that the practice frailty nurse was piloted in a single GP practice (Oxford Terrace) in Gateshead in 2013-14\(^{23}\). During the pilot a specialist nurse for older people was seconded to the GP practice to work with 101 older people with complex needs living in their own homes, sheltered accommodation and assisted living schemes. It predominantly functioned on the basis of referrals to the service from GPs or practice-based nurses, with an element of proactive case finding. An evaluation of the pilot found that the introduction of the role resulted in a 54% reduction in A&E attendances, 54% reduction in hospital admissions and an 81% fall in house call requests for GPs compared to the nine month period prior to the introduction of the role.

\(^{20}\) A glossary of key terms is included at appendix D.

\(^{21}\) NHS South of Tyne and Wear Community Health Services. Supporting Care Homes A Pilot Project August 2009 – August 2010 Final Report.

\(^{22}\) Ibid.

\(^{23}\) Oxford Terrace and Rawling Road Medical Group Frail Elderly Nurse Project Draft Interim Evaluation
In 2015, following the pilot, Oxford Terrace GP practice elected to privately-employ one full-time equivalent (FTE) practice frailty nurse to work with patients in their own homes. They subsequently extended this to include an additional 0.4 FTE role to work with practice-registered residents in Springfield residential home, which is aligned to the GP practice and does not have an allocated older person nurse specialist.

In addition, a further FTE practice frailty nurse has been employed to work at a locality-level in West Gateshead. The locality is covered by three GP practices, which have pooled budgets to employ this practice frailty nurse. Like the FTE practice frailty nurse based in the single GP practice, the nurse works with patients in their own homes.

At the time of this review, the FTE practice frailty nurse based in Oxford Terrace was involved in piloting an extension of the role to cover the three other GP practices in the locality.

A job description for each individual role has not been provided, and therefore it is not clear in this review to what extent the core components of these roles differ.

### 3.7 Definition of frailty

Stakeholder accounts of the development of local case management approaches indicate that a key driver for the newer roles of older person nurse specialist and practice frailty nurse was improving support for older people with multiple and complex needs and shifting the emphasis away from managing health conditions to managing frailty.

However, it was not clear during this review whether a locally-agreed definition of frailty exists. As with the term case management, a consistent definition of frailty would promote shared understanding of the term amongst professionals commissioning and providing services for frail older people. This would help to ensure that it is applied consistently in the development and delivery of systems and services.

**Recommendation:** If a locally-agreed definition of frailty does not already exist, this should be developed. The existing or newly-developed definition should be promoted to all relevant stakeholders and included in all strategic and operational documentation relating to support for frail older people.

There is no set national definition of frailty, however the definition frequently reproduced in NHS documentation is:

24 Feedback on this recommendation from key stakeholders indicates that it is already being taken forward and a definition is being developed via the frailty group.

“Frailty develops as a consequence of age-related decline in multiple body systems, which results in vulnerability to sudden health status changes triggered by minor stress or events such as an infection or a fall at home. People with frailty have a substantially increased risk of falls, disability, long-term care and death.”

Source: NHS England, 2014
Characteristics of teams delivering nurse-led case management approaches in Newcastle Gateshead

4.1 Overview

This chapter presents an overview of some of the key characteristics of the three nurse-led case management roles and approaches which are the focus of this review. The implementation of local case management approaches, including discussion of the key activities delivered in the case management roles, is then considered in more detail in chapter 5.

A note on documentation

The primary documentation available to the review was a role description for each of the roles in both Gateshead and Newcastle. For the older person nurse specialists in both locations and the community matrons in Gateshead this was a formal job description or service specification. For community matrons in Newcastle and the practice frailty nurse it was a less formal role description listing key duties and components of the role.

In addition, the teams delivering the case management roles provided information on team structure and salary bands, as well as a limited amount of activity, output and outcomes data.

The documentation and data did not include full details of the different components of the roles and approaches, and therefore much of this information has been gathered through consultation, including the E-survey, focus groups and interviews.

**Recommendation:** In the future roles, teams and approaches involving case management should be clearly documented to provide clarity for both case managers and wider stakeholders. This includes documenting how the roles and their remits relate to each other to offer a systemic approach case management for older people in Newcastle Gateshead. This will ensure institutional knowledge is maintained with less reliance on personalities.

4.2 Key findings

The main characteristics of the teams delivering the three case management roles in Newcastle Gateshead are summarised in Figure 11.

In comparing these characteristics, key findings that emerge are:

- The cohorts of patients who are eligible for support from each of the three
roles/approaches are relatively distinct but with some small areas of overlap which need to be carefully managed to ensure that the roles work together efficiently to form a case management system.

- There appear to be no detailed, documented eligibility criteria for the majority of case management roles. This makes it difficult to judge the extent to which these are common across different roles. It may also pose challenges for potential referrers to the services in terms of understanding which patients are eligible for referral. The broad eligibility criteria for the roles based in care homes (i.e. being resident in that care home) mean that case managers in these roles have no basis other than their professional judgement on which to prioritise patients and manage demand.

- Up-to-date activity data on patient profile were not available for the case management roles and teams. However, historic data and consultation with stakeholders suggest that co-morbidity and complexity are key reported characteristics of the patients case managed by all three roles. A proportion of staff in all three roles reported that they consider themselves to be case managing some older people who are not frail. Key differences in patient profile include the fact that community matrons work with patients who are aged 18-64 in addition to those aged 65+, and that long-term conditions rather than frailty are often the primary feature in community matrons’ caseloads.

- The teams delivering the three nurse-led case management approaches differ considerably in size, structure and composition. The community matrons and older person nurse specialist teams in both Gateshead and Newcastle are employed by the local hospital trust and are based in the community as a core element of community services. Meanwhile the practice frailty nurses operate only in Gateshead and are employed by the specific GP practices whose patients they support. The decision to employ a practice frailty nurse is at the discretion of the GP practice itself, rather than being mandated by the CCG or any other commissioning body.

- Caseload size is not consistent across the different roles involving case management for older people. Nor is it consistent within the same role.

- Caseloads are conceptualised in different ways within the different roles. For instance, the caseloads older person nurse specialists and the practice frailty nurse working in a care home were described as the number of beds which were covered, whereas the caseloads for community matrons and practice frailty nurses working predominantly in patients’ own homes were described as the number of patients being worked with at any one time.
Figure 11: Overview of nurse-led case management roles

<table>
<thead>
<tr>
<th>Role</th>
<th>Employer</th>
<th>Setting/ Patient cohort</th>
<th>Eligibility criteria</th>
<th>Patient profile</th>
<th>Case load size(^{26})</th>
<th>Team Structure and estimated cost</th>
</tr>
</thead>
</table>
| Gateshead community matron| Gateshead Health NHS Foundation Trust              | Available across Gateshead. Predominantly working with patients living in their own homes. | Individuals aged 18+. Nominally individuals with 2 or more long-term conditions (LTCs), though there is some flexibility on this. Frail older people registered with GP practices without a practice frailty nurse. | Majority of caseload aged 65+ Majority of caseload living in own homes Common presenting issues include:  
  - LTCs such as respiratory disease, heart failure, diabetes, Parkinson’s Disease, cardiovascular disease.  
  - Frailty.  
  - Psychological/mental health issues.  
  - Social needs. | Reported average caseload for FTE nurse was 45-60. Self-reported individual caseloads of between 26 and more than 50.  
  100% of caseload case managed. | 15 FTE Band 7 nurses. Currently undergoing reorganisation. Moving from single team to split locality based teams. | Estimated cost: £543,750 |
| Newcastle community matron | Newcastle Upon Tyne Hospitals Trust                | Available across Newcastle. Predominantly working with patients living in their own homes. | Documented eligibility criteria. Individuals aged 18+ with at least one LTC coupled with an additional issue or concern (see section 4.3.2). | Majority of caseload aged 65+ (at least 70%). Majority of caseload living in own homes (85%). Remainder in care homes (15%). Profile is increasingly complex. Common presenting issues include:  
  - LTCs such as COPD, heart failure, diabetes, neurological conditions. | Combined caseload size of 238 (as at Nov 2017) Self-reported individual caseloads of between 30 and 78. (Varies by nurse due to work patterns and level of experience).  
  100% of caseload case managed. | 3.9 FTE Band 7 nurses. (5 team members in total) | Aligned to the community nursing clusters. | Estimated cost: £141,375 |

\(^{26}\) The reasons for different sources of data on caseload size are discussed in section 4.3.5
<table>
<thead>
<tr>
<th>Role</th>
<th>Employer</th>
<th>Setting/ Patient cohort</th>
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<th>Case load size</th>
<th>Team Structure and estimated cost</th>
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<tbody>
<tr>
<td><strong>Gateshead older person nurse specialist</strong></td>
<td>Gateshead Health NHS Foundation Trust</td>
<td>Available to all residents in all older people’s care homes with nursing beds and two residential homes in Gateshead. Covering: 19 (61%) of 31 older people’s care homes 1158 (70%) of a total 1663 older people’s care home beds in Gateshead.</td>
<td>Residents of linked care homes</td>
<td>Varies between care homes. All patients are aged 65+. Common presenting issues include: Frailty. LTCs. Deterioration in health and well-being. Dementia-related mental health issues and behaviour that challenges. Frequent/recent hospital admissions. Infections.</td>
<td>26</td>
<td>8 FTE Band 7 nurses. 9 team members in total Estimated cost: £290,000</td>
</tr>
<tr>
<td>Role</td>
<td>Employer</td>
<td>Setting/ Patient cohort</td>
<td>Eligibility criteria</td>
<td>Patient profile</td>
<td>Case load size</td>
<td>Team Structure and estimated cost</td>
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<tr>
<td>Newcastle older person nurse specialist</td>
<td>Newcastle Upon Tyne Hospitals Trust</td>
<td>Available to all residents in 23 of 28 nursing or dual-registered older people’s care homes in Newcastle. Covering: 23 (85%) of 27 older people’s care homes with nursing beds 1235 (87%) of total 1423 beds in older people’s nursing or dual-registered homes.</td>
<td>Residents of linked care homes</td>
<td>Varies between care homes. All patients are aged 65+. Common presenting issues include: Frailty. LTCs. Degenerative conditions. Dementia-related mental health issues and behaviour that challenges. Frequent/recent falls. Infections. Pressure sores.</td>
<td>26</td>
<td>1 FTE Band 7 Team Leader 8.8 FTE Band 6 nurses (13 team members in total). Nurses are aligned to specific care homes. Older person nurse specialists sit within the specialist care home support team, which also includes 0.8 FTE occupational therapist and 0.8 FTE palliative care nurse. Estimated cost: £303,392</td>
</tr>
<tr>
<td>Practice frailty nurse (Gateshead only)</td>
<td>GP practices in Gateshead</td>
<td>Available to patients registered with specific Gateshead GP practices which have employed a practice frailty nurse.</td>
<td>For patients living in their own homes, patients identified as moderately or severely frail. All residents in Springfield care home who are registered with Oxford Terrace GP practice.</td>
<td>For patients living in their own homes, common presenting issues include: Frequent or recent falls Respiratory and cardiac issues. Social isolation. In Springfield care home, average patient is aged 90+. Common presenting issues include:</td>
<td>Varies for each Practice Frailty Nurse. For nurse in Springfield care home, 49 residents are currently registered with Oxford Terrace GP practice. Nurse does not actively case manage all residents at any one time. For nurse at Oxford</td>
<td>Oxford Terrace GP Practice: 1.0 FTE Band 7 nurse covering patients in their own homes and 0.4 FTE Band 7 nurse covering Springfield care home. West Gateshead</td>
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<td>Role</td>
<td>Employer</td>
<td>Setting/ Patient cohort</td>
<td>Eligibility criteria</td>
<td>Patient profile</td>
<td>Case load size(^{26})</td>
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<td></td>
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<td></td>
<td>• Acute health problems, such as chest infections and UTIs.</td>
<td>Terrace working with patients in own home, patients are drawn from practice frailty register of approx. 220 people. Nurse does not consider herself to have a consistent caseload or to be actively case managing the majority of these patients at any one time. The nurse in West Gateshead locality has a caseload of 80-90 but it is not clear how many are case managed</td>
<td>locality: 1.0 FTE Band 7 nurse aligned to 3 GP practices and covering patients in their own homes.</td>
<td>Estimated cost: £87,000</td>
</tr>
</tbody>
</table>
4.3 **Summary comparison**

This section summarises key points for comparison between the teams delivering the three case management roles on which the review focuses.

4.3.1 **Patient cohorts**

Evidence from documentation and consultation suggests that the cohorts of patients who are eligible for support from each of the three roles/approaches are relatively distinct but with some small areas of overlap. 

**Community matrons**

Community matrons in both Newcastle and Gateshead work predominantly with adults living in their own homes (as opposed to care homes). However, the community matrons in Newcastle reported that 15% of their patients live in care homes. These are predominantly patients in residential care homes (which do not have an allocated older person nurse specialist). However, in some cases patients moving into homes with nursing beds might be kept on the community matron caseload to support their transition into the care home. Similarly, the community matrons in Gateshead highlighted that patients who were working with them at the time they moved into care homes might be retained on the caseload temporarily to support transition.

In Newcastle community matrons are aligned to the community nursing clusters which cover West, Central and East Newcastle. They are allocated patients based on the GP practice with which the patient is registered. In Gateshead, the team is currently undergoing reorganisation and is moving from a single team to a number of locality-based teams.

**Older person nurse specialists**

Older person nurse specialists in both Newcastle and Gateshead work exclusively with residents of older people’s care homes and are primarily aligned to homes which have nursing beds (either nursing homes or mixed nursing and residential homes). At the time of this review:

- 23 (85%) of the 28 older people’s care homes with nursing beds in Newcastle had an allocated older person nurse specialist. This amounts to 1,235 (87%) of total 1,423 beds in older people’s nursing or mixed homes. One home has opted out of the service, and there are plans to allocate a nurse to at least one further home in 2018.

- All 17 (100%) of the older people’s care homes with nursing beds in Gateshead had an allocated older person nurse specialist. In addition, two

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27 There was a variable level of documentary evidence available regarding which cohorts and/or localities are covered by staff in each of the three case management roles. This section therefore draws evidence from consultation with stakeholders, and especially staff in the case management roles.

28 The independent evaluation team is not aware of the reason(s) why the home opted out.
residential care homes had an allocated older person nurse specialist. This amounts to 19 (61%) of the 31 older people’s care homes or 1,158 (70%) of a total 1,663 older people’s care home beds in Gateshead.

*Practice frailty nurses*

At present, practice frailty nurses operate only in Gateshead. They are employed directly by GP practices who have chosen to use their budget for supporting patients aged 75+ to fund practice frailty nurse posts. Each of the three practice frailty nurses has a specific cohort of patients, which does not overlap. This can be summarised as follows:

- Two practice frailty nurses work with patients registered at Oxford Terrace and Rawling Road Medical Group GP practice.
  - One nurse works only with practice-registered residents in Springfield care home, which is aligned to the GP practice.
  - One nurse works with patients living in their own homes and residents of other residential care homes, which are not aligned to the GP practice.
- One practice frailty nurse works with patients who are registered with three GP practices in the West Gateshead locality and who are living in their own homes.

*Areas of overlap*

The main area of overlap exists between the cohorts of the community matrons and the older person nurse specialists. This is because patients who move into care homes and whose cases were previously managed by community matrons in the community are sometimes retained on community matron’s caseloads, at least initially. Whilst this might be helpful in supporting a patient’s transition into the care home and ensuring continuity of care, it did not appear to be clear who was case managing the patient’s care during this transitional period or at what point community matrons would cease to be involved with the patient’s care.

**Recommendation:** A more formalised hand-over period should be agreed and implemented between community matrons and older person nurse specialists for patients moving into care homes with an aligned older person nurse specialist. This should ensure that that handover is timely and structured, and provide patients and professionals with clarity about who is case managing a resident during this settling-in period.

The second area of overlap is between the cohorts of the community matrons in Gateshead and the practice frailty nurses working with patients in their own homes. This only applies to frail patients registered with GP practices which employ a practice frailty nurse, who theoretically fall within the cohorts of both

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29 Two residential only care homes were included as a condition of a GP practice remaining aligned with the home.
services. During the focus group with the community matrons in Gateshead it was reported that the limited availability of the practice frailty nurse does create some confusion for referrers, but that this was managed by referrals between the two services.

The limited number of practice frailty nurse posts and the fact that they are linked to specific GP practices whereas potential refers are likely either to be covering either the whole of Gateshead or to be locality-based does pose a challenge in ensuring that referrers understand the role and remit of practice frailty nurses and which GP practices they cover. It also poses a challenge in supporting referrers to retain this information on an ongoing basis, in light of the fact that they may not regularly encounter patients who would be eligible to work with one of the practice frailty nurses.

4.3.2 Eligibility criteria

The only case management role for which documented eligibility criteria was provided for this review was community matrons in Newcastle. However, consultation with staff in the different case management roles indicated that there are also eligibility criteria for the community matrons in Gateshead and for the practice frailty nurses working with patients in their own homes.

For the older person nurse specialists and practice frailty nurse working in care homes, there appear to be no specific eligibility criteria beyond being resident in an aligned care home (and, in the case of the practice frailty nurse working in a care home, being registered with the aligned GP practice).

This makes it difficult to judge the extent to which these are common across different roles. It may also pose challenges for potential referrers to the services in terms of understanding which patients are eligible for referral. The broad eligibility criteria for the roles based in care homes (i.e. being resident in that care home) mean that case managers in these roles have no basis other than their professional judgement on which to prioritise patients and manage demand.

Community matrons

The eligibility criteria for community matrons in Newcastle are presented in Figure 12. The service will accept referrals for all patients who meet at least one criteria in column 1 and one criteria in column 2. However, the inclusion of “other” in column 1 is potentially problematic as this is open to interpretation by referrers. This could mean that patients meeting only one of the criteria in column 2 and one “other” presenting issue which does not meet the threshold for acceptance to the service might be referred to the service. The only exclusion criteria are that the service does not accept referrals for patients with urgent medical needs, acute mental health needs, primary alcohol or drug addiction.
Figure 12: Eligibility criteria for Newcastle community matron

<table>
<thead>
<tr>
<th>Column 1</th>
<th>Column 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>COPD</td>
<td>Poor understanding of their condition</td>
</tr>
<tr>
<td>Unplanned hospital admission for chronic disease</td>
<td>Frequent attendance at emergency department</td>
</tr>
<tr>
<td>Asthma</td>
<td>Poor adherence to prescription/multiply medication</td>
</tr>
<tr>
<td>Heart Failure</td>
<td>LTC (from column 1) with depression/anxiety</td>
</tr>
<tr>
<td>Coronary Heart Disease</td>
<td>Frequent attender at GP or Health Service Provider</td>
</tr>
<tr>
<td>Diabetes – Type 1</td>
<td>Poor health but scope to improve with lifestyle change (not at end of life)</td>
</tr>
<tr>
<td>Diabetes – Type 2</td>
<td></td>
</tr>
<tr>
<td>Osteoporosis</td>
<td>Social isolation</td>
</tr>
<tr>
<td>Neurological conditions</td>
<td>Nutritional/dietary concerns</td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>

During consultation with community matrons in Gateshead, they indicated that there are not strict eligibility criteria for the service. However, the service generally aims to work with patients who have two or more LTCs. If patients are registered with a GP practice which does not employ a practice frailty nurse, they will also take referrals where frailty is the primary concern.

**Older person nurse specialists**

No specific eligibility criteria were documented or reported by stakeholders. Stakeholders indicated that all residents in care homes with an aligned older nurse specialist were eligible for case management by an older person nurse specialist.

**Practice frailty nurses**

The practice frailty nurse based at Oxford Terrace and Rawling Road Medical Group and working with patients in their own homes works with patients who receive a score on EMIS\(^3\) that indicates moderate or severe frailty.

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\(^3\) The primary care clinical system used by GP practices in Gateshead.
Recommendation: Commissioners and providers should review the eligibility criteria for patients to receive support from the different case management roles and develop formal eligibility criteria for all roles. These should be clear and accessible to all staff delivering case management and to all potential referrers, as well as to strategic and operational managers and to commissioners. When developing the criteria, it will be important to consider how the different roles interact to create a local system of case management, and whether this can be further supported and clarified by ensuring effective eligibility criteria.

It is recognised that criteria which are too stringent could preclude the referral of patients who would benefit from case management. In order to mitigate against this, it is recommended that the criteria are developed on the basis of the knowledge and experience of staff working in the case management roles and other stakeholders who have insight into:

- The characteristics and circumstances of patients most frequently referred to the case management roles currently.
- The characteristics and circumstances of those who most benefit from case management.
- The intended outcomes of case management for patients and the health and social care system.

It is also recommended that the criteria are reviewed periodically in order to check that they are still appropriate.

4.3.3 Patient profile

Activity data on the profile of patients currently being case managed by each role was not available during this review. However, historic data on the profile of patients case managed by pilot projects for the older person nurse specialist and practice frailty nurse in Gateshead was available. For all roles, information about patient profile was captured via consultation with case managers and wider stakeholders. However, this is no substitute for reliable, valid and accurate monitoring data.

Co-morbidity and complexity are key reported characteristics of the patients case managed by all three roles. A proportion of staff in all three roles reported that they consider themselves to be case Managing some older people who are not frail. However, it is not known whether this assessment was based on an objective measure of frailty, such as the Rockwood scale, or on the case managers’ subjective judgement based on their clinical expertise.

There is some variation in the profiles of patients working with staff in the different roles. Equally, there appear to be differences in the profile of patients being case managed by the same role in Gateshead and Newcastle. Key differences include the fact that community matrons work with patients who are aged 18-64 in
addition to those aged 65+, and that long-term conditions rather than frailty are often the primary feature in community matrons’ caseloads.

The patient profile for each role is summarised below.

Community matrons

Gateshead

During the focus group with community matrons in Gateshead staff reported that at least 90% of their caseload are aged 65+ and that this has stayed largely constant since the team was first implemented. They also reported that the majority of patients are living in their own homes. Common presenting issues highlighted by community matrons in both the focus groups and the E-survey included:

- LTCs such as respiratory disease, heart failure, Parkinson’s Disease, cardiovascular disease and diabetes.
- Frailty.
- Recent or regular falls.
- Psychological/mental health issues.
- Social needs.

5 of 12 community matrons in Gateshead who responded to the E-survey reported that they worked with patients aged 65+ who are not frail.

Newcastle

Case managers and wider stakeholders reported that there is variation in the typical profile of community matrons’ patients across Newcastle, driven by differing levels of deprivation in different localities.

Common presenting issues highlighted by community matrons in both the focus group and the E-survey included:

- Frequent hospital attendance.
- LTCs such as COPD, heart failure, diabetes and neurological conditions.
- Co-morbidities.
- Frailty.

Newcastle community matrons who took part in the focus group reported that the profile of patients on their caseloads is increasingly complex. They also stated that following change to their referral criteria to include all adults aged 18+ and moving to a fixed referral criteria they are working with more patients whose
predominant needs are around neurological conditions, heart failure, diabetes and social isolation.

Both of the community matrons in Newcastle who responded to the E-survey reported that they work with patients aged 65+ who are not frail.

**Older person nurse specialists**

During focus groups with older person nurse specialists in both Gateshead and Newcastle it was highlighted that the profile of patients being case managed depends on the nature of the particular care home to which individual older person nurse specialists are aligned. For example, in Newcastle it was highlighted that there are specialist mental health nursing homes which therefore include more residents with advanced dementia than other homes.

The internal evaluation of the Gateshead pilot of the older person nurse specialist role in 2009-10\(^\text{31}\) reported that the average age of residents’ case managed during the pilot was 85 and that the average number of co-morbidities per patient was five. It also reported that 74% of patients has been in hospital in the 12 months prior to the nurse’s involvement. However, the extent to which this profile is reflective of the current caseloads of the older person nurse specialists in Gateshead or Newcastle is not known.

Common presenting issues in the current caseloads, as highlighted by older person nurse specialists in the focus groups, include:

- Frailty.
- LTCs.
- Degenerative conditions.
- Deterioration in health and well-being.
- Dementia-related mental health issues and behaviour that challenges.
- Frequent/recent falls.
- Frequent/recent hospital admissions.
- Infections.
- Pressure sores.

---

1 of the 2 older person nurse specialists in Gateshead who responded to the E-survey reported that they work with patients aged 65+ who are not frail\(^{32}\).

**Practice frailty nurses**

During the focus group with practice frailty nurses they reported that for practice frailty nurse patients living in their own homes, common presenting issues include:

- Frequent or recent falls
- Respiratory and cardiac issues.
- Social isolation.

For residents in Springfield care home who are working with the practice frailty nurse the most common presenting issue was highlighted as acute health problems, such as chest infections and UTIs.

In an internal interim evaluation of the pilot, produced in June 2014\(^{33}\), it was reported that the average age of patients supported by the practice frailty nurse was 85. However, it is not known whether this reflects the average age of patients working with the service following the pilot period. The practice frailty nurse working into Springfield care home reported that the average age of residents in the home is at least 90.

Further evidence from the internal interim evaluation of the pilot indicated that the most frequent referrals were made to the occupational therapy (OT) and physiotherapy services, suggesting significant levels of mobility problems in the cohort. Again, it is unclear to what extent this is mirrored in the post-pilot caseloads.

Both practice frailty nurses who responded to the E-survey reported that they work with patients aged 65+ who are not frail.

### 4.3.4 Team structures

The teams delivering the three nurse-led case management approaches differ considerably in size, structure and composition. The community matrons and older person nurse specialists in both Gateshead and Newcastle constitute teams whose staff are employed by the local hospital trust and are based in the community as a core element of community services.

Meanwhile the practice frailty nurses operate only in Gateshead and are employed by the specific GP practices whose patients they support. The decision to employ a practice frailty nurse is at the discretion of the GP practice itself, rather than being mandated by the CCG or any other commissioning body.

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\(^{32}\) No older person nurse specialists in Newcastle responded to the E-survey.

\(^{33}\) Oxford Terrace and Rawling Road Medical Group Frail Elderly Nurse Project Draft Interim Evaluation.
The team structures are summarised in Figure 13. Yearly cost estimates for the teams have also been provided. These estimates are likely to be conservative as they do not include costs of any administration support and also management support and oversight. It should be noted that these estimates could not be contextualised by relative caseload size due to the challenges outlined in section 4.3.5.
### Figure 13: Team structures for the nurse-led case management roles

<table>
<thead>
<tr>
<th>Role</th>
<th>Size</th>
<th>Employer</th>
<th>Salary band(s) and annual team cost estimate[^34]</th>
<th>Structure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gateshead community matron</td>
<td>15 FTE nurses[^35]</td>
<td>Gateshead Health NHS Foundation Trust</td>
<td>15 FTE Band 7</td>
<td>£543,750</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Currently undergoing reorganisation.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Moving from single team to split locality-based teams.</td>
</tr>
<tr>
<td>Newcastle community matron</td>
<td>3.9 FTE nurses (5 staff in total)</td>
<td>Newcastle Upon Tyne Hospitals Trust</td>
<td>3.9 FTE Band 7</td>
<td>£141,375</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Aligned to the community nursing clusters in West, Central and East Newcastle.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Team base in Westgate College.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Team supported by 1.6 WTE Band 3 healthcare assistants.</td>
</tr>
<tr>
<td>Gateshead older person nurse specialist</td>
<td>8 FTE nurses (9 staff in total)</td>
<td>Gateshead Health NHS Foundation Trust</td>
<td>8 FTE Band 7</td>
<td>£290,000</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Nurses are aligned to specific care homes.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Team base at Bensham hospital.</td>
</tr>
<tr>
<td>Newcastle older person nurse</td>
<td>9.8 FTE nurses (13 staff in total)</td>
<td>Newcastle Upon Tyne Hospitals Trust</td>
<td>1 FTE Band 7, 8.8 FTE Band 6</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Nurses are aligned to specific care homes.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Older person nurse specialists sit within the specialist care home support team, which also includes 0.8 FTE</td>
</tr>
</tbody>
</table>

[^34]: Royal College of Nursing (2016) Pay scales for NHS nursing staff in England, Wales, Scotland and Northern Ireland from 1 April 2016. Available: [https://www.rcn.org.uk/employment-and-pay/nhs-pay-scales-2016-17](https://www.rcn.org.uk/employment-and-pay/nhs-pay-scales-2016-17). For the purposes of this calculation, salary costs have been calculated only for staff in the case management role itself (i.e. not including other supporting team members). Mid-salary band estimates have been used for the calculations. Mid Band 7 salary = £36,250. Mid Band 6 salary = £30,357.

[^35]: As at November 2017, 1 FTE post was vacant. Previously there was also an additional FTE safe care lead position but this remains vacant at present as a result of service reorganisation.
<table>
<thead>
<tr>
<th>Role</th>
<th>Size</th>
<th>Employer</th>
<th>Salary band(s) and annual team cost estimate[^34]</th>
<th>Structure</th>
</tr>
</thead>
<tbody>
<tr>
<td>specialist</td>
<td></td>
<td></td>
<td>£303,392</td>
<td>occupational therapist and 0.8 FTE palliative care nurse.</td>
</tr>
<tr>
<td>Practice frailty nurse</td>
<td>2.4 FTE nurses</td>
<td>GP practices in Gateshead</td>
<td>2.4 FTE Band 7</td>
<td>• Oxford Terrace GP Practice: 1.0 FTE Band 7 nurse covering patients in their own homes and 0.4 FTE Band 7 nurse covering Springfield care home.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>£87,000</td>
<td>• West Gateshead locality: 1.0 FTE Band 7 nurse aligned to 3 GP practices and covering patients in their own homes.</td>
</tr>
</tbody>
</table>
4.3.5 Size of case manager caseloads

Challenges in estimating caseload size and proportion of caseload case managed

During this review it was difficult to establish accurate and comparable evidence on the size of case manager caseloads, and the proportion of caseloads which were being actively case managed. There were a number of reasons for this:

- Activity data on the overall caseload size for the teams were not available for the majority of roles. Proxy data used for this was not comparable across roles.
- Activity data on the average length of time for which patients are case managed and/or held on the caseload were also not available for any of the teams.
- Self-reported estimates of caseload size and the proportion of caseload being case managed for staff in different teams were not consistent across the focus group and E-survey responses from staff in that role.
- Not all staff members in each team participated in consultation so individual staff members’ self-reported caseload sizes cannot be summed to determine the overall caseload size for each team.

Estimates of caseload size per FTE staff member in each role, as well as the proportion of caseload being case managed have been calculated on the basis of the most reliable available data for each role. These are summarised in Figure 14, which indicates the source of the data. Figure 14 also includes commentary on length of time patients are likely to remain on caseloads, and what proportion of patients on caseloads might be case managed at any one time.

The first key finding illustrated by these data is that caseload size is not consistent across these different roles involving case management for frail older people. For example, whilst community matrons work with an average of 61 or fewer patients, older person nurse specialists can work with an average of up to 145 patients, more than twice as many as the community matrons. These caseload sizes may not be directly comparable due to the difference between case managing patients in their own homes (requiring additional travel and possibly a wider range of partnerships with other local services) and case managing a number of patients based in the same care home.

However, it is certainly reasonable to compare the caseload sizes of staff members within the same role. Here there is substantial variation within the role of older person nurse specialist, where the smallest caseload size is 39 care home beds and the largest is 220 care home beds. Some of this variation is explained by the number of hours worked by individual staff members, by their level of experience, and by the complexity of work with particular care homes and/or GP practices.

Both case managers and wider stakeholders indicated that it would be beneficial to move towards more consistent caseload sizes within the same role in the
future, as part of ensuring that the roles are delivered in a high-quality, consistent and standardised way by all staff members working in them. Standardisation is discussed in more detail in section 5.9.

Equally, a minority of case managers and wider stakeholders suggested that caseload complexity might be different for staff members working in the same role, as a result of patient profiles in different localities and care homes. They reported that this complexity should be taken into account when allocating caseloads.

A minority of stakeholders also reported that caseload size should be equitable across the different case management roles, assuming that the expected outputs, impacts and outcomes for different case managers are similar.

**Recommendation:** Those responsible for the allocation of caseloads ensure that the caseload size for individual case managers in the same role is as equitable as possible, taking into account the number of hours worked by each staff member. The rationale for any differences in caseload size should be clearly articulated to all staff members.

A further finding emerging from this data is that caseloads are conceptualised in different ways within the different roles. For instance, the caseloads older person nurse specialists and the practice frailty nurse working in a care home were described as the number of beds which were covered, whereas the caseloads for community matrons and practice frailty nurses working predominantly in patients’ own homes were described as the number of patients being worked with at any one time.

Further differences were evident in the nature of the case management being delivered in the roles and these are discussed in chapter 5.
### Figure 14: Caseload and case management estimates for nurse-led case management roles

<table>
<thead>
<tr>
<th>Role</th>
<th>Caseload size per FTE role</th>
<th>Caseload range</th>
<th>Time on caseload</th>
<th>Proportion case managed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gateshead community matron</td>
<td>45-60 patients (focus group data)</td>
<td>26- &gt;50 (E-survey data)</td>
<td>Ranges depending on patient needs. Can involve more intensive, shorter term interventions and subsequent discharge or transfer to another service. However, can also involve longer-term ongoing support to patients, who remain on the caseload for a prolonged period of time.</td>
<td>75% - 100%³⁷.</td>
</tr>
<tr>
<td>Newcastle community matron</td>
<td>61 patients (activity data)</td>
<td>40-78 patients (focus group data)</td>
<td>Ranges depending on patient needs. Can involve more intensive, shorter term interventions and subsequent discharge or transfer to another service. However, can also involve longer-term ongoing support to patients, who remain on the caseload for a prolonged period of time.</td>
<td>100%³⁸.</td>
</tr>
<tr>
<td>Gateshead older person nurse specialist</td>
<td>145 care home beds (alignment data)</td>
<td>60-220 care home beds (alignment data)</td>
<td>Residents are nominally on caseload from moving into care home until death or transfer to another place of residence (focus group/interview data). Average length of stay in a care home is 24 months³⁹.</td>
<td>100%⁴⁰.</td>
</tr>
</tbody>
</table>

³⁶ The reasons for different sources of data on caseload size are discussed below.
³⁷ Focus group participants reported that team case manages all patients on caseload. 6 (55%) of 11 Gateshead community matrons responding to the E-survey indicated that they case manage more than 75% but less than all of their caseload. 5 (45%) of 11 indicated that they case manage all of their caseload.
³⁸ Focus group participants reported that team case manages all patients on caseload. Only 1 Newcastle community matron responded to this question in the E-survey and also indicated that they case manage all of their caseload.
⁴⁰ Focus group participants reported that team case manages all patients on caseload. Both (100%) Gateshead older person nurse specialists responding to the E-survey indicated that they case manage all of their caseload.
<table>
<thead>
<tr>
<th>Role</th>
<th>Caseload size per FTE role</th>
<th>Caseload range</th>
<th>Time on caseload</th>
<th>Proportion case managed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newcastle older person nurse specialist</td>
<td>126 care home beds (alignment data)</td>
<td>39-211 care home beds (alignment data)</td>
<td>Residents are nominally on caseload from moving into care home until death or transfer to another place of residence (focus group/interview data). Average length of stay in a care home is 24 months(^{41})</td>
<td>Focus group participants indicated that they do not consider themselves to be case managers because they consider nursing home staff to be managing patients’ care.</td>
</tr>
<tr>
<td>Practice frailty nurse</td>
<td>Average not calculated: roles cover different cohorts</td>
<td>49 care home beds-220 eligible patients(^{42}) (focus group data)</td>
<td>Varies for the different practice frailty nurse posts. The practice frailty nurse working into Springfield care home can hold patients on the caseload from moving into the care home until death or transfer to another place of residence. The other practice frailty nurse based at Oxford Terrace conducts shorter-term, intensive work and then discharges patients from the caseload. The practice frailty nurse in West Gateshead conducts shorter-term, intensive work but then retains patients on her caseload for review.</td>
<td>Varies for different practice frailty nurse posts. The practice frailty nurse working into Springfield considers that they deliver some ongoing case management functions but is more often delivering intensive and reactive support to those with acute needs. The other practice frailty nurse at Oxford Terrace reported that they are case managing all</td>
</tr>
</tbody>
</table>

\(^{42}\) Please note: these caseload sizes are not directly comparable. The caseload of 49 is for the nurse based at Oxford Terrace and Rawling Road Medical Group and is the number of beds aligned to the GP practice as at November 2017. The caseload of 220 is for the nurse based at Oxford Terrace and Rawling Road Medical Group and working with patients in their own homes. It is the total number of patients on the practice register who are moderately or severely frail and therefore eligible for the service, but the nurse reported that she considers only those patients she is working with at any one time to be on her current caseload. The reported caseload for the practice frailty nurse covering West Gateshead was 80-90 as at November 2017 but this was not verified directly with this nurse, who was unable to take part in the consultation for this review.
It is not known what proportion of the West Gateshead practice frailty nurse is case managed by the practice frailty nurse, because this nurse was unable to take part in the consultation for this review.

<table>
<thead>
<tr>
<th>Role</th>
<th>Caseload size per FTE role</th>
<th>Caseload range</th>
<th>Time on caseload</th>
<th>Proportion case managed</th>
</tr>
</thead>
</table>

\[43\] It is not known what proportion of the West Gateshead practice frailty nurse is case managed by the practice frailty nurse, because this nurse was unable to take part in the consultation for this review.
5 Implementation of case management approaches

5.1 Overview

This chapter presents findings on the implementation of case management approaches for frail older people. It considers the key activities and functions of the three case management roles which are the focus of this review, and the extent to which these vary across the roles, in order to present an understanding of the local approach to case management for older people. It also presents findings from consultation on the clarity of case management allocation and the efficacy of partnership working, as well as the consistency of case management approaches and the approaches taken to performance monitoring.

5.2 Key findings

Consultation with case managers suggested that the way they view their own case management responsibility varies across roles; some roles believed themselves to be case managing all patients on their caseload, whereas other roles reported that they do not necessarily view themselves as case managers at all.

No outline of the core expected activities of case managers for older people in Newcastle Gateshead was evident in the documentation provided to the independent evaluation team for this review. However, the key activities reported by stakeholders as important to the roles and to case management were broadly consistent and could potentially be used as a basis for developing a model for local case management approaches. These can be categorised into the four stages of: (1) comprehensive assessment; (2) care planning and coordination; (3) delivery of care; and (4) monitoring and review.

There is one important function of the older person nurse specialist role in both Gateshead and Newcastle which is not directly connected to the case management of individual care home residents. This is training and support for care home staff. Whilst this was viewed as important by older person nurse specialists in both locations, it was outlined as a more significant component of the role by staff working in Newcastle.

Staff from each case management role reported that the time input required for the case management of patients varied significantly from patient to patient and also during different stages of work with individual patients. However, patients tended to fall into one of two broad categories: those requiring intensive support for a period of time, and those requiring lighter touch monitoring and review.

There is evidence from this review that the clarity of case management allocation for frail older people in Newcastle Gateshead could be strengthened. A minority of consulted staff in case management roles and wider stakeholders...
indicated that it is not always clear to them who is case managing a patient, or who should be.

Consultation with staff in case management roles and wider stakeholders suggested that partnership work with a range of services was improved by the existence of the case management roles, which have a clear focus on coordinating care through close communication with the different services involved in a patient’s care. The main groups of professionals with whom case managers reported experiencing challenges in partnership working were: secondary care staff, district nurses, care home staff and GPs.

There appears to be significant consistency in case management approaches across the three roles which are the focus of this review. However, a minority of consulted staff in case management roles and wider stakeholders reported that the approach taken by different staff members working in the same role may vary due to the different backgrounds, knowledge, skills and confidence levels of individual staff members.

The documentary evidence and consultation identified areas for improvement in the performance monitoring of case management approaches for older people. These are addressed in chapter 6.

5.3 Understanding of case management responsibility

Consultation with case managers suggested that the way they view their own case management responsibility varies across roles. In particular, the older person nurse specialists in Gateshead and the community matrons in both locations tended to report that they held case management responsibility for anyone on their caseload. On the other hand, the older person nurse specialists in Newcastle did not tend to view themselves as case managers, although they described elements of case management which they were delivering (such as comprehensive assessment and review). There was no consensus amongst the consulted practice frailty nurses about their level of case management responsibility, which may in part be explained by the different settings in which their patients are based.

Recommendation: For each role, the extent to which case management responsibility corresponds to caseload should be clarified. This should be clear to staff in the case management roles, and to other professionals working with them. If staff in these roles do not hold case management responsibility for any proportion of patients on their caseload who require case management then alternative case management arrangements should be in place and clear to all stakeholders.

5.4 Key activities of case management approaches

No outline of the core expected activities of case managers for older people in Newcastle Gateshead was evident in the documentation provided to the
independent evaluation team for this review. A range of activities relating to case management were referenced in the role descriptions and a number of these were common across the majority or all of the different roles. In addition, consultation with case managers and wider stakeholders about the key activities involved in their role and the key components of case management indicated that stakeholders generally have a similar understanding of the key components constituting a case management approach. This has been used to develop a suggested model for case management approaches currently delivered in Newcastle Gateshead. Figure 15 presents this model, which is divided into four key stages, each of which is discussed in more detail in sections 5.4.1 to 5.4.4.

**Recommendation:** Commissioners and providers should agree and document a local approach to case management for older people. This approach should be built-in to all roles and services involving case management. Again, this would contribute to a common vision of case management. It would also help to ensure that case management is being delivered consistently within and between different roles and teams. The approach could draw on evidence of the common understanding of case management approaches by local stakeholders, as identified by this review.
Figure 15: Key activities in nurse-led case management approaches

- Comprehensive assessment
- Risk assessment

- Includes general, anticipatory and emergency care planning
  - Primary contact for patient and family members
  - Leading on referrals and liaison with other services
  - Attendance at MDTs as required
  - Decisions to admit to hospital

- Ordering and interpreting diagnostic tests
- Medication review and prescribing
- Treating wounds and minor ailments
- Organising equipment

- GP-led ward rounds in care homes
- Home visits to patients in own homes
- Follow-up on discharge from hospital
- Comprehensive review every 6 months at a minimum.
5.4.1 Comprehensive assessment

Both the wider stakeholders and the case managers who were consulted as part of this review described comprehensive assessment as the cornerstone of effective case management for frail older people. They indicated that this assessment must be holistic and person-centred, considering a patient’s health, lifestyle, home environment and relationships, as well as how these aspects interrelate.

The assessment was described partly as a process of identifying the needs, circumstances and wishes of a patient, in order to be able to plan care to achieve the best possible outcomes for a patient, in line with their own preferences, and those of their family members where appropriate. It was also understood as a mechanism for identifying those patients who might most benefit from a period of more intensive case management, in order to improve current care and/or the outcomes associated with this.

In focus groups staff in the different roles explained that the comprehensive assessment requires significant face-to-face time with patients and, where appropriate, their family members. Staff who quantified the amount of face-to-face time required for a comprehensive assessment suggested that it takes between 90 minutes and two hours, and that it is important that assessment is carried out over more than one visit with a patient in order to be more confident that it is representative of a patient's usual levels of health, wellbeing and functioning. In addition, staff indicated that the assessment period frequently requires significant follow-up and liaison with other professionals in order to gain an accurate picture of a person's medical history and history of contact with other services.

The review did not find evidence that case managers in different roles were using the same approach or tools for comprehensive assessment. The majority of case managers and wider stakeholders referenced Comprehensive Geriatric Assessment (CGA) and several stated that local approaches are “based on the principles of CGA”. However, it was not clear whether the assessments which are taking place could actually be categorised as CGAs.

The British Geriatric Society defines CGA as⁴⁴:

“The gold standard for the management of frailty in older people is the process of care known as Comprehensive Geriatric Assessment (CGA). It involves an holistic, multidimensional, interdisciplinary assessment of an individual by a number of specialists of many disciplines in older people’s health and has been demonstrated to be associated with improved outcomes in a variety of settings.”

Source: British Geriatrics Society, 2016

Whilst the assessments described by case managers were holistic and multi-dimensional, there was no evidence that they were inter-disciplinary or involved assessment by a number of professionals.

It is likely that CGA is a desirable component of the case management approach because of its association with improved outcomes. It is also likely that the introduction of CGA by case managers and colleagues would require additional resource to be available for this activity, including both additional case manager time per assessment and the allocation of time by other professionals to contribute to this assessment.

**Recommendations:**

Commissioners and providers should collectively review and decide whether CGA should be introduced in lieu of the current approach to comprehensive assessment. If a decision is taken to move from the current comprehensive assessment to CGA, resource implications will need to be addressed.

Whether the assessment is CGA or another form of comprehensive assessment, this should be common across all case management roles. A shared assessment tool should therefore be introduced for all roles and services involving the case management of older people. This would ensure consistency in assessment and also increase the likelihood that assessments performed by one service could be transferred to another service in the event of a patient’s case management being transferred.

### 5.4.2 Care planning and coordination

Care planning and care coordination were highlighted as key facets of local case management approaches by all wider stakeholders and case managers who were consulted as part of this review.

The most frequently referenced types of care planning were:

- **Anticipatory care planning**, to plan for future care resulting from expected changes in health and wellbeing as a result of long-term conditions or chronic health problems.

- **Emergency healthcare planning**, to plan for how care would be delivered in times of crisis or escalating need.

A minority of consulted stakeholders also referred to end of life care planning, including planning for palliative care in a patient’s preferred place of death. Common characteristics across all of these types of care planning were that they constituted proactive case management and maximised the opportunities for consulting patients and family members in advance about their future care.

45 A review of CGA in the community is being prepared by the Cochrane Collaboration. See: http://www.cochrane.org/CD012705/EPOC_comprehensive-geriatric-assessment-community-dwelling-high-risk-frail-older-people
Formal care planning for the delivery of day-to-day care was highlighted less frequently during consultation, but the majority of stakeholders described taking the lead on coordinating care, including referral and liaison with other services and professionals. In addition, a minority of stakeholders described an advocacy role in ensuring that patients who might experience barriers to engaging with other services (such as difficulty in attending appointments at services) received equitable access to services and equitable quality of care.

Care coordination was reportedly achieved through formal referrals and discussion at MDT meetings, such as the Virtual Ward in Gateshead (which is attended by older person nurse specialists in Gateshead and also the practice frailty nurse based at Oxford Terrace GP practice) and working with patients in their own homes. Stakeholders reported that care coordination was also achieved through one-to-one liaison with relevant services, and through seeking informal advice and guidance from other professionals, based on the networks and relationships built up by staff in case management roles.

In addition, staff in all three case management roles reported that they take on an important role as the key contact for patients and family members in relation to a patient’s healthcare.

5.4.3 Delivery of care

The extent to which delivering elements of ongoing care is considered as a key case management activity appears to vary across the three different case management roles considered here, and across the locations of Gateshead and Newcastle.

Staff in all roles reported that they complete or contribute to a number of tasks relating to ongoing care delivery, several of which might otherwise be undertaken by a patient’s GP. These include ordering and interpreting diagnostic tests, reviewing medication and prescribing. Older person nurse specialists and practice frailty nurses also visit and assess patients who are unwell and would otherwise require a GP visit.

In the older person nurse specialist roles and the practice frailty nurse role working in a care home, there appeared to be a greater emphasis on the delivery of other aspects of care, such as wound dressing and treating minor ailments. However, the extent to which staff in case management roles are required to complete these tasks relates to the confidence and skills of care home staff. This is discussed further in section 5.8.

5.4.4 Monitoring and review

Monitoring and review were identified as a key stage of case management by all stakeholders consulted during this review. The older person nurse specialists, community matrons and the practice frailty nurse working into a care home
reported that planned reviews for all patients on their caseload should take place as a minimum once every six months. They also reported that earlier reviews could be triggered by specific events or episodes, such as discharge from hospital or a deterioration in health and wellbeing. However, staff in roles working into care homes also reported that they are not consistently able to deliver six-monthly reviews for all patients due to the high proportion of their time spent on more intensive, and often reactive care to less stable patients. This raises an important question about the balance of proactive and reactive case management being delivered in the roles, which is considered in more detail in section 5.5.

The mechanisms for ongoing monitoring and review of patients differ across roles. For older person nurse specialists and the practice frailty nurse working in a care home the primary mechanism is weekly ward rounds with the aligned GP practice for the care home. This provides an opportunity to review patients who have recently received additional input from the older person nurse specialist and/or the GP, and also to discuss patients who might require additional input.

In addition to the ward rounds, the older person nurse specialists and one of the practice frailty nurses in Gateshead also attend a weekly Virtual Ward meeting, which is an MDT meeting involving a community geriatrician and old age psychiatrist from Gateshead Health NHS Foundation Trust.

For community matrons and the practice frailty nurses working with patients in their own homes, the primary review mechanism is home visits. Community matrons reported that these would be undertaken at least monthly for patients who are stable, and more frequently for patients currently requiring more intensive support. They also reported that they would complete up to five planned home visits per day, in addition to unplanned visits as required.

5.5 Time spent on case management activities

Staff from each case management role reported that the time input required for the case management of patients varied significantly from patient to patient and also during different stages of work with individual patients. This included both direct face-to-face work with patients and family members and follow-up work, such as referrals and liaison with other professionals.

Following this assessment, patients appeared to fall into two main categories:

- Those requiring intensive support for a period of time because of the complexity of their presentation and/or one or more acute need to be addressed immediately.

The formal review process for the remaining practice frailty nurses was not clearly established during the review. This mechanism is less well embedded in Newcastle than in Gateshead due to a higher proportion of care homes in Gateshead being aligned with GP practices and a higher proportion of residents in care homes in Gateshead being registered with their aligned GP practice.
Those requiring monitoring and 6 monthly review in order to prevent escalation of need and to identify and address any new concerns on a regular basis.

Other factors which were identified during the review consultation as impacting on the time spent on case management of individual patients were:

- The number of patients on the caseload.
- The flow of new patients onto the caseload.
- The levels of complexity across the overall caseload.
- The level of skill and input by other staff members involved with the patient, such as care home nurses and carers, GPs and district nurses.

5.6 **Key functions other than case management**

Almost all of the key day-to-day activities which are reportedly delivered by staff in the three case management roles can be related directly to case management.

However, there is one important function of the older person nurse specialist role in both Gateshead and Newcastle which is not directly connected to the case management of individual care home residents. This is training and support for care home staff. This is included as an objective in the job description for the older person nurse specialists in both locations. It was also described as an important element of the role by consulted staff working in the roles and by wider stakeholders.

In fact, the extent to which the older person nurse specialists considered themselves to be case managers varied in the two locations. The Gateshead older person nurse specialists described the ongoing case management of patients as their primary function, with training and support to care home staff as an important complementary activity. The Newcastle older person nurse specialists, on the other hand, reported that the care home has ultimate responsibility for patients’ care and care coordination and saw the key function of their role as providing support to care home staff to deliver and coordinate this care as effectively as possible.

Detail on the specific training provided to care homes was not provided, but older person nurse specialists stressed that training is delivered to reflect the needs of staff in individual care homes rather than a generic programme of standard training. This reportedly includes more formal training, as well as role modelling by the older person nurse specialists and informal advice and guidance.

**Recommendation:** Commissioners and providers should clarify, agree and document the balance in the older person nurse specialist role between delivering case management activities and delivering training and support to care home staff to support high-quality care and case management.
5.7 Clarity of case management allocation

There is evidence from this review that the clarity of case management allocation for frail older people in Newcastle Gateshead could be strengthened.

The majority of consulted case managers and wider stakeholders described a clear distinction between case management, which they saw as taking the lead in planning and coordinating care, and having a patient on your caseload, which they reported involves delivering specific elements of care. However, a minority of consulted wider stakeholders also indicated that the distinction between case management and holding a patient on your caseload was not always clear to them.

The majority of consulted staff in the three case management roles indicated that it is clear to them who is case managing a patient, or who should be. For example, in the E-survey, 13 (76%) of 17 staff members who responded to the relevant question indicated that it is always clear to them which staff role should be case managing a patient. Similarly, 12 (71%) of 17 staff members indicated that it is always clear to them which staff role is case managing a patient. This is illustrated in Figure 16.

Figure 16: E-survey responses on clarity of case management allocation (n=17)

However, during the focus groups a minority of case managers indicated that it is not always clear to them who is case managing a patient, or who should be. This was echoed by the majority of wider stakeholders who took part in interviews.

The lack of clarity was predominantly attributed to the lack of a shared system across all professionals who might be working with a patient in the community, or to inconsistent use of systems by different organisations. For example, GP practices reportedly take different approaches to recording information about which of their patients are working with a community matron. Whilst some practices put a flag on the system for all patients working with a community
matron, others receive updated lists from the team but do not necessarily transfer this information to their systems. In addition, community matrons in both areas highlighted that not all professionals working with a patient would automatically be notified (e.g. via a shared case management system) that a community matron was working with a patient. They stated that as a result of this the community matron would have to directly contact other professionals involved in a patient’s care to notify them of the community matron involvement.

**Recommendation:** The CCG, local authorities and NHS Trusts should consider how case management responsibility could be recorded on local systems and databases, to ensure that staff in all roles are able to determine whether a patient has a case manager and who this case manager is. This may include flags on a range of systems used by different healthcare professionals. It would need to include guidance on who is responsible for updating the systems with new case manager information, and how regularly.

Consulted stakeholders highlighted a number of other roles in which professionals might be, or consider themselves to be, managing a patient’s case.

The most commonly-highlighted role was that of district nurse. However, all consulted stakeholders who commented on the relationship between district nurses and the three case management roles included in this review indicated that they believed that the district nurse should not be case managing a patient if one of the three roles was involved in their care. The majority saw the district nurses’ role as more task-oriented, so that they were involved with patients in order to deliver specific aspects of their care rather than to plan or manage their overall care.

A minority of stakeholders also identified specialist nursing teams as professionals who might potentially be undertaking case management activities with a patient, or perceive themselves to be managing cases. Examples included Parkinson’s nurses, respiratory nurses and the community stroke rehabilitation team. It was highlighted that these teams work in patients’ own homes and in care homes so had the potential to overlap with all three nurse-led roles on which this review focuses.

In relation to community matrons and practice frailty nurses, one stakeholder indicated that these nurses could case manage for a period of time when a patient needed more intensive or holistic input and then discharge and hand on (or back) to a district or specialist nurse for ongoing case management if complexity was reduced as a result of their input.

A second area of overlap which was highlighted by community matrons in Newcastle was with social workers or Continuing Healthcare case managers, who might also be managing a patient’s case on an ongoing basis or at particular points in time (e.g. during Continuing Healthcare assessment and subsequently care planning).
5.8  **Efficacy of partnership working**

Consultation with case managers and wider stakeholders suggested that professionals in roles involving case management of frail older people work in close partnership with a range of different professionals and services. The majority of consulted stakeholders reported that this partnership work was improved by the existence of the case management roles, which have a clear focus on coordinating care though close communication with the different services involved in a patient’s care. For example, wider stakeholders in GP practices reported that the ease with which they could communicate with other community services was greatly improved by the presence of practice frailty nurses and older person nurse specialists, who had built up relationships with these services over time and could dedicate more time to liaising with them.

Despite the overall positive assessment of partnership working, the review consultation identified a number of challenges to effective partnership working. These are discussed in sections 5.8.1 to 5.8.3.

5.8.1  **Secondary care**

In both Gateshead and Newcastle, a minority of case managers and wider stakeholders reported that partnership work with secondary care services can be a challenge. This was chiefly attributed to:

- Delays in communication from hospitals about planning patients’ discharge from hospital.

- A limited understanding of some hospital-based staff of both community-based case management roles and the services available in the community.

5.8.2  **District nurses**

In Gateshead, focus groups with staff members in all three case management roles operating locally identified that the greatest challenge of effective partnership working is in relation to the district nursing service. Staff in all three roles reported that it was sometimes difficult to refer patients into the district nursing service. It was reported that the district nursing service may not clearly understand the functions of the three case management roles, and that therefore district nurses will ask why the case managers do not carry out the nursing tasks that are referred to the district nursing service.

5.8.3  **Care home staff**

Effective and consistent partnership working with care home staff was highlighted as a challenging area by older person nurse specialists, the practice frailty nurse working in a care home and wider stakeholders commenting on these roles.

First, older person nurse specialists and the practice frailty nurse working in a care home stated that at times care home staff ask or expect those in case management roles to undertake nursing tasks which should in fact be completed by nursing staff in the care home itself. They indicated that this sometimes
resulted from a misunderstanding of the role of the older person nurse specialist/practice frailty nurse and sometimes it stemmed from staff members lacking the confidence or skills to complete these tasks themselves. This was not raised as an issue in Newcastle, and the extent of the issue appeared to vary in Gateshead.

Second, older person nurse specialists and wider stakeholders reported that their regular presence in care homes sometimes enables them to identify safeguarding concerns in these homes. However, the process for reporting these often places them in a compromised position as they seek to maintain strong relations with care staff and fulfil their responsibility to maintain resident welfare.

Third, older person nurse specialists outlined the challenges in supporting care home staff to understand and implement improved practice whilst also maintaining a positive relationship in which care home staff do not feel over-scrutinised or criticised.

5.8.4 GPs

The majority of consulted staff members in case management roles and wider stakeholders reported that partnership working between GPs and the different nurse-led case management roles was generally effective.

However, older person nurse specialists in Newcastle reported that they experience some obstacles to effective partnership work with GPs which stem from the absence of a link GP practice for all care homes and the relatively high numbers of residents in homes with a linked GP who chose to register with alternative GP practices. They indicated that this can lead to variations in the approach to case management, even for patients in the same care home.

Examples provided were that GPs have different views about when EHC plans should be completed and about the frequency with which they choose to conduct rounds in the care home. The link GP for a home will also only attend to their own patients during a ward round, which means that there are significant proportions of patients potentially not receiving weekly/fortnightly input from their GP. As such, there is a clear potential for an inequitable quality of care for patients as a result.

This suggests that partnership working between case managers in care homes and GP practices might be improved by increasing the proportion of care homes with an aligned GP practice, and by encouraging a higher proportion of residents in homes with an aligned GP practice to register with this practice.

**Recommendation:** Information available to professionals who might work alongside case managers should be improved in order to promote better understanding of case management and the specific case management approach.

48 This is not included as a formal recommendation of this review because further research into the levels of GP alignment in Newcastle or the proportions of care home residents registered with the aligned GP practices was outside the scope of this review.
services available. This might include producing clear and succinct leaflets about case management, the case management roles and remits, how they inter-relate and how to refer to them. It might also include ensuring that information about case management approaches and roles is included in workforce development and training. As a promotional tool, case studies could be produced about how case managers have worked with different partners previously to improve outcomes for patients and the system.

5.9 Consistency of case management approaches

5.9.1 Consistency between different roles

As discussed in section 5.3, there appears to be significant consistency in case management approaches across the three roles which are the focus of this review. Differences in approaches between different roles appear to be primarily as a result of either working in different settings or working with different target cohorts. Other differences are a result of organisational or contextual factors such as the proportion of care home residents registered with a care home’s linked GP, or working in a locality instead of a single team.

5.9.2 Consistency within the same role

There is some evidence that the approach taken by different staff members working in the same role may vary. A minority of consulted case managers and wider stakeholders reported that different staff members in the same team take different approaches to case management. These stakeholders attributed differences in approach to the different backgrounds, knowledge, skills and confidence levels of individual staff members. In relation to the older person nurse specialist role, consulted staff and wider stakeholders explained that individual staff members had taken the approach which was most pragmatic given the different care homes and GP practices with which they were working.

The majority of consulted case managers and wider stakeholders stated that they thought standardisation within the same role was desirable. However, one wider stakeholder highlighted that this standardisation is a significant undertaking because it requires strong clinical leadership, the development of professional standards for the roles, as well as wider work to develop and implement a competency framework across the whole system. This latter has reportedly already been started as part of the Enhanced Health in Care Homes Vanguard work in Newcastle Gateshead.

**Recommendation:** The CCG and partners should continue their work to develop and implement a workforce competency framework. This is a good example of local work to produce a system-wide approach to supporting older people through ensuring that professionals are appropriately qualified and that their continuous professional development is promoted. It would support standardisation and the development of transferable skills within and between roles.
5.10 Performance monitoring

The documentary evidence and consultation identified areas for improvement in the performance monitoring of case management approaches for older people. These relate to collating and analysing detailed activity data and evidence of impact for roles involving case management. Suggested improvements to monitoring data are detailed in section 6.5. The issues varied considerably between the different case management roles and are discussed in more detail in sections 5.10.1 to 5.10.3.

5.10.1 Community matrons

Gateshead

Stakeholders reported that the Gateshead community matron service monitors performance through clinical audits, the data for which can be downloaded from EMIS\textsuperscript{49}. They previously submitted data onto the Hydra system to feed into the community dataset, which was hosted with NECS. Stakeholders stated that this reporting mechanism was discontinued due to data being deemed unreliable and unrepresentative of the service. The community matrons suggested that ideally they require monitoring data that has the ability to demonstrate any impact of their work on preventing hospital admissions.

Newcastle

Stakeholders reported that the Newcastle community matron service records activity data using SystmOne\textsuperscript{50}. However, staff suggested that the data may be unreliable because it requires staff members to self-record all contacts. For example, phone calls conducted while matrons are on visits are reportedly not reliably logged. They also suggested that data about the quantity of contacts and the time spent per contact does not reflect the nature of their work well, due to the complexity of their caseloads, time to travel between visits and the level of follow-up often required to meetings.

5.10.2 Older person nurse specialists

Gateshead

Stakeholders reported that the Gateshead older person nurse specialist team monitors performance through clinical audits, the data for which can be downloaded from EMIS\textsuperscript{51}. They previously submitted data onto the Hydra system to feed into the community dataset, which was hosted with NECS. It is unclear in documentary evidence and the focus group evidence what performance monitoring activity is taking place in Gateshead.

Data covering the usage of secondary care services by residents of care homes in Gateshead has been provided to inform this review. However, this data should

\textsuperscript{49} This data was not available for analysis or inclusion in this review.
\textsuperscript{50} This data was not available for analysis or inclusion in this review.
\textsuperscript{51} This data was not available for analysis or inclusion in this review.
be treated with caution because: a) the impact of the OPSN approach for residents might appear diluted when using data for the whole older persons’ care home population; and b) there are challenges in attributing any change in service usage to the older person nurse specialist approach as opposed to other interventions/services. Please see Section 6.4 for an overview of the trends.

Newcastle

The service specification written for the Newcastle OPNS includes in detail what activity and outcome data should be recorded for the service. It includes five outcome measures and four process measures. The full list can be viewed at appendix B. However, during the focus group discussion with staff in the role these were not specifically mentioned. It was not clear during the review whether data against these measures are being collected as specified, who is responsible for collation, whether the data is being systematically analysed and reported back to the team or to other stakeholders.

Additionally, the Newcastle older person nurse specialists also reported concerns around the system which they use themselves to record interactions. They highlighted that the system only allows a maximum of two activities to be recorded per interaction with a patient which they suggested does not reflect the number of activities that may take place per interaction. The system also gives the option to record whether or not the activity will prevent hospital admissions, but the group thought that the system lacked nuance in terms of the recording of the likelihood of an action preventing a hospital admission.

Patient and care home staff feedback was collected in May-June 2016 from 14 care homes working with an older person nurse specialist but there was no evidence that this has been collected since.

5.10.3 Practice frailty nurses

During the pilot of the role, there is evidence of activity and outcomes monitoring via clinical audit. This included data on: the number of patients managed by the service, their place of residence, source of referral into the service, their status at the point of review (i.e. are they still on caseload or the cause of exit), onward referrals, number of A&E attendances, hospital admissions and house call requests. However, stakeholders reported that this monitoring data has not been maintained since the role was introduced permanently at Oxford Terrace and Rawling Road Medical Group practice. During the focus group staff reported that activity data could be accessed through EMIS on request.

52 This data was not available for analysis or inclusion in this review.

53 During consultation some stakeholders reported that the practice frailty nurse working across West Gateshead maintains a database of activity data. However, this could not be verified directly with the nurse, who was unavailable during the consultation period for this review.
6 Impact of case management approaches

6.1 Overview

This chapter summarises the evidence of impact of local case management approaches for frail older people in Newcastle Gateshead, using evidence relating to the three nurse-led roles which are the focus of this review. It considers quantitative evidence of outcomes, where this is available, but it is primarily based on evidence from qualitative consultation on the perceived outcomes of case management approaches and roles.

Challenges in assessing the impact of case management approaches

During this review it was difficult to generate robust findings in relation to the outcomes of local case management approaches for frail older people in Newcastle Gateshead. A number of factors contributed to this.

First, input, activity, outputs, impact and outcomes data (such as data extracted from EMIS, SystmOne and any other systems that were reported to be used to monitor the performance of the roles and related services) were not consistently available for analysis as part of the review.54

Second, population-level data on a range of secondary care service use were available, but any changes in service use could not be directly attributed to case management approaches because it was not possible to exclude the potential impact of other interventions which might also have outcomes for service use.

In addition, any impact of case management approaches might be diluted in the population-level data because this includes patients who have not received case management.

As a result of the limited quantitative data available for review, evidence in this chapter is mainly drawn from qualitative consultation with case managers and wider stakeholders. Therefore, unless otherwise stated, it relates to the impact of case management approaches as perceived by local stakeholders, rather than impact that can be verified by quantitative analyses.

Potential improvements in the identification, collation and analysis of data are discussed in section 6.4.

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54 The exception to this was that data on estimated hospital admissions avoidance were provided for the Newcastle community matron team.
6.2 Key findings

This review considers quantitative evidence of outcomes, where this is available, but it is primarily based on evidence from qualitative consultation on the perceived outcomes of case management approaches and roles.

There is considerable consistency between the case management roles in respect of the outcomes that stakeholders report are being achieved, and these are broadly aligned with the objectives and intended outcomes of case management approaches.

Key patient outcomes which are perceived to be achieved by case management approaches relate to improvements in the health and wellbeing of patients and the quality of care delivered to them. Stakeholders identified that this begins with improved comprehensive assessment which results in a better understanding of patients’ needs and preferences, which then informs the planning and delivery of care.

The primary perceived outcomes of case management approaches for professionals are improved job satisfaction and improved partnership working. In addition, the stakeholders reported that the older person nurse specialist role impacts on the levels of understanding, skills and confidence of care home staff.

In terms of the health and social care system, the main outcomes to which case management approaches were reported to contribute are reducing unnecessary and inappropriate hospital admissions; improving care coordination to ensure that patients are referred to appropriate services and that tasks are allocated more efficiently, avoiding duplication; and reducing the input required from GPs for patients who are receiving case management.

The only case management role for which economic evaluation analysis was possible during this review is the community matrons in Newcastle. This analysis is based on the salary costs of the team and reported avoidance of hospital admissions over a four-month period. It suggests that the team could be responsible for contributing to a net saving on hospital admissions in the region of £153,000 per annum.

The outcomes data provided for this review have been limited. This has, in turn, restricted the level of analysis which could be conducted in relation to the outcomes achieved by case management approaches. This review therefore recommends a number of improvements to the performance monitoring of case management roles. Analysis was shared in relation to the older person nurse specialist role in Gateshead which indicates that work is underway to collate and analyse a wider range of outcomes data to understand the impact and outcomes of this role.
6.3 Perceived impact of case management roles

Figure 17 summarises the outcomes of the different case management roles, based on those which were highlighted by case managers and wider stakeholders. As this is based on qualitative accounts of perceived impact, it does not offer any comparison of the scale of the impact achieved by different roles. It demonstrates that there is considerable consistency between the case management roles in respect of the outcomes that stakeholders report are being achieved, and that these are broadly aligned with the objectives and intended outcomes of case management approaches outlined in section 3.5.
Figure 17: Summary of perceived outcomes of case management roles ( ✓ = outcome reported as achieved; - = outcome not specifically reported as achieved. This does not indicate negative performance in relation to this outcome, simply that stakeholders did not highlight positive performance in this area. Stakeholders were not asked explicitly about each outcome)

<table>
<thead>
<tr>
<th>Role</th>
<th>Health and wellbeing outcomes for patients</th>
<th>Quality of care outcomes</th>
<th>Health and social care system outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Improved health outcomes(^{55})</td>
<td>Improved self-management</td>
<td>Improved comprehensive assessment</td>
</tr>
<tr>
<td>Gateshead community matron</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Newcastle community matron</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Gateshead OPSN</td>
<td>✓</td>
<td>-</td>
<td>✓</td>
</tr>
<tr>
<td>Newcastle OPSN</td>
<td>✓</td>
<td>-</td>
<td>✓</td>
</tr>
<tr>
<td>Practice frailty nurse</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>

\(^{55}\) Includes reduced incidence of care-acquired infections and pressure sores.

\(^{56}\) Includes proactive, preventative and anticipatory care planning and review.

\(^{57}\) Includes improved access to health and social care services.
6.3.1 Outcomes for patients

Evidence of outcomes for patients or residents is predominantly drawn from the focus groups with case managers and the interviews with wider stakeholders. In the case of the older person nurse specialists in Newcastle, this is supplemented by patient feedback collated in May-June 2016. Most consulted case managers and wider stakeholders were able to identify a range of outcomes which they believed were being achieved for patients. However, they often found it challenging to quantify the scale of the impact.

The key findings for patient outcomes included:

- Stakeholders identified a number of common perceived outcomes for community matrons and practice frailty nurses. These included better access to services and improved health management. However, these were framed in distinct, service-specific terms.

- Despite differences in team structure and skill mix, the older person nurse specialists in Newcastle and Gateshead reportedly impact on similar outcomes, particularly improved quality of life. However, stakeholders described a wider range of perceived outcomes in relation to the Gateshead older person nurse specialists than those in Newcastle.

- Stakeholders also stressed the efficacy of case management roles in ensuring more effective identification of patients’ needs and preferences as a result of improved comprehensive assessment. This was particularly highlighted in relation to the older person nurse specialist and practice frailty nurse roles.

Further detail on the outcomes which stakeholders reported that case management approaches are achieving for patients is included in the remainder of this section.

*Improved identification of patients’ needs and preferences*

Almost all consulted case managers and wider stakeholders reported that the improved identification of patients’ needs and preferences is a key outcome of all case management approaches.

Stakeholders stated that the primary mechanism for achieving this outcome is comprehensive assessment. They reported that this assessment process results in a holistic understanding of patients’ needs and preferences, and how these inter-relate. In turn, they reported that this enables more effective care planning to address needs and achieve positive outcomes with patients. In addition, the older person nurse specialists in both locations reported that regular presence in the care home provides them with opportunities to identify any changes in a patient’s needs and circumstances. Practice frailty nurses also reported that comprehensive assessment can help to identify concerns that are not recognised by patients themselves. As a result, they reported that their role can be particularly effective for patients who do not necessarily recognise that they are unwell or do not understand that their long-held behaviours are having a negative effect on their wellbeing.
Improved outcomes for patients living in their own homes

Evidence from consultation suggests that the two community matron teams and the practice frailty nurse working with patients in their own homes achieve a number of similar outcomes for patients. Particularly, stakeholders highlighted the role of these case managers in supporting patients to better self-manage their own health and to maintain or increase their choice and independence.

For both roles, specific outcomes included helping patients to avoid unnecessary hospital admissions and remain in their own home. In terms of improving independence and choice, the most commonly reported outcome of the community matrons was improved compliance with medication. For practice frailty nurses working with patients in their own homes, it was improved patient understanding of their own health, and greater awareness of their own responsibilities in terms of keeping healthy.

Community matrons and practice frailty nurses working with patients in their own homes also reported that they improve patients’ access to services. They described ensuring that patients are referred to appropriate services following comprehensive assessment, but also advocating for patients who may have difficulty in engaging with services (due, for example, to difficulties with memory or attending appointments) to make sure that they receive equitable access in comparison to patients who do not have difficulties in engaging. They also reported that home visits enable them to support patients who might otherwise have not received services due to an inability or reluctance to attend GP surgeries in person.

Improved outcomes for patients living in care homes

Evidence from consultation suggests that the two older person nurse specialist teams and the practice frailty nurse working with patients in a care home reportedly achieve several similar outcomes for patients. In particular, stakeholders highlighted that these roles result in improved health and wellbeing outcomes for patients and improved quality of care. In particular, stakeholders indicated that these roles result in improved care planning, especially for anticipatory and emergency care planning. They also reported that through direct delivery of care to patients and support to care home staff to deliver care differently they were able to improve both the efficacy of care and the health and wellbeing outcomes resulting from it. A minority of stakeholders also stated that improvements in these outcomes result in improved quality of life for patients, although these stakeholders acknowledged that it is difficult to provide evidence of this latter outcome. One example of an improved quality of life outcome was supporting patients to maintain family interactions.

Patient and relative feedback was collected for 11 patients working with older person nurse specialists in Newcastle in May 2016. This feedback is summarised in Figure 18, which shows that the majority of patients/family members rated their care as “very good” across all elements that they were asked to rate. Whilst this is a small dataset, it does indicate that those who provided feedback received a service that they considered to be of high quality, felt well informed about their
care, felt their care was planned effectively and found the manner and contact with staff to be very good.

*Figure 18: Patient and family member feedback on the Newcastle older person nurse specialists, May 2016 (n=11)*

<table>
<thead>
<tr>
<th></th>
<th>Excellent</th>
<th>Very good</th>
<th>Good</th>
<th>Poor</th>
</tr>
</thead>
<tbody>
<tr>
<td>The time provided to sit and talk to the staff</td>
<td>0</td>
<td>6</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>The information given to you</td>
<td>1</td>
<td>7</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>The care planned</td>
<td>0</td>
<td>5</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>The personal manner of the staff you saw</td>
<td>1</td>
<td>8</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>The contact overall</td>
<td>1</td>
<td>8</td>
<td>2</td>
<td>0</td>
</tr>
</tbody>
</table>

6.3.2 Outcomes for professionals

Consulted case managers and wider stakeholders identified three groups of professionals that benefit from case management approaches for frail older people: the case managers themselves; primary care staff, particularly GPs; and carers and nursing staff working in care homes. They identified three categories of outcomes for these professionals, which are: improved job satisfaction; more efficient working practices; and improved skills and knowledge.

*Improved job satisfaction*

Improved job satisfaction for professionals was highlighted as an important outcome of case management approaches by case managers in the majority of roles and also by wider stakeholders working with the case managers.

For example, community matrons in both locations and the older person nurse specialists in Newcastle reported that providing continuity of care enables them to observe positive outcomes for their patients over time, which increases their job satisfaction. In addition, one wider stakeholder reported that the older person nurse specialist role has provided an excellent opportunity for professional development for staff recruited to the role.

Consulted GPs and pharmacists working in care homes reported that both the older person nurse specialist and practice frailty nurse in care homes were invaluable and made their role easier and more satisfying by proactively managing the care of patients.
In addition, the older person nurse specialists in both Newcastle and Gateshead reported that care home staff value their input. Feedback collected on the Newcastle older person nurse specialists found that 100% of care home staff rated the service as 'excellent' or 'very good'. Qualitative feedback from the same survey suggests that a majority of care home staff believe the OPNS is able to provide additional expertise that both reassures the staff and improves the quality of health care provided.

However, the older person nurse specialists in Newcastle reported that their job satisfaction could be increased if they were provided with greater guidance on the purpose of the older person nurse specialist role, and more feedback on whether they are fulfilling the role effectively and achieving the desired outcomes.

More efficient partnership working

All consulted case managers and wider stakeholders identified improved partnership working as an outcome of the case management approaches. Different roles, however, reportedly had the greatest impact on different partnerships.

All roles have reportedly improved partnership working between community nursing services and GP practices. Practice frailty nurses were described as being able to forge particularly effective partnerships with GPs due to being based in the practice themselves. This was reported to result in swift and regular communication, as well as shared learning between staff in the nurse role and GPs. To a slightly lesser extent, the older person nurse specialists were reported to be able to build effective relationships with GP practices due to working predominantly with aligned GP practices and focusing on particular care homes. Community matrons were also reported to maintain strong relationships with GP practices due to taking regular referrals from them, coordinating care on the GP’s behalf and regular information sharing about individual patients.

Stakeholders reported that the roles working into care homes have also improved partnership working between community health services, including GP practices, and care homes. Stakeholders described how these roles can act as a first point of contact for both care home staff and GPs and other community health services, working as a conduit for referrals, information sharing and task allocation between these services and resulting in more effective care coordination.

Improved staff skills and knowledge

In relation to the older person nurse specialist role, all consulted staff working in the role and wider stakeholders who commented on the role reported that care home staff knowledge, skills and confidence were improved through training, support and advice provided by the older person nurse specialists. This review did not include consultation with care home staff members themselves.

58 Feedback was collected in May-June 2016. It was received from 25 staff in 14 care homes.
Nevertheless, in feedback collected from a survey of Newcastle care home staff, 100% of respondents reported that they found training facilitated by the older person nurse specialists to be either ‘excellent’ or ‘very good’.

6.3.3 Outcomes for the health and social care system

All consulted case managers and wider stakeholders reported that the case management approaches result in improved outcomes for the health and social care system. The main perceived outcomes were:

- Reduced unnecessary or inappropriate use of health and social care services.
- Reduced input required from GPs, particularly in relation to home visits.

However, the majority of case managers acknowledged that they had neither collated nor seen robust quantitative evidence of these outcomes, as related specifically to their services. A limited amount of quantitative outcomes data on system outcomes was provided for this review and analysis of these data is presented in section 6.4. Potential improvements in outcomes monitoring are discussed in section 6.5.

Reduced unnecessary or inappropriate use of health and social care services

The two main ways in which stakeholders reported that the case management approaches reduced unnecessary and inappropriate use of health and social care services were:

- Reducing unnecessary and inappropriate hospital admissions through:
  - Earlier identification of deterioration in health and wellbeing.
  - Better emergency and anticipatory care planning to enable patients to remain in their usual place of residence in more circumstances.
  - Better support to care home staff to manage risk and deliver care in the care home, rather than admitting patients to hospital.
- Improving care coordination to ensure that patients are referred to appropriate services and that tasks are allocated more efficiently, avoiding duplication.

For community matrons and the practice frailty nurses working with patients in their own homes, the perceived impact in enabling people to remain in their own home might also reduce or delay the need for patients to move into long-term care facilities.

However, the practice frailty nurses and older person nurse specialists in Newcastle also included an important caveat to the discussion of health and social care service use. They suggested that the introduction of the new roles has in some instances uncovered significant unmet need, and therefore in places

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59 Feedback was collected in May–June 2016. It was received from 25 staff in 14 care homes.
may have resulted in additional resource being required from the health and social care system, including individuals appropriately being moved into secondary care.

**Reduced input required from GPs**

The majority of consulted case managers and wider stakeholders identified that case management approaches have resulted in reduced input from GPs for patients who are receiving case management. The primary examples of how their input has been reduced were:

- Fewer GP call-outs and home visits.
- Reduced time required per patient during planned visits to care homes, such as ward rounds.
- Reduced need for GPs to coordinate care because this is being undertaken by the case manager.

### 6.4 Health economics analyses

Quantitative data on outcomes were provided in relation to some of the case management roles. Where possible, this has been used to conduct health economics analyses. However, the limitations in available data for this review mean that systematic robust analysis of the impact of case management approaches was not possible.

#### 6.4.1 Community matrons in Newcastle

The Newcastle community matron team provided four months of outcome data demonstrating the number of hospital admissions avoided between July-October 2017, shown in Figure 19. Using an average of these four months we estimate that 525 hospital admissions will have been avoided over a 12 month period. It is important to note that this does not account for possible fluctuations in the scale of impact on hospital admissions for the months for which data was not available.

*Figure 19: hospital admissions avoided by Newcastle community matrons, July-Oct 2017*[^60]

<table>
<thead>
<tr>
<th>Month</th>
<th>Admissions Avoided</th>
</tr>
</thead>
<tbody>
<tr>
<td>July 2017</td>
<td>40</td>
</tr>
<tr>
<td>Aug 2017</td>
<td>50</td>
</tr>
<tr>
<td>Sep 2017</td>
<td>47</td>
</tr>
<tr>
<td>Oct 2017</td>
<td>38</td>
</tr>
</tbody>
</table>

Using a combination of tariffs and estimated figures for the salary costs of the Newcastle community matron team, a limited economic analysis can be done.

[^60]: These data were reported by the community matron service and are re-produced here. Detail of how they were calculated was not provided and therefore they cannot be independently verified by the evaluation team.
conducted. However, it is important to stress strongly that such a calculation is based on limited evidence of outcomes, would not encapsulate all outcomes achieved by the community matron team, and may not reflect other costs required to operate the team. The tariffs used within the value for money calculations are presented in Figure 20.

Figure 20: Value for money calculation tariffs

<table>
<thead>
<tr>
<th>Outcome measure</th>
<th>Tariff</th>
<th>Unit</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-elective inpatient stays (short stays) for adults aged 65+</td>
<td>£616</td>
<td>Per episode</td>
<td>PSSRU61 – Hospital services non-elective inpatient stays (short stays)</td>
</tr>
<tr>
<td>Band 7 Nurse Salary mid-range</td>
<td>£36,250</td>
<td>Annual</td>
<td>NHS Pay scale62</td>
</tr>
<tr>
<td>Band 3 Nurse Salary mid-range</td>
<td>£18,152</td>
<td>Annual</td>
<td>NHS Pay scale62</td>
</tr>
</tbody>
</table>

Using these tariffs it is calculated that the total estimated cost avoidance saving achieved by the Newcastle Community Matron team is £152,982 per annum. The method for calculating these savings is presented in Figure 21.

Figure 21: Value for money calculations

<table>
<thead>
<tr>
<th>Calculations</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Savings from avoided hospital admissions</td>
<td>£323,400</td>
</tr>
<tr>
<td>Cost of the community matron team</td>
<td>£170,418</td>
</tr>
<tr>
<td>Net saving</td>
<td>£152,982</td>
</tr>
</tbody>
</table>

The total cost of the team is £170,418. The estimated net saving could therefore be in the region of £153,000 per annum. As stated, however, this does not take into account other services which may also have worked with people to avoid hospital admissions or other outcomes that the Community Matron team may have achieved.

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62 Royal College of Nursing (2016) Pay scales for NHS nursing staff in England, Wales, Scotland and Northern Ireland from 1 April 2016. Available: [https://www.rcn.org.uk/employment-and-pay/nhs-pay-scales-2016-17](https://www.rcn.org.uk/employment-and-pay/nhs-pay-scales-2016-17) For the purposes of this calculation, salary costs for the community matrons and healthcare assistants within the team have been included.
6.4.2 Older person nurse specialists in Gateshead

Monitoring data showing the total secondary care usage and cost by all residents of care homes in Gateshead for the period 2013-2017 were reviewed by the independent evaluation team. This coincides with the introduction of the Older Person Nurse Specialist team in Gateshead. However, to date only 70% of care home beds in Gateshead are in a home with an allocated older person nurse specialist and it is not clear when individual care homes began working with an older person nurse specialist.

Further, practices within the care homes and the other services available to them may have changed significantly during this period (for example, the practice frailty nurse was also introduced into Springfield care home in this period). Therefore it is not possible to calculate the extent to which any change in the use or cost of secondary care services is attributable to the introduction of older person nurse specialists.

Figure 22 shows that between 2013 and 2017 there was an increase of £1,288,359 spent on secondary care for care home residents in Gateshead, although the 2016-17 expenditure of £6,976,313 is below the peak spend of £8,737,679 in 2014-15. In respect of non-elective admissions there has been a steady decline, with more than 338 fewer admissions in 2016-17 than 2013-14. However, during this period there was also a steady increase in A&E attendances from care homes, from 1,676 in 2013-14 to 2,042 in 2016-17. Full figures can be viewed at appendix C.

Figure 22: Changes in secondary care use by care home residents in Gateshead, 2013-17

However, because these outcomes cannot be directly attributed to the Gateshead older person nurse specialists, it is not possible to make a robust value for money calculation. Any inferred impact by the Gateshead older person nurse specialists should be treated with considerable caution.
In addition to the population-wide data, an internal evaluation report was also available for the pilot older person nurse specialist service in Gateshead in 2009-10. This included estimates of reductions in hospital use and related costs which might be attributable to the pilot. It reported an estimated saving of 542 bed days at a cost of £289,248 as a result of the pilot. The original data from the clinical audits and the tariffs used for these calculations were not available during the review so this analysis could not be independently verified. However, if similar reductions are being achieved by the current service then this would represent a significant saving in cost and time for secondary care services.

A more recent analysis completed by NECS indicates that secondary care service usage rates for the 2016-17 financial year may be lower for care home residents who have access to an older person nurse specialist than for care home residents who do not have access to an older person nurse specialist.

This analysis compared secondary care service usage rates for GP practices in two cohorts: those practices linked only to care homes with an allocated older person nurse specialist and those practices linked only to care homes without an allocated older person nurse specialist.

The secondary care service usage data for the GP practices included in the analysis was drawn from Secondary Uses Service data for the 2016-17 financial year using a number of activity metrics and an age limit of over 80.

This was then used alongside data on the number of care home residents registered at the GP practices, taken from the Gateshead Primary Care Extract (which is a local data flow managed by NECS), to calculate the rate of activity per 100 practice-registered care home residents for practices in each cohort.

These data are presented in Figure 23. They indicate, for example, that the rates per 100 registered care home residents of A&E attendance, non-elective admission to hospital, and attendance at outpatient appointments are all lower for GP practices linked only to care homes with an older person nurse specialist. However, because this is a snapshot for one year it is not possible to explore trends over time or to compare current rates at these GP practices with rates prior to the introduction of the older person nurse specialists. Therefore it is difficult to say with any certainty that the lower rates are attributable to the work of the older person nurse specialists.

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63 This analysis was conducted at GP practice level rather than care home level because of ongoing difficulties with obtaining accurate secondary care service usage data at care home level. These difficulties are experienced in other localities and are being addressed at a national level, and are therefore not exclusive to Newcastle Gateshead.
Figure 23: Secondary care service usage rates per 100 residents at specific GP practices with and without access to an older person nurse specialist\(^6^4\)

<table>
<thead>
<tr>
<th>Status</th>
<th>Number of GP practices included</th>
<th>Number of care home residents registered at included GP practices</th>
<th>A &amp; E attendances</th>
<th>All non-elective admissions</th>
<th>Non-elective admissions for UTI</th>
<th>Non-elective admissions for chest infections</th>
<th>Outpatient appointments</th>
</tr>
</thead>
<tbody>
<tr>
<td>With OPNS</td>
<td>7(^6^5)</td>
<td>461</td>
<td>0.84</td>
<td>1.39</td>
<td>0.16</td>
<td>0.27</td>
<td>2.57</td>
</tr>
<tr>
<td>Without OPNS</td>
<td>3(^6^6)</td>
<td>90</td>
<td>1.43</td>
<td>2.04</td>
<td>0.22</td>
<td>0.36</td>
<td>4.79</td>
</tr>
</tbody>
</table>

\(^6^4\) It was not possible to include GP practices who are linked with multiple care homes where some homes have an allocated older person nurse specialist and some homes do not as it was not possible to identify which home individual patients were resident at (and therefore to determine whether they had access to an older person nurse specialist or not).

\(^6^5\) GP practices linked only to care homes which have an allocated older person nurse specialist.

\(^6^6\) GP practices linked only to care homes which do not have an allocated older person nurse specialist.
There are a number of limitations to this analysis, which were identified by NECS, and as a result the findings should be treated with caution. Limitations include:

- The analysis only includes a small number of GP practices.

- The numbers of care home residents registered at these practices are relatively small, particularly for the cohort of practices without access to an older person nurse specialist.

- The analysis assumes that the number of care home residents registered at the GP practices remained static over the 2016-17 financial year.

### 6.4.3 Practice frailty nurses

Current activity and outcomes data were not available for the practice frailty nurses. However, an internal evaluation report was available for the pilot, which ran in 2013-14. This found that the introduction of the role resulted in a 54% reduction in A&E attendances, 54% reduction in hospital admissions and an 81% fall in house call requests for GPs compared to the nine month period prior to the introduction of the role. The original data from the clinical audits were not available during the review so this analysis could not be independently verified. These estimated reductions are very significant and the collation and further analysis of ongoing performance monitoring data would be required to verify them. However, if similar reductions are being achieved by the current service then this would represent a significant saving in cost and time for both GPs and secondary care services.

### 6.5 Possible improvements to outcomes data

The outcomes data provided for this review have been limited. This has, in turn, restricted the level of analysis which could be conducted in relation to the outcomes achieved by case management approaches.

**Recommendations:**

This review recommends a number of improvements to ongoing performance monitoring, which are outlined in Figure 23. These are based on a logic model approach that would facilitate more systematic collation and analysis of input, activity, output, impact and outcomes data. Clear metrics should then be determined to ensure that data can be captured in relation to the SMART outputs, impacts and outcomes, and therefore that performance against them can be monitored on an ongoing basis. It will be important to ensure that these metrics enable the monitoring of individual, person-centred impacts and outcomes for patients as well as system-level impacts and outcomes.

Responsibility for recording and collating performance monitoring data should be clearly allocated to one or more staff member in each team. In allocating this, consideration must be made of the time/resource required to record and collate this data. If this cannot be absorbed by current staff members, further
administrative resource may need to be identified. The findings of performance monitoring should be shared with case managers and other professionals at regular intervals. This would enable any benefits of case management to be communicated to both case managers and other professionals. This might help to address concerns expressed by some stakeholder that the purpose and impact of their role is not always clear to them. It might also increase engagement with case management by other professionals.

Figure 24: Suggested improvements to performance monitoring

<table>
<thead>
<tr>
<th>Logic model element</th>
<th>Data requirements for outcomes analysis</th>
</tr>
</thead>
</table>
| Inputs              | - Outline of budget allocated to case management, including breakdown of funding sources and areas of expenditure. This may be provided per case management team or as a total budget across Newcastle Gateshead.  
- Staffing details, including team structures, roles, FTE posts and salary bands.  
- Detail of any other resources required to deliver case management approaches, which are not directly funded by the budget (e.g. equipment, input from other non-funded staff teams) |
| Activities          | Description of the key activities delivered under case management, and the organisation/professional responsible for delivery. Examples include:  
- Referral pathways  
- Eligibility criteria  
- Comprehensive assessment  
- Care planning  
- Home visits  
- Liaison with family members  
- Checking records for medical history  
- Medication review  
- Prescribing  
- Diagnostics ordered  
- Onward referrals  
- Exit criteria |
| Outputs             | As a minimum the following should be recorded for each case management service over the whole delivery period for case management and reported at regular intervals:  
- Numbers of patients referred  
- Referral sources for those referred (professional and (if applicable) care home at which patient resides)  
- Number of referrals accepted |
## Logic model element

<table>
<thead>
<tr>
<th>Data requirements for outcomes analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Number of referrals not accepted and reasons for this</td>
</tr>
<tr>
<td>• Profile of patients who access case management</td>
</tr>
<tr>
<td>• Waiting times to access case management</td>
</tr>
<tr>
<td>• Number of patients discharged.</td>
</tr>
<tr>
<td>• Weekly caseload numbers, indicating how many are receiving case management and how many on the caseload but not being case managed by the service.</td>
</tr>
<tr>
<td>• Average length of time patients are only the caseload/case managed.</td>
</tr>
</tbody>
</table>

This data could be supplemented by outputs in relation to specific activities outlined in the logic model (such as, for example, numbers of patients receiving CGA, care plans, onward referrals to different services, etc. These data could also be used to provide the average number of tasks undertaken by case managers per patient).

## Impacts

As a minimum the following should be recorded for each case management service over the whole delivery period for case management and reported at regular intervals:

<p>| |</p>
<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Outcomes at review and (if applicable) discharge for all patients.</td>
</tr>
<tr>
<td>• Indicators to enable assessment of clinical impact (from data already collected in the course of clinical work with patients). Examples include:</td>
</tr>
<tr>
<td>• Patients’ care plan goals and whether these were achieved, to understand the numbers of patients who achieve some or all of their goals.</td>
</tr>
</tbody>
</table>

These could be supplemented by Patient Reported Outcome and Patient Reported Experience (PROMs & PREMs) Measures, gathered through systematic and structured patient and family member feedback on work with case managers, quality of care, quality of life and/or health and wellbeing.

## Outcomes

As a minimum, the following system-level data should be collated and reported for both Newcastle and Gateshead for the care home population and the general population of over 65s and analysed at regular intervals:

<p>| |</p>
<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Numbers of patients attending A&amp;E</td>
</tr>
</tbody>
</table>

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67 If up-to-date profile data is available for case management services, which suggests that they are working predominantly with people in a particular age group (e.g. over 80s), population-level data could be collated for patients in this age group rather than over 65s.
### Logic model element | Data requirements for outcomes analysis
--- | ---
|  | • Numbers of patients admitted to the emergency department  
|  | • Numbers of patients non-electively admitted to hospital  
|  | • Average length of stay in hospital  
|  | • Numbers of patients attending outpatient appointments  
|  | • Numbers of residents dying in their preferred place of death  
|  | (or, if preferred place of death is not known, numbers of residents dying in care homes or their own home)  
|  | • Number of patients dying in hospital  
|  | This could be supplemented by patient-level data for an agreed time period (e.g. 12-month prior to admission and a 12-month period following discharge) for residents who access case management. Examples include:  
|  | • Secondary care service use.  
|  | • Primary care service use.  

If the recommended performance monitoring arrangements were in place and the ensuing data were available, it would be possible to conduct a range of health economic analyses to comment more robustly on the impact of case management approaches. Examples include:

- Actual caseload size for different case management roles, and therefore unit cost calculations for the provision of different case management approaches to patients.

- Comparison of patients’ health service use prior to, during and (if discharged from the service) following receipt of case management. Value for money or cost saving estimates related to this service use and the unit costs of delivering case management approaches.

- Change over time in unit cost, value for money and cost savings as well as between role comparisons.
7 Future development of case management approaches

7.1 Overview

This chapter reports findings on the future development of case management approaches. This is based on evidence drawn from the consultation case managers, as well as wider stakeholders with insight into case management approaches for frail older people.

7.2 Key findings

There is no national case management competences framework for frail older people. However, a competences framework for the care of people with long-term conditions was published by NHS England in 2005. The role descriptions of the different case manager roles have been compared to this competences framework. This revealed that the extent to which the competences are formalised in role descriptions varies across the different case management roles (from 8 of 9 competences well-referenced in the Gateshead community matron role description, to 4 of 9 competences partially-referenced in the Newcastle community matron role description).

There were a number of key attributes of effective case managers which were commonly-identified by consulted case managers and wider stakeholders. In particular, in-depth knowledge of local services was seen as essential, as were advanced clinical skills. Experience in medicine for the elderly was also seen as important, although this was identified by a smaller majority of those consulted.

A number of key factors which support effective case management for frail older people were frequently identified by those consulted during this review. These included comprehensive assessment, access to MDT support and the alignment of case managers to GP practices and/or care homes.

Consultation conducted as part of this review identified several areas for potential improvement in the delivery of case management for frail older people in Newcastle Gateshead, which are not already discussed in previous sections of the report and related recommendations. These included:

- The roll-out of the case management role into all care homes.
- Improvements in the balance of reactive and proactive case management.
- Arrangements for caseload cover.

Four future challenges to effective case management for frail older people were highlighted by case managers and wider stakeholders during the consultation as part of this review. These were:

- Increasing levels of local need.
7.3 Knowledge, skills and experience of case managers

7.3.1 Knowledge, skills and experience in existing role descriptions

There is no national case management competences framework for frail older people. However, a competences framework for the care of people with long-term conditions was published by NHS England in 2005. The role descriptions of the different case manager roles have been compared to this competences framework and the findings are presented in Figure 25. Colour coding within the figure is as follows:

Green: Evidence that a majority of knowledge and skills are included in person specification.

Orange: Evidence that a minority of relevant knowledge and skills are included in person specification.

Red: Evidence that the majority of required knowledge and skills are absent from person specification.

Grey: Insufficient evidence available to judge competencies required for case management role.

A note on the role descriptions

As discussed in section 4.1, the quality of role descriptions available to the evaluation varied for the different roles. For the older person nurse specialists in both locations and the community matrons in Gateshead this was a formal job description or service specification. For community matrons in Newcastle and the practice frailty nurse it was a less formal role description listing key duties and components of the role.

It is possible that more detailed descriptions exist and were not shared and as such these findings should be treated with caution.

This evidence points to two key findings. First, the extent to which the competences are formalised in role descriptions varies across the different case management roles (from 8 of 9 competences well-referenced in the Gateshead

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community matron role description to 4 of 9 competences partially-referenced in the Newcastle community matron role description).

Second, managing end of life care is not referenced in any of the role descriptions.

**Recommendation:** In developing any future case management roles or job descriptions (including updated job descriptions for existing roles), consideration should be given as to whether it is appropriate to map the job description and person specification to NHS England’s *Case management competences framework for the care of people with long term conditions.*
### Figure 25: Comparison of case management competency framework (NHS 2005) and Newcastle Gateshead case manager role descriptions

<table>
<thead>
<tr>
<th>Case Management Competency</th>
<th>Knowledge and skills</th>
<th>Newcastle Community Matron</th>
<th>Gateshead Community Matron</th>
<th>Newcastle OPSN</th>
<th>Gateshead OPSN</th>
<th>Practice Frailty Nurse</th>
</tr>
</thead>
</table>
| Advance Clinical Nursing Practice (For Advance Health Professionals only, working with category one patients) | • Advanced clinical assessment skills, risk assessment and appropriate management of risk  
• Advanced ability to use information in undertaking assessments, clinical decision-making and diagnosis  
• In-depth knowledge and understanding of  
  • the presentation, progression, pathophysiology and prognosis of common long term conditions  
  • Therapeutic interventions, including relevant pharmacology and medicines management  
  • relevant legislation, and full understanding of the ethical issues involved in caring for people with long term conditions  
• Advanced communication and interpersonal skills  
• Sophisticated application of holistic person-centred approaches to care. | | | | | |
| Leading Complex Care Co-ordination | • Advanced skills in use and management of knowledge  
• In-depth knowledge and understanding of:  
  • Health and wellbeing issues for people with long term conditions  
  • Interdisciplinary and team-based approaches to care  
  • Government policy and guidance on long term conditions  
  • Service and resource procurement and management | | | | | |
<table>
<thead>
<tr>
<th>Case Management Competency</th>
<th>Knowledge and skills</th>
<th>Newcastle Community Matron</th>
<th>Gateshead Community Matron</th>
<th>Newcastle OPSN</th>
<th>Gateshead OPSN</th>
<th>Practice Frailty Nurse</th>
</tr>
</thead>
</table>
| Proactively Manage Complex LT conditions | - Relevant legislation and full understanding of the ethical issues involved in caring for people with long term conditions.  
- Skills in identifying and protecting those at risk (particularly in relation to adult abuse), and caring for and supporting those individuals who have suffered abuse.  
- Advanced communication and interpersonal skills  
- Sophisticated application of holistic person-centred approaches to care | | | | | |
| Managing Cognitive Impairment and Mental Well Being | - Knowledge and understanding of:  
  - Sources of information on mental health and related services  
  - Physical, behavioural, emotional and | | | | | |
<table>
<thead>
<tr>
<th>Case Management Competency</th>
<th>Knowledge and skills</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supporting self-care, self-management, and enabling independence</td>
<td>Psychological indications of mental health needs</td>
</tr>
<tr>
<td></td>
<td>- Counselling and psychological support methods</td>
</tr>
<tr>
<td></td>
<td>- Therapeutic interventions</td>
</tr>
<tr>
<td></td>
<td>- Diversity, discrimination and stigmatisation</td>
</tr>
<tr>
<td></td>
<td>- Skills in the assessment of mental health needs, including risk assessment</td>
</tr>
<tr>
<td></td>
<td>- Skills in interpreting responses to long term conditions, including recognising the signs of depression</td>
</tr>
<tr>
<td></td>
<td>- Advanced communication and interpersonal skills.</td>
</tr>
<tr>
<td></td>
<td>Supporting self-care, self-management, and enabling independence</td>
</tr>
<tr>
<td></td>
<td>- Skills in partnership working with patients and carers</td>
</tr>
<tr>
<td></td>
<td>- Advanced conflict and dispute management skills</td>
</tr>
<tr>
<td></td>
<td>- Advanced skills in empowering patients and enabling self-care</td>
</tr>
<tr>
<td></td>
<td>In-depth knowledge and understanding of:</td>
</tr>
<tr>
<td></td>
<td>- Community resources and support networks</td>
</tr>
<tr>
<td></td>
<td>- Self-advocacy</td>
</tr>
<tr>
<td></td>
<td>- The impact of long term conditions on everyday living</td>
</tr>
<tr>
<td></td>
<td>- The impact of lifestyle choices on long term conditions.</td>
</tr>
<tr>
<td></td>
<td>- Individual rights</td>
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<tr>
<td></td>
<td>- Of cognitive behavioural therapy techniques, and its application</td>
</tr>
<tr>
<td></td>
<td>- Advanced skills in facilitating participation and independence</td>
</tr>
<tr>
<td></td>
<td>- Advanced change management skills</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Newcastle Community Matron</th>
<th>Gateshead Community Matron</th>
<th>Newcastle OPSN</th>
<th>Gateshead OPSN</th>
<th>Practice Frailty Nurse</th>
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<tr>
<td>Case Management Competency</td>
<td>Knowledge and skills</td>
<td>Newcastle Community Matron</td>
<td>Gateshead Community Matron</td>
<td>Newcastle OPSN</td>
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<td>----------------------------</td>
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</tr>
<tr>
<td>Professional practice and leadership</td>
<td>• Advanced teaching, learning and coaching skills</td>
<td></td>
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<td></td>
</tr>
<tr>
<td></td>
<td>• In-depth knowledge and understanding of:</td>
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<tr>
<td></td>
<td>• Professional accountability.</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>• Workforce development, professional development, supervision and appraisal.</td>
<td></td>
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<tr>
<td></td>
<td>• Relevant clinical governance issues.</td>
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<tr>
<td></td>
<td>• Organisational development and change management.</td>
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<td></td>
<td>• Issues relating to personal and professional competence.</td>
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<tr>
<td></td>
<td>• Highly developed reflective practice skills.</td>
<td></td>
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<tr>
<td></td>
<td>• Advanced leadership skills.</td>
<td></td>
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</tr>
<tr>
<td>Identifying high risk people, promoting health and preventing ill health</td>
<td>• Skills in analysing, interpreting and presenting public health data.</td>
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<tr>
<td></td>
<td>• Knowledge and understanding of evaluation methodologies and associated ethics.</td>
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<tr>
<td></td>
<td>• In-depth knowledge and understanding of social constructions of health and illness.</td>
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</tr>
<tr>
<td>Managing care at the end of life</td>
<td>• Knowledge and understanding of:</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>• life stages and changes and losses associated with long term conditions</td>
<td></td>
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<tr>
<td></td>
<td>• how individuals respond to distress</td>
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<tr>
<td></td>
<td>• Skills in the care of the dying and bereavement care.</td>
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<tr>
<td>Interagency partnership</td>
<td>• In-depth knowledge and understanding of collaborative and interagency working</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Case Management Competency</td>
<td>Knowledge and skills</td>
<td>Newcastle Community Matron</td>
<td>Gateshead Community Matron</td>
<td>Newcastle OPSN</td>
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<tr>
<td>working</td>
<td>• Knowledge and understanding of performance review</td>
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<td></td>
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<td></td>
<td>• Advanced conflict and dispute management skills</td>
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<tr>
<td></td>
<td>• Advanced communication and interpersonal skills.</td>
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</tbody>
</table>
7.3.2 Stakeholder views on key attributes

There were a number of key attributes of effective case managers which were commonly-identified by consulted case managers and wider stakeholders. In particular, in-depth knowledge of local services was seen as essential, as were advanced clinical skills. Experience in medicine for the elderly was also seen as important, although this was identified by a smaller majority of those consulted.

**Recommendation:** Advanced clinical skills and experience in elderly medicine should be included as essential requirements in any future person specification for roles involving the case management of frail older people. Staff recruited to the role should also be provided with a comprehensive induction to ensure that they have adequate knowledge and understanding of local services.

**Knowledge and understanding of local services**

Across all roles consulted staff and wider stakeholders highlighted that a good knowledge of the range of services that are available to patients is critical to any case management role. Stakeholders recognised that the number and type of available services will vary according to their specific cohorts and settings of case managers. Yet they consistently reported that understanding the eligibility criteria and referral pathways into these services is crucial to effective care coordination and therefore case management.

**Advanced clinical skills**

Across all roles consulted staff and wider stakeholders indicated that case managers require advanced clinical skills if they are to deliver effective case management. Examples of such skills included ordering and interpreting diagnostic tests, reviewing medication, and presenting cases at MDT meetings.

A minority of wider stakeholders highlighted that prescribing skills are an important requirement for an effective case manager and this is identified as a key skill in the job descriptions for the majority of case management roles. Staff working in case management roles reported that they were nurse prescribers, or were working towards becoming nurse prescribers. In most cases, they reported that being able to prescribe enabled them to case manage more effectively. However, staff in roles involving close integration into a GP practice (such as practice frailty nurses) reported that independent prescribing was not a pre-requisite for delivering effective case management because this function could still be undertaken by GPs.

**Recommendation:** Local commissioners and providers should conduct additional consultation to understand the extent to which prescribing skills allow case managers to more effectively manage the care of a patient. It is not clear based on the evidence of this review the extent to which prescribing is an important function of case management.
Experience in medicine for the elderly

The majority of consulted staff members in case management roles and wider stakeholders reported that experience in medicine for the elderly was crucial to delivering effective case management of older people. Consulted wider stakeholders in particular indicated that they felt that it was crucial that a case manager was a senior nurse with a number of years of experience in working with older people. Community matrons did not identify this element, but this may relate to the fact that their patient cohort does not exclusively include older people because they also work with patients aged 18-64.

7.4 Factors contributing to effective case management

A number of key factors which support effective case management for frail older people were frequently identified by those consulted during this review. These included comprehensive assessment, access to MDT support and the alignment of case managers to GP practices and/or care homes.

7.4.1 Comprehensive assessment

As discussed in section 5.4.1, consulted case managers and wider stakeholders who were consulted as part of this review described comprehensive assessment as the cornerstone of effective case management for frail older people.

7.4.2 Access to MDT support

During focus group and interview consultation, wider stakeholders and staff from across the case management roles reported that taking a holistic, MDT approach to planning and delivering case supports effective case management. For example, older person nurse specialists in Gateshead, who have access to a weekly MDT meeting to discuss patients with a consultant community geriatrician and consultant old age psychiatrist, reported that this is an important mechanism in enabling them to plan and deliver care for more complex patients.

This view was supported by responses to the E-survey, where respondents from across different case management roles highlighted the importance of a holistic or MDT approach to care planning. 5 (45%) of 11 respondents to relevant questions identified it as among the three greatest strengths of their case management approach.

7.4.3 GP alignment

Consulted case managers and wider stakeholders working in Gateshead identified the importance to effective case management of close ties with specific

69 This MDT, known as the “Virtual Ward”, is the focus of a separate review and report, which is produced under separate cover.
GP practices. The model of the practice frailty nurse, linked to one or more specific GP practices was seen to be an efficient method of identifying and supporting frail older people. Equally, the model of the older person nurse specialist linked to specific GP practices as a result of their alignment to the same care homes was reported to be an effective way of achieving this close relationship between GPs and case managers.

7.4.4 Care home alignment

All consulted staff members delivering case management in care home settings reported that having case managers aligned to specific care homes supported effective case management. This was echoed by all wider stakeholders with insight into these roles. Chiefly this was reported to be a result of the relationships built between case managers and care home staff, and of regular presence in individual care homes enabling case managers to more closely monitor the progress of a relatively large number of patients simultaneously.

**Recommendation:** All future development of case management approaches for older people, or for roles involving case management, should maximise the possibility of care home and GP alignment for case managers and stipulate arrangements for case managers to access MDT input for patients.

7.5 Areas for improvement in case management approaches

Consultation conducted as part of this review identified several areas for potential improvement in the delivery of case management for frail older people in Newcastle Gateshead, which are not already discussed in previous sections of the report and related recommendations. These included:

- The roll-out of the case management role into all care homes.
- Improvements in the balance of reactive and proactive case management.
- Arrangements for caseload cover.

7.5.1 Roll-out of case management role into all care homes

The majority of consulted case managers and wider stakeholders with insight into case management roles in care homes reported that case management should be rolled out to all care homes in order to ensure equitable quality of case management and care for all care home residents. Chiefly this would require introducing nurse-led case management into residential homes, which in most cases are not currently aligned with either an older person nurse specialist or a practice frailty nurse. There was no clear consensus amongst stakeholders as to which of these roles should be rolled out, or whether coverage should be provided by a combination of roles.
Recommendation: Commissioners and partners should collate and analyse more systematic quantitative data on the outcomes of nurse-led case management for care home residents, in order to determine whether this evidence supports the views of stakeholders that this case management approach should be introduced into all care homes in Newcastle Gateshead. This would be likely to require clinical audits or a resident data study, which might be supplemented by consultation with a sample of residents, family members, care home staff and GPs working with case managers in care homes70.

7.5.2 Balancing reactive and proactive case management

Across all three of the case management roles, staff working in the roles identified that at times they are case managing in a more reactive way, when ideally they would undertake a greater proportion of proactive case management. They reported that this was often the result of managing relatively large caseloads and of working with patients with complex needs who might require intensive support to achieve improved outcomes or prevent unnecessary deterioration in health and wellbeing.

One example of this difficulty, which was reported by staff working in all roles, was a difficulty in balancing the reviews for more stable patients as part of case management, and involvement in supporting the coordination of care for individuals in times of acute need. Case managers reported that they are regularly unable to complete planned reviews in a timely fashion because of the time required to manage more intensive and sometimes unplanned interventions with other patients.

Recommendation: The resourcing of the different case management approaches should be reviewed to ensure that case managers have sufficient capacity to manage both the reactive and proactive elements of their role.

7.5.3 Arrangements for caseload cover

Staff working in a number of case management roles where individual staff are responsible for specific care homes or localities reported that there are no formal arrangements for covering caseloads in the event of staff leave, sickness or absence. They indicated that it can be very challenging for the remaining team members to try to cover these additional patients on top of their own workload.

70 Feedback on this recommendation from key stakeholders indicates that it is already being taken forward as part of the Community Services transformation in Gateshead. In addition this decision may be informed by the findings of the current review of CGA in the community being prepared by the Cochrane Collaboration. See: http://www.cochrane.org/CD012705/EPOC_comprehensive-geriatric-assessment-community-dwelling-high-risk-frail-older-people
**Recommendation:** Formal arrangements should be made to cover case managers’ caseloads if they are absent from work and to ensure that teams have adequate resource in place to provide this cover. This would ensure that patients continue to receive case management support during staff absences.

7.6 Future challenges to effective case management

Four future challenges to effective case management for frail older people were highlighted by case managers and wider stakeholders during the consultation as part of this review. These were:

- Increasing levels of local need.
- Effective use of resources to meet future demand.
- Leadership for case managers.
- Lack of understanding of case management roles.

7.6.1 Increasing levels of local need

Increasing levels of local need were recognised as a key future challenge by 6 (38%) of 16 respondents to the relevant questions in the E-survey. This was also explicitly referenced by the community matron teams in both Gateshead and Newcastle and by a minority of consulted wider stakeholders. Concerns related to both the increasing numbers of older people in the population and the increasing complexity of presentation of those older people requiring case management.

7.6.2 Effective use of resources to meet future demand

Linked to increasing levels of local need, case managers and wider stakeholders reported concerns about the resources available to meet future demand for case management. This was the most frequently highlighted challenge by respondents to the E-survey; 9 (56%) of 16 respondents to relevant questions indicated their belief that either current resources are not adequate to deliver high-quality case management to meet demand, or that future resources are unlikely to be adequate to meet demand. For example, community matrons in Newcastle stated that there is currently a six-week waiting list for initial assessments for newly-referred patients. Similarly, staff in roles working into care homes indicated that they are not always able to conduct comprehensive assessments for new residents as soon as they would like to be able to.

During consultation, a number of staff working in case management roles referred to plans to transform local community health services. 9 (56%) of 16 respondents to relevant questions in the E-survey reported that service transformation was a concern to them and this was echoed in a number of the focus groups with case managers. However, half of wider stakeholders highlighted transformation plans as a means to better align resources with demand and increase the efficiency of service provision across the system.
7.6.3 Leadership for case managers

Leadership for case managers was highlighted as a potential future challenge by a minority of interviewed wider stakeholders and also staff in a minority of the case management focus groups. Those stakeholders who identified this challenge reported that it will be important to ensure that leadership is strong at every level, including strategic, clinical and operational leadership. Specific potential challenges to leadership which were described by one or more stakeholder were ensuring that:

- Strategic leaders are able to make joint, evidence-based decisions across the system in order to deliver high-quality care as efficiently as possible.

- Clinicians and other professionals delivering services have confidence in strategic decisions that affect their work.

- Operational leaders have the skills and resources to ensure that case managers feel valued and understand the impact of their work.

7.6.4 Lack of understanding of case management roles

5 (31%) of 16 respondents to relevant questions in the E-survey reported that a lack of understanding of the nature or impact of case management roles was a key challenge or area for improvement. This was also reported by a minority of consulted wider stakeholders and case managers. For example, practice frailty nurses stated that there was still a need for both professionals and the public to improve their understanding of frailty and the need for frail patients to receive case management.

In fact, even staff working in case management roles were not always familiar with the other case management roles which are the focus of this review. For instance, Figure 26 shows the proportion of respondents to the E-survey who were familiar with case management roles in which they were not themselves employed. This indicates that 50% or fewer of staff who were not working in each role felt familiar with it.

*Figure 26: E-survey responses on familiarity with case management roles (n=4-16)*

<table>
<thead>
<tr>
<th>Role</th>
<th>Number/proportion of respondents not working in the role who were familiar with it</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community matron</td>
<td>2 (50%) of 4</td>
</tr>
<tr>
<td>Older person nurse specialist</td>
<td>7 (44%) of 16</td>
</tr>
<tr>
<td>Practice frailty nurse</td>
<td>4 (25%) of 16</td>
</tr>
</tbody>
</table>
Recommendations

Figure 27 summarises the recommendations of this review. It includes a description of the recommendation and lists the report sections from which it emerges. Evidence for the recommendation is presented in the relevant section.
### Figure 27: Recommendations for the future development of case management approaches

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Relevant report section(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Strategic</strong></td>
<td></td>
</tr>
<tr>
<td>1. If a locally-agreed definition of frailty does not already exist, this should be developed.</td>
<td>3.7</td>
</tr>
<tr>
<td>The existing or newly-developed definition should be promoted to all relevant stakeholders and</td>
<td></td>
</tr>
<tr>
<td>included in all strategic and operational documentation relating to support for frail older</td>
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<tr>
<td>people(^{71}).</td>
<td></td>
</tr>
<tr>
<td>2. A local definition of case management should be developed and agreed by commissioners and</td>
<td>3.4</td>
</tr>
<tr>
<td>providers. This definition should then be promoted to all stakeholders and applied to all</td>
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<tr>
<td>services involving case management, including those for older people.</td>
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<tr>
<td>3. Following the agreement of a local definition of case management, commissioners and providers</td>
<td>3.5.1</td>
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<tr>
<td>should agree a set of common objectives of case management, including (if applicable) specific</td>
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<tr>
<td>objectives for the case management of older people. These objectives should then be promoted to</td>
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<tr>
<td>all stakeholders and should form core objectives of all local services involving case</td>
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<tr>
<td>management: This should ensure that case management services are all contributing towards the</td>
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<td>same objectives, and that there is a common understanding of these objectives amongst those</td>
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<tr>
<td>commissioning and providing services.</td>
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<tr>
<td>4. Commissioners and providers should agree and document a local approach to case management</td>
<td>5.4</td>
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<td>for older people. This approach should be built-in to all roles and services involving case</td>
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<tr>
<td>management. Again, this would contribute to a common vision of case management. It would also</td>
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<tr>
<td>help to ensure that case management is being delivered consistently within and between different</td>
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<tr>
<td>roles and teams. The approach could draw on evidence of the common understanding of case</td>
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<tr>
<td>management approaches by local stakeholders, as identified by this review.</td>
<td></td>
</tr>
<tr>
<td>5. Alongside the agreement of common objectives for case management approaches, commissioners</td>
<td>3.5.2</td>
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<tr>
<td>and providers should agree and document a local approach to case management for older people.</td>
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<tr>
<td>This approach should be built-in to all roles and services involving case management. Again,</td>
<td></td>
</tr>
<tr>
<td>this would contribute to a common vision of case management. It would also help to ensure that</td>
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<tr>
<td>case management is being delivered consistently within and between different roles and teams.</td>
<td></td>
</tr>
<tr>
<td>The approach could draw on evidence of the common understanding of case management approaches</td>
<td></td>
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<tr>
<td>by local stakeholders, as identified by this review.</td>
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</table>

\(^{71}\) Feedback on this recommendation from key stakeholders indicates that it is already being taken forward and a definition is being developed via the frailty group.
### Recommendation

| Providers should also agree a set of common intended outcomes which is specific to the case management of older people\(^{72}\). Ideally these should be developed through a logic model approach. This should clearly articulate the inputs and activities, as well as SMART\(^{73}\) outputs, impacts and outcomes\(^{74}\) of case management. This would be beneficial in promoting a shared vision for case management and in ensuring that the expected impacts and outcomes are realistic in light of the resources available for case management. It would also be helpful in developing future performance monitoring arrangements for case management approaches. |

<table>
<thead>
<tr>
<th>Relevant report section(s)</th>
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#### Logic model element

<table>
<thead>
<tr>
<th>Data requirements for outcomes analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inputs</strong></td>
</tr>
<tr>
<td>- Outline of budget allocated to case management, including breakdown of funding sources and areas of expenditure. This may be provided per case management team or as a total budget across Newcastle Gateshead.</td>
</tr>
<tr>
<td>- Staffing details, including team structures, roles, FTE posts and salary bands.</td>
</tr>
</tbody>
</table>

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\(^{72}\) It is recognised that the desired outcomes for individual older people will vary based on their circumstances, needs and preferences. It is entirely appropriate that these desired outcomes are person-centred and developed on an individual basis. However, an over-arching set of intended outcomes of case management approaches could be developed which would encompass these person-centred outcomes and therefore not preclude the use of case management to achieve individual outcomes with older people.

\(^{73}\) SMART stands for Specific, Measurable, Achievable, Relevant and Timebound.

\(^{74}\) Definitions of these key terms are presented in appendix D.
### Recommendation

<table>
<thead>
<tr>
<th>Relevant report section(s)</th>
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<tbody>
<tr>
<td>- Detail of any other resources required to deliver case management approaches, which are not directly funded by the budget (e.g. equipment, input from other non-funded staff teams)</td>
</tr>
</tbody>
</table>

### Activities

Description of the key activities delivered under case management, and the organisation/professional responsible for delivery. Examples include:
- Referral pathways
- Eligibility criteria
- Comprehensive assessment
- Care planning
- Home visits
- Liaison with family members
- Checking records for medical history
- Medication review
- Prescribing
- Diagnostics ordered
- Onward referrals
- Exit criteria

### Outputs

As a minimum the following should be recorded for each case management service over the whole delivery period for case management and reported at regular intervals:
- Numbers of patients referred
- Referral sources for those referred (professional and (if applicable) care home at which patient resides)
- Number of referrals accepted
- Number of referrals not accepted and reasons for this
**Recommendation**

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<thead>
<tr>
<th>Relevant report section(s)</th>
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<tbody>
<tr>
<td>Profile of patients who access case management</td>
</tr>
<tr>
<td>Waiting times to access case management</td>
</tr>
<tr>
<td>Number of patients discharged.</td>
</tr>
<tr>
<td>Weekly caseload numbers, indicating how many are receiving case management and how many on the caseload but not being case managed by the service.</td>
</tr>
<tr>
<td>Average length of time patients are only on the caseload/case managed.</td>
</tr>
</tbody>
</table>

This data could be supplemented by outputs in relation to specific activities outlined in the logic model (such as, for example, numbers of patients receiving CGA, care plans, onward referrals to different services, etc. These data could also be used to provide the average number of tasks undertaken by case managers per patient).

**Impacts**

As a minimum the following should be recorded for each case management service over the whole delivery period for case management and reported at regular intervals:

- Outcomes at review and (if applicable) discharge for all patients.
- Indicators to enable assessment of clinical impact (from data already collected in the course of clinical work with patients). Examples include:
  - Patients’ care plan goals and whether these were achieved, to understand the numbers of patients who achieve some or all of their goals.

These could be supplemented by Patient Reported Outcome and Patient Reported Experience (PROMs & PREMs) Measures, gathered through systematic and structured patient and family member feedback on work with case managers, quality of care, quality of life and/or health and wellbeing.

**Outcomes**

As a minimum, the following system-level data should be collated and reported for both
### Recommendation

Newcastle and Gateshead for the care home population and the general population of over 65s and analysed at regular intervals:

- Numbers of patients attending A&E
- Numbers of patients admitted to the emergency department
- Numbers of patients non-electively admitted to hospital
- Average length of stay in hospital
- Numbers of patients attending outpatient appointments
- Numbers of patients dying in their preferred place of death (or, if preferred place of death is not known, numbers of residents dying in care homes or their own home)
- Number of patients dying in hospital

This could be supplemented by patient-level data for an agreed time period (e.g. 12-month prior to admission and a 12-month period following discharge) for residents who access case management. Examples include:

- Secondary care service use.
- Primary care service use.

In the future roles, teams and approaches involving case management should be clearly documented to provide clarity for both case managers and wider stakeholders. This includes documenting how the roles and their remits relate to each other to offer a systemic approach case management for older people in Newcastle Gateshead. This will ensure institutional knowledge is maintained with less reliance on personalities.

4.1

7

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75 If up-to-date profile data is available for case management services, which suggests that they are working predominantly with people in a particular age group (e.g. over 80s), population-level data could be collated for patients in this age group rather than over 65s.
<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Relevant report section(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>8. The resourcing of the different case management approaches should be reviewed to ensure that case managers have sufficient capacity to manage both the reactive and proactive elements of their role.</td>
<td>7.5.2</td>
</tr>
<tr>
<td>9. Commissioners and partners should collate and analyse more systematic quantitative data on the outcomes of nurse-led case management for care home residents, in order to determine whether this evidence supports the views of stakeholders that this case management approach should be introduced into all care homes in Newcastle Gateshead. This would be likely to require clinical audits or a resident data study, which might be supplemented by consultation with a sample of residents, family members, care home staff and GPs working with case managers in care homes.</td>
<td>7.5.1</td>
</tr>
<tr>
<td>10. All future development of case management approaches for older people, or for roles involving case management, should maximise the possibility of care home and GP alignment for case managers and stipulate arrangements for case managers to access MDT input for patients.</td>
<td>7.4.4</td>
</tr>
<tr>
<td>11. Commissioners and providers should clarify, agree and document the balance in the older person nurse specialist role between delivering case management activities and delivering training and support to care home staff to support high-quality care and case management.</td>
<td>5.6</td>
</tr>
</tbody>
</table>

**Operational**

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Relevant report section(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>12. Commissioners and providers should review the eligibility criteria for patients to receive support from the different case management roles and develop formal eligibility criteria for all roles. These should be clear and accessible to all staff delivering case management and to all potential referrers, as well as to strategic and operational managers and to commissioners. When developing the criteria, it will be important to consider how the different roles interact to create a local system of case management, and whether this can be further supported and</td>
<td>4.3.2</td>
</tr>
</tbody>
</table>

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76 Feedback on this recommendation from key stakeholders indicates that it is already being taken forward as part of the Community Services transformation in Gateshead.
<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Relevant report section(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>clarified by ensuring effective eligibility criteria.</td>
<td></td>
</tr>
<tr>
<td>13 Those responsible for the allocation of caseloads should ensure that the caseload size for individual case managers in the same role is as equitable as possible, taking into account the number of hours worked by each staff member. The rationale for any differences in caseload size should be clearly articulated to all staff members.</td>
<td>4.2.5</td>
</tr>
<tr>
<td>14 For each role, the extent to which case management responsibility corresponds to caseload should be clarified. This should be clear to staff in the case management roles, and to other professionals working with them. If staff in these roles do not hold case management responsibility for any proportion of patients on their caseload who require case management then alternative case management arrangements should be in place and clear to all stakeholders.</td>
<td>5.3</td>
</tr>
<tr>
<td>15 The CCG, local authorities and NHS Trusts should consider how case management responsibility could be recorded on local systems and databases, to ensure that staff in all roles are able to determine whether a patient has a case manager and who this case manager is. This may include flags on a range of systems used by different healthcare professionals. It would need to include guidance on who is responsible for updating the systems with new case manager information, and how regularly.</td>
<td>5.7</td>
</tr>
<tr>
<td>16 Commissioners and providers should collectively decide whether CGA should be introduced in lieu of the current approach to comprehensive assessment. If a decision is taken to move from the current comprehensive assessment to CGA, resource implications will need to be addressed.</td>
<td>5.4.1</td>
</tr>
<tr>
<td>17 Whether the assessment is CGA or another form of comprehensive assessment, this should be common across all case management roles. A shared assessment tool should therefore be introduced for all roles and services involving the case management of older people. This would ensure consistency in assessment and also increase the likelihood that assessments performed by one service could be transferred to another service in the event of a patient’s case management being transferred.</td>
<td>5.4.1</td>
</tr>
</tbody>
</table>
### Recommendation

<table>
<thead>
<tr>
<th>Number</th>
<th>Recommendation</th>
<th>Relevant report section(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>18</td>
<td>Information available to professionals who might work alongside case managers should be improved in order to promote better understanding of case management and the specific case management services available. This might include producing clear and succinct leaflets about case management, the case management roles and remits, how they inter-relate and how to refer to them. It might also include ensuring that information about case management approaches and roles is included in workforce development and training. As a promotional tool, case studies could be produced about how case managers have worked with different partners previously to improve outcomes for patients and the system.</td>
<td>5.8.4</td>
</tr>
<tr>
<td>19</td>
<td>The CCG and partners should continue their work to develop and implement a workforce competency framework. This is a good example of local work to produce a system-wide approach to supporting older people through ensuring that professionals are appropriately qualified and that their continuous professional development is promoted. It would support standardisation and the development of transferable skills within and between roles.</td>
<td>5.9.2</td>
</tr>
<tr>
<td>20</td>
<td>Responsibility for recording and collating performance monitoring data should be clearly allocated to one or more staff member in each team. In allocating this, consideration must be made of the time/resource required to record and collate this data. If this cannot be absorbed by current staff members, further administrative resource may need to be identified.</td>
<td>6.5</td>
</tr>
<tr>
<td>21</td>
<td>The findings of performance monitoring should be shared with case managers and other professionals at regular intervals. This would enable any benefits of case management to be communicated to both case managers and other professionals. This might help to address concerns expressed by some stakeholder that the purpose and impact of their role is not always clear to them. It might also increase engagement with case management by other professionals.</td>
<td>6.5</td>
</tr>
<tr>
<td>22</td>
<td>In developing any future case management roles or job descriptions (including updated job descriptions for existing roles), consideration should be given as to whether it is appropriate to map the job description and person specification to NHS England’s Case management competences framework for the care of people with...</td>
<td>7.3.1</td>
</tr>
<tr>
<td>Recommendation</td>
<td>Relevant report section(s)</td>
<td></td>
</tr>
<tr>
<td>-------------------------------------------------------------------------------</td>
<td>---------------------------</td>
<td></td>
</tr>
<tr>
<td>long term conditions.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>23 Advanced clinical skills and experience in elderly medicine should be included as essential requirements in any future person specification for roles involving the case management of frail older people. Staff recruited to the role should also be provided with a comprehensive induction to ensure that they have adequate knowledge and understanding of local services.</td>
<td>7.3.2</td>
<td></td>
</tr>
<tr>
<td>24 Local commissioners and providers should conduct additional consultation to understand the extent to which prescribing skills allow case managers to more effectively manage the care of a patient. It is not clear based on the evidence of this review the extent to which prescribing is an important function of case management.</td>
<td>7.3.2</td>
<td></td>
</tr>
<tr>
<td>25 A more formalised hand-over period should be agreed and implemented between community matrons and older person nurse specialists for patients moving into care homes with an aligned older person nurse specialist. This should ensure that that handover is timely and structured, and provide patients and professionals with clarity about who is case managing a resident during this settling-in period.</td>
<td>4.3.1</td>
<td></td>
</tr>
<tr>
<td>26 Formal arrangements should be made to cover case managers’ caseloads if they are absent from work and to ensure that teams have adequate resource in place to provide this cover. This would ensure that patients continue to receive case management support during staff absences.</td>
<td>7.5.3</td>
<td></td>
</tr>
</tbody>
</table>
8 Appendix A: Research tools

8.1 Focus group topic guide

Case management focus group topic guide

8.2 E-survey

Newcastle Gateshead case management E-survey

8.3 Stakeholder interview topic guide

Case management wider stakeholder inte
## Appendix B: performance monitoring requirements for Newcastle older person nurse specialists

<table>
<thead>
<tr>
<th>Quality Requirement</th>
<th>Threshold</th>
<th>Method of Measurement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contribute to reduction in avoidable UTI admissions to hospital from aligned care homes</td>
<td>5% reduction in avoidable UTI admissions for 2015/16</td>
<td>Monthly</td>
</tr>
<tr>
<td></td>
<td>Total number of avoidable admission to secondary care for UTI from aligned care homes</td>
<td></td>
</tr>
<tr>
<td>Contribute to a reduction in number of avoidable hospital admissions, recognising SCHST are part of a wider health economy programme of support</td>
<td>5% Reduction in avoidable hospital admissions for 2015/16</td>
<td>Monthly</td>
</tr>
<tr>
<td></td>
<td>Total number of unplanned admissions to hospital</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total number of unplanned admissions to hospital in the equivalent period the previous year</td>
<td></td>
</tr>
<tr>
<td>Contribute to a reduction in number of unplanned A&amp;E attendances from aligned care homes, recognising SCHST are part of a wider health economy programme of support</td>
<td>5% Reduction in number of unplanned A&amp;E attendances in 2015/16</td>
<td>Monthly</td>
</tr>
<tr>
<td></td>
<td>Total number of unplanned attendances to hospital</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total number of unplanned attendances to hospital in the equivalent period the previous year</td>
<td></td>
</tr>
<tr>
<td>Contribute to a reduction in patients admitted with a length of stay 0-1 days, recognising SCHST are part of a wider health economy programme of support</td>
<td>5% Reduction compared to previous years admission rates (equivalent to an accumulative 1.25% per quarter)</td>
<td>Monthly</td>
</tr>
<tr>
<td></td>
<td>Total number of patients admitted to secondary care with 0-1 day length of stay</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total number of patients admitted to secondary care with 0-1 day length of stay in the equivalent period the previous year</td>
<td></td>
</tr>
<tr>
<td>Contribute to a reduction in 30 day readmission rates from aligned care homes, recognising</td>
<td>5% Reduction in 30 day re-admission rates in 2015/16</td>
<td>Quarterly</td>
</tr>
<tr>
<td></td>
<td>Total number of residents readmitted within 30 days of</td>
<td></td>
</tr>
<tr>
<td>Quality Requirement</td>
<td>Threshold</td>
<td>Method of Measurement</td>
</tr>
<tr>
<td>-----------------------------------------------------------------------------------</td>
<td>----------------------------------</td>
<td>----------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>SCHST are part of a wider health economy programme of support</td>
<td></td>
<td>discharge from hospital Total number of residents readmitted within 30 days of discharge from hospital in the equivalent period the previous year</td>
</tr>
<tr>
<td>Number of residents with advance care plans in place</td>
<td>&gt;85% of residents</td>
<td>Quarterly Number of patients with advance care plans in place Total number of patients within aligned care homes</td>
</tr>
<tr>
<td>Number of residents with care plans in place that have an identified preferred place of death</td>
<td>&gt;95% of care plans</td>
<td>Quarterly Number of care plans with identified preferred place of death Total number of care plans</td>
</tr>
<tr>
<td>Contribute to a reduction in number of residents of aligned care homes dying within 24 hours of admission to acute care (excluding those residents whose preferred place of death is hospital), recognising SCHST are part of a wider health economy programme of support</td>
<td>5% reduction in 2015/16</td>
<td>Quarterly Number of deaths occurring in hospital within 24 hours of admission Number of deaths occurring in hospital within 24 hours of admission in the equivalent period the previous year</td>
</tr>
</tbody>
</table>

*Source: service specification for Newcastle specialist care home support team*
## Appendix C: Secondary care service use for Gateshead care home residents, 2013-17

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Secondary Care Spend</th>
<th>Non-Elective Admissions</th>
<th>A&amp;E attendances</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013-14</td>
<td>£5,687,954</td>
<td>1,860</td>
<td>1,676</td>
</tr>
<tr>
<td>2014-15</td>
<td>£8,737,679</td>
<td>1,882</td>
<td>1,694</td>
</tr>
<tr>
<td>2015-16</td>
<td>£6,441,346</td>
<td>1,514</td>
<td>1,975</td>
</tr>
<tr>
<td>2016-17</td>
<td>£6,976,313</td>
<td>1,522</td>
<td>2,042</td>
</tr>
</tbody>
</table>
Appendix D: Glossary of key terms

11.1 Definitions of key terms

11.1.1 Frailty

There is no set definition of frailty, however the wording frequently reproduced in NHS documentation is:

“Frailty develops as a consequence of age-related decline in multiple body systems, which results in vulnerability to sudden health status changes triggered by minor stress or events such as an infection or a fall at home. People with frailty have a substantially increased risk of falls, disability, long-term care and death.”


11.1.2 Long-term condition

The following definition of a long-term physical health condition is drawn from the NHS data dictionary, 2017: http://www.datadictionary.nhs.uk/data_dictionary/nhs_business_definitions/l/long_term_physical_health_condition_de.asp?shownav=1

A Long Term Physical Health Condition (also known as a Chronic Condition) is a health problem that requires ongoing management over a period of years or decades.

A Long Term Physical Health Condition is one that cannot currently be cured but can be controlled with the use of medication and/or other therapies.

This includes a wide range of health conditions including:

- Non-communicable diseases (e.g. cancer and cardiovascular disease);
- Communicable diseases (e.g. Human Immunodeficiency Virus (HIV) / Acquired Immunodeficiency Syndrome (AIDS));
- Certain mental disorders (e.g. schizophrenia, depression) and
- Ongoing impairments in structure (e.g. blindness, joint disorders).

Examples of Long Term Physical Health Conditions include:

- Diabetes
• Cardiovascular (e.g. Hypertension, Angina)

• Chronic Respiratory (e.g. Asthma, Chronic Obstructive Pulmonary Disease (COPD))

• Chronic Neurological (e.g. Multiple Sclerosis)

• Chronic Pain (e.g. Arthritis)

• Other Long Term Conditions (e.g. Chronic Fatigue Syndrome, Irritable Bowel Syndrome (IBS), Cancer) etc.

11.2 Key components in logic models

<table>
<thead>
<tr>
<th>Component</th>
<th>Description</th>
<th>Focus</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inputs</td>
<td>The resources available to deliver the model</td>
<td>The model budget, staffing and equipment</td>
</tr>
<tr>
<td>Activities</td>
<td>The things the model does or offers to participants</td>
<td>The model’s pathways and interventions</td>
</tr>
<tr>
<td>Outputs</td>
<td>Counting the “products” that result from running the activities</td>
<td>The model’s target audience</td>
</tr>
<tr>
<td>Impacts</td>
<td>The immediate consequences and change for the participants that are a result of the work of the model. There are usually 4 key areas of change for participants: (1) knowledge, (2) skills, (3) attitudes &amp; (4) behaviour</td>
<td>Patients admitted to the model and staff working in the model.</td>
</tr>
<tr>
<td>Outcomes</td>
<td>The higher level and usually longer-term results in participants’ lives, which the model may contribute towards, but which go beyond the direct and immediate change</td>
<td>The local population and health and social care system</td>
</tr>
</tbody>
</table>

11.3 SMART outcomes and indicators

• **Specific:** Is the indicator clear, concise and does it capture the essence of what you are trying to measure?

• **Measurable?** Can the indicator be measured and quantified? Do you know how you are going to do this?

• **Achievable?** Is it challenging but realistic? Or is it just an unachievable aspiration?
- **Relevant?** Is this indicator important in terms of the overall outcomes you are trying to measure?

- **Timebound?** Can you say “by when” this will be achieved?