Reducing hospital admissions from care homes: considering the role of a local enhanced service from GPs

Daniel Briggs
Senior Lecturer in Criminology and Criminal Justice, University of East London, UK

Les Bright
Independent Consultant, BCD Care Associates, UK

Abstract
In some areas where there is a concentration of care homes, GPs have expressed concern about their capacity to provide an effective service to residents without additional resources. Some primary care trusts (PCTs) have since responded by making funds available to enable an improved service to be established. This article looks at the impact of one local enhanced service on the work of GPs, care staff and residents in one London borough.

Key words
Care homes; GPs; hospital admissions; local enhanced service; patients’ experiences.

Introduction
The characteristics of care home residents have been changing for some time, with many older people making the decision – or having it made for them – to move into care homes later in life, frequently with more complex health needs. The NHS is now a minor player in the long-term care of older people; the number of places it provides has fallen from 75,000 in 1970 to around 15,000 at the present time. In parallel with this, nursing home places provided by private and voluntary organisations have risen from 20,300 in 1970 to not far short of 200,000 in 2010 (Laing & Buisson, 2010).

It is therefore unsurprising that GPs, faced with substantial growth in the number of homes caring for people with complex healthcare needs, or occasional but unpredictable requirements, should express concern about their capacity to provide an adequate service. In some cases this led to demands by GPs for care homes to pay a retainer fee to enable them to provide a service to the home. To date, there has been no systematic study of the prevalence of such charges being sought or paid, but the issue attracted the attention of the House of Commons Health Select Committee during the course of an inquiry into elder abuse (2004). Responding to the report, the government
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suggested that it considered such charges to be a legitimate cost on the business, where it assisted providers to manage their businesses effectively. It did not appear to either condone or condemn the prospect of such costs being passed on to residents, so that in effect they would – unlike any other citizen – be paying in order to have access to a doctor.

A small study arising from the concerns of a number of its members that ran care homes (Association of Charity Officers, 2005), established that either individual older people or the charities that set out to make their lives better had to meet these demands. On occasions, this was with no obvious or appreciable difference from the service provided to their peers living in similar circumstances, where the GP or practice had taken the view that it was not legitimate to make a charge to the home. Concern about the situation was not the sole preserve of GPs. Home managers had also become extremely bothered that GPs were already overstretched and that this may impact on individual residents. Consequences included longer waits for a consultation; increased hospital admissions; problems in securing prescriptions or having medicines reviewed; difficulties in accessing other primary care services.

It could be argued that the principal reason why residents receive a less efficient service – or have to pay in order to enjoy the same level as their contemporaries in the wider community – is their address. GPs managing heavy workloads may consider care home residents a lower priority because they are in a home and are therefore being looked after, unlike their peers living independently who cannot draw on such support. However, this misrepresents both the intensity and complexity of individuals’ needs, and the limits of the care provided in homes. While those registered for nursing care are obliged to employ nurses, there are no such requirements on residential care homes.

Indeed, for some time now there have been increased calls to address the healthcare needs of care home residents. The Medical Director of a primary care trust (PCT), giving evidence to an inquiry stated: ‘People in care homes get sub-standard health care. It’s as simple as that’ (The Centre for Social Justice, 2010). And the Chair of a London PCT, responding to the same inquiry bluntly said:

‘There is little incentive for GPs to attend specially to the needs of care home residents, even though more often than not this is a group of people who are more dependent on regular and intensive medical care to maintain good health.’

In some areas, PCTs have committed funds to supporting practices to offer a more comprehensive and better-organised approach to looking after patients living in care homes. This has removed the justification for approaching individual home managers for a ‘retainer fee’ and the development of differential levels of service based on the size of fee paid. Such arrangements have taken a variety of forms, but are likely to specify a level of service such as availability, visits, links to other healthcare professionals and arrangements for public health work such as administering flu jabs.

The request for payment of fees has attracted attention, but this issue may be an indicator of unease among some doctors that they should be required to spend time subsidising the activities of commercial organisations that have taken on work previously undertaken by specialist NHS doctors in hospitals. The boundaries between state provision and personal responsibility have been shifting for some time and the care of older people living in registered care homes has been contested territory. The local enhanced service (LES) we report on here is one way of ensuring that this group of already vulnerable people do not continue to be adversely affected.

Aims and methods

From November 2009 to January 2010, a London-based PCT (‘Borough’ hereafter) commissioned a review of the existing practices of the GP LES across Borough’s care homes. The rationale for the review was to report ‘thematically’ on the effectiveness of current practice, potential gaps and suggest improvements. The review made use of 30-minute telephone and face-to-face interviews with care home professionals (n=8) and GPs (n=3). Professionals were required to reflect on elements of current practice, the efficiency of those processes and offer suggestions to improve the configuration of the service. In addition, three care homes were visited (Tree
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Road, Garden Road, River House) and face-to-face interviews were also undertaken with care home residents (‘residents’ hereafter) (n=23) and their family members (n=2). These interviews were also open-ended and required participants to reflect on their general experiences of GPs and the ease of accessing support, and comment on any improvements to the service.

This review was not commissioned as research and therefore ethical approval was not required. However, ethical conduct followed established procedures through The British Sociological Association (see: www.britsoc.co.uk). For the purpose of this paper, Borough, its care homes and participants have been anonymised. Two main barriers hindered the review: some GPs did not respond to the request for interview (n=4) and some residents found it difficult to reflect on their experiences (in particular those with dementia), however, family/staff members helped to convey their opinion.

Findings

Three main themes of current practice emerged from the data: current working relationships and communication; service efficiency; and residents’ experiences. It was found that positive working relationships were integral to levels of communication, which, in turn, affected the level of service efficiency. This appeared to influence the quality of the service that care home residents received. The next section of this article will provide an overview of the current care home LES service provision.

Current service delivery

Generally, both GPs and care home professionals considered the operation of the LES for GPs in care homes to function efficiently. GPs attended their allocated care homes on time and at the same times, week in, week out. Regular health checks and medication reviews were administered for care home residents every three to six months. While some care home professionals had not been in post prior to LES implementation, most agreed that the quality of the service had improved since the implementation of the LES. Specifically, they felt that the LES had streamlined service delivery and reduced the number of referrals to hospital. For example, Raquel, a Care Home Manager, recalled how it was beneficial that GPs had helped reduce hospital numbers:

‘I don’t have the figures but we have a regular register and the last person to be admitted was March 2009. That lady was in [for] heart failure. Since, the numbers have reduced significantly, and this is because of the GP. For example, we can now have palliative care nurses referred by the GP and we can liaise with them so our clients can stay in homes rather than be transported to hospital. We have these things in place to now make them [patients] comfortable.’ (Raquel, Care Home Manager)

This indeed seemed to be reflected in the figures. A GP provider receives a fixed payment of £15,000 per year to deliver LES services in care homes. Prior to LES in 2009, one care home registered 35 deaths; 20 of which occurred in hospital. If we consider that visits to hospital for frail elder populations average £3,000 per visit, this potentially cost the care home £60,000. In 2010, however, the same home registered 36 deaths; only 14 of which had occurred in hospital. By the same measure, this cost the care home £42,000 and saved £18,000. If we balance the cost of the GP service (£15,000) and the savings made (£18,000), £3,000 was saved in one care home in the borough. We can therefore assume that, given the staff testimonies, similar savings were also made in other care homes. It must also be noted that this was the first full year of operation and staff expected that processes and procedures would improve. This reduction was attributed directly to LES implementation.

In addition to a reduction in hospital numbers, another benefit of the care home LES was that it promoted the opportunity for client continuity of care and good working relationships. Another Care Home Manager said the establishment of one specific GP to visit the home was a positive move:

‘I don’t know too much about the changes [since LES implementation] as I can only speak from 2007 onwards. It used to be that several different GPs were covering our home but now it is one. This is a positive move’
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because they get to know the patients, it saves time and we can build relationships.' (Ernest, Care Home Manager)

It was also broadly agreed that the care home LES had ensured that more preventive measures took place regarding the care and monitoring of patients. For example, in this excerpt, Dr Fellow highlights how more regular monitoring and ‘check ups’ benefitted two care home groups:

‘Before LES, patients with chronic illnesses were seen more regularly and some missed out because they didn’t have discernable problems but now [because of LES implementation] we are reviewing them regularly. As a result, we can better pick up and can monitor patients… Now patients with chronic diseases have a higher standard of living, they are covered better so we can get round to everyone on a regular basis to check, for example, to see they are not losing weight, and ensuring they don’t get depressed.’ (Dr Fellow, GP)

Care home professionals preferred to deal with one person – and this they attributed to the LES implementation. The benefits for the patients included improved referral processes, and streamlined medication and prescribing procedures. This Care Home Manager said:

‘Two years before LES, a number of different GPs visited the home and referral processes took longer. Now the LES has brought the whole service together and it is quicker. It really has been amazing for us; good for relationships between GPs and next of kin or friends, and has cut down referrals to hospital. Having someone come in and refer to clients personally has made a difference.’ (Charles, Care Home Manager)

The reduction in hospital numbers, better continuity of care for residents, and better monitoring measures appeared to be the main features for the efficient operation of the care home LES. These elements, however, relied on positive working relationships and communication, which was also a feature of the care home LES.

Working relationships and communication

The effectiveness of the care home LES appeared to rely heavily on positive working relationships. Many care home professionals were extremely positive that their allocated GP came to the care home at fixed times each week. This meant positive working relationships could be developed:

‘We are lucky in the sense we have Dr Simmons, and we cannot complain one dot on her, she is excellent. Whenever we phone her out of hours, she advises us. Every week she comes to the home and if they [the residents] say yes or no, they are treated the same and that is so unique; she is professional. She is working with clients and relatives because some of them are forgetful and demented and she doesn’t go ahead making decisions for them, she consults them and if they say yes and she will refer.’ (Miriam, Care Home Manager)

Because there were good working relationships, it meant GPs often went the ‘extra mile’: some stayed late, provided out-of-hours advice and, in some cases, made out-of-hours visits. Care home staff valued their professional direction on the health and treatment of the residents because regular visits meant that they did not have to take residents to the GP surgery or hospital. The LES also meant that good relations were fostered between GPs, and residents and their families. For example:

‘It is very consistent because I get to know everyone so well whether they have problems or not. I look after people with dementia, and most know who I am but some don’t but they are reassured by seeing a familiar face. I can keep people out of hospital. You know what they do and don’t want in their old age, and you talk to the relatives as well and you get to know them. No one really wants to go to hospital. When I am away, they [care home staff] have knee-jerk reactions and it is a bit of a mess but the consistency is still great – it saves money.’ (Dr Davies, GP)
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For these reasons, it was easy to see that communication between GPs and care home professionals appeared to be, on most occasions, of a high standard. Care home staff felt reassured that they were able to contact their allocated GP at any time through email, fax or mobile phone:

‘Excellent, we are lucky to have somebody who is aggressive in the good sense of the word. She [GP] covers the bases and tells us what we need to do if we need direction, there are rarely gaps, the medication always starts on the day prescribed, and we use local pharmacies to avoid delays. Other medications don’t have to be started because there is time but we tolerate any delay in medication.’ (Ernest, Care Home Manager)

This was also evident in GPs’ responses:

‘We have brilliant communication. Although we are just around the corner, they [care home staff] have access to my out-of-hours number, my direct line, and fax number. They tend to fax requests across outside regular visits but also they fax for medication and dressing. It all works very well. We also have the regular meetings with the care home manager to discuss little details around communication on medication or anything which might be topical at the time. We recently had meetings to discuss swine flu so we talk about the potential consequences.’ (Dr Fellow, GP)

Good working relationships and positive communication had implications for service efficiency.

Service efficiency

Established working relationships and positive communication meant that the level of service efficiency was high. For example Raquel, a Care Home Manager, said the 33 residents were seen on ‘Tuesday and Thursday for two to three hours respectively’, and received regular medication reviews every three months. If residents were healthy and ‘had not been ill’, they would automatically be on the list for a health check up. In the main, changes to medication treatment plans were well communicated between care home staff and GPs:

‘The GP lists changes to medication on a professional log and fills it in each time she visits. Then we issue prescriptions and then we would transfer them to service user administration records, and update the process. If she comes with the computer she can generate the prescription right after her visit – sent straight to the home. She has her own laptop and all the information is on there. It is pretty good.’ (Ernest, Care Home Manager)

There appeared to be some small problems with the current prescription referral system. GPs suggested that some patients were transferred without the necessary information about their medical history and details of medication. In addition, they also felt that inexperienced ‘agency workers’ could make the medication and referral system a little more haphazard:

‘I do medication reviews each six months, then every time someone is in hospital we will look at what they have been discharged on. I look at most on a weekly basis and find the carers are on the ball. In the dementia home, however, the agency people are not that qualified and lack common sense. They are nice people, but it is typical of dementia homes; they [some of the staff] are not well paid and not well respected. It is a horrible job but their training is variable and I think without a doctor going in twice a week, they would be all over the place. I also try and make it absolutely clear what to do so the pharmacist will write it out but even despite this, at times they don’t adhere to the instructions. Because of that I have more work.’ (Dr Davies, GP)

One care home assistant manager at Tree Road said that, on occasions, chemists and pharmacies did not receive faxes for medication. They also said there was some miscommunication with regard to transport to hospital appointments, which often resulted in the care home funding the cost of taxis. Nevertheless, praise was given to the efficiency of GPs. They were commended for their high standard of maintaining paperwork and
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prescriptions. There was also praise for the role GPs had in referring residents for palliative care and district nursing:

‘[Referral processes are] quite good. We can always fax them, phone anytime, and can get prescriptions quickly. She always gets back to us if she can’t get here then the practice nurse will call. Both of them [the GP and practice nurse] can refer to district nurses because we are not allowed to do nursing or dressing.’ (Rochelle, Care Home Manager)

‘If they are in acute distress, then we have to revisit hospital. We do palliative care here and they come in and work with the GP to prescribe medications. We activate emergency services so people can be transferred out but most of the time it happens out of hours. Sometimes [we] just have to do without a GP but there is no other alternative. Sometimes Nightdoc advise us to transfer to hospital.’ (Ernest, Care Home Manager)

The second quote is important because it highlights perhaps an unavoidable area of service delivery; that is, when there is little other choice but to refer to hospital. All professionals agreed that there were times when hospital referral could not be avoided: either in the event of a ‘serious fall’ or on advice from the out-of-hours medical service, Nightdoc. Care home staff recognised that they were not medically qualified and did not want to ‘take the risk’. Rochelle summarised that: ‘We are keen not to rush them into hospital and do it here’ and that ‘only if they were really ill’ would they be ‘taken to hospital’. Nevertheless, while there were some small issues of communication, in general residents and their family members had a positive experience with GPs.

Views from residents and their family members

Care home residents and their family members were very satisfied with the GP service. While most residents could not recall with accuracy the frequency of the GP visits, they liked the fact that they could talk to the same person and appreciated that their concerns were heard. Peter felt that the GP was ‘good’ and although he did not know how often he came, he knew that he ‘had not long been visiting the home [that he was new’]. Douglas was regularly seeing the GP for ‘various things’ to do with his chest: ‘he is new but he listens to you, and he helps me out with my breathing’. Similarly, Claire liked the way the GP ‘listened to everything I had to say’. The residents also liked the regularity of the visits and the fact that more thorough checks were undertaken every three to six months:

‘I only see him once a week when he comes to do the rounds – he is a very nice young man and he is very good. He understands you and wants the best for you and listens to what you say. I’ve been here a year and seen another student doctor but have had no problems with either. Sometimes he is on holiday but it doesn’t matter. He always orders the prescriptions monthly or something and they are sent over automatically – he is very conscientious.’ (Angus)

Even when residents had to make a journey to hospital, most seemed to understand that all efforts had been made to solve the problem ‘in house’. This was also the case in the context of pain management – that is, residents knew it might take time to find the right balance to manage their pain:

‘I have been to casualty a few times. Been here just over a year because had a fall and had to go to hospital as well. The doctors saved my life. Dr Andrews is absolutely brilliant. He may not be able to solve all the problems but I am intelligent and I understand him. Only a month ago he discovered why I got paralysed and he was able to discuss it all with me and I now know what it means.’ (Anne)

‘[The GPs are] very good, they listen to you and they will help you. I see mine for all sorts [thyroid problems and multiple sclerosis] and they give me all sorts of medication. I don’t have much pain now. They had to find out about the medication so it took a little time but now it is precise. I can see him when I want to or all the time, depends on how ill I am. Last week, I was calling the night doctor and he was very nice and good to me.’ (Linda)
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GPs’ persistent monitoring and chasing up referrals often made these experiences positive. For example, Mary, who also had dementia, saw the GP twice a week for check ups. She had been referred to hospital eight times in 2009 for various medication reviews and persistent stomach problems. Stella, who had recently lost her confidence after a bad fall, had been referred by her GP to a physiotherapist. There was some delay but the GP was proactive in chasing up and wrote a letter in support of a customised frame:

‘[The GP is] very friendly – she said “don’t worry, I will look after you” [after she had the fall]. We did have one a few years ago but he went abroad but this one is just as good. My legs have gone down and the swelling is nearly gone [from the fall]. I am waiting for a special frame but have been waiting for weeks.’ (Stella)

A few of the family members interviewed for this review were also comforted by the level of care that GPs provided. On a visit to River House, we spoke briefly to Hassan whose wife had dementia. He said: ‘The GP is very nice. I have met her personally. I have been here when she has taken her to her room because I cannot support my wife. The truth is she [the GP] goes out of her way to make sure she [his wife] is ok.’ When we briefly met Sonya on her way out of Garden Road, she was also positive about the role of the GP in her grandmother’s care: ‘sometimes she [GP] will call me to inform me about changes they make to her care plan because my grandma is very fragile at the moment’. In a similar vein, care home professionals, the residents and their families appreciated the fact GPs were able to build relationships with the residents. Here one care home manager commented on her observations of the positive interactions between GPs, care home residents and their families:

‘Obviously she [the GP] knows all the residents and with the elderly, continuity is very important. She comes twice a week, Monday and Thursday so three to four hours a week and with any queries she will know straight away, will know a lot of the families and it is more personal care.’ (Raquel, Care Home Manager)

There were, however, some areas that professionals suggested could benefit from improvement.

Gaps and suggested improvements

While professionals felt that the prescribing process was reasonably efficient, what hindered a smoother operation was that GPs had to return to the surgery to prescribe. A few care home professionals suggested the use of ‘pods’ (mobile prescription tools), which would speed up the prescription process. A few said that the PCT had considered the use of these but were not sure what had been agreed about their use. The GPs, however, were a little more sceptical about their use and instead suggested that prescribing technology be installed in the care homes. One consequence of not being able to prescribe in the care home was that it was often difficult for some care home professionals to collect prescriptions. Others relied on deliveries from hospital or pharmacists, which could not always take place on the same day. In a few cases, this meant some residents waited two days without prescriptions. This was not the case for all care homes as some had established systems that meant same-day prescriptions were often received from their pharmacist, who was able to deliver.

Some care homes had short-stay residents (those who needed housing and care in emergencies). This group, the care home professionals suggested, tended to be hospitalised more than other residents. Less was known about these residents and their medical histories and that more information was needed on this group. There was also some suggestion that care home professionals receive training on emergency situations, which may also help further reduce hospital admissions. A few care home professionals also called for the same quality of GPs when their usual GPs were away on holiday. They suggested that the quality of service delivery deteriorated slightly in these periods because the replacement GPs did not know the patients. This is, however, perhaps an unavoidable part of delivering care for this cohort. Despite these suggestions to make the LES more efficient, almost all interviewees reflected that they would not make any changes to the basic structure of the LES service delivery.
Conclusion and discussion
This article has attempted to comment on current practice and examine possible gaps to improve service delivery for care home LES implementation in one London borough. In doing so, it has canvassed the opinions of GPs, care home professionals, residents and their family members. This paper seems to show that the establishment of the care home LES in one London borough appears to have enhanced current practice and improved life for care home residents. In particular, the implementation of the care home LES appears to have significantly reduced hospital referrals and improved client continuity of care. It also appears to have enhanced the method by which residents are monitored for health problems and enhanced the prescribing systems. The care home LES in this borough seems to offer a more complete monitoring system of all residents rather than just those with the most serious health problems.

The success of these procedures appears to rest on the establishment of positive working relationships between GPs and care home professionals. Fixed, regular visits to care homes aided communication and consistency and allowed for positive working relationships to flourish. These interactions have clearly impacted on the efficiency of the service and filtered down to residents’ perceptions and experiences of the GP service. The residents appreciated the ‘familiar’ faces and that GPs listened to their concerns. The current process could be improved with closer attention to prescribing processes and consultation on the use of ‘pods’ or alternative prescribing technology in care homes. Communication in some places could improve particularly between GPs and pharmacists. Nevertheless, this article shows that commendable efforts have been made to work with a demanding population under pressured circumstances.

The fact that the Care Quality Commission has identified the provision of healthcare services for homes’ residents as a topic for a ‘special review’ highlights the variability of existing arrangements. People living in care homes should expect to receive services broadly in line with those available to the wider population and, in an era of increased patient choice, should not have their personal options closed off by systems and approaches that are aimed at improving efficiency while narrowing choice. Older people moving to a care home outside their GP’s catchment area will most likely need to change their doctor. Transition to a new practice needs to be handled sensitively, with patient needs rather than bureaucratic requirements acting as the key driver.

Implications for practice
■ Balancing efficiency of arrangements against a commitment to enabling resident (patient) choice.
■ Consider the use of mobile prescription tools/fixed prescription tools in homes to enhance the prescription process.
■ Consider some basic training for ‘emergency situations’.
■ Improve agreements with local chemists/pharmacies to ensure quicker delivery of prescriptions.
■ Deliver a half-day knowledge exchange event or produce good practice guidance in the area of GPs working in care home contexts.

Acknowledgements
Thanks to all the professionals, residents and their families for participating in the review. Thanks also to Deborah Klée for the editorial direction.

Address for correspondence
Daniel Briggs
Senior Lecturer in Criminology and Criminal Justice
University of East London
Duncan House
High Street
London E15 2JB
UK
Email: D.Briggs@uel.ac.uk

References

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Derek Wells Cartoon Slot

So if I turn the switch on, this technology allows you to recall your hippy lifestyles!