Time to change care home resident management:

reflections on a GP-led service

INTRODUCTION

Over the past few years, there have been numerous discussions on shared experiences with many GPs, care home staff, managers, and some patients. These have demonstrated a largely shared view that the current model for providing primary care to care homes can be suboptimal and haphazard, and is an inefficient use of primary care resources.

Various alternative models exist,¹ including dedicated GP-led services, matron- or district nurse-led services, or attaching a care home to an individual practice. The evidence base for the impact of such models on patient outcomes and on cost-effectiveness is, to date, patchy. A new approach is needed if we are to meet the needs of care home residents.

THE CURRENT MODEL OF CARE PROVISION

Patients usually remain with their own GP when they move into a care home, provided that care home is in the GP's catchment area. A common expectation is that the GP is readily available to deliver all primary care (acute and chronic disease management) within the care home setting. Home visits to multiple care homes may result in suboptimal medical care due to limited facilities and inefficient use of several GPs' time.

Still, this model of care persists, even though many patients attend secondary care appointments in hospital through the support of family, staff, charitable, NHS, or private transport services.

Primary care for this population tends to be reactive, responding to problems as they develop. This reactive approach, coupled with suboptimal utilisation of the care home staff's skill set, contributes to high rates of unplanned admissions and an unpredictable workload for GPs.

Issues that contribute to the strain on the current system include:

- variable quality of care home visit requests, some of which provide limited clinical information, leaving little option but to visit the patient;
- guideline- and protocol-driven training and clinical practice of nurses may not lend itself to some of the complex decisions to be made on care home residents;

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- high staff turnover, lack of continuity of care, and utilisation of (sometimes temporary and/or inexperienced) agency staff, especially on night shifts may result in a relative lack of knowledge about a patient's medical histories, influencing decision making with sick patients, and contributing to unnecessary use of unplanned care services and/or hospital admissions; and

- a sense of isolation among care home staff. Some staff feel uncomfortable with some decision making, which can be compounded by pressure from patients or their families to seek medical assistance. Requests for GP visits can be preceded by 'I want to cover myself' or 'The family want a visit'. Some nurses voice concerns over medical litigation or the risk of disciplinary proceedings with the Nursing and Midwifery Council (NMC).

THE CASE FOR CHANGE

Analysis of figures in the year prior to the service showed that the care home population accounted for 43% of all GP home visits. Considering the geography of the care homes an average visit could take up to 1 hour to manage. The GP will see about 30 other patients that day, yet about 15% of the day is spent managing only one patient.

The over 65-year-old population in England is predicted to increase from

16% in 2008 to 23% in 2033,² with faster growth predicted in the over-85s. The care home population will inevitably grow. A sustainable approach that delivers quality, proactive primary care, and improves patient outcomes despite ever-growing financial pressures is urgently needed.

A CARE HOME GP SERVICE

In Wirral we introduced a care home GP service. It was designed primarily by the care home GP in conjunction with the practice partners and practice manager. The care homes were consulted about the frequency and preferred day of planned visits and methods of communication with the care home GP. The care home GP had no particular prior experience of specific care home work but did have a clear understanding of the need to improve and change what was becoming an untenable situation. It aimed to deliver high-quality, continuous, proactive care, to develop a relationship with the care homes by providing support and education, and optimise the use of the skill mix among staff. Daily telephone and face-to-face meetings occurred with care home staff and managers, providing support and raising awareness of the service being provided. In addition formal and (mainly) informal individual and small group teaching sessions were delivered.

A key outcome measure was the unplanned hospital admissions rate. Cost-effectiveness was also explored.

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Three practices operating from the same building employed a GP for six sessions/week to manage their care home population, which was about double the average care home population for Wirral practices (around 1.5% of the total list size) (M Gilmore, unpublished data from Wirral Data Repository, 2010). A timetable of weekly planned visits to some care homes, predetermined to be the most in need of GP support or the busiest, was delivered. Unplanned visit requests were managed as usual. Need was assessed based on GP experiences and objective data on numbers and patterns of care home visit requests in the year prior to the post. Unplanned hospital admission/attendance data were not used to design the service.

RESULTS

Patient outcomes

After 12 months, the rate of emergency department (ED) attendances reduced by 11% (152 attendances compared with 195 the previous year: 11% rate reduction allows for changes in care home population numbers).

GP workload

After 12 months care home visit requests reduced by 26% (1350 visit requests over the year compared with 1829 the previous year), and the pattern of visit requests improved to a more predictable pattern that generally reflected the care home GP's working pattern.

Cost-effectiveness

Predicted costs of ED attendance and subsequent hospitalisation of care home residents were modelled and it was estimated the reduced ED attendance rate equated to savings of £59 000 over 12 months (K Gie and M Gilmore, unpublished data from NHS Wirral, 2010), more than covering the cost of the care home GP service, including management and overheads.

Although data collection over a longer time period would provide more robust evidence, the data collected demonstrated very encouraging results.

Throughout, and after, the first year

of the service, all care homes were opportunistically asked for their views by the care home GP. Although it is recognised that this method of consultation may have introduced a degree of bias in favour of the new service, all reported that they felt the service was beneficial and an improvement on traditional care.

DISCUSSION

Most GPs have triaged many care home visit requests using information provided that varies in quality. Fewer GPs will, I would suggest, have had the opportunity or perhaps inclination to consider or address the reasons why each staff member provided very different information, but the care home GP post enabled just that.

The care home GP provided regular 'ward round style' visits, educational sessions, frequent planned and unplanned telephone contact with staff and families, and active involvement of care home staff in healthcare decisions. These activities, some of which were outside the norm for traditional primary care in care homes, helped to maximise the use of the skill mix among care home staff and manage ongoing educational needs. It encouraged an active two-way relationship between the care homes and the GPs, enhancing ongoing engagement between two groups who have worked closely for years but perhaps not closely together for years!

The traditional nursing role where the nurses nursed and doctors made healthcare decisions is dated and not in keeping with current demands of the care home patient population nor the expectations of many GPs and nursing staff.

The extra and ongoing support provided by the care home GP gave staff a more autonomous role in residents' health care and increased confidence levels in caring for their patients.

Clinical commissioning gives GPs the ideal opportunity to develop initiatives around models of care for their patients. Primary care is the gatekeeper to the NHS and it is here that we must continue to direct our initiatives to improve geriatric health care and improve patient outcomes while reducing expenditure for primary and

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secondary care services. Health care in care homes is integral to ensuring the development of community geriatric care, and traditionally there has been comparatively little communication between the public sector NHS and the privately-funded care homes. Improving communication and widening available services within the care homes would help alleviate the burden on local primary and secondary care. The ultimate goal should be to maximise the capabilities of healthcare provision in care homes.

The care home GP model works. It reduces hospital admissions, enhances communication and relationships between GPs and care homes, and provides a proactive model of care.

It is hoped that this will raise awareness of the need for change in addressing the current model of care for the care home population.

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Provenance

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