Community Care for Older People

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Objectives

- Update regarding community developments and reasons why required
- Community MDT
- Care Home Project
- Step up Unit- Princess Anne
- Step Down units- CICCS and Rosedale
- DAU link with community
- Domiciliary Visits
- Potential further developments- telephone advice ‘clinic’
Population Demographics

• An ageing population (9% over the age of 80) burdened with long term conditions and polypharmacy
• Also increase in prevalence of Dementia adding to complexity of case management
• 4897 patients with diagnosed dementia in Southend and CPRR (Predicted to rise by at least 15% by 2015 )
• "Tip of iceberg" Evidence to suggest that much higher percentages of patients have evidence of chronic cognitive impairment
Statistics of Admissions in Acute Hospitals

- Unplanned care admissions account for 65% of hospital bed days

- Patients 65+ account for biggest proportion of attendances and admissions

- The frail elderly are at highest risk of repeated readmissions and account for the majority of readmissions.

- Frail Patients especially with cognitive problems benefit from community based approaches rather than care in hospital.
Old Model

- Historic high volume of unplanned care admissions, rising volume of short stay admissions
- Previous disjointed/slow integration between health (primary and secondary care), social care, and mental health
- Large variation in skill mix/experience and practice between clinicians both in primary (inter-practice variation) and secondary care.
- Multiple assessments/ OOH
- Lack of End of life planning for patients with cancer and dementia
Objectives of Community Project(s)

- **Growing population of frail elderly with complex care needs; Can their services be improved?**
- **Recent “Community developments” in the form of investment/ added resources**
- **Risk stratification and patient identification**
- **Improving the patient pathway- maximising efficiency and integration.**
- **The MDT approach.**
Integrated working

- Patient
  - Social care
  - Primary care
  - Specialist care
  - Community nursing
Practice level MDT and Community Specialist MDT- risk stratification

- 2 or more unplanned admissions in the last 6 months (Esp. if Admissions are recurrent for same reason)
- Increasing frailty/ falls
- Evidence of cognitive problems (acute or chronic)
- Inadequate social support at home
- Multiple long term conditions (especially progressive chronic conditions such as dementia, Parkinson's, end stage cardiac or respiratory disease etc.)
- Polypharmacy
- Extremes of age ( > 85 years )

Southend Estuary CCG
Community Older Person specialist MDT

- Held once weekly
- Referrals received from variety of sources including hospital post discharge/ GPs/ ECP/ Allied health professionals such as dementia specialist nurses
- The specialist MDT aims to complement the practice level MDT and to focus on people with complex elderly care needs
Community Older Person MDT

Objectives

Improve quality of care for elderly people in this region within their own homes and within care homes

Improve access to healthcare services for elderly people within care homes

To reduce unplanned admissions to hospital and reduce recurrent admissions for patients with complex long term conditions and increasing frailty

To enable timely access to support services within the community which address medical, social and psychological aspects of an older persons health needs

To enable health professionals within both primary care and secondary care to work closely together with regard to older persons holistic health requirements
Specialist MDT Members

- Consultant Community Geriatrician
- GP Intermediate care lead
- End of Life Case Manager
- Community Matron
- Dementia liaison Specialist Nurse
- Emergency Care Practitioners
- Care Home and Nursing Team Support (CHANT)
- Day Assessment Unit Ward Manager
- Rapid response Team
Referral

- There is a standard Referral form which can be faxed or emailed to SPOR. Referral Forms can be obtained from SPOR and also on the hospital intranet.
  - Fax 01702314323
  - Email spor@nhs.net
  - Phone 01702 314321

- Outcomes from GP referral of patient may include DAU/ DV from member of team/ Community Clinic.
Care Home Project

- Residents of care homes represent most frail and vulnerable members of our society
- Cost of providing health services to the elderly is significantly higher than other populations, in 2008 >70s account for 11% population but 35% of NHS costs (1)
- 25% emergency admissions from care homes avoidable, 40% of which are exacerbations of long term conditions (1)
Care Home Project

- Currently no model of co-ordinated healthcare has been developed to meet the needs of care home residents. ‘Traditional’ general practice in many areas, including Essex, does not appear equipped or supported to fill this void.

- Care home residents are denied equitable access to suitable NHS primary and secondary healthcare

- We urgently require a structured, proactive approach to care, with coordinated teams working together built on primary care and supported by a range of specialists. A multi-disciplinary approach is crucial, with a ‘partnership’ development with care homes and social care professionals.
Issues surrounding Care Homes

- Over reliance on emergency services for crisis management
- Residents of same home registered with multiple practices leading to inefficient systems and poor communication
- Lack of proactive care in managing chronic diseases
Issues surrounding Care Homes

- Lack of Care Planning, especially around EOL/ further admissions
- Uneven GP workload and some GPs not visiting (1)
- Lack of resource or incentive for GPs to provide appropriate care (1)
UK models for care homes-

- Various UK models described- principle of ‘one GP practice per home’ may offer better prospects for partnership working and relationship development

- Weekly visits by GPs on a fixed day focusing on clinical attention for people in the care home who may be at highest risk and assessment of residents newly admitted to care homes, to develop appropriate care plans and ensure they are agreed by family members in specific circumstances (eg palliative care, DNAR).
Care Homes

- At each visit to the home GP reviews
- New patients regarding medications and immediate problems
- Residents that Staff are concerned about
- Residents that have had a&e attendances/ECP reviews
- Resident that family member or other person actively involved in care have directly contacted the practice
Benefits of One Practice Model

- Agreed annual care plan and full comprehensive medicines review
- Fewer exacerbations of LTC and better management of LTC
- Reduction in Hospital visits
- Good regular relationship with GP and GP decisions based on experience of patient over time. Care home staff have a source of medical advice and reduction in inappropriate consultations/ admissions
- Opportunity for EOL planning
- GPs supported by ‘link’ to Community Geriatrician/ MDT in reach team
Efficiency Benefits

- Savings dependent on scale of scheme
- Small scale pilot over 18 months reversed trend of rising admissions from care homes, 9% reduction in admissions from care homes and 10% reduction in a&e attendances (rising nearby)
- Calls to 999 reduced by one third (1)
- Excellent qualitative feedback from GPs, residents and care home staff
MDT In Reach team

- Focused ‘in reach’ support visits designed to support primary care service described above
- Two separate teams comprising of; Clinician-Geriatrician or Lead GP, Community Matron, Emergency Care Practitioner, End of Life Coordinator and or CHANT team, Dementia Liaison Specialist Nurse (with direct access to old age psychiatry), Community Pharmacist
- (not all members of team present at each visit but close working relationship)
MDT In reach Team

- Two to Three sessions per week spent at care homes
- Care homes are reviewed in a systematic manner and will initially focus on homes with ‘highest call out rate per resident’/ highest admission rate.
- Some care homes will require more frequent visits due to size and or needs.
- MDT ‘in reach’ teams will focus on training and education and each member of team will provide short ‘workshop’ type presentation addressing own area of expertise and any specific issues that care homes would like to address. The remainder of the session will be for specific concerns regarding individual residents.
- The residents own GP must be kept fully informed of any changes to the circumstance of individual residents as a result of the MDT in reach visit, allocated GP practice encouraged to attend
Best Practice Steering Group

- First meeting due to be held end of January 2013. Care Home educational forum held November 2012
- Care Home managers from all regions invited
- Sharing of best practice and facilitation of ‘My Home Life’ themes
My Home Life

- Evidence base best practice for Care Homes developed by more than 60 academic researchers from universities across the UK

- Eight themes- maintaining identity, creating community, sharing decision making, managing transitions, improving health and healthcare, supporting good end of life care, keeping workforce fit for purpose, promoting a positive culture
Step Up Unit – Princess Anne

- Princess Ann unit is a bed based Intermediate Care unit
- There are 25 beds of which 6 are male beds, 16 female and 3 siderooms.
- The aim of Princess Ann unit as a bed based intermediate care unit is to promote faster recovery from illness, prevent unnecessary acute hospital admission and premature admission to long-term residential care, support timely discharge from hospital and maximise independent living
- As a step up unit the function is to receive patients from home/community settings to prevent unnecessary acute hospital admissions or premature admissions to long-term care
Princess Ann Ward Unit- Inclusion Criteria

Aged over 65 years of age

Patients who are medically stable- (those that do not need continuous/24 hour medical cover or twenty four hour Consultant input)

There should be an assessed potential to improve independence with clear rehabilitation potential and rehabilitation goals

Patients with medical conditions which could usually be managed in community setting but due to other factors, such as frailty or social factors, require a short stay on Princess Ann unit-

Patients who are predicted to be fit for discharge in less than seven days
Princess Ann Unit Exclusion Criteria

- Aged under 65 years of age
- Patients with medical illness requiring specialist medical input or complex nursing care
- Patients with life threatening illness or medical instability (unit does not provide continuous medical cover)
- Patients who have been in AMU/A&E or other wards greater than 24 hours
- Patients with no medical issues, requiring social input only (for example those awaiting enhancement of an existing package or a new social package/change of accommodation)
Disadvantages

- Difficult for patients and carers to understand that this is NOT in the hospital! Good communication is vital
- Unit should not be viewed as a location for offloading difficult/complex social cases
- Problems can be overcome if we adhere to admission criteria and to a patient assessment prior to arrival on PAU for the more complex patients
PAU: Access of Patients to the Unit

- Single Point of Referral
- Direct referral to PAW via middle grade doctor or GP filter OOH
- Complex cases: can discuss with community geriatrician
PAU- appropriate patient selection and assessment

- Clinical Reasons: Older patients present often with atypical symptoms and definitive diagnosis delayed (no such thing as ‘acopia’ and not everyone who deteriorates has a UTI!)

  1) Silent Myocardial Infarction presenting with confusion and ‘off legs’

  2) Sepsis secondary to necrotic bowel requiring requiring emergency colectomy, presenting with ‘off legs-needs rehab’

  3) Back Pain and reduced appetite, diagnosed with Metastatic Pancreatic Cancer
PAU- appropriate patient selection

- PAU patients require adequate comprehensive geriatric assessment prior to their arrival onto PAU for step up care and rehab and the importance of a timely medical working diagnosis with access to appropriate investigations is paramount.

- Patients presenting to bed based intermediate care should be assessed in the same manner as any other patient admitted to urgent care elsewhere (3)
PAU: Why is appropriate patient selection vital

- Respecting our “clients”: Patients have to be in the right bed at the right time, receiving the right level of care
- Potentially dangerous or life threatening conditions could be missed
- Patients’ and carers’ experience: Not nice to move wards 2 or 3 times during a hospital stay and will increase formal complaints
- LOS will lengthen instead of getting shorter: evidence suggests that every ward move adds 2 days of in-hospital stay. Currently PAU LOS 8.1 days cf 12 days last year
Princess Ann Unit

Disadvantages

- Difficult for patients and carers (and sometimes health professionals!) to understand that this is NOT in the hospital! Good communication is vital.

- Unit should not be viewed as a location for offloading difficult/complex social cases.

- Problems can be overcome if we adhere to admission criteria and ensure CGA done.
DAU Role

- DAU has crucial role in development of community geriatrics and access to CGA and timely diagnostics
- Patients reviewed by rehab team, social worker, access to DIST and DAU team attend community older person MDT
- Crisis response referrals from GPs and other community practitioners

-- Currently enhancement of medical junior doctor cover required
Domicillary Visits

- Occasionally arranged for patients with true requirement for domicillary visit
- Can be arranged via Community Older Person MDT (Tuesday afternoon) or contact Community Geriatrician directly
Step Down Units

- CICCS and Rosedale
- Community Geriatrician input through attendance at MDT (bi monthly) and review of patients with complex care needs requiring geriatrician input
- The aim of the service is to facilitate early discharge from hospital and prevent avoidable hospital re-admission
- The units provide short term rehabilitation, including, nursing and therapy, to enable people to fully recover from an acute episode or following hospital treatment, so they can try to regain a level of independence to enable them to return home.
Community Clinics

- Currently being held in Canvey and Tyrells
- Frequency-
- Can refer directly or via SPOR
Future developments

- Telephone ‘clinic’ for GPs to contact Community Geriatrician
- Ideal time would be Monday afternoons
- Telephonic advice to GPs from community geriatrician (for care homes and along with some reviews after the telephone consultation) saw a reduction in cost of hospital admissions by 60%
Summary

- Flagging high risk cases (discharge summaries) for either practice level or specialist MDT case based discussion.
- Coordinating Care and improving speed of care through use of the Single Point of referral.
- Partnership working Primary care - Secondary Care - Community geriatrics - Social Care – Mental Health
Community Geriatrics

- References (1)- Delivering Healthy Ambitions- Better for Less Yorkshire and Humber
- Reference (2)- Quest for Quality, BGS June 2012
- Reference (3)- Silver Book- national clinical directors
- Reference (4)- Leicester scheme- Professor Finbarr Martin current evidence regarding access to health services for people in care homes
Thank You

Questions?