Better medical care in care homes

Professor Finbarr Martin
Consultant Physician, Guys and St Thomas’
&
President, British Geriatrics Society
Summary

• The current situation
• How did we get here?
• A geriatricians perspective on the clinical needs of care homes residents
• What could and should the NHS do about it?
• Recommendations for development
Aim: To see what PCTs commissioned and how they were monitoring
(and how residents etc were involved in day to day care)

- Wide stakeholder engagement to identify the most important NHS services and what might be adequate standards of provision.
- 9 specific NHS services identified
Publications from the CQC review

Care Quality Commission

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

March 2012

British Geriatrics Society

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

<table>
<thead>
<tr>
<th>Service</th>
<th>No. of PCTs (152)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geriatricians</td>
<td>144</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>128</td>
</tr>
<tr>
<td>Dietetics</td>
<td>112</td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>96</td>
</tr>
<tr>
<td>Physiotherapy</td>
<td>80</td>
</tr>
<tr>
<td>Podiatry</td>
<td>80</td>
</tr>
<tr>
<td>Continence</td>
<td>72</td>
</tr>
<tr>
<td>Falls</td>
<td>64</td>
</tr>
<tr>
<td>Tissue Viability</td>
<td>64</td>
</tr>
</tbody>
</table>
Variation in standards of response time

2B - Response standards for the exemplar services

- Tissue Viability
- Falls
- Continence
- Occup Therapy
- Physiotherapy
- Psychiatry
- Geriatricians
- Dietetics
- Podiatry
How were services provided?

Specific provision for care homes

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

Bar chart showing the number of PCTs providing care home specific services for various healthcare specialties.
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 at the forefront
Common 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

• Guidelines do not integrate co-morbidities
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 EoL and may need mainly palliative care,
- Many stabilise and may live years
Common clinical challenges

- Pain at rest or on movement
- Infections
- Disengagement or agitation (depression etc)
- Behavioural and psychological symptoms
- Contractures and spasticity
- Mouth care: Eating and drinking difficulties
- Positioning in bed or chair
- Instability and falls
- Continence and skin integrity
- *Plus Acute illnesses and End of Life Care*
But healthcare needs are not unpredictable

*eg 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
Are the usual clinical approaches suitable?

• Will the patient set the pace?
• Is “demand led” response suitable?
• Who will notice and report symptoms?
• Interventions usually involve others as well as the patient, ie a resident in the context of care
• Are hospital clinics realistic or useful?

.... The usual approaches do not work

50% of care homes residents who died in hospital could have been cared for elsewhere

(National Audit Office Balance of Care, Nov 08)
What does research tell could work 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
Do current service models enable this pro-active approach?

- Mostly NOT – haphazard, many GPs with few residents, no co-ordinated specialist support
- Most care homes find this unsatisfactory
- Elsewhere – plenty of initiatives with average lifespan of 7 years
- Often provider rather than commissioning led
Examples of service models in UK

- 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
• BGS led
• Stakeholder engagement
• Professional collaboration
• Inclusion of researchers
**Recommendation 1 (of 7)**

- Local NHS planners/commissioners should agree 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.