**BGS Commissioning Guidance – High Quality Healthcare for Older Care Home Residents**

**Supporting documentation**

**Introduction**

Around 400,000 older people in the UK live in care homes, comprising nearly 20% of over-85s. Care home residents are amongst the most vulnerable of people. Their health and social care needs are complex. All have some disability, most have dementia, and they have high rates of both primary care consultation and hospital admission. The standard model of healthcare provision, with ad hoc support using existing primary care resources, inadequately meets their needs.

Despite this, most local health services do not commission specifically for residents. The few who do so describe benefits. There are statutory obligations regarding funding arrangements, which differ between the four UK nations, but the principles of effective healthcare are common.

The British Geriatrics Society has produced a brief two page summary document as guidance for commissioners who wish to develop models of health care delivery which more effectively meet the needs of care home residents (hyperlink to brief guidance). This paper summarises the evidence-base for those recommendations.

**Why specialist commissioning for older people in care homes?**

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<th>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.</th>
<th>The health and functional status of care home residents has been described both in a detailed cohort study with longitudinal follow-up and in large national surveys of care home providers: Gordon AL, Franklin M, Bradshaw L et al Health status of UK care home residents: a cohort study. <em>Age and ageing</em> 2013:aft077–.</th>
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<td>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 part of the response but is often beyond the scope of routine general practice.</td>
<td>Bowman C, Whilster J, Ellerby M et al A national census of care home residents. <em>Age Ageing</em> 2004, 33:561–566.</td>
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<td>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.</td>
<td>The failure of existing models of healthcare to provide adequately for the complex needs of care home residents has been described both in detailed qualitative studies and in database studies which have looked at compliance with indicators on the quality outcomes framework: Robbins I, Gordon A, Dyas J et al Explaining the barriers to and tensions in delivering effective healthcare in UK care homes: a qualitative study. <em>BMJ open</em> 2013, 3:e003178–.</td>
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<td>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</td>
<td>Shah SM, Carey IM, Harris T et al Quality of chronic disease care for older people in care homes and the community in a primary care pay for performance system: retrospective</td>
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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.

The difficulties faced by care home residents in accessing the services provided by existing primary healthcare teams has been demonstrated in national surveys of care delivery:


A rationale for more integrated provision has been outlined in national reports and research publications:


Gordon AL. University of Nottingham; 2012. Does Comprehensive Geriatric Assessment (CGA) have a Role in UK Care Homes? PhD thesis available online at [http://etheses.nottingham.ac.uk/2619](http://etheses.nottingham.ac.uk/2619) 24 Jan 2013, date last accessed.

### What are the outcomes needed from commissioned services?

- **Improved experience through high quality essential care** – reducing distress from depression, disorientation, agitation, pressure sores, contractures, constipation, pain and sleeplessness.

- **Minimisation of predictable acute events** - urinary infections, aspiration and pneumonia.

- **Reduced risks of falls, fractures and other injuries.**

The evidence base for intervention in care homes has usefully been reviewed across a number of articles:


| Avoidance of unnecessary progression of long-term conditions coupled with a reduction in adverse drug events and the unnecessary burdens of irrelevant treatments. Reduction in the costs and risks of prescribing. | The difficulty of safe prescribing and dispensing in care homes was outlined in the Care Home Use of Medications (CHUMS) study: Care Home Use of Medicines Study (CHUMS) Medication errors in nursing & residential care homes - prevalence, consequences, causes and solutions. Report to the Patient Safety Research Portfolio, Dept of Health. Report available online at [http://bit.ly/1akAf1o](http://bit.ly/1akAf1o) |
| More efficient use of local resources – reductions in Accident and Emergency attendances, non-elective hospital admissions, and a proactive collaborative approach to community healthcare. | The intensive use of primary and secondary care resources by care home residents has been documented in a number of studies and there is reason to suspect that this might be modifiable. Gordon AL, Franklin M, Bradshaw L et al Health status of UK care home residents: a cohort study. *Age and ageing* 2013:aft077–. D Briggs & L Bright, Reducing hospital admissions from care homes: considering the role of a local enhanced service from GPs, *Working with Older People*, March 2011 15:1, 6 |
| Enhanced equity in care (bearing in mind the Equality Act 2010) and health related quality of life – by shaping services to suit patients. A culture of partnership, support and shared clinical governance. Clarity on mutual obligations and responsibilities with regard to equipment and expertise. | The equality act can be viewed online at [http://www.legislation.gov.uk/ukpga/2010/15/contents](http://www.legislation.gov.uk/ukpga/2010/15/contents) The importance of collaborative working with the care home sector was identified and described over a number of papers written by the APPROACH study group: Goodman C, Drennan V, Scheibl F et al Models of inter professional working for older people living at home: a survey and review of the local |
What activities will achieve these outcomes and what services should be commissioned to do these things?

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| Sheffield | A locally enhanced service (LES) evaluation of the Sheffield PCT scheme demonstrated that the overall care planning process is carried out well and there is widespread evidence of good relationships developing between practices and homes. Feedback from the pilot showed that, of care home residents:  
  - 94% agreed that the GP service gave them the help they needed  
  - 84% felt they received better care with the new GP service.  
For care home staff  
  - 97% agreed that their relationship with GPs had improved  
  - 86% agreed that the new service helped them understand more about residents’ health.  
25% of admissions from care homes are avoidable and that 40% were due to aggravated long-term conditions. |
| Sandwell | In Sandwell, a one year pilot sought to help support holistic and joined up health care to its local care homes. Detailed multidisciplinary review by a geriatrician, nurse specialist and pharmacist achieved positive results. One care home experienced a 16% reduction in hospital admissions and a 43% reduction in occupied bed days; another another the decrease was 29% and 71% respectively.  
The estimated annual medication savings were £39,090. |
| Leicester | In Leicester, shared management of patients in residential homes between GP practices and community geriatricians demonstrated that after six months  
  - out-of-hours consultations fell by 16%  
  - out-of-hours consultations fell by 16% |


Optimum access and uptake of immunisation against influenza for staff and residents.
- requests for visits fell by 37%.
- hospital admissions were reduced by more than half.
- The total cost of hospital admissions fell by 60%.

The lessons learned have now been incorporated into a new primary care based LES.

In **Peterborough**, nutritional screening with the ‘Malnutrition Universal Screening Tool’ resulted in:
- a 31% reduction in hospital admissions
- a 27% reduction in emergency admissions
- a 58% reduction in the length of hospital stays.


In **London** a locally enhanced service (LES) contract focusing on care homes:
- saved money
- improved service continuity
- improved working relationships
- ensured that preventative measures took place through regular monitoring and ‘check up’ of care home residents
- Demonstrated high levels of satisfaction amongst care home residents.

D Briggs & L Bright, Reducing hospital admissions from care homes: considering the role of a local enhanced service from GPs, Working with Older People, March 2011 15:1, 6.

In **Bath and Somerset** a joint NHS and local authority initiative providing a dedicated nursing and physiotherapy team to three residential care homes reported:
- reduction in hospital admissions and prevention of nursing home transfers.
- estimated cost savings ranging from a ‘worst case’ scenario of £2.70 extra per resident to the more likely scenario of £36.90 savings per week.

Savings were mainly through reduced use of NHS services, while the PCT and social services both funded the intervention.