COMMENTARY

Care home medicine in the UK—in from the cold

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Abstract

The quality of care within care homes comes under frequent media scrutiny, and is underpinned by the medical support to the staff. In the UK, medical care to care homes is provided by general practitioners. A GP is likely to have patients in many homes, and each home relates to many GPs. The growing complexity of patients in care requires proactive models of care delivered by those with an understanding of care home medicine. A range of innovative models of medical care are emerging across the UK which have the potential to improve the standard of care in homes, and reduce inappropriate use of secondary care admissions. These models are described, and the need for them to be subjected to evaluation.

Keywords: medical models, care home, anticipatory, managed care

The hallmark of a caring society is surely the way it provides for its weakest members. The negative media attention in care homes reflects a lack of confidence in the quality of care experienced by many older people in care homes. Quality of care has many dimensions: the environment and the nature of the staff are likely to be most transparent to families and prospective clients. Good medical care may be less visible, despite being crucial to well-being, given the complexity of health problems present in the majority of residents today. Surveys such as the census of 751 UK care homes in 2006 [1] confirm the very high prevalence of multiple disabilities and frailty in residents. Poor nursing care can reflect inadequate training and direction from medical staff in these complex patients. In most countries outside the UK, medical care in care homes is provided by dedicated staff, usually employed by the home. Geriatric medicine in the UK began by providing medical care on long stay wards but, as these wards closed in the 1980s, the care home sector enlarged and the responsibility for the medical care of the residents transferred from geriatricians to general practitioners (GPs). Many residents retain their own GP on admission to the home, and this means that a GP might have patients in more than one care home, and that care homes will relate to more than one GP. A survey of 765 care homes in England [2] found that the median number of GPs serving a home was 7, ranging from 1 to 50. Such arrangements cause practical difficulties for communication between care home staff and doctors, although they offer the benefits of continuity of care. In 10% of homes, residents were encouraged to register with the ‘home’ GP. It is hardly surprising that many GPs are questioning whether good care can be provided without specific remuneration and a change to the current model of care.

New models of medical care are emerging across the UK. These are described briefly here to stimulate debate, to consider the role which geriatricians may play and the need for research to evaluate these options. Care home medicine in the UK is coming in from the cold.

The key ingredients of medical care in care homes

Residents, like all individuals, want a doctor they can trust. This is assisted by continuity of care. Residents have a number

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Enhanced medical care with lead practice

One model being implemented, for example in Edinburgh, seeks to provide anticipatory care through a service level agreement (a contract between the commissioner and GP) which attracts modest additional payment per resident linked to specified standards of anticipatory care. An additional sum is available for one practice in each home to become the lead practice, taking responsibility for identifying training needs for staff, and providing a link to other bodies such as infection control and the care commission. In time the lead practice may become the dominant provider of medical care. This relatively small-scale investment may be inadequate to effect any improvements since each home still has to relate to several GPs. This model depends upon the interest, experience and workload of local GPs, as well as local arrangements for reimbursement. These factors could result in inequitable geographical differences in provision.

Attached primary care service

The specific attachment of one general practice to a home occurs naturally in many rural settings. Alternatively, a nursing home may purchase medical care from one general practice—a model previously found in 33% of nursing homes in England [2]. In Leeds, GPs historically and geographically linked to homes have agreed a locally enhanced service to provide weekly visits, anticipatory care and regular reviews. Homes find this model to be responsive to their needs with improved working relationships. In these models, residents have the choice of moving to the linked GP, or retaining their own. Experience shows that around 85% opt for the linked GP.

For some homes, this model has been enhanced by further support from community matrons and by a community geriatrician, visiting complex cases every 6 weeks. The benefits emerging from these arrangements include closer working relationships between primary and secondary care, an initial 63% reduction in emergency admissions without loss of access to the benefits of secondary care, helping difficult ethical decisions, improved clinical information following recent hospital admission, and supporting diagnosis and management plans for complex patients.

Potential drawbacks of this model are that it is not known if the GPs acquire expertise in care home medicine and deliver the expected standards of care. Loss of continuity of medical care will potentially be reduced, and some residents will feel that they will have lost choice.

Dedicated primary care service

Another style is the establishment of a dedicated primary care specialist service to deliver medical care. This is illustrated in Durham, where a small practice has been created by the Primary Care Trust (the body responsible for the commissioning of local primary care services) to provide primary medical care to 200 patients in 14 care homes, two intermediate care units and a hospice. The team comprises a nurse practitioner, community matron, part-time GP specialist in geriatrics and additional GP sessions. Weekly visits by the nurse are pro-active in style. The UK’s primary care incentive scheme, the Quality and Outcome Framework (QOF) has been locally modified. Areas considered less relevant (e.g. use of statins) have been replaced with falls prevention, osteoporosis, end-of-life planning in people with a palliative care diagnosis and the use of nutritional screening tools. The service has also provided training for the staff in nursing and residential homes around falls, palliative care, syringe drivers and catheters, leading to reduced urgent calls to district nurses.

The Nursing Home Medical Practice is a similar but larger model in Glasgow, and was established in 2003 to provide a dedicated service using a combination of salaried doctors and 12 contracted practices, and now covers 2,700 residents in 61 homes—85% of homes in the city. The service has expanded to include care home liaison nurses, pharmacists and a small multidisciplinary team. Each home receives twice weekly medical visits and out-of-hours cover. Observed outcomes have included improved palliative care, reduced crisis care and improved working relationships with secondary care and old age psychiatry.

Dedicated services such as these, like attached practice services, mean that residents have to leave their usual GPs when entering a care home, potentially leading to a loss of continuity. Care home standards may improve as long as the majority of residents join the service. They also require doctors to be attracted and retained who have an interest and sufficient expertise to run the service—a workforce with specialist expertise in care home medicine. Yet most doctors in the UK interested in older people are likely to train as geriatricians rather than GPs. Dedicated services may well be expensive, and the cost effectiveness of such approaches is not known.

Integrated primary and secondary care service

In Manchester, an advanced practitioner nurse, GP and sessions of consultant time have been brought together to form
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a team to deliver comprehensive medical care to over 400 residents in nine care homes. The team has been running since 2005 in three large homes, and is now being expanded to cover all care homes in their locality. The team has provided routine reviews of all residents, and anticipatory care focussed on the management of sepsis, hydration and nutrition, and discussion of the value and wish for future hospitalisation. For terminally ill patients, the Liverpool Care Pathway (a standardised protocol for end-of-life care) has been embedded in practice, including robust links to the out-of-hours service. Team networking to other community services including tissue viability, SALT, dietetics, physiotherapy, palliative care and diabetes has also been important.

The team has regularly met with the management teams in each home to develop partnership and pursue opportunities for training. Audit has suggested a number of significant improvements in outcome, including a 35% reduction in emergency admissions to hospital, 68% reduction in emergency bed days and 56% reduction in the length of stay for those admitted over a 6-month period of intervention (unpublished data).

Cost-effective outcomes?

Commissioners will be interested to know whether additional investment in medical care to care homes is cost-effective. There are several potential targets to off-set the increased costs. Costs of emergency medical admissions might be reduced through anticipatory care. Closer attention to prescribing might reduce prescribing costs. Outcomes could be improved by increasing the number of residents able to choose to die at the home. The Medicare managed care programme in the United States (Evercare) demonstrated that a nurse practitioner, working with around 100 residents, led to reduced use of hospital but no clear improvement in quality of care [4]. There is evidence that medication review reduces costs [5]. A large well-conducted cluster randomised trial carried out in Canadian care homes showed that the systematic implementation of advance care planning in stable individuals, led by trained nurses, reduced health service costs without decreasing individuals’ satisfaction or increasing mortality [6].

Conclusion

Models for improving the quality of care home medicine are emerging in the UK. They range from a modest enhancement of traditional UK primary care services, through attached primary care staff, and to dedicated specialist multidisciplinary teams. The time is ripe to refine these services, and to submit them to rigorous evaluation including cost effectiveness.

Conflicts of interest

None declared.

References


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