



BGS Commissioning Guidance

High Quality Health Care for Older Care Home Residents

Introduction

Nearly 400,000 older people live in care homes in the UK, nearly 20% of those aged 85+. Their health and social care needs are complex. All have some disability, many have dementia, and collectively they have high rates of both necessary and avoidable hospital admissions. Standard healthcare provision meets their needs poorly, but well-tailored services can make a significant difference.

The British Geriatrics Society (BGS) report *Quest for Quality* describes current NHS support for care homes and makes recommendations as to how care home residents' quality of care can be improved. This guide describes the clinical and service priorities for meeting care home residents' needs. It details the outcomes needed from commissioned services and suggests how these can be achieved.

A more detailed version of this guide is available on the BGS website along with reference material and links to useful resources.

Why special commissioning for older people in care homes?

Health needs are different: Most residents have a mix of comorbidities affecting both physical and mental health. Dementia is prevalent, the majority of residents in most care homes being affected to some degree, and depression is common.

Managing disability: The physical aspects of conditions which are common in care home residents (such as late stage neurodegenerative conditions including Parkinsonism and dementia, and severe stroke disease) are complicated. Care home staff need support from specialist health services to identify, understand and respond to the everyday impact of providing essential care. This includes appropriate provision of food and drink, preserving residents' skin integrity and preventing contractures. Medical treatment remains an important part of the response but requires a systematic approach and attention to detail, which GPs may find difficult to deliver with existing time and resource constraints. Some medical treatment may need specialist support from geriatricians.

Disease based models are insufficient: Single condition based programmes don't work for people with co-existing late stage diseases. An individualised approach is needed: shorter term priorities of alleviating symptoms usually outweigh the longer term value of disease control. Frailty and age significantly impact the response to drugs so that the burden and risks of adverse events may be greater. Community pharmacists and specialist nurses can help, but the work cannot be managed through standard protocols.

The usual services can't provide this approach: Access to GP surgeries and outpatient clinics is difficult and less effective than assessment and care planning in the care home. Urgent responses out of hours are insensitive to individual needs and overuse hospital attendance and admissions. There is wide variation in access to community-based therapies and long waiting times.

Access and advocacy: Most residents cannot initiate their access to doctors or community healthcare. Care home staff must become both advocates and facilitators.

The reactive mode is not enough: Establishing the objectives of care is the basis for success. Palliative approaches may be prominent from admission, but the balance of approach changes over time. Patient-centred health care and support plans are needed which include advance care planning.

Integrated provision: The needs of care home residents require co-ordinated input from generalists and specialists of multiple disciplines in partnership with social care professionals and care home staff. Partnerships are essential, built on shared goals, reliable communication and mutual trust.

What are the outcomes needed from commissioned services?

For residents themselves?

- ▶ Improved experience through high quality essential care – reducing distress from depression, disorientation, agitation, pressures sores, contractures, constipation, pain and sleeplessness.
- ▶ Minimisation of predictable acute events - urinary infections, aspiration and pneumonia.
- ▶ Avoidance of unnecessary progression of long term conditions coupled with a reduction in adverse drug events and the unnecessary burdens of irrelevant treatments.
- ▶ Reduced risks of falls, fractures and other injuries.
- ▶ Enhanced autonomy and involvement in decisions about care, place of care and place of dying.
- ▶ Reduced fear of dying and enhanced experience of dying for residents and their families.

For the local NHS?

- ▶ Enhanced equity in care (bearing in mind the Equality Act 2010) and health related quality of life – by shaping services to suit patients.
- ▶ More efficient use of local resources – reductions in Accident and Emergency attendances, non-elective hospital admissions, and a proactive collaborative approach to community healthcare.
- ▶ Reduction in the costs and risks of prescribing.
- ▶ Improvements to safety of care - by reducing falls, falls related injuries, and nosocomial infections.
- ▶ Fewer premature deaths as a result of patient-centred approaches to the management of long term conditions, with individualised treatment goals and reliable access to specialist advice.

To support a sustainable care home sector?

- ▶ A culture of partnership, support and shared clinical governance.
- ▶ Reliable access to familiar health professionals, including GPs.
- ▶ Agreed goals of care based on proactive multidisciplinary review with residents and families.
- ▶ Clarity on mutual obligations and responsibilities with regard to equipment and expertise.
- ▶ Optimum access and uptake of immunisation against influenza for staff and residents.
- ▶ Agreed systems of communication including for out of hours and urgent needs.

What activities will achieve these outcomes?

- ▶ Comprehensive assessment of new residents on admission and the development of a patient-centred care plan within a specified time period.
- ▶ Prompt recognition of residents requiring imminent end of life care, identifying issues and goals and making appropriate treatment plans within a shorter specified time period.
- ▶ A regular structured multidimensional review at least every six months, or sooner if clinically indicated. This should be used to modify healthcare goals, and guide clinical interventions in and out of hours.
- ▶ Assessments to include medication review in partnership with the community/care home's pharmacist at a frequency over and above essential GMS standards, at least every six months. A medication review should also be completed following discharge from an acute hospital admission.
- ▶ Assessments to include risk assessment, for example for falls, with appropriate prevention strategies.
- ▶ Creation of an advanced care plan for acute events and for preferred end of life care, in partnership with residents, their families and advocates.
- ▶ Agreement of reliable systems with appropriate support tools to enable effective telephone consultation and use of out of hours referrals.
- ▶ Regular scheduled visits by an appropriately commissioned GP or specialist nurse to review particular residents with new needs, perform routine reviews and to liaise with other health and social care professionals - including geriatricians - who are, or who need to be, involved in a patient's care.
- ▶ Clarification of referral pathways and response times for specialist input including community rehabilitation services, palliative care teams, specialist nurses (for example, tissue viability), community mental health teams and geriatricians.
- ▶ When and where feasible, extension of the scope of enhanced clinical interventions for example sub-cut fluids and parenteral antibiotics for carefully selected patients and according to locally agreed protocols.
- ▶ A robust interdisciplinary and interagency clinical governance system which promotes quality improvement and involves the care home manager and relevant staff. The system should support education and training and encourage the development or use of clinical tools, protocols and service improvements. It should also allow for review of individual cases involving complaints and adverse incidents as well as reviewing overall performance of the local system by regular monitoring of chosen outcome measures (see suggestions under Monitoring and Evaluation).

What services should be commissioned to do these things?

There is no definitive evidence which dictates whether these activities will be better provided by enhanced primary care or specialist services. It is likely that a combination of approaches whereby residents have access to enhanced, proactive, primary care and through this, access to a range of specialist services (such as community geriatricians and old age psychiatrists, allied health professions and community pharmacy) will deliver the best outcomes. Further detail about examples of these services and their evaluation is available on the BGS website.

Many services commissioned for care homes are relatively short-lived. It has been suggested that this is a consequence of failure to engage the care home sector in the design, development and day-to-day running of services. We would recommend that commissioners consider early involvement of local care home representatives in commissioning discussions.

Monitoring and Evaluation

Possible measures could be:

- ▶ A defined and separately identified register of individual patients for whom the service provider or practice is contracted to provide services under a commissioned contract.
- ▶ Evidence of individualised health care plans, 6 monthly reviews and advanced care plans.
- ▶ Evidence of on-going and relevant training.
- ▶ Evidence of preventative medicine: for example, % coverage of this population for immunisation against influenza and pneumococcus (vaccinated or declined). A target could be 90%.
- ▶ Evidence of effective medication management: for example % reduction in the number of prescriptions, costs of prescribing, and reported adverse events by community pharmacists.
- ▶ Improved safety of residents: for example % reduction in rate of fractures or reported falls.
- ▶ Integrated services delivering patient-centred care: for example % of people dying in preferred place.
- ▶ Evidence of reduction in residents' unplanned hospital services use: for example, % reduction in the number of Accident and Emergency attendances and non-elective hospital admissions.
- ▶ Evidence of reduction in residents' use of unplanned community services: for example, % reduction in emergency ambulance use or out of hours GP call outs.

For more information, please refer to the detailed version of this guide available on the British Geriatrics Society website: www.bgs.org.uk [Select Resources/Campaigns/Commissioning]

The BGS is the professional body of specialists in health care of older people in the United Kingdom.

The BGS has a Community Geriatrics Special Interest Group which brings together health professionals with an interest in the management of frail older people in community settings. If you would like to join this group or receive its e-bulletin, sign up on the BGS website [Select Special Interest/Community Geriatrics]. It also holds an annual event to share best practice and facilitate networking see www.bgs.org.uk [Select BGS Events].

Follow the BGS on Twitter @gerisoc and see the BGS blog for discussion of topical issues regarding the care of older people www.britishgeriatricsociety.wordpress.com