Providing NHS Healthcare in Care Homes: a geriatrician’s experience

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Summary

- What I do in care homes
- Who are the residents?
- Issues from current NHS policy perspective
- What does the NHS provide and why?
- What needs to be done better?
- Examples - how it can be done better
- Policy and practice issues for the NHS
Who are the residents?

Bebbington et al, for PSSRU, 2011

Longitudinal cohort study 2000

- Representative sample of funded admissions from 20 councils
- Median survival of 19.6±0.9 months
  - 11.9±0.9 months for “nursing”
  - 26.8±1.0 months for residential
- 34% had severe confusion, 46% mild and 20% none

- Similar results from the BUPA survey
Current issues from NHS perspective

• Is it primary care?
• Acute admissions
• Management of long term conditions
• End of life care
• (Polypharmacy)
Hospital admissions from care homes - UK

- 1-3 per resident per year
  - But in our NHS home is <0.3 per year)
- Highest rates from mental health residential
- LOS variable but probably similar to age and condition matched individuals
  - But could be lower?
- Clinic attendances lower for “nursing homes”
  - Essentially useless on most occasions
Hospital admissions from care homes - South Australia in 6 years
(Hillen JB et al 2011)

- 3310 admissions from 147 care homes
- Frequent primary diagnoses
  - fractured femur/pelvis
  - Pneumonia
  - ischaemic heart disease
  - infections, urinary tract most common

But this does not explain why the decision to admit the resident was made
What influences GPs decisions?
(McDermott et al, 2012)

GPs views - purposive sample of 21 GPs from two counties in the South of England

• patient factors
  – perceived benefits and risks of admission
  – patients' and relatives' preferences
• poor documentation of clinical issues
• medico-legal concerns
• capability of nursing homes and GP workload
• lack of a systematic palliative care approach
Risks for Mortality

Norwich: (Alrawi et al, 2012)
• 410 admissions over 3 years
  – 32% male, mean age: 84.2 years
• 23% died
  – 73% in the first week
  – 50% in 3 days
• Predictors
  – Acute illness severity (MEWS, eGFR, CRP)
  – *Were some inevitable and thus futile admissions?*

Similar results from Bolton (Ahearn et al, 2010)
What were the avoidable reasons for the fatal admissions? (Ong et al, 2011, Norfolk)

- lack of advance care plans
- poor access to General Practitioners OOH
- Poor access to palliative care and specialist nurses
- poor communication between patient, relatives, GPs, hospitals and care home staff.
Hospital acquired problems

• Discontinuity of care plan and techniques
  – Poor communication of detail

• Wrong treatment objective
  – Poor communication of advance plans

• Failure to recognise likely adverse
  – Common failing for frail patients

• Usual HC associated infections
  – Consequence of frailty and antibiotics

• Protracted post acute care
  – Lack of community rehabilitation for care homes
How might admissions or days in hospital have been avoided? Our local study.
(Steves et al, London, 2008)

- Advance care plans for predictable final illness
- Better OOH response by GP
- Medication reviews to avoid drug problems
- Up skilled care homes for acute nursing (*but..*)
- Preventing delayed discharges
  - easier access for reviews in community
  - Post acute rehab support
  - Trust between ward and care homes
Preventing hospital admissions
(New York, Tena-Nelson et al, 2012)

• Education and training for all levels of CH staff
  – advance care planning
  – communication tools (care to doctor)
  – clinical change assessment tools
• Overall 10.6% ↓
• CH with high participation 14.3% ↓
• CH with high admission rates 27.2%↓
The effect of End of Life strategies on deaths in hospital (Hockley J et al, 2010)

- 7 private nursing care homes within one district in Scotland
- Gold Standards Framework for Care Homes (GSFCH) and an adapted Liverpool Care Pathway for Care Homes (LCP)
- Introduced over 18 months
- High support from specialist team
  - visiting the homes every 10-14 days + staff training

RESULTS
- use of Do Not Attempt Resuscitation (DNAR) ↑
- advance care planning ↑ LCP ↑
- hospital deaths ↓ from 15% deaths pre-study to 8% deaths post-study
Geriatricians with MDTs can reduce admissions from care homes-UK (Lisk R et al, 2011)

- Analysed the reasons for 1954 admissions over 3 yrs
- Implemented 4 strategies for 9 months: included telephone consultations and visits
- An alert was also sent to the geriatrician if one of the residents was admitted so that their discharge from hospital could be expedited.
- Significant ↓ admissions
- Length of stay in hospital ↓
Common long term conditions

- Dementia (progressive)
- Neurodegenerative eg Parkinson’s Disease
- Stroke
- Late stage cardio-respiratory illness

BUT a typical long term condition orientated approach is insufficient or even irrelevant
Why typical LTC approach does not work

• NICE guidance on long term conditions:
  – Not derived from research with care home residents
  – Potential to benefit depends upon which conditions are the main factors at this stage of life
  – Relative benefits differ with frailty etc
  – Burdens of treatments also affected by frailty etc
• Guidelines do not integrate co-morbidities
• Residents less able to participate
So, a different clinical perspective on need

Residents differ

Trajectories towards death

Median survival is short, ~ a year or so, but variability

• Some are clearly at end of life and may need mainly palliative care,
• But many stabilise and may live years
But healthcare needs are not unpredictable
e.g. Clinical Course of Advanced Dementia (Mitchell et al NEJM 2010)

323 nursing home residents with advanced dementia followed for 18 months in 22 nursing homes
Therefore …..

• Residents are different but mostly complex
• Support needs are different over time but the common problems are common
• Success needs establishing realistic individual healthcare goals, in context of overall goals and stage of life
  – Balance of palliative and other approaches
  – Realistic long term condition treatments
  – Anticipate clinical challenges
  – Work in partnership
Are the usual clinical approaches suitable?

• Will the patient set the pace?
• Is “demand led” response suitable?
• Who will notice and report symptoms? - staff
• And who will listen and respond?
• Who has to be involved along with the resident?
• Are hospital clinics realistic or useful?

*The usual approaches do not work*
What does research tell us about what works better?

- Shared perspective between residents, relatives, staff and clinicians
- Clarify health-related objectives
- Assess and anticipate challenges and needs
- Advance clinical plans
- Relevant observations and assessments
- Planned input of the right professionals in collaboration with each other
What can the NHS do to help? What does it do now?

- CQC review - March 2012
- Aim: To see what PCTs commissioned and how they were monitoring
- 9 key services were the focus
- All PCTs self assessed
- Detailed interviews with a sample
Publications from the CQC review

**Health care in care homes**
A special review of the provision of health care to those in care homes

March 2012

**Failing the Frail:**
A Chaotic Approach to Commissioning Healthcare Services for Care Homes

Analysis of data collected by CQC about PCT support for the healthcare of older people living within nursing and residential care homes
Standards and monitoring

The setting and monitoring of response standards

- Services commissioned
- Response standard set
- Standard monitored & data provided

Chart 2

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<tr>
<th>Service</th>
<th>No. of PCTs (152)</th>
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<td>Psychiatry</td>
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<td>Falls</td>
<td>32</td>
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<tr>
<td>Tissue Viability</td>
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How were services provided?

Specific provision for care homes

- Care home specific provider
- Services undertaking scheduled visits
- Specific referral pathways

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Guy's and St Thomas' NHS Foundation Trust
Variable access to community health services.

Only in 43% of PCTs are older people likely to have access to all the nine selected services.

Healthcare commissioners had inconsistent standards and did not monitor them

- 40% of all services lacked a response standard.
- Response standards varied greatly
- 31% used the general NHS ‘18 week target’

Despite variable access of care home residents to community health these non-ambitious standards, they were not met in nearly half of services for which there was data.

Limited access for care home residents to specialist mental health or geriatrician care. (60% of PCTs)
Why did this happen?
-a history of disengagement

• Privatisation of care in 1980s onwards led to withdrawal of NHS specialist clinicians
• Lack of clarity around NHS obligations
• NHS continuing care funding NOT followed by NHS care
• NHS aimed at working age population with single conditions not frail older people with co-morbidity
• Assumption that ordinary general practice is sufficient
• Care homes left as “islands of care”
• Ageism? In any case, healthcare not designed with the reality of the residents
• But Equality Act 2010 could challenge this.
Examples of service models in UK that might work

• Enhanced primary care
• Dedicated primary care
• Specialist support teams
• Integrated primary-secondary care
• Single issue initiatives

But we need the NHS to commit to a consistent and sustainable approach
Dedicated primary care - Durham

- Provides primary medical care to 200 patients in 14 care homes, two IC units and a hospice.
- A nurse practitioner, community matron, part-time GP specialist in geriatrics and additional GP sessions.
- Weekly visits pro-active in style.
- Quality & Outcome Framework modified
  - less relevant issues (e.g. statins) replaced with falls, osteoporosis, EoL planning
- Training - reduced reliance on community
Nursing Home Medical Practice in Glasgow

- 2003 - dedicated service, combination of salaried doctors and 12 contracted practices
- 2,700 residents in 61 homes—85% of homes in the city.
- Now includes liaison nurses, pharmacists and a small multidisciplinary team.
- Twice weekly medical visits and out-of-hours cover.
Leeds: LES + sessional geriatrician

- LES with local GPs
- Weekly visits, anticipatory care, regular reviews.
- For some homes, additional support from community matrons and a community geriatrician, visiting complex cases every 6 weeks.
- Initial 63% reduction in emergency admissions
- Management plans for complex patients after hospital admissions
Integrated primary and secondary – Manchester 2005

- Nurse practitioner, GP, consultant sessions
- Routine reviews of all residents
- Anticipatory care focused on the management of sepsis, hydration and nutrition
- Advance clinical plans
- Liverpool Care Pathway is embedded in practice
- Networks to other community services
- Significant improvements in outcome
  - 35% drop in emergency hospital admissions
  - 80% deaths occur in nursing homes
  - 93% compliance with wish re place of death
Care Homes Support team in South London (0.9 million) 2002

- 2 specialist nurses per 500 residents
- Mental health specialist nurse
- *Old age psychiatrist* (till 2010)
- Sessional geriatricians from local NHS trusts
- Pharmacist from community service
- GPs on LES (since 2009)

Nurse reviews prompt others activities + training
GPs may refer direct
Infrastructure for GSF etc,
Quest for Quality – June 2011

- BGS clinician led
- Stakeholder engagement
- Care homes fora
- Professional collaboration
- Inclusion of researchers
Recommendation 1

- Local NHS planners/commissioners should agree on clear and specific service specifications with their local NHS providers.
- These need to link with quality standards based on patient experience and appropriate clinical outcomes.

(My Home Life and EU have produced sets of standards)
Thank you, any questions?

(If you want any of these slides, finbarr.martin@gstt.nhs.uk)