Responding to the needs of older people resident in care homes

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Introduction

The care home sector – nursing and residential homes – moves in and out of public and professional attention. Often this is due to scandals, for example 'The national homes swindle' portrayed in *Panorama* in March 2006.[1] Another cause for concern is the growing cost of caring for older people, and the King's Fund Wanless Report has provided a scholarly review of the political choices to be made to balance what we are prepared to pay for, and what we wish to receive, in our own old age.[2]

Health problems and need for care in care homes

Key to understanding this phenomenon from a medical perspective is to understand the nature of the current care home residents. If we presume that the majority of people in these settings are genteel old ladies pottering about as if in a television sitcom rather than people with significant disability then we are mistaken and will underestimate what level of care needs to be provided. In 2006 a census of 32,301 residents of 751 UK care homes was undertaken under the auspices of CCC (a coalition established in 1992 as the Continuing Care Conference, comprising commercial, charitable and public service organisations involved in long-term care) and the results were presented to the Royal College of Physicians (RCP) in July 2006.[3] The principal findings were that:

- 72% of residents were immobile or reliant on assistance to mobilise
- 62% were confused or forgetful
- 86% had one or more diagnoses clearly driving the need for personal care
- 54% of care related to dementia, stroke or Parkinsonism
- 24% had the 'unholy trinity' of confusion, immobility and incontinence.

These figures clearly show that the sort of 'care' that is given in care homes is much more than the provision of board and lodgings. The hope that significant numbers of these people could be easily managed in other community settings seems rather futile.

Although the majority (71%) received state-funded accommodation, the remaining 29% were paying for their lodgings and care themselves. Under the terms of the survey the results were anonymised to region, but regions showed wide variation in the registered nursing care contribution banding into which residents were assessed (these bands are used to identify how much nursing care is given, how much of a 'health' problem is posed and therefore how much the NHS should contribute towards care). This postcode variation was not explainable due to case mix, as it was seen even for those with the combination of confusion, immobility and incontinence. It is easy to see why the situation is seen as scandalous, and this also explains the context for current government interest in the revision of these arrangements.[4]

Improving healthcare for this sector

In 1997, Black and Bowman described the medical care in the care home sector as poorly defined, haphazard and idiosyncratic.[5] In 2000 the RCP, Royal College of Nursing and British Geriatrics Society made several recommendations to improve matters which the CCC census reminds us are still needed.[6] These recommendations included:

1 *The development of teaching nursing homes to act as a venue to develop expertise.* This simply has not happened.
2 *Specialist gerontological nurses as case managers.* US case management systems such as Evercare are based in care homes, and there is evidence to support their effectiveness, in reducing healthcare costs at least.[7] The introduction of case management as a form of chronic disease management in the UK, however, has focused upon people living in their own homes, leaving those in care homes without such evidence-based practitioners.
3 *The use of comprehensive assessment tools to aid the identification of health and social needs.* The National Service Framework for Older People introduced the concept of a single assessment process to aid the matching of people to services that meet their needs. But this is insufficient to plan care in care home settings, and although

the Commission for Social Care Inspection (the body responsible for the registration of care homes in England) requires all care home residents to have individual care plans, these differ from home to home. Comprehensive assessments, such as the Minimum Data Set Resident Assessment Instrument (MDS-RAI),[8] are not mandatory even though there is a growing evidence base that they are helpful in triggering more detailed assessments and evidence-based interventions.[9]

4 *The integration of geriatricians and old age psychiatrists into the structure of care.* The expansion of the care home sector largely took place in the 1980s and was largely unplanned – certainly no plans were made to train or employ community geriatricians or more old age psychiatrists on the basis of this expansion. Recently there has been a resurgence of interest in this area among geriatricians.[10] This has been partly fuelled by the development of new community resources such as intermediate care and community matrons who now allow comprehensive geriatric assessment to be delivered in the community, as opposed to solely in hospital settings. Hitherto, it was assumed that proven benefits of comprehensive geriatric assessment were confined to hospital-based services.[11]

Opportunities

The concept of practice-based commissioning gives primary care organisations the opportunity to recognise even more than before that the care of older people in the community is core general practice, and that with community matrons, specialist nursing practitioners and intermediate care, there is the scope to develop integrated community-based teams for older people at a practice cluster level.[12] This requires the commissioners and the rapidly developing commissioning process to see this possibility before the opportunity associated with this wind of change is missed. It requires commissioners to think across traditional boundaries in which care is planned. For example in-hours and out-of-hours care has become separated. The tendency to see the health needs of people in care homes as entirely the responsibility of the private sector has created an artificial planning boundary between community services in and out of care homes. Incentive payments to general practitioners (GPs) such as the Quality and Outcomes Framework or other enhanced payments could be adjusted to drive healthcare activity care towards the care home sector.[13] Savings from unnecessary admissions, ambulance calls and GP calls could offset the costs.

Conclusion

The title of this conference was 'Responding to the needs of older people resident in care homes'. It would seem that these needs remain largely as described in the RCP Working Party report of 2000.[6] It would also appear that, by virtue of changes to NHS commissioning, an opportunity has arisen that might enable progress to be made. How well we look after the most vulnerable people in our society is a measure of how civilised our society is.

Conference programme

Chairman's introduction
Martin Green, Chief Executive, English Community Care Association

CCC's 2006 Census of 32,000 care home residents
Dr Clive Bowman, Chairman, CCC

Reflections on the census findings

A policy perspective
Julien Forder, King's Fund Wanless Team

A provider's perspective
Des Kelly, Executive Director, National Care Forum

A nursing perspective
Sylvia Denton CBE, President, Royal College of Nursing

The self funder's dilemma
Sandy Johnstone (CCC)

A perspective from primary care
Dr Steven Iliffe, Royal Free and University College London

A consultant physician's perspective
Dr Finbarr Martin, St Thomas' Hospital

Regulation and quality
David Walden, Commission for Social Care Inspection

Quality of clinical care
Dr Jonathan Potter, Clinical Effectiveness and Evaluation Unit, Royal College of Physicians

It is up to individuals, professional bodies, commissioners and policymakers to make the most of this opportunity.

References

1 *Panorama*, 'The national homes swindle: a growing scandal', BBC1, 23 July 2006. news.bbc.co.uk/1/hi/programmes/panorama/5188580.stm
2 Wanless D. *Securing good care for older people. Taking a long term view.* London: King's Fund, 2006. www.kingsfund.org.uk/resources/publications/securing_good.html
3 CCC. *Care at the crossroads: CCC care census survey points the way forward.* London: CCC, 2006. www.ccc-ltc.org.uk/pr/2006-07-03.pdf
4 Department of Health. *National framework for NHS continuing healthcare and NHS-funded nursing care in England.* London: DH, 2006. www.dh.gov.uk/assetRoot/04/13/63/88/04136388.pdf
5 Black D, Bowman C. *Community institutional care for frail elderly people. BMJ* 1997;315:441–2.
6 Royal College of Physicians, Royal College of Nursing, British Geriatrics Society. *The health and care of older people in care homes. A comprehensive interdisciplinary approach.* Report of a Working Party of the Royal College of Physicians, the Royal College of Nursing and the British Geriatrics Society. London: RCP, 2000.
7 Kane R, Keckhafer G, Flood S, Bershadsky B, Siadaty M. The effect of Evercare on hospital use. *J Am Geriatr Soc* 2003;51:1427–34.
8 Challis D, Stewart K, Sturdy D, Worden A. Towards a national standard assessment instrument in continuing care homes: use of the MDS/RAI. Canterbury: PSSRU, University of Kent, 2002. www.pssru.ac.uk/pdf/MCpdfs/MDS_PO.pdf
9 InterRai. www.interrai.org

10 British Geriatrics Society. *The specialist health needs of older people outside an acute hospital setting.* London: BGS, 2005. www.bgs.org.uk/Publications/Compendium/compend_4-3.htm
11 British Geriatrics Society. *Comprehensive assessment for the older frail patient in hospital.* London: BGS, 2005. www.bgs.org.uk/Publications/Compendium/compend_3-5.htm
12 *Practice based commissioning: promoting clinical engagement.* London: DH, 2004. www.dh.gov.uk/assetRoot/04/09/85/65/04098565.pdf
13 Department of Heath. *Quality and Outcomes Framework guidance.* London: DH, 2004. www.dh.gov.uk/assetRoot/04/08/86/93/04088693.pdf