



**GREATER GLASGOW  
PRIMARY CARE NHS TRUST**

DRAFT DOCUMENT

**ANNUAL REPORT ENHANCED SERVICES:  
NURSING HOMES MEDICAL PRACTICE**

**Report and recommendations**

**DECEMBER 2005**

**Our dedicated practice team will provide enhanced patient care in nursing homes, working in partnership with patients, carers and multi-professional agencies. We will provide regular contact and address the health needs of each individual.**

## **ANNUAL REPORT ENHANCED SERVICES: Nursing Homes Medical Practice**

Contact information

Background including original service aims and objectives

Current medical services provision to nursing home patients

- NHMP GP providers to nursing care homes
- Demographics
- Registration rates
- Wider health information
- Death rates
- Location of death
- GP visit information: appointment types and *consultation reasons*
- Referral patterns
- Emergency referrals to hospital
- Appropriateness of admission
- Out of hours calls
- *Differences between assisting and central practices*

Palliative Care

Clinical Pharmacy & Prescribing

Expected versus reported benefits for patients

- Original view of anticipated benefits and evidence of their achievement or otherwise
- Patient and carer views: patient focus public involvement

Nursing care home managers views

Expected versus reported benefits for general practitioners

- Original view of anticipated benefits and evidence of their achievement or otherwise

Expected versus reported benefits for NHS and other agencies

- Original view of anticipated benefits and evidence of their achievement or otherwise

Information management and technology

- Original proposal, current status and impact

Evaluation and influencing factors

Cost and accountability

Proposal for revised service specification

- The need for a truly enhanced level of care
- Outstanding aspects of care
- Central practice
- Assisting practice
- The need for a multidisciplinary approach to care
- Cost implications

## Summary

### Appendices: Please ignore!!!

- Appendix 1 Original service proposal and specification
- Appendix 2 List of local and central practices involved in the service, the homes covered and numbers of patients in each
- Appendix 4 January 2005: workload analysis
- Appendix 5 Assisting practices: patient contacts and reasons
- Appendix 10 PFPI Officer job specification
- Appendix 11 Views of nursing care home managers
- Appendix 12 SWCT analysis – 2004
- Appendix 13 Appropriateness of admissions – the hospital specialist and GP views
- Appendix 14 The views of other providers on the impact of the NHMP

## Contact information

Address                    Nursing Homes Medical Practice  
First Floor, Clutha House  
120 Cornwall Street South  
Glasgow, G41 1AF

Telephone Number : 0141 427 8297  
Fax Number            : 0141 427 6569

Contacts                 Dr Jean Hannah, Clinical Director        jean.hannah@nhs.net  
Madge Durkan, Practice Manager  
madge.durkan@nhs.net

David McLackland General Manager  
david.mackland@nhs.net

## **ANNUAL REPORT ENHANCED SERVICES: Nursing Homes Medical Practice**

### Background including original service aims and objectives

The Nursing Homes Medical Practice was established in November 2002, set against a history of significant variations in general practitioner care for those living in nursing care homes. Its aim was to deliver an enhanced personal medical service through:

- Minimum twice weekly pre-arranged visits to homes
- 6 monthly holistic assessment of each individual
- Public health and health promotion interventions
- Multi-agency and multi-partnership working for example with associated health care services: Care Homes Training Team, Gerontology Nurse Outreach Service, Psychiatric Older People Outreach Service, Falls Service and Clinical Pharmacy
- Daytime on call and out of hours cover
- Clinical governance
- Participation in local decision making about older people's services
- Continuing professional development

The "high quality, effective and efficient service" was anticipated to result in improvements in medical care through:

- Increased level of personal medical services
- Specified service to meet needs of patients
- GPs developing skills regarding nursing home patient care
- GPs advising NH, community health and social care staff on medical care issues
- Multi-agency/multi-disciplinary working

The NHS was to benefit through:

- Proactive management health care
- Reduction in out of hours calls and hospital admissions
- Establishing care pathways to improve patients health' care and well-being
- Increase sharing of knowledge between health and social care
- Ease access of health professionals to medical information through storage of case-notes in nursing homes

A target registration rate of 80% of patients living in nursing care homes was set for the practice i.e. 80% of 3700 patients (2960). The PMS funding model required a minimum of a 50% salaried general practitioner service (Central Practice – CP), with the remaining provided through Assisting GMS Practices (AP). Following changes to funding sources, this restriction was lifted. However, in the interim, this led to a position where the CP GPs were responsible for providing care to a geographically widespread population, "filling the gaps" between AP areas.

The service specified was to be evaluated through participation of the central and assisting practices in partnership with acute and elderly services. The primary emphasis of reports was to be upon service uptake. Thereafter, reviews were to

include user and nursing home satisfaction, impact on emergency call outs and review of local audits. The main evaluation of care was to be undertaken in year three. A framework for the evaluation, required to assess the services impact on patients and doctors within the service and on other primary, secondary and social care services involved in the delivery of care, was to be discussed and developed with stakeholders.

The full proposal and specification can be seen in Appendix 1.

## Current medical services provision to nursing home patients

### NHMP GP providers to nursing care homes

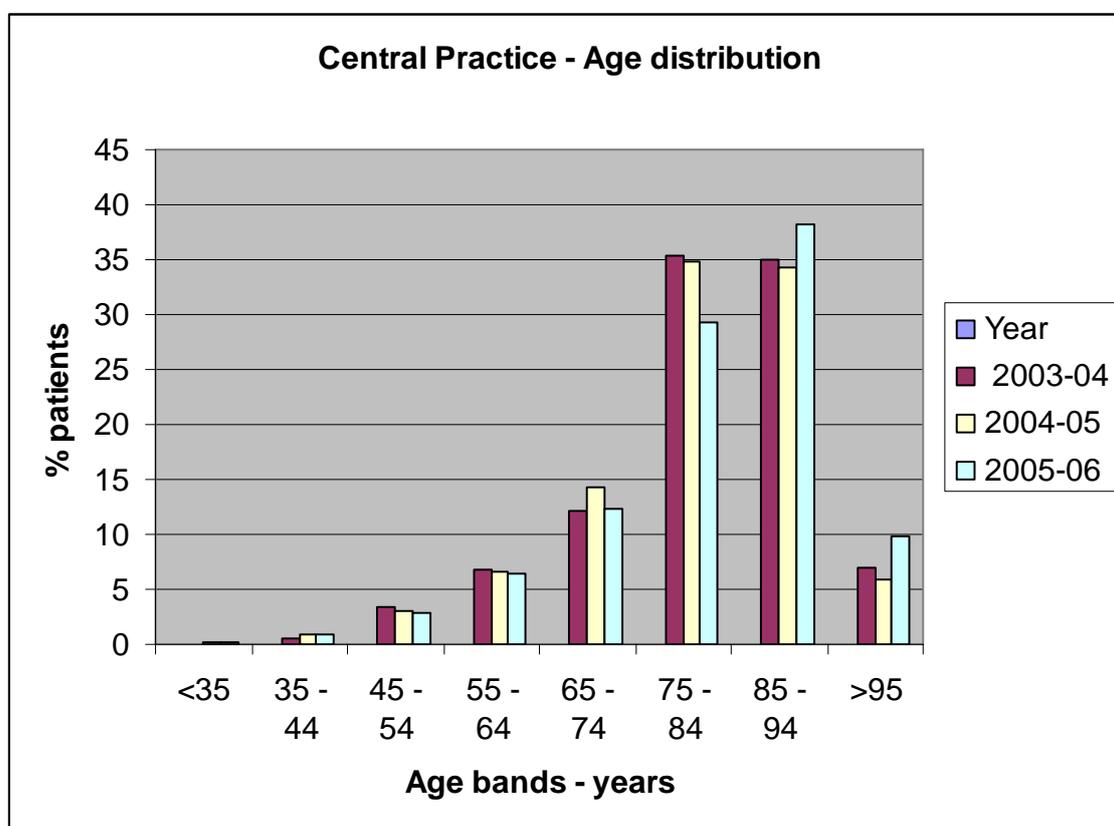
The Nursing Homes Medical Practice now has 2690 patients and is made up of the Central Practice with just over 5 FTE GPs covering 24 homes and 12 Assisting Practices with 37 homes. Details about the practices, their patient numbers and percentage uptakes can be seen in Appendix 2. The Central Practice (CP) is gathering increasingly accurate information on the GPASS database about both patients and the service, some of which can be extrapolated for the service as a whole.

### Demographics

The table below demonstrates that the NHMP has reached the 80% uptake target in the 61 homes in which it is working. 76% of all Greater Glasgow nursing home patients are now registered with the practice.

Practice	Bed No.	Patient No.	% Uptake
Central	1167	885	76
Assisting	2146	1805	84
Total	3313	2690	81
7 NH Declined	267	267	
Overall Uptake	3544	2690	76

Further demographic detail is available for the central but not the assisting practices. The graph and table below show the central practice age distributions from 2003 to the present time, with 2005-06 being an incomplete year.



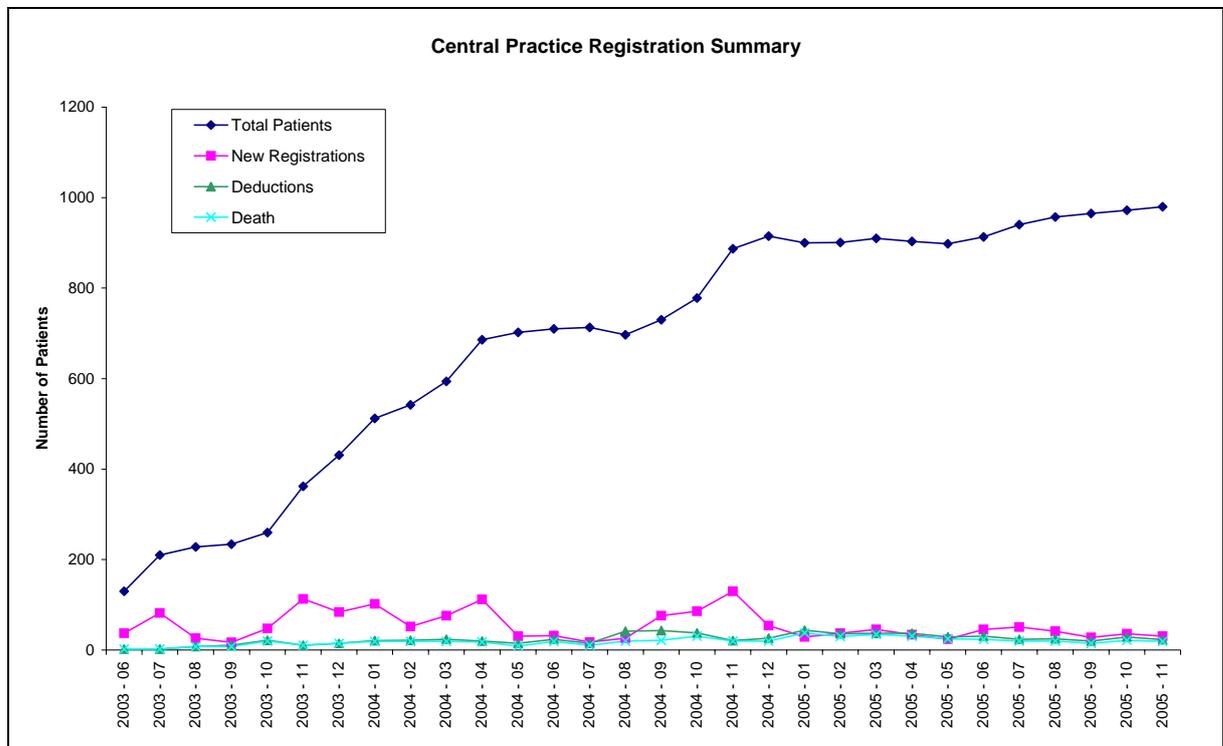
Central Practice Year	% in each age band (years)							
	<35	35 - 44	45 - 54	55 - 64	65 - 74	75 - 84	85 - 94	>95
2003-04	0	1	3	7	12	35	35	7
2004-05	0	1	3	7	14	35	34	6
2005-06	0	1	3	6	12	29	38	10

The figures demonstrate that the under 65 age group remains at approximately 11%, whilst there has been a reduction in the 75-84 year group and increase in the 85 and over group, with 10% of patients now being over 95 years.

At this time, December 2006, there are 34% males and 66% females registered.

### Registration rates

The graph below reflects central practice patient registration rates since shortly after it began in March 2003.



The November 2005 figures include approximately 100 patients who are now registered with one of the assisting practices. It can be seen that the registration rates have plateaued and roughly equate to death rates.

### Wider health information

The Central Practice database allows extraction of a wide variety of data from the numbers of patients recorded as having a specific health problem to visit types and numbers per home. Examples of health data extracted from November 2005 include:

- 65% have a mental health problem recorded
- 14% of those with a mental health coding are under 65 years
- 12% have had a fracture neck of femur

- 32% of patients have a current Adults with Incapacity Certificate in place, including 41% of the 359 patients with a dementia diagnosis (May 2005)
- 12% have an alcohol dependence of alcohol psychosis related diagnosis
- 10% have diabetes
- 10% have an epilepsy or seizure related code, with an even higher proportion on anti-epileptic drugs
- 5% have Parkinson's disease

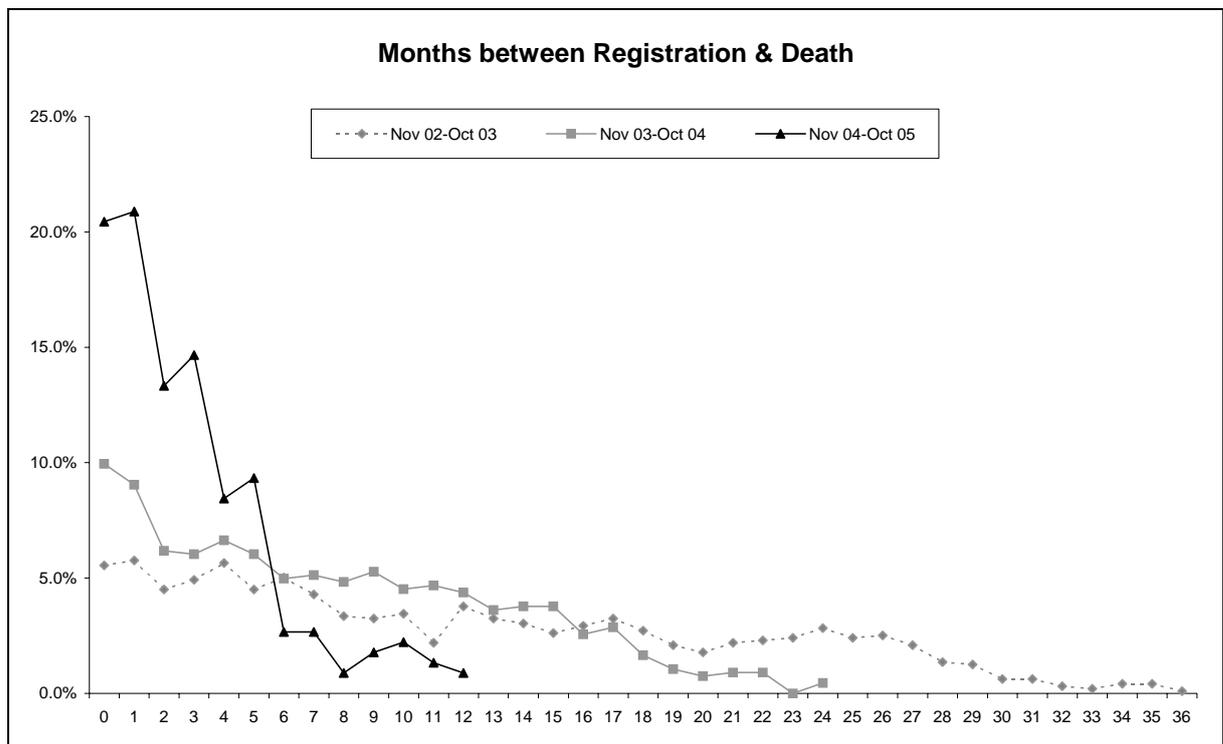
Similar figures can be extracted for continence, mobility etc. and linked with the 6 month assessment form used by the central practice.

### Death rates

Information on deaths has been gathered from the central database and has also been provided by Practitioner Services. The latter have shown that 1865 patients have died since the service began in November 2002. Thus of the 4525 who have registered with the NHMP, 41% have died.

The graph below shows the number of months between patient registration and death within the NHMP. In 2002-2003, the majority of patients will have been living in the nursing home prior to registration with the NHMP. As time has passed, it is far more likely that patients have registered with the NHMP on admission to the nursing home.

The 2004-2005 figures at this stage have incomplete follow-up, but the suggestion is that some people are dying more rapidly following registration.



There are three possible reasons for the implied increased likelihood of death shortly following admission: firstly a deterioration in the level of health care provided, secondly increased complexity of health problems and thirdly utilisation of nursing care homes as palliative care providers. It is of interest to note that as demonstrated

in the table below, although the average patient number for the central practice has increased between 2004/05 and 2005/06, the number of deaths is very similar.

Central Practice	2004/05	Predicted 2005/06 based on 04-11 2005 figures
Average patient number	520	799
New Registrations	677	438
Deaths	273	264

The combination of the information available suggests that although in the initial months following admission, death is more likely than in previous years, those surviving this period are living longer.

#### Location of death

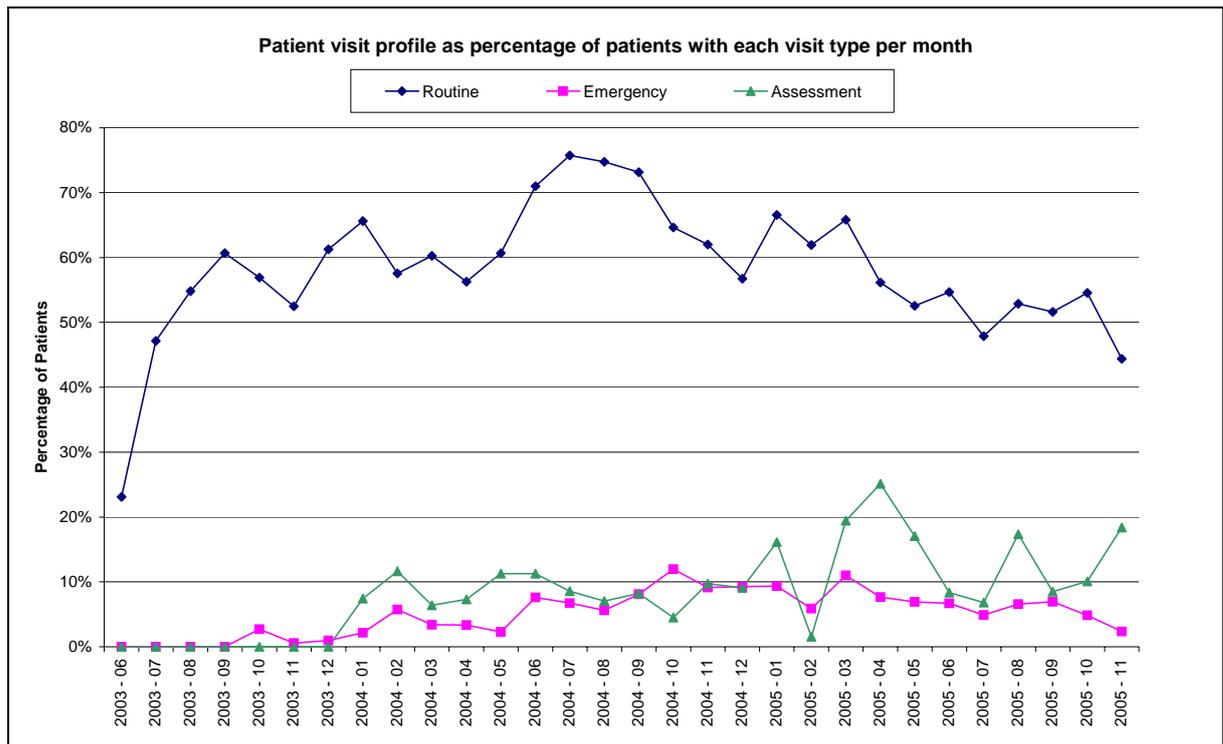
The central practice has recorded 176 deaths from April to November 2005, this being equivalent to 264 for 2005-2006. 119 of the 176 (68%) were recorded as occurring within the nursing home, 48 (27%) in hospital, and for 9 (5%), the place of death was not recorded. Further work is underway for the NHMP as a whole through Practitioner Services, Clinical Effectiveness and Public Health to establish causes and locations of death since the NHMP began, as this has not been possible till now.

A NHMP audit of reasons for out-of-hours contact with the Glasgow Emergency Medical service showed that 27% of calls were due to deaths i.e. deaths occurring in nursing homes. Annually this would equate to approximately 400 deaths in nursing homes of patients registered with the NHMP.

A three month audit report (01/04/05 to 30/06/05) from Shona McKenzie, Liaison Nurse, Victoria Infirmary, showed that 12.5% (10 of 80) people died following admission from nursing homes. Anecdotally, the liaison nurses report that more patients are dying in nursing homes and less are being admitted to hospital for palliative care. Further work is underway to look at causes and places of death i.e. whether in the nursing home, hospital or hospice. It is hoped that this will enable service developments focussing on the avoidance of inappropriate admissions where end of life care could have been more appropriately provided in nursing homes.

#### GP visit information

Within the Central Practice, GP visits are categorised into three types: routine, within hours emergency and assessment. The visit rates are demonstrated in the graph below which shows the percentage of patients per month with each visit type.



emergency cover (“floating sessions”), that any visits are categorised as emergency rather than routine for that GP. However, the figures overall reflect patient need and GP activity.

In the year 2004 to 2005, there were 10365 routine, 883 emergency and 957 assessment central practice visits. This equated to 8.9 routine, 1.8 emergency and 1.7 assessment visits per patient. Based on these figures, total patient contacts for the NHMP as a whole are estimated as 31095 routine, 2649 emergency and 2871 assessment visits per annum.

Two pieces of work have been undertaken looking at assisting practice workload, this following on from evidence from one assisting practice that they were working for nine sessions per week, though receiving payment for seven.

*January 2005: Week-long “snapshot” of workload*

Practices were asked to collect data related to all aspects of work related to the NHMP, primarily GP and administrator activity. The GPs expressed the following concerns about this form of data collection:

- GPs reported a “quieter” week than normal.
- Not all activities undertaken occurred within the week studied
- They did not feel it accurately reflected workload

Data was collected under a number of headings e.g. workload related to new patient registrations. The GPs and administrators were asked to record the number of times an activity was undertaken, the duration and if someone else might be best placed to do it.

The analysis (Appendix 4) highlighted a number of points:

- Although some practices appeared to be recording data accurately, others were not

- Using the data from the four assisting practices with least likelihood of error in their recording, it was confirmed that practices were working more sessions than they were being paid for, and that in effect the practices were financially compensating the service.
- The practice with least likelihood of error in data collection and most financially viable differs from the other practices due to a low GMS practice list size and dedicated practice administration support which functions almost entirely within the nursing homes, rather than being sited in the practice itself.
- Little suggestion was made about the role of other health professionals and how they might work with the NHMP to reduce GP workload.

#### *Patient contact data collection: October – December 2005*

Further evidence was requested from assisting practices about health reasons resulting in patient contacts. The data has been collected over an eight week period (not yet complete). Of 1890 patient contacts, 262 were emergency appointments when patients were seen, 619 involved discussion about the patient only and 1009 were routine appointments in which the patient was seen. 12 contacts resulted in hospital admissions and 10 due to deaths. 23% were related to chest or urine infections, 10% six month assessments, 7% mental health, 6% cardiac failure, 6% other chronic disease management and 24% medication review. These results indicate that there is scope for a wider multidisciplinary approach to patient care.

#### Referral patterns

Referral patterns for the central practice are shown in the table below. Data is routinely gathered about central practice referral letters produced using Second Opinion. Referrals made on handwritten forms e.g. podiatry have not been recorded to the same degree of accuracy, although this is currently being addressed. However, the highest referral rates appear to be to dietetics and speech and language therapy. It is of interest to note that there has been a significant reduction in total referrals between 2004-05 (587 referrals equating to 1.13 referrals per patient) and the predicted figures for 2005-06 (549 referrals equating to 0.67 referrals per patient) based on available data for the April to November 2005. As with other aspects of data analysis, referral patterns can be linked to both GPs and homes.

Referral period	30/09/03-31/03/04			01/04/04 to 31/03/05			01/04/05-18/11/05			Proj. 01/04/05-31/03/06		
	Av. no. patients registered			520			799			820		
Name of clinic	Total	Ref. rate per pt.	% of pts	Total	Ref. rate per pt.	% of pts	Total	Ref. rate per pt.	% of pts	Total	Ref. rate per pt.	% of pts
Dietician	24	0.12	12%	88	0.17	17%	62	0.08	8%	93	0.11	12%
Physiotherapy	24	0.12	12%	68	0.13	13%	59	0.07	7%	89	0.11	11%
Psychogeriatrician	22	0.11	11%	50	0.10	10%	32	0.04	4%	48	0.06	6%
S&LT	16	0.08	8%	48	0.09	9%	30	0.04	4%	45	0.05	6%
Ophthalmology	13	0.06	6%	43	0.08	8%	27	0.03	3%	41	0.05	5%
Care of the Elderly	12	0.06	6%	41	0.08	8%	23	0.03	3%	35	0.04	4%
Surgeon	11	0.05	5%	39	0.08	8%	22	0.03	3%	33	0.04	4%
Other	10	0.05	5%	28	0.05	5%	20	0.03	3%	30	0.04	4%
ENT	7	0.03	3%	27	0.05	5%	15	0.02	2%	23	0.03	3%
Gen. Psychiatry	6	0.03	3%	21	0.04	4%	13	0.02	2%	20	0.02	2%
Dermatology	6	0.03	3%	7	0.01	1%	11	0.01	1%	17	0.02	2%

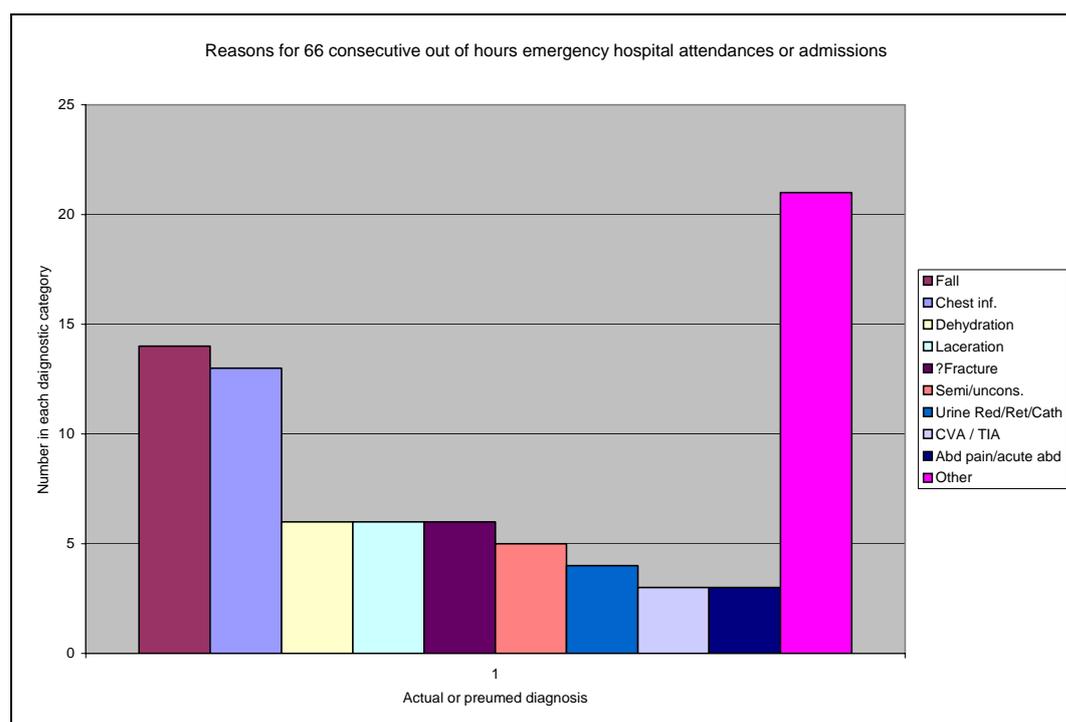
Each colour allocated to each specialty in column 1 continues throughout the table. "Other" applies to other specialties listed in the "top 10" for each year, which have not been represented consistently throughout. Although further other specialties have been referred to, the numbers have been so small that they have not been included here.

### Emergency referrals to hospital

The emergency referral pattern for the central practice GPs has been looked at through review of emergency ambulance requests. The table demonstrates a significant reduction in ambulance requests in 2005 (to Dec 22) compared to 2004.

Year	No. ambulances ordered	Average no. of patients in central practice	Ambulance rate per pt
2004	247	440	0.6
2005 (to Dec 22)	225	800	0.3

A two month audit of out of hours calls for the whole of the NHMP showed that of 246 contacts, 66 (27%) resulted in hospital attendance or admission. This would equate to approximately 792 out of hours emergency referrals to hospital per annum. The next graph demonstrates the presumed or actual diagnoses leading to admission or hospital attendance.



79 presumed or actual diagnoses were linked with these 66 hospital admissions or attendances, for example a fall may have been associated with a laceration or possible fracture.

### Appropriateness of admission

The appropriateness of admissions has been looked at through:

- Audit (2005) carried out by Dr Arun Singh, Department of Medicine for the Elderly, Glasgow Royal Infirmary: the written report is awaited. Dr Singh sought views of both GPs and hospital consultants on the appropriateness of 30 admissions from nursing care homes. A verbal report indicated that 70% of those admissions reviewed were regarded as appropriate.
- NHMP pilot audit (2005). On NHMP receipt of discharge letters from hospitals, the relevant consultant was sent a short questionnaire on the appropriateness of admissions. Similar questionnaires were completed by GPs when referring a patient for admission, or to comment from their perspective on the appropriateness of admission by out of hours (GEMS) GPs. During the pilot, the forms completed by the GPs and consultants were not about the same patients, this being the planned phase 2 of the audit. From the information obtained during the pilot, the most admissions were regarded as appropriate, and although there was an indication of more potential use of fluids (i.v. or subcutaneous), for the admissions examined this was not a seem as a major factor contributing to admission. Dehydration was listed once as a reason for admission.
- Anecdotal information from the hospital liaison nurses suggests that less inappropriate admissions are occurring. They report increasing use of subcutaneous fluids in nursing homes and less admissions for palliative care. In the NHMP pilot audit, although patients died following admission, end of life care was not seen as the reason for admission in the majority of cases. The findings of the NHMP pilot audit is shown on the next page.

<b>Pilot audit of appropriateness of hospital admissions, based on 28 admissions, Nov 2005</b>					
Statements in bold: hospital consultant views. Statements in italics: GP views					
Percentage responses to each statement:					
	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
<b>Admission was for end of life care</b>	69	8	23	0	0
<i>The admission is for end of life care</i>	56	33	0	0	11
<b>Care could have been more appropriately provided in an intermediary care setting</b>	54	38	0	8	0
<i>The admission is at the request of relatives or carers</i>	30	10	10	40	10
<b>Cognitive impairment prevented all meaningful inv.</b>	38	38	15	8	0
<i>Cognitive impairment is likely to prevent all meaningful inv.</i>	40	40	20	0	0
<b>NH iv antibiotics could have prevented admission</b>	62	8	8	23	0
<i>NH iv antibiotics could have prevented admission</i>	40	20	0	20	20
<b>NH ubcut or iv fluids could have prevented admission</b>	46	8	0	23	23
<i>NH sub cut fluids could have prevented admission</i>	44	22	0	11	22
<i>NH iv fluids could have prevented admission</i>	40	20	10	10	20
<b>With a nursing ratio of 1:30 nurse:patient ratio, diagnosis could have been managed in NH</b>	46	31	8	15	0
<i>My decision to admit was influenced by my level of confidence in the NH staffing levels and abilities</i>	56	33	11	0	0
<i>The admission is at the request of NH staff</i>	23	8	8	46	15
<b>The admission was totally appropriate</b>	8	15	15	23	38
<i>The admission is totally appropriate</i>	14	0	14	57	14
<b>Consultant view: reason for admission</b>					
Diarrhoea and dehydration					
Acute renal failure					
Collapse/?seizure					
Fall/confusion					

Cystoscopy	
Diff. swallowing	
Dehydration, RhArth, Parkinson's disease	
Family request – aspiration pneumonia, end stage cerebrovascular disease	
Chest infection (3 patients incl. One aspiration pneumonia)	
Fracture distal ulna and radius	
Pedunculalted polyp at OG junction and constipation	
<b>GP reasons for admission:</b>	<b>Comments:</b>
Confusion	Has liver cirrhosis. Becomes acutely unwell. Difficult to ascertain cause.
Aspiration pneumonia	Muscular dystrophy. Prone to swallowing problems. Died in hospital.
Fracture femur (2 pts)	Admission appropriate
Status epilepticus	2Y to chest infection. Tried rectal diazepam. Seizures continued.
Dehydration	Subcut fluids diff. In nursing home as staff didn't have much experience.
Infected cyst on back	
Prolonged seizure	This lady has history of recurrent seizures
Pneumonia/Poor swallow	Patient had not responded to antibiotics and deteriorated rapidly
P.V haemorrhage	Large haem. Recurrent problem. However, hosp. Not keen to investigate.
<b>GP views GEMS admissions:</b>	<b>Comments:</b>
?TIA	Recurrent CCF. Adm. Arr. By new nurse and GEMS. Died in hospital.
Diarrhoea, presumed infectious	? Admission could have been avoided if fluid intake had improved
Cut to leg	A & E attendance for laceration that required surgery
Bowel obstruction	Acute bowel obstruction. Declined intervention. Now in NH for pall. Care.
Pneumonia / subsequent CVA	Patient had a number of courses of antibiotics & seemed to recover, then deteriorated overnight. During adm. suffered CVA and died.

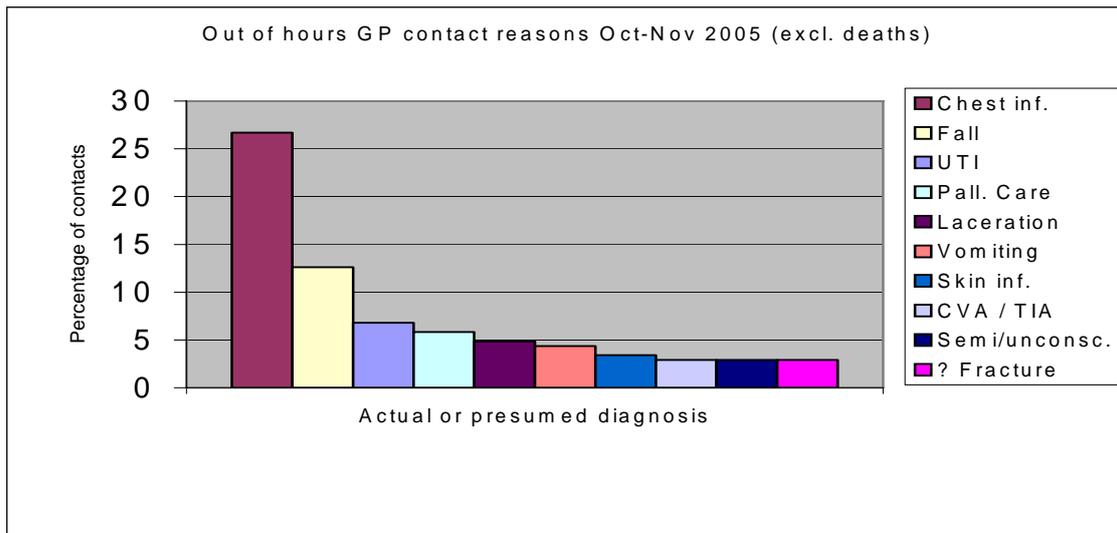
### Recommendations regarding monitoring of hospital admissions and their appropriateness

This is an area for potentially significantly stronger working relationships between the NHMP, palliative care, GEMS, the liaison nurses, secondary care, social work and the Care Commission. There is a need for agreement on the information to be gathered, data entry and analysis procedures, and sharing of information. This would enable targeted patient interventions to be developed according to the issues flagged up through identification of reasons for admission and in particular where admission might have been avoided.

### Out of hours calls

The NHMP carried out a two month audit in October and November 2005 to examine the reasons for contacts. Of these, 27% were due to deaths, 27% resulted in attendance or admission to hospital, 27% required advice only and 31% resulted in a prescription being changed or issued. Excluding those who had died, 28% of contacts were due to a chest infection or UTI, 13% due to a fall and 5% for palliative care reasons. The presumed or actual diagnoses, excluding deaths, made during out of hours visits are demonstrated in the next graph.

It is hoped that through the adoption of the Verification of Death Procedure by nursing care homes, that in 2006 there should be a gradual and sustained reduction in the numbers of out of hours calls for verification of death. This is because the nurses in the homes should formally be able to verify death, with the NHMP GPs issuing death certificates on the next working day.



### Differences between the assisting and central practices

This is of importance when looking to the future and ongoing service delivery. On the surface, the central practice is a costlier model: the patient ratio is approximately 17 patients per one GP session, compared to 30 patients per assisting practice session. However, when the additional unpaid hours worked by the assisting practices are taken into account, the assisting practice patient number reduces to 23 per session. The central GPs cover homes throughout Greater Glasgow (this having come about due to lack of interest from local GPs in working with these homes and because of setting up restrictions of the service) thus spend a significant proportion of their week (up to 25%) travelling. The assisting practices tend to work in nursing homes in the close proximity of their practices.

There is no available evidence of a difference in the overall quality of care offered by the assisting versus the central practice. However, it will be possible in the future to carry out some comparisons of what is being achieved through the IMT developments.

The homes and the support offered by the NHS throughout the service vary too, this impacting on practice or individual GP workload. The practice which appears to function most “effectively”, benefits from the input of a hospital liaison nurse (who co-ordinates discharges but also gives clinical support and supervision to staff in homes) and a palliative care clinical nurse specialist. GPs in other homes still spend time carrying out procedures such as phlebotomy because of a lack of trained staff.

## Palliative Care

The NHMP has been very fortunate to have had the support of both Sandra Sanderson, Project Manager, Non-Cancer Palliative Care, GGHB, and Isabel Penny, Palliative Care Clinical Nurse Specialist for Care Homes, HARPS, in working with nursing care homes to improve the level of palliative care offered. Both have great expertise in palliative care and many years of experience within nursing homes. They thus have high levels of understanding of the difficulties in providing good levels of palliative care in such settings and the challenges faced by many of the staff, including those within the NHS.

Whilst palliative care within nursing homes is for non-cancer reasons, it is important for any practice to have a cancer register. This ensures that those with a cancer diagnosis are known and that appropriate follow-up and treatment is in place. The central practice has established a cancer register, with rates somewhat lower than expected at 7.2% of patients. This step will help in the practice's aims of working towards the Gold Standard Framework requirements and achieving Quality Practice Accreditation.

Cancer diagnosis	Number of people
Malignant neoplasm of female breast	22
Malignant neoplasm of colon	8
Malignant neoplasm of prostate	7
Malignant neoplasm of bronchus or lung NOS	4
Malignant neoplasm of urinary bladder NOS	4
Malignant neoplasm of brain	3
Malignant neoplasm of cervix uteri NOS	3
Malignant neoplasm of body of uterus	2
Malignant neoplasm of rectum	2
Chronic myeloid leukaemia	1
Malignant neoplasm of lip, oral cavity and pharynx NOS	1
Malignant neoplasm of oesophagus	1
Malignant neoplasm of ovary	1
Malignant neoplasm of skin	1
Malignant neoplasm of stomach NOS	1
Malignant neoplasm of thyroid gland	1
Multiple myeloma	1
Primary vulval cancer	1
Total	64 (of 884 patients)

## Palliative care recommendations

Regrettably, palliative care support is one of the greatest voids in health care provision by the NHS. The current inequity in support between the homes covered by Sandra and Isabel and those lacking this input has palpable effects and requires to be addressed as a matter of urgency. From the NHS perspective, this will require investment in palliative care specialist nurses, NHMP nurses to support care homes and a permanent commitment to funding training for palliative care for the clinical members of the NHMP and those they work with in this field. It should be remembered that the main professional group leading on the Gold Standard Framework and Liverpool Care Pathway for the Dying is nursing. Within general practices as a whole, it is nurses who co-ordinate the Gold Standards Framework and who are driving patient care forward. Although there is huge commitment from the GPs to improve palliative care, without the appropriate support being present, the likelihood of success is significantly diminished.

The following report and further recommendations has been written by Sandra Sanderson on behalf of the NHMP. This follows her experience of working as a community nurse, a manager in a nursing home, a MacMillan Facilitator, and Project Manger in Non-Cancer Palliative Care. She is the most experienced individual in this field that the NHMP has the privilege to work. She works strategically within the NHS Board and with particular groups such as the NHMP. has provided training for the NHMP and others and works with the NHMP GPs clinically in nursing homes on a weekly basis.

#### Where are we now?

- Recent palliative care research has indicated that a service model similar to the NHMP in Glasgow will improve the quality of life and death for all people in care homes in Scotland. We are therefore in a unique and fortunate position to be the leaders in this field of medicine (Hockley, Dewar and Watson, 2004)
- The Nursing Homes Medical Practice (NHMP), has a vision to improve palliative care for all people living in care homes (nursing) and to effectively collaborate with care home staff (nursing) to enhance their palliative care knowledge, skills and expertise
- Unlike hospital settings, the goals of care homes (nursing) are usually emphasising restoration and maintenance of functional status and quality of life, therefore the NHMP embrace the World Health Organisation's definition of palliative care, recognising that palliative care is philosophy of care
  - *"an approach that improves the quality of life of patients and families facing problems associated with life threatening illness, through prevention and relief of suffering, by means of early intervention and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual"* (WHO 2004)
- The NHMP recognises that in most care homes there is inequity of palliative care in general but there is also inequity of specialist palliative care provision for care homes in particular (Jordhoy et al, 2003). This inequity is similar in elderly care wards in the acute division (DoH, 2001a)
  - One in four people will end their lives in a care home and due to an ageing population which is estimated to rise to 26% of the UK's total population by 2020. This demographic represents potential demand from specialist palliative care services (WHO, 2004). This will also place higher demands on the NHMP who care for older people in care homes (nursing)
  - 10-25% of all cancer deaths occur in care homes (nursing) (Jordhoy et al, 2003)
  - However, there is a growing recognition that people with a non malignant disease also require palliative care, their needs and wants are similar (Addington Hall and Higginson, 2002)

- Local audit would suggest that end of life palliative care is often reactive rather than proactive and that end of life care in care homes is suboptimal (Sanderson, 2005)
- There is recognition that this can be improved by introducing the Gold Standards Framework (GSF) (Thomas, 2002) and the Liverpool Care Pathway (LCP), (Ellershaw and Ward 2003), as well as the Preferred Place of Care Tool, which enables doctors, nurses and practitioners to discuss with residents and families their preferences around end of life care so that they are able to make informed choices. The tool also invites the resident and carers to comment on their experience of care, thereby including users in the development of service provision (Lancaster and South Cumbria Cancer Network, 2003)
- The NHMP collaborate effectively with the project manager for non malignant palliative care (GGNHSB) and receive support and advice regarding palliative care issues. This provision will continue until August 2007
- The Palliative Care Clinical Nurse Specialist for Care Homes (CNS) for the North/East also provides advice and support specifically for people who work and live in care homes
- Links have been forged between the Macmillan GP facilitators and the nursing staff and they will provide support and advice with the GSF and LCP models of care

#### Where are we going?

The NHMP is committed to:

- Recognising Government Drivers and evidence based practice that will improve palliative care for example the National Institute for Clinical Excellence's (2004) Guidelines for Improving Supportive and Palliative Care for Adults with Cancer; The National Service Framework for Older People (DoH, 2001a); The Draft National Palliative Care Practice Statements for Care Homes in Scotland (SPPC, 2005)
- Improving the palliative care needs for people living in care homes
  - From admission to the care home and throughout the resident's journey until death
  - Improving bereavement services for those who matter to the resident
- Collaborating with all service users in order to improve the standards of service provided by the NHMP and other stakeholders
- Evaluating the effectiveness of the NHMP by measuring
  - Palliative Care Outcomes
- Reducing the inequity of service by
  - Enhancing the palliative skills, knowledge and expertise of the General Practitioners (GPs) and enhancing the skills of care home staff (nursing) when opportunities arise. Drivers such as the Palliative Care Education Competencies Framework (West of Scotland

Palliative Care MCN, 2005) should also be fostered by palliative care champions.

- Identifying other resource allocation issues
- Collaborating with the Palliative Care Planning and Implementation Group in order to gain appropriate resources required in order to be a dynamic and effective service

### How do we get there?

In order to change the vision to a reality the NHMP will wish and be required to:

- Collaborate with the Macmillan GP Facilitators and nursing staff and “sign up” to the GSF
- Continue to enhance palliative care education for all members of the NHMP through links with the Macmillan GP Facilitators and nurses with regular coordinated training to enhance professional development
- Encourage care homes (nursing) to develop services to include the elements which underpin good bereavement care (DoH 2005b)
- Signpost all stake holders to the National Palliative Care Practice Statements for Care Homes
- Strive to collaborate with other multi-professional agencies through joint working in order to provide seamless care between primary, secondary, tertiary and voluntary care
- Work with the CNS in the North/East and GGNHSB Project Manager to implement the LCP in care homes
- Implement a Palliative Resource Manual in all care homes (nursing). This will include information relating to the GSF, LCP PPCD and local networks that will provide palliative care advice over a twenty four hour period
- Involve people living in care homes and those who matter to them. User involvement initiatives have a potential to validate practice and effective strategies such as the Essence of Care (DoH, 2001b) and the LCP and GSF can identify successful palliative care change management
- Recognise that in order to reduce inequity of service further resources will be required
  - Backfill monies to enable General Practitioners (GPs) to continue with palliative care professional development. For example study days and perhaps working for a number of weeks at the local hospice. The anticipated cost for NHMP GP attendance at a five day course providing the foundation for the Gold Standards Framework is £55K, this cost covering locums and venues.
  - Care Home Palliative Care CNS for the South and West

- Nurse(s) to help take forward the GSP and LCP in care homes (nursing)
- Nursing staff are pivotal in implementing the palliative care philosophy in care homes (Froggatt et al). The NHMP does not have a team of nurses similar to other GP practice. A realistic number of nurses for the NHMP population and geographical spread would be **XXXX WTE**
- This work should develop within GGNHSB Palliative Care Planning and Implementation Group

### References

Addington-Hall J and Higginson I. (2002). *Palliative Care for Non-Cancer Patients*. Oxford University Press. Oxford.

Department of Health. (2001a). *National Service Framework for Older People*. DoH. London.

Department of Health. (2001b). *Essence of Care*. DoH. London.

Department of Health. (2004). *National Service Framework for Older People*. DoH. London.

Department of Health. (2005). *When a Patient Dies. Advice on Developing Bereavement Services in the NHS*. DoH. London.

(326) pp30-34.

Froggatt K A. Poole K. and Holt L. (2002). The provision of palliative care in nursing homes and residential care homes: a survey of clinical nurse specialist work. *Palliative Medicine* (16) pp481-487.

Hockley J. Dewar B and Watson J. (2004). *St Columba's Hospice Bridges Initiative Project. Phase 111-Executive Summary*.

Jordhoy S. Saltvedt I. Fayers P. Loge H J. Ahlner-Emqvist M and Kassa S. (2003). Which cancer patients die in nursing homes? Quality of life, medical and sociodemographic characteristics. *Palliative Medicine*. (17). pp 433-444.

Lancaster and South Cumbria Cancer Network. (2003). Preferred Place of Care Tool.

National Institute for Clinical Excellence. (2004). *Improving Supportive and Palliative Care for Adults with Cancer*. NICE. London.

SPPC (2005). *Scottish Partnership for Palliative Care: Draft National Palliative Care Practice Statements for Care Homes in Scotland: A Consultation Document*. SPPC. Edinburgh.

Sanderson S. (2005). (Unpublished work). *Liverpool Care Pathway. An audit of two Glasgow Care Homes*. GGNHSB.

Thomas K. (2002). *Gold Standards Framework in Community Palliative Care. Cancer Services Collaborative*. NHS Modernisation Agency. The Stationery Office, London.

West of Scotland Palliative Care MCN. (2005). *palliative care educational competencies framework*. West of Scotland MCN. Education Sub Group.

WHO (2004). *Better Palliative Care for Older People*. WHO. Geneva.

## Clinical Pharmacy & Prescribing

This has been an area of the greatest success for the NHMP, and is due in particular to the work of Dr Rachel Bruce, Clinical Pharmacist, in identifying and leading on priority areas. The following report has been written by Rachel Bruce on behalf of both the Clinical Pharmacy Support team and the NHMP.

### Background

The original clinical pharmacist post was created to assist the Primary Care Division in the delivery of quality cost effective prescribing to care homes under the direction of the lead clinical pharmacists and the clinical director of the Nursing Homes Medical Practice. This is in recognition of previous research in this patient population which highlighted care home residents receive four times as many prescriptions than any other patient group. The main job remit of the clinical pharmacist was to effectively undertake medication review for a wide range of patient groups within selected care homes. In addition, the role involved the development and implementation of a quality repeat prescribing system, along with other duties including education and training, clinical audit and development of prescribing policies. The post was originally a one year fixed term contract. With the savings generated from the pharmacist's reviews, this post is now permanent.

As a result of an audit of the current repeat prescribing system, two pharmacy technicians were successfully recruited. Both technicians are 8 months into a two year fixed term contract. Evaluation of their impact is ongoing, with savings generated detailed below.

### Impact of Prescribing Support Pharmacist

1. Savings generated from comprehensive medication reviews:

Sep 04-05:	£50k
Projected savings to end of financial year (Oct 05-Mar 06):	£50k
Average saving per patient per annum: approx	£100

Due to the high turnover of patients this saving will be sustainable.

Potential to cover a greater number of homes per annum with recruitment of additional pharmacist. Business proposal to be drafted.

Savings above include implementation of Primary Care Division's drugs of choice policy and therapeutic switches (GGNHS prescribing action plan).

2. Repeat prescribing audit carried out by pharmacist highlighted huge wastage and over-ordering using the current system. Business proposal worked up leading to recruitment of two technicians.

3. Development of vaccination documentation and co-ordination of influenza vaccination programme.

#### Central Practice

Influenza vaccination rate	2003:	55 % (prior to pharmacist involvement)
documentation)	2004:	54% (development and piloting of
	2005:	82% (following implementation of standardised procedure and documentation)

### Impact of Prescribing Support Technicians

### 1. Savings

Actual savings to date June 05-Nov 05:	£33k
Average saving per home per month:	£253
Anticipated to cover 44 homes in total per annum: saving/year	£133.5k
Projected savings Dec 05- Mar 06:	£67k

2. Sustainability of technician input investigated by a “non-intervention” audit. 3 homes where there had been previous technician input were selected over a 2 month period. Stock checks were carried out as normal however no blocking of over ordering was carried out by the technician in this time to assess the impact of not continuing to provide technician input to the monthly order.

“Non-intervention” resulted in a total of £3600 of unneeded stock being ordered (£1800 per month). This highlights the need for ongoing technician input to sustain savings.

### 3. Care home staff training

In addition to prescribing savings generated, the technicians have been involved in care home staff training. A substantial part of their time is also taken up with quality issues including prescription queries, in particular discrepancies between care home, surgery and community pharmacy records. Anecdotal evidence has suggested freeing up of both GP and administrator time dealing with prescription queries. Development of new documentation has also been undertaken to improve current ordering systems.

### Ongoing and Planned Future Developments

1. Pharmacist medication reviews ongoing. Planned to have 300 reviews completed by end March 06.

2. Pharmacy technician repeat prescribing interventions ongoing. Planned to have 44 homes by end June 06.

3. Prescribing reports generated by the pharmacist have highlighted the areas of greatest spend for the practice. From this, target areas have been identified to ensure prescribing in these areas is appropriate.

#### - Continence Products

One of these areas is the prescribing of continence products, in particular catheters and bags. Joint working with the Continence Service is underway to develop a continence product “formulary.”

#### - Wound Management Products

Another target area is wound management products. Planned work is to adopt/develop the “First Dressings Initiative” employed by the district nurses to care homes. Pilot work to be fed back via the Tissue Viability Nurse to implement into care homes. Discussions with Care Commission will be central to the implementation of this initiative.

#### - Enteral Nutrition (Sip Feeds)

The highest spend for the practice is for sip feeds. In conjunction with the Medicines Management Team and dietitians, prescribing of the “Forti” range is promoted in line with GGNHS guidelines. In addition, a business proposal has been drafted with the

Medicines Management Dietitian recommending dietetic input to the NHMP to ensure appropriate prescribing.

- Proton Pump Inhibitors

A fairly high spend in this area is to be expected due to most of the patients being at high risk of GI complications by virtue of age alone. However, the appropriate prescribing of high dose PPI's was audited by Dr. Tracey Gray with pharmacy support. This resulted in 32 patients being reduced to a maintenance dose of PPI, generating savings of £5200 per annum. The second cycle of the audit showed that 78% (42/54) patients were appropriately prescribed high doses of PPIs.

- Antipsychotic prescribing

Prescribing of antipsychotics in care homes is always an area of interest and indeed many of these drugs are widely used within our practice. An audit of antipsychotic prescribing, in conjunction with Dr. Murray Hardie, has highlighted approx 20% of our patients are prescribed a regular antipsychotic. This percentage is less than that highlighted by other research in this area. However, the appropriateness of prescribing of these drugs should be investigated and reviewed regularly.

#### 4. Palliative care

Areas where quality of medicine provision could be improved are also being investigated. In particular, local audit would suggest that end of life palliative care is often reactive rather than proactive and that end of life care in care homes is suboptimal. One area contributing to this is the inability to access palliative care drugs timeously. To address this problem, discussions are underway with relevant authorities to introduce "just in case" boxes to care homes.

#### 5. Joint working with the Care Commission, Social Work and other pharmacists/Health Boards undertaking similar work to address:

- provision of wound management products
- provision of "just in case" palliative care drugs
- correct, legal documentation for use in care homes (such as immunization consent forms)

### Recommendations

For the maximum potential to be achieved from the clinical pharmacy service, there is the need to expand the service to include a minimum of one further FTE pharmacist and one FTE pharmacy technician. However due to the savings achieved by these posts, it is anticipated that this should be at worst a cost neutral process though is more likely to generate further savings whilst improving the quality and appropriateness of prescribing, and reducing wastage.

A further practical recommendation to maximise the likelihood of overall success is that the pharmacy technician model developed for the central practice is adopted fully by the assisting practices. Till now, the technicians roles in the assisting practices has been more constrained due to assisting practices wishing to retain their practical input into repeat prescribing processes. The implementation of the IMT system is likely to reduce assisting practice concerns about the level of technician involvement as the technicians will be able to generate repeat prescriptions in the homes whilst carrying out stock control. This will then reduce the workload of the assisting practice administration workload.

## Expected versus reported benefits for patients and carers

### Original view of anticipated benefits and evidence of their achievement or otherwise

It was stated that the specified PMS would improve care through a variety of means. These are now listed and the current status described. The wording from the original specification is in italics, with comments on current status following each statement.

*The planned PCT PMS practice will provide enhanced PMS to nursing home patients who choose to register with the practice. Enhanced PMS have been designed and specified to meet their medical health care needs and form part of a strategic package of health and social care initiatives aimed at improving the care of nursing home residents.*

- *Providing access to an enhanced level of medical care which has been designed to ensure patients will benefit from high quality, effective and efficient personal medical services. The enhanced service will benefit patients through:*
  - *A regular prearranged presence in the nursing home (minimum of twice a week).*  
Achieved
  - *An individual holistic assessment of each patient (minimum of 6 monthly per patient).*  
Not fully achieved due to lack of time available. Realised by GPs that much of the review recommended in the original specification is nursing rather than medical in nature.
  - *Public health and health promotion interventions (as required).*  
The 2005 influenza vaccination rate for central practice 82%, with 75% in the 10 of 12 assisting practices who provided the relevant information. Calcium and vitamin D is currently prescribed for 54% of central practice patients. This may be lower than expected and an audit is planned to look at appropriateness of prescribing. It is known that a number of patients do not like taking calcium and vitamin D as they find whatever preparation used unpalatable. Where this is known to be the case, the pharmacy technicians (who are most likely to pick up concordance issues when reviewing MARR sheets for monthly prescription orders), trigger a query with the homes and GPs, which can result in the drug being discontinued. Overall health promotion advice for this patient population often lacks the strong evidence base that exists for other populations and may not be appropriate if looked at on an individual patient care basis.
  - *Comprehensive medical record keeping.*  
Partially achieved. Central practice GPs summarise all case notes, this information being entered onto GPASS along with appointment lists, contact reasons, referrals, blood results etc. Lots of duplication of recording because case note in one site and GPs in another and IMT solution awaited. Medical record keeping more difficult in assisting practices due to more difficult IMT situation. Some assisting practices have opted to keep notes in the practice rather than the nursing homes. One assisting practice in effect works with two sets of notes for each patient, one in each site.
  - *Multidisciplinary and multiagency partnership working.*  
This is an ongoing development area. However significant frustration on the part of GPs that they cannot access clinical support from other health disciplines, and that the emphasis appears to be upon training and facilitation when direct clinical care is lacking.
  - *Provision of daytime on call and out of hours cover.*  
Achieved

- *Clinical governance.*
- *Participation in local decision making about services for older people.*

The NHMP is involved within the Health Supports to Care Homes Group. It is difficult to evidence at this time how the practice has contributed to any decision

making: views may be expressed but at present there is a lack of cohesion between the different groups. It is understandable that individuals retain loyalty to their own team, views and experience. However, reluctance to consider and implement change with particular regard to direct clinical care and joint working within this, can limit the potential of what could be achieved and directly benefit patients.

- *A commitment to relevant continuing professional development.*  
Successful area. Three of five central GPs have the Diploma in Geriatric Medicine and a fourth is undertaking an MSc in Palliative Medicine. One GP is supporting a specialist nurse through the prescribing course. The clinical pharmacist has completed the prescribing course. Bi-annual training days are organised for the NHMP, with topics relevant or requested. Proposed 5 day Gold Standards Framework training course for 2006 – awaiting confirmation of funding availability.

*The PMS approach of the practice will provide improved medical health care to its patients and assist the development of other health and social care inputs to nursing home residents. This will come about as a result of:*

- *The practice being funded to provide the increased level of personal medical services required by this patient group.*  
The GPs view patient care as being improved and not enhanced, due to lack of time and access to other services. They regard and can evidence that the NHMP is underfunded.
- *The practice providing the specified service designed to meet the need of its patients.*  
Partially achieved as above.
- *The doctors developing skills in the provision of medical services to nursing home patients.*  
The doctors are gaining expertise, although this is an ongoing development area with resource and training implications. The current priority training area is around palliative care.
- *The doctors advising nursing home, community health care and social care staff on medical care issues.*  
This is a difficult area. The GPs cannot currently access services for patients they wish to be able to. There are many barriers – both organisationally and in terms of attitude – towards community health care support for nursing home patients. A current example is that the Community Diabetic Specialist Nurse still exclude nursing home care patients from their services.  
The differences in training and experience between GPs and social care staff mean that in the same way as GPs might not grasp fully the rationale behind the approach of social care staff or developments which would enhance patient care from the social care perspective, the reverse is also true. This is an area where raising awareness of each others' roles and how teams operate would be very beneficial.
- *The doctors will also be able to develop their input to the delivery of co-ordinated health and social care through multidisciplinary and multiagency working.*  
As above.

*The well-being of patients should also benefit from the planned approach to their health and social care. This may lead to some patients taking more control over their health care and other elements of daily living.*

- Lack of time means that the GPs do not have the desired opportunities to speak to patients and their carers which would increase the likelihood of patients taking more control over their health care. Many patients have certificates issued under the Adults with Incapacity Act, as a result of difficulties in making decisions due to health reasons. The GPs strongly support the aim of greater patient and carer involvement, particularly in relation to end of life care planning and preferred place of care.

#### Patient and carer views: patient focus public involvement

Information has been gathered in different ways and has been categorised accordingly.

##### Benefits

Sarah Burgess April 2004 MPH

Based on one to one interviews with patients and carers about health care needs and how these were addressed: "the views and opinions expressed about the caring staff and the dedicated General Practitioner service was very positive."

##### Challenges

Sarah Burgess April 2004 MPH

Patient unaware of change of GP.

Feedback form Patient Choice of GP Meeting 18<sup>th</sup> February 2005

Patients, carers and nursing care home managers unhappy about rotation of GPs. Had been told that each home would be cared for by a specific GP and this had not been the case due to rotation and changes of GPs. Resulted in lack of continuity of care for a very vulnerable patient group.

#### Current development work and recommendations

The central practice and Clinical Effectiveness from the Board is addressing this at present, including through the NHMP Patient Focus Public Involvement (PFPI) working group. The recommendation of this group is that a PFPI Officer (see Appendix ???) is appointed to take forward this vitally important work. The purpose of the proposed job is described as follows:

"To work in collaboration with the Nursing Homes Medical Practice, Palliative Care, Health Supports to Care Homes Group and Greater Glasgow NHS staff, nursing home owners, managers and staff, health partners, statutory and voluntary agencies, community groups and patients, carers and members of the public to deliver a Nursing Homes Medical Practice Patient Focussed and Public Involvement (PFPI) plan and promote a patient-centred approach to health and well being, linking the work to identified Nursing Homes Medical Practice priorities."

#### Nursing care home managers views

##### Benefits

#### Survey of NH Managers Views, Jan 2005

Regular scheduled visits, continuity of GP, reduces emergency and out-of-hours visits, networking through NHMP with other health professionals, relatives supported by the NHMP and feel confident with their presence, ease of prescription ordering, 6 monthly medicals and medication reviews, case notes in nursing care home which is of value in acute situations, allows intervention with client prior to becoming critical, immediate response to problem solving, scheduled visit reduces 'phone calls, medicals, blood tests and examinations up-to-date, all staff find GPs are more approachable, increased communication with GP, higher standard of medical care, pro-active GPs, chance to discuss legal aspects of care e.g. AWIA.

#### Dr Sue Williams: Providing Care in Care Homes – The Providers Perspective: Sept 2005

Dr Williams undertook this care home manager survey (questionnaire study following focus group work) on behalf of the NHMP, looking at all aspects of health care provision by the NHS within care homes. General practitioner services were asked about specifically and the comments received are as follows:

There were 74 responses to the question on GP service provision. Thirty-six (49%) homes used the Nursing Home Medical Practice, 28 (38%) used the clients own GP and ten (14%) used specific practices arranged by the home. Regularity of visits, consistency and continuity of care were the particular advantages of using the Nursing Home Medical Practice. The main reason for using a person's own GP were familiarity and the previous relationship built up between patient and practice. The main advantages of using practices arranged by the home were close proximity and the development of close working relationships between the home and the practice in the past.

#### Challenges

##### Survey of NH Managers Views, Jan 2005

Pharmacy request system cumbersome, initially confusion about out-of-hours services, frequency of change of GP rather than the named GP promised, filing sporadic, closeness of scheduled visits to home, funding requirements for training for e.g. catheterisation, GP pressed for time – attention not paid to relatives causing frustration for staff as they bear the brunt, staff views dismissed at times, equipment, greater links with Community Mental Health Team, delays in IT preventing printing of scripts at nursing home, weekend cover, lack of cover by NHMP on quite a frequent basis for meetings/study days.

#### Areas suggested for development

##### Survey of NH Managers Views, Jan 2005

Health promotion classes, GP to carry out more regular total care reviews with care staff and families, iv and subcutaneous fluids, more specialist domiciliary visits instead of outpatient appointments, quicker access to other healthcare staff, one GP surgery per home, staff training on symptom control, support groups for homes to share good practice, nurse prescriber "in house" for dressings etc., diabetic reviews, proactive support for people with incontinence, include residential homes.

#### Dr Sue Williams: Providing Care in Care Homes – The Providers Perspective: Sept 2005

Dr Williams study asked about care home managers views about how general practitioner services could be improved or developed. The suggestions made are as follows:

Provision of specialist nurse services and practice nurses were the main improvements/developments suggested for the Nursing Home Medical Practice. Other improvements identified were reducing the number of changes in GPs, better communication between GPs and hospitals, more time for GPs to spend with patients, more time for routine health checks and better ordering of medication.

For those using the patients' own GPs the main improvements/ developments suggested were regular reviews of medication, easier and regular access to GPs, shorter waiting times for visits, providing a GP in the practice with expertise in old age medicine and better out of hours provision.

Main improvements/developments suggested for those using GP practices arranged by the home were improvements in out of hours service, more time for visits, automatic home visits for clients.

Provision of staff training and an allied health professionals support service were also suggested as other services to be provided by or complementary to the care provided by GPs.

*"Continuity and support is necessary for residents, relatives and care staff."*

*"One doctor who could visit twice a week and has an interest in care for the elderly would make a big difference"* (currently provided by NHMP).

#### Expected versus reported benefits for general practitioners

- Original view of anticipated benefits and evidence of their achievement or otherwise

#### Benefits

##### SCOT Analysis April 2004

Co-ordination, standardisation, continuity of care, holistic reviews, increased time for patients. Improved patient care – "massively better". Twice weekly visits. More time effective medical input for NHs. NHs have identifiable GP. Improved team working. Integration with other services. Increased multidisciplinary links and training/PDP. GP with special interest. Advocacy. Enthusiasm. Opportunity to audit & evaluate. Polypharmacy/cost issues. Training for care staff.

##### NHMP GP Meeting 23<sup>rd</sup> June 2005

Still a view held that service has advantages to standard GP care in terms of regular visits to homes and better continuity of care. However positivity about the service was greatly outweighed by concerns and the strong view that those involved were unable to deliver the enhanced level of care they signed up to deliver. The increased time for patients had not materialised as previously thought.

#### Challenges

#### SCOT Analysis April 2004

IMT. Not all homes covered. Time. Twice weekly visits - ?could be less. NH generate work to fill GP time. Split between supporting practices and central service.

Geography

Funding & training for nurses within care homes – varying standards at present

Poor quality of communication with NH staff – especially language difficulties

Staff turnover. Lack of AHP input. “True” multidisciplinary working.

Staffing levels – community & NH. Outcome measure – is quality better?

Lack of patient choice

Expansion of numbers of patients in nursing homes

Workload to increase

Quality of nursing homes themselves

Burnout

5 year lifespan of service. Funding of service.

Care Commission – how responsible is our service for overall provision of care?

?inclusion of residential homes

Threat to partnership in assisting practices if only some GPs involved in NH work

Temporary residents

#### NHMP GP Meeting 23<sup>rd</sup> June 2005:

“Two years down the line the “enhanced” service is 90% fire-fighting.”

“The service is not enhanced.”

One practice indicated that they were planning on resigning if significant improvements in support and funding for the service were not made. A second practice agreed that they were likely to follow suit.

Particular concern about Palliative Care which was regarded as being managed in an acute rather than planned way. End of life care and registration are the areas of greatest work intensity for GPs. It was viewed that this had not been taken into account in planning and funding processes.

Lack of support and true joint working with other health providers, Social Work and Care Commission. Inequity of health care support from home to home. All the GPs involved had signed up to providing care to nursing home patients under the belief that they would be supported by AHPs, Mental Health, Nurse Specialists and Palliative Care. Without this support, nursing home patients were disadvantaged compared to patients in standard practices.

Great concern about staffing levels within nursing care homes, in particular the apparent agreement of the Care Commission to reduce nursing levels when the GPs are concerned about the issues and pressures on existing staff to provide adequate nursing care. Language barriers persist.

Poor quality of discharge information and inadequate discharge support, particularly examples were given where palliative care issues had not been addressed.

Expectation of GPs to provide training for nursing staff. What is the role of the Facilitators?

Chronic disease management: inadequately addressed at present. This aspect of care in a standard practice would be undertaken mainly by the practice nurse with support from the GPs.

Agreement needed on what the GPs could do within their available time: could not meet the “enhanced” level they anticipated.

Recognition that much of the 6 month assessment is nursing in nature and that GPs are not best placed to advise or review patients in such areas.

Assisting Practice Financial Implications of involvement in NHMP: NHMP meeting 23<sup>rd</sup> June 2005

Practices reported working more hours than they were being paid for in order to deliver care for their nursing home patients. The practices were therefore financially subsidising the service. Particular issues surrounded: GP sessions worked, increasing practice staff costs, 3.25% uplift, high turnover of patients due to death rate.

GPs are unlike other disciplines who can say they are unable to accept a caseload

Summary of GP views

As indicated previously, there is a great deal of frustration within the GPs about what they are currently achieving. They recognise that patient care is improved, but the “enhanced” service they all signed up to be involved in delivering has not materialised due to factors outwith their control. The GPs spend more time in nursing care homes than almost all other health or social care groups, yet they do not feel they are being listened to and are concerned that the main influences in service development are being made by others with less nursing care home experience. They are concerned by the “policing” role they feel others expect them to take, though realise the risk of complicitness if they do not speak up if they have concerns about patient care.

Expected versus reported benefits for NHS and other agencies

- Original view of anticipated benefits and evidence of their achievement or otherwise

The following section includes statements in italics is from the original specification, with comments in normal font reflecting current status.

*The proposed PCT PMS practice and assisting GMS practices will provide nursing home patients with enhanced PMS to an agreed specification. To do this the practices will share knowledge and experienced and work in partnership and with other primary health and social care services. Provision of the planned comprehensive and high quality medical input to nursing home patients will benefit the NHS by:*

- *Providing a higher level of medical input to nursing home patients than can presently be provided within the structure of GMS.*

Twice weekly visits to homes, with continuity of GP providers to a significantly greater extent than under GMS.

- *Improving the level of medical care to nursing home patients. This will be achieved through increased knowledge and skills developed as a result of the PCT PMS practice GPs and assisting GMS practices' GPs providing comprehensive health care to patients in a nursing home grouping with 173 to 355 beds.*

Improved though not enhanced. Concerns held by all GPs that initial target patient numbers per session were unrealistic which have resulted in compromises in the delivery of the original specification.

- *Proactive management of health care. This should reduce out of hours call outs and secondary care admissions.*

Improved health care though in the main part still described as “fire-fighting”.

There is evidence within the central practice that within hours emergency hospital

attendance and admission have diminished significantly in the last year. An audit process for out of hours calls has now been established, as until now there has been no way of identifying changes. A hospital based audit (Dr Arun Singh, GRI) has shown that 70% of hospital admissions are appropriate. This is supported by an ongoing pilot audit within the NHMP looking at both the hospital consultant and GP views of admissions. Anecdotal views of the liaison nurses are that the majority of admissions are appropriate.

- *Establishing care pathways to improve patients' health care and well-being.* At development stages, particularly with regard to chronic disease management.
- *Establishing the PMS pilot will facilitate a greater understanding of health and social care provision and planning for nursing home patients. It will also increase the sharing of health and social care knowledge between doctors and other health and social care providers.*

A significant benefit of undertaking the production of this report is that it is identified that other health professionals and other agencies do not have a clear understanding of what the NHMP does and what it is trying to achieve. This needs to be a priority area for us, to enable stronger working relationships and improvements in patient care to occur.

### Survey of other services views of the impact of the NHMP

This questionnaire survey was undertaken in December 2005. The target group was other agencies or NHS staff who have patient associations with the NHMP. Regrettably there has not as yet been any response from the Care Commission. The responses are grouped according to question type (any perceived benefits of the service, any observed deterioration in patient care compared to previous GP care, any impact on their own or their department's workload, and any ways in which the service could improve) and to occupational grouping.

#### Any benefits you have perceived

##### Physiotherapist

Regular medical input to NH residents where there is need

##### Community Psychiatry Liaison Nurses

Staff are much more confident due to marked improvement with rapport with set GPs.

Weekly clinics have pre-empted many problems.

Referrals to Community Mental Health Service are at an earlier stage.

Feedback from relatives have been positive (appears to have more access to their relatives GPs).

The patients receive a regular proactive approach to their care and less "crisis" approach.

Communications with all disciplines and specialties are more open and healthy debate and quick plans of care can be provided.

##### Medicine For the Elderly Hospital Liaison

That the resident has continuity of medical care within the nursing home, during twice weekly visits problems can be highlighted and hopefully resolved early.

The medical notes are kept at the nursing home therefore out of hours medical cover has access to past medical history and present treatments.

Closer monitoring and reviewing of medication.

GP letters sent with patients on transfer to hospital are much more detailed.

Improved transfer letters to hospital now include detailed recent events, blood results etc.

Medical issues are picked up and acted upon more quickly.

Stats indicate reduction in hospital admissions with dehydration, chronic disease and in a collapsed state.

#### Public Health Medicine

Almost everyone I speak to is very satisfied with the Practice: particularly having (in the main) a single GP to interface with and who is able to take a PROACTIVE as well as reactive role.

#### General Psychiatry

I think that the continuity of care which your service provides to Nursing Homes is hugely beneficial. This is obviously influenced by the quality of the GP covering the Nursing Home (in turn it is also influenced by the quality of the Consultant providing secondary care cover). In my case, I provide Consultant input into .... , The GP there is ..... I think the care he provides has been excellent and a real benefit to .... NH.

#### Dietician

Liaison with GP's has enabled a more timely and effective response to patient care. When local guidelines are in place the closer working together has led to a greater understanding of the nutritional screening tool.

Having a named GP to link with in relation to the homes, has meant identified problems and action have been easier to achieve.

#### Podiatrist

Care homes staff have voiced positive remarks concerning the service on behalf of their residents and appreciate that they have a named and approachable GP, providing a good package of care (i.e. regular visits, assessments/reviews), which is a proactive, rather than a reactive service.

#### Medicine For The Elderly

I am assuming that the GPs who do this are genuinely interested. If true this has to be a good thing.

Very few. The impact has probably been to lower the threshold of nursing homes sending patients into hospital.

There should be improved chronic disease management with anticipatory care rather than crisis intervention alone. However there still seems to be a number of potentially avoidable admissions from nursing homes to hospital.

#### Social Work Services NARS Team

Residents regular access to GPs. Facilitates communication between contract managers and care commission. Has helped with closures re transfer of information and health checks. Feedback from GPs re issues in homes.

#### Psychiatry for older people

Fewer referrals. I think the patients now receive a higher quality of care.

Improved continuity of care. Medication regularly reviewed.

Regular GP input meant improved communication between homes and GP and psychiatrist and GP. Medication changes are more promptly dealt with. Better patient care

More consistent approach - better communication with our own service. Much less "fire-fighting" and more time looking at ongoing needs of patients. Much easier to arrange medication changes.

#### Palliative Care

Patients are seen on a regular basis. Dr's have an interest in palliative care therefore network with palliative care nurses and others for advice and support. Drs also provide more support to nursing

homes. Nursing staff will contact the NHMP because they have developed a close professional relationship with them. ( this information was retrieved from a focus group re end of life care in care home. Reid and Sanderson 2005)

Any areas where you think patient care has deteriorated compared to previous GP service

Physiotherapy

No, it's an improvement

Community Psychiatry Liaison Nurses

There are no areas where patient care has deteriorated due to the onset of this development.

You notice the difference in homes that do not have this service and you have to return to delays and dealing with different GP practices.

Medicine For the Elderly Hospital Liaison

None

No

Public Health Medicine

None

General Psychiatry

None from my perspective.

Dietician

Don't know what it was like previously, not long enough in post

Podiatrist

Very few nursing home staff mention that some residents would like to have kept their previous family doctor, but this would not have been possible anyway due to the residents move out of their GP's area.

Medicine For The Elderly

One might make adverse comparisons with "old Fashioned GP" where the GP knew all patients very well and could provide that very valuable link. In general, most problems that I perceive now relate to out of hours cover, when elderly patients are sent in by someone with no time, or possibly interest, to address the real issues. I confess that I do not know if the PMS team provide out of hours cover.

Lack of knowledge of the individual patients. Perhaps a lack of "seeing the big picture" reflecting the inexperience of the doctors manning the service, particularly with respect to geriatric medicine.

Not aware of any areas where this has occurred.

Social Work Services NARS Team

None known

Psychiatry for older people

I don't think patient care has deteriorated.

No

None

Palliative Care

No visible evidence

### Any impact on your own or your department's workload

#### Physiotherapy

Has resulted in requests for input from CHTT physio to show carers how to encourage and support residents to do exercise etc. I notice that the distribution list does not include any of the domiciliary physiotherapists, who would be directly affected by referrals.

#### Community Psychiatry Liaison Nurses

Difficult to measure due to changes in own service but much easier to contact GPs within this service.

I feel psychiatric assessment have continued to be numerous but more appropriate now esp. ruling out physical cause initially. I am fortunate that in my area there is a very good relationship between psychogeriatricians, NHMP and myself and find often a phone call resolves a lot of issues.

#### Medicine For the Elderly Hospital Liaison

No

No

#### Public Health Medicine

Not applicable

#### General Psychiatry

Before the NHMP was in place, I might have to liaise with a number of different GPs. There have been huge advantages in dealing with just one GP and, as I have highlighted above, I am fortunate that the GP for .... is Dr .... . It is hard to measure the effect of the NHMP on workload. However I think this has been less. Dr .... is very containing regarding medical problems at .... and, when he does refer, it is always appropriate. Having only one GP to liaise with also means that it is possible to build up clinical relationships with that GP and this too is helpful in dealing with the work that arises.

#### Dietician

Yes increased referrals initially, the nutritional screening education day at the hospice helped with that

#### Podiatrist

The GP's are focussed on "frail elderly care" so appreciate the holistic needs of the residents. They appreciate the importance of surgical shoes, when requested by podiatrists, as podiatrists do not request them unless there is any other alternative. For example, GP's in the past (fortunately in the minority) have not appreciated the importance of residents wearing suitable footwear and have been known to comment that since the residents don't go out, they don't need shoes. Footwear is vital for daily stability, balance, gait and protection of the residents feet, and is important in reducing the likelihood of falls. It is great to have GP's that work in partnership with the care home and other health professionals.

#### Medicine For The Elderly

Negligible

Undoubted increase. Increased ( unrealistic) expectation of what we can deliver.

Not sure without access to further data e.g.. Hospital admissions from nursing home pre and post introduction of the NHMP

#### Social Work Services NARS Team

Potential to reduce work by aiding communication but also increase work as at long last, we have people to work with.

### Psychiatry for older people

We feel much more able to make suggestions about how someone's physical health might be impinging on their mental health and find that physical causes have often been ruled out before referral to us which decreases our workload.

Lessened

Not that I am aware

### Palliative Care

My workload has increased! This is a positive comment. I have been able to gain access to the care homes as a result of the NHMP. This has helped with the pilot of the LCP in two Glasgow care homes (nursing). This work has evolved because of the nature of the post and I have appreciated the professional connection with the NHMP.

??

Probably increased workload in referral but decreased workload in chasing up poor communication/response to our letter/medication change.

### Any suggestions for ways in which the NHMP could improve its services

#### Physiotherapy

No response

#### Community Psychiatry Liaison Nurses

To include all Care Homes / care associations i.e. registered residential, enhanced, specialist as well as certain housing associations (catering for people with learning difficulties, dementia). To have an umbrella of specialist links.

To provide this service in all homes both nursing and residential.

#### Medicine For the Elderly Hospital Liaison

It was apparent through a survey of the (Hospital Liaison) service I provide that some of the GPs were not aware of the service. It would be helpful if all were aware of the link service within the acute service

Written information to nursing home staff working out of hours e.g. GP aware of resident's condition and will review next day may help prevent hospital admission.

More formal communication with liaison nurse. At present informal meeting in nursing home can identify areas of GP concern and advice from liaison nurse is often beneficial.

Discharge information from liaison nurse may be useful prior to GP receiving letter from hospital consultant.

#### Public Health Medicine

By using patient/resident contacts as opportunities to teach care home staff. Would take very little extra time - but could be enormous benefit.

#### General Psychiatry

As with the rest of medicine, part of the aim of Continuing Professional Development within your service should be to equip your GPs to deal with nursing homes as well as possible. As you will know, .... is a unit dealing with patients with alcohol related brain injuries. I would therefore hope that in the future, as a result of caring for so many patients with this condition and further training in that area, that the GP at ..... will become the expert in managing such patients and will be teaching the psychiatric services about it.

### Dietician

Regular liaison with the teams going into the homes, not at management level, but GP, Therapist and home meetings to iron out and identify issues at local level.

### Medicine For The Elderly

Limited exposure makes it hard to know, two way communication is the key. Now that we, and the current generation of geriatricians in training, do not visit patients at home (or in the NH), I think there is a real danger that we shall lose this traditionally very important closeness with GP colleagues. Perhaps some sort of joint CME initiative? "grand rounds", either in NH or hospital or alternately.

I think experience is probably the way forward. Perhaps those working in the service should have educational attachments to the various geriatric medicine services, where they can shadow consultants involved in continuing care work. A 6 month job DME as it is currently organised is not enough to prepare one for LTC work

As with all new services, optimise communication, e.g., with secondary care, and conduct clinical audit, utilise standard documentation for diagnoses functional status and medication. Conduct regular reviews and where relevant, AWI certification and treatment plans. Have early documented management plan, especially in palliative care situations to avoid inappropriate interventions.

### Social Work Services NARS Team

Keep GPs longer than 6 Months in the one home, changes impede communication. Extend services to residential care

### Psychiatry for older people

Service varies in different homes – much easier if there is face to face or telephone discussion of difficult cases. Meetings with our own staff are very helpful in helping to shape respective roles and improve communication.

No response

Cover all nursing and residential homes.

### Palliative Care

Nurses working with the team would make a huge impact re empowering nursing home nurses and carers, chronic disease management, minor injuries, research ( there needs to be further research re patients and relatives views about what their needs and wants are) If nurses worked with the team they could build on relationships with others. i.e. District nurses, other NHS staff etc.

??

Involve residential care homes too?

### Summary of view of other health care providers and other agencies

Many positive statements have been made about the NHMP although there are of course ways in which improvements could be made, for example through joint meetings and improved communication. Most caution appears to be expressed by the consultants in medicine for the elderly, and most positivity by colleagues with whom the NHMP has the stongest working relationships and probably greatest understanding of each other's roles within the nursing homes. Interestingly, there appears to be a disparity in views between medicine for the elderly and the psychogeriatricians, psychiatry and the liaison nurse from both mental health and Medicine for the Elderly. This may be because, as one of the consultants in medicine

for the elderly stated, that they do not visit patients in nursing homes, and thus have less contact with the GPs in that environment compared to the others mentioned. In addition, they have the care of the acute admissions, with Dr Arun Singh's audit reporting 70% "appropriate" but therefore 30% "inappropriate" admissions. The comment made about the need for hospital admission patterns is highly valid. Finally, whilst referrals overall have reduced significantly over the last two years, this appears to be a clearer reduction for the psychogeriatricians rather than for medicine for the elderly.

Although of different backgrounds and at times having different views on how best to approach issues surrounding patient care, the relationship between the Social Work Department and the NHMP is strong and continuing to develop. Sharing of knowledge about difficulties in homes is invaluable as are joint meetings, which occur roughly three times per year. There is a need for the NHMP to provide the Social Work Department with a clearer understanding of how practices best operate and develop.

The relationship with the Care Commission is proving slower to establish, but is improving. There is often a view held by the GPs that we are trying to pull in different directions from the Care Commission. This is especially true around nursing staffing levels in homes. There is also concern about variations in attitudes towards prescribing, which has hindered developments such as the First Dressing Initiative going ahead. Again it is hoped through stronger joint working that progress can be made.

#### Information management and technology: original proposal, current status and impact

#### Evaluation and influencing factors

The following statement in italics is from the original specification, with comments in normal font reflecting current status.

*The PCT PMS practice and assisting GMS practices will participate in monitoring and evaluating delivery of the specified service.*

*The service will be monitored by the PCT in partnership with acute and elderly services. An interim 6 monthly report and annual review will be key elements of the monitoring and evaluation process. The interim report will focus on service uptake and delivery by the PCT PMS practice and assisting GMS practices. The annual review will include user and nursing home satisfaction, impact on emergency call outs and review of local audits.*

*An evaluation of the care provided to patients registered with the PCT PMS practice will be commissioned by the PCT. It will be undertaken in year three of the pilot and funding for this (£11,300) is identified at section 10. A framework for the evaluation, which is required to assess the services impact on patients and doctors within the service and on other primary, secondary and social care services involved in the delivery of care, will be discussed and developed with stakeholders.*

*The PCT PMS practice and assisting GMS practices will also participate in any national evaluation and, when requested, provide available data to the PCT and the Scottish Executive Health Department or its representatives.*

Evaluation of the service has proven difficult. The original 80% uptake target has been achieved in the homes the NHMP is working with, and 75% has been reached if homes which have declined the service are included.

A number of factors have hindered or affected the full evaluation of the Nursing Homes Medical Practice:

- *Clinical effectiveness.* There is a need for any new service to determine where it is being effective and where it is not, to allow services to be adapted to make best use of available resources and maximise positive impact on patient care. It would have been hugely advantageous, not just to the NHMP but to the Primary Care Division and Health Board, had the need for formal and permanent input from Clinical Effectiveness been factored into the service from the outset. The NHMP is deeply indebted to Alasdair Buchanan (PCD) and Sue Williams (Clinical Effectiveness, GGHB) for the support they have been able to offer when gaps in their timetables have arisen. This report would not have been possible without their significant contributions. It is essential that for the long term successful development of the NHMP that a Clinical Effectiveness Lead becomes an integral part of the team.
- *Information and management technology.* The lack of and ongoing delays in the installation of a central database connecting all the practices within the NHMP has meant that although progress is being made within the central practice around standardisation of data collection and analysis, this is not yet possible for the NHMP as a whole.
- *Nursing care home bed and patient numbers.* It has proven very difficult to obtain independent verification of nursing care home bed numbers. Neither the Care Commission nor Social Work Department have been able to help with this, in particular since the term “care home” replaced specific categories. Although divisions in bed categories still exist, these may fluctuate from one type to another. NHMP policy is to obtain bed and patient numbers from the respective practices, and where any changes are known to have occurred in bed numbers, to seek verification from care home managers.
- *Lack of baseline figures or systems for obtaining them around hospital admissions, referrals and GEMS call outs.* Where figures are obtainable, there are questions around accuracy e.g. coding for hospital admissions from nursing homes has been found to include other care home types and at times non-care home addresses. This has created difficulties in efforts to measure any change, but is being addressed through systems within the central practice and with the help of individuals at the Health Board.
- *Multi-factorial issues surrounding health care.* Many of the issues affecting health care within nursing care homes are out with the control of the NHMP. It is not clear whether the multi-factorial reasons surrounding admissions, referrals and GEMS call outs were taken into account in establishing these as outcome measures for the practice. The NHMP provides Monday to Friday 7.30am to 6pm care, thus events out with these times are often out of the control of the GPs.
- *Palliative care.* Palliative care and its importance in a population with such a short life expectancy was not prioritised within the original specification. This is

reflected by the fact that the NHMP was set up as a GP team only. It was not recognised at the time that palliative care in general practice requires a multi-disciplinary approach, that the nursing home nurses frequently lack the skills provided by community nurses, and thus patient care may be compromised.

- *Prescribing.* Although medication reviews were included in the service specification, impact on prescribing per se was not, despite this being an area where improvements were both likely to be possible and measurable.
- *User satisfaction.* Again although patient and carer benefits were listed in the specification, it is likely that the complexities surrounding measurement of satisfaction had not been taken into account. Both patients and carers alike frequently have to undergo huge adjustment processes related to very difficult health problems often with poor prognoses plus the reality of changing from living in their own home with loved ones to a care home environment. Carers may experience “living bereavements” due to the impact of dementia and feel as if their main caring role is being taken over suddenly by care home staff, who have little knowledge of who their relative is or “was”. Many patients and carers may lose contact with their GP of many years or decades duration when they chose to register with the NHMP: this can be experienced as another loss or add to the difficulties already being faced. Thus, user satisfaction cannot be compared to patients in a standard practice who often attend with self-limiting or easily cured illnesses, or on the other hand, chronic illnesses supported by the whole practice team, with whom they develop long term relationships and support systems. For many NHMP patients, the NHMP has only a very short time to “get things right”, in an environment which in the main part is completely out with the control of the GPs.

*Specific patient needs.* The NHMP was established with an emphasis upon the needs of those patients who might traditionally have had links with the departments of medicine for the elderly. However, the main health problems of many of those under the care of the NHMP are linked to other health areas e.g. palliative care, old age psychiatry, general psychiatry, brain injury services and the young chronic sick. It is thus important that as the NHMP evolves that it focuses on all the patient groups under its care. Similarly practice audits flag up where “improvements” can be made but also raise awareness that standard approaches to care (e.g. target levels for specific risk factors) must be carefully balanced against the impact decisions may have on quality of life.

1.2 Please provide details of any enhanced services, which your practice would be interested in providing in the future.

The GPs wish to be able to provide a truly enhanced level of patient care, working in a multidisciplinary way.

1.3 Are there any specific local issues you wish to highlight regarding possible future enhanced services?

**2. ADDITIONAL SERVICES**

2.1 Is your practice considering opting out of the provision of any of the additional services in the future?

Please provide details below and indicate if considering permanent or temporary opt out:

**3. PREMISES**

3.1 Please provide details of any specific premises issues relating to your practice.

**4. INFORMATION MANAGEMENT AND TECHNOLOGY**

4.1 Please provide details of any specific IM&T issues relating to your practice.

**5. BOARD ADMINISTERED FUNDS/PAYMENTS FOR SPECIFIC PURPOSES**

5.1 Please provide details of any particular issues regarding claims from Board Administered Funds (e.g. Seniority, Golden Hello payments and locum costs in connection with maternity leave and sickness absence of doctors in the practice).

**6. WORKLOAD**

**6. WORKLOAD**

6.1 Please comment on the effect of the new GMS contract implementation on GP/practice workload and patient services.

6.2 To what extent has practice based arrangements allowed you to develop a more multi-disciplinary approach and improved skill mix ? – please give examples

6.3 Is the new GMS contract enabling modernisation and redesign of services for the benefit of your practice and patients? – please give examples


## NURSING HOMES MEDICAL PRACTICE:

### 5. EXPECTED VERSUS REPORTED BENEFITS FOR PATIENTS

The following paragraph is from the original specification:

*The planned PCT PMS practice will provide enhanced PMS to nursing home patients who choose to register with the practice. Enhanced PMS have been designed and specified to meet their medical health care needs and form part of a strategic package of health and social care initiatives aimed at improving the care of nursing home residents.*

It was stated that the specified PMS would improve care through a variety of means. These are now listed and the current status described. The wording from the original specification is in italics.

- *Providing access to an enhanced level of medical care which has been designed to ensure patients will benefit from high quality, effective and efficient personal medical services. The enhanced service will benefit patients through:*
  - *A regular prearranged presence in the nursing home (minimum of twice a week).*  
Acheived
  - *An individual holistic assessment of each patient (minimum of 6 monthly per patient).*  
Achieved in the minority of cases due to lack of time available and following from that queries about the actual patient benefits of such reviews.
  - *Public health and health promotion interventions (as required).*  
This year's influenza vaccination rates awaited. Central practice: pneumococcal vaccinations in 50% patients. Health promotion advice for this patient population often lacks evidence base and may not be appropriate if looked at on an individual patient care basis.
  - *Comprehensive medical record keeping.*  
Partially achieved. Central practice GPs summarise all case notes, this information being entered onto GPASS along with appointment lists, contact reasons, blood results etc. Lots of duplication of recording because case note in one site and GPs in another and IMT solution awaited. Medical record keeping more difficult in assisting practices due to more difficult IMT situation. Some assisting practices have opted to keep notes in the practice rather than the nursing homes. One assisting practice in effect works with two sets of notes for each patient, one in each site.
  - *Multidisciplinary and multiagency partnership working.*  
This is an ongoing development area. However significant frustration on the part of GPs that they cannot access clinical support from other health

disciplines, and that the emphasis appears to be upon training and facilitation when direct clinical care is lacking.

- *Provision of daytime on call and out of hours cover.*

Achieved

- *Clinical governance.*

- *Participation in local decision making about services for older people.*

The NHMP is involved within the Health Supports to Care Homes Group. It is difficult to see at this time how the practice has contributed to any decision making. Despite the aims of the group, it would appear that members retain loyalty to their own team, views and experience, and are reluctant to adapt to what would best directly benefit patients.

- *A commitment to relevant continuing professional development.*

Central practice – achieved. Three of five central GPs have the Diploma in Geriatric Medicine and a fourth is undertaking the Diploma in Palliative Medicine. One GP is supporting a specialist nurse through the prescribing course. The clinical pharmacist has completed the prescribing course.

Bi-annual training days are organized for the NHMP, with topics relevant or requested.

*The PMS approach of the practice will provide improved medical health care to its patients and assist the development of other health and social care inputs to nursing home residents. This will come about as a result of:*

- *The practice being funded to provide the increased level of personal medical services required by this patient group.*

The GPs view patient care as being improved and not enhanced, due to lack of time and access to other services.

- *The practice providing the specified service designed to meet the need of its patients.*

Partially achieved as above.

- *The doctors developing skills in the provision of medical services to nursing home patients.*

The doctors are gaining expertise, although this is an ongoing development area with resource and training implications.

- *The doctors advising nursing home, community health care and social care staff on medical care issues.*

This is a difficult area. The GPs cannot currently access services for patients they wish to be able to. There are many barriers – both organizationally and in terms of attitude – towards community health care support for nursing home patients. The differences in training and experience between GPs and social care staff mean that in the same way as GPs might not grasp fully the rationale behind the approach of social care staff or developments which would enhance patient care from the social care perspective, the reverse is also true.

- *The doctors will also be able to develop their input to the delivery of co-ordinated health and social care through multidisciplinary and multiagency working.*

As above.

*The well-being of patients should also benefit from the planned approach to their health and social care. This may lead to some patients taking more control over their health care and other elements of daily living.*

Lack of time means that the GPs do not have the desired opportunities to speak to patients and their carers which would increase the likelihood of patients taking more control over their health care. Many patients have certificates issued under the Adults with Incapacity Act, as a result of difficulties in making decisions due to health reasons. The GPs strongly support the aim of greater patient and carer involvement, particularly in relation to end of life care planning and preferred place of care.

### **Seeking patient and carer views: patient focus public involvement**

The NHMP is currently piloting satisfaction survey forms for patients and carers. It is recognized and anticipated that this may throw up a multitude of issues. When an individual moves into a nursing home, both they and their carers must work through a period of transition, related to the reason for admission (deteriorating physical and / or mental health). For some carers of those with for example, dementia, this can in effect be a living bereavement.

The NHMP has a Patient Focus Public Involvement (PFPI) Group which has recommended the appointment of a PFPI Officer who would develop support systems and links for patients, carers and nursing homes (Appendix 10). There is also a need to support staff (nursing homes and NHS) as working in nursing homes and addressing the complex health and palliative care needs of the patients can be very emotionally demanding.

### **Nursing Care Home Managers views**

The service in the main part has been warmly welcomed by managers of nursing homes, as can be seen in Appendix 11. They appreciate the regularity of visits, improved continuity of care and have reported a more proactive approach to care than previously. Complaints have arisen when GPs have changed (central practice) but it is hoped that improved communication between the NHMP and the homes and patients should reduce this potential in the future.

## **6. EXPECTED BENEFITS FOR GENERAL PRACTITIONERS**

The following statement in italics is from the original specification.

*The approach of the proposed PMS practice will help doctors providing the service to develop skills in the medical treatment of nursing home patients. In addition, doctors will be able to share and further develop their skills through working with nursing home staff and associated health and social care service providers. This collaborative approach will assist the development, planning and delivery of integrated health and social care services for nursing home patients.*

*The planned PMS practice approach will incorporate managerial and professional links to:*

- *Trust Primary Care Division, General Manager*

- Trust Medical Directors
- Trust Clinical Governance and Audit Services
- Trust Nursing, PAMS, Pharmacy and Dental Directors

Doctors and administrative staff will have access to the Trust's personal and professional development services. This will include support to further develop GP and administrative service provision and expertise.

## 8. COST AND ACCOUNTABILITY – David- ?you and Fiona?

The proposed medical service to nursing home patients is set out at section 5.

The planned service has two distinct cost elements. They are:

- Funding provision for salaried PCT based PMS practice.
- Funding provision for assisting practices.

### Service Costs and Funding Required

The following tables summarises the service costs and sources of funding. It also identifies the appendices which detail the costs and funding.

Service Costs	£000s		
	2002/03 (6 months)	2003/04	2004/05
PCT PMS Practice (Appendix E)	349.0	733.0	769.7
Start-up Costs (Appendix E)	93.4		
Assisting Practices (Appendix F)	261.4	548.9	576.4
Evaluation Cost (Appendix E)			11.3
Prescribing Costs (based on £755/patient/year)	1,094.8	2,299.0	2,413.9
<b>Total Service Cost</b>	<b>1,798.6</b>	<b>3,580.9</b>	<b>3,771.3</b>

Funding Required (Sources of Funding)	£000s		
	2002/03 (6 months)	2003/04	2004/05
GMS Non Cash Limited Funding (Appendix G)	86.4	181.5	190.6
GMS Cash Limited Funding (Appendix H)	47.7	76.2	80.0
Prescribing Funding	1,094.8	2,299.0	2,413.9
PMS Development Funding Required (Total Service Cost less GMS Non Cash, Cash Limited and Prescribing Funding)	569.7	1,024.2	1,086.8
<b>Total Funding</b>	<b>1,798.6</b>	<b>3,580.9</b>	<b>3,771.3</b>

9

Note:

1. A 5% annual increase has been included for 2003/04 and 2004/05 (costs and funding).
2. GMS non cash limited funding for 2,900 patients is included from the start of PMS contract. Alternatively GMS non cash limited funding could be phased on the basis of patient uptake. This approach would require additional PMS development funding to make up the shortfall until the 2,900 patient level is reached. (Refer Appendix G.)
3. GMS cash limited funding for the PCT PMS practice staff has been included from the start of the PMS contract. (Refer Appendix H.) The practice profile (nominal funding) for GMS practices with registered nursing home patients will be adjusted, as appropriate, to reflect any change.
4. GMS cash limited funding for flu vaccination has been included from the start of the PMS contract because vaccinations are undertaken in the second half of the year. Alternatively flu vaccination funding could be phased on the basis of patient uptake. This approach would require additional PMS development funding to make up the shortfall until the 2,900 patient level is reached. (Refer Appendix H.)
5. There may be a need to adjust funding if there is a significant shift in bed complement or a drop in patient registration below 80% in a grouping. We will develop a mechanism in conjunction with assisting practices to manage the resource implications.

### **Accountability**

*The PMS practice will operate as a Trust based pilot. It will be required to deliver the services as set out in this application.*

*Progress against delivery of the planned service will be formally monitored every 6 months. The practice will submit a half year progress report on performance against implementation and outcome of the planned service to the PCT Divisional General Manager, Primary Care Division. An annual business plan will report on performance for the full year and set out the planned service for the following year.*

*The Primary Care Trust Divisional General Manager, will be the accountable officer responsible for service delivery and expenditure. Professional support will be available via the Trust's Medical, Nursing and PAMS Directorates.*

*The practice will be subject to the same level of financial monitoring and accountability as GMS practices.*

## **9. PROPOSAL FOR REVISED SERVICE SPECIFICATION**

**David – have been trying to speak to Margaret Roberts about this**

*The provision of enhanced PMS to nursing home patients, together with existing and planned health and social care services, is designed to bring about an overall improvement in their health care and well-being.*

*It is planned to provide enhanced PMS to some 80% of nursing home residents (some may wish to remain on their present doctor's list). In addition, a separately funded package of strategic health and social care services aimed at improving the care of people living in nursing homes will be available to all nursing home residents. The*

*PMS practice will work in partnership with the providers of these services to achieve delivery of an optimal level of care.*

*The increased level of medical care set out in the proposal will result in an increase in GP and practice staff levels. Resource requirements have been identified at section 5 and 10.*

## 10. SUMMARY

### APPENDIX D

#### **Service Specification for New Medical Service for Nursing Home Patients**

In addition to standard general medical service provision an enhanced level of service will be provided. The enhanced service will encompass the provision of regular clinical sessions to each home. (The model assumes a planned presence equivalent to one GP session for every 30 nursing home beds.) A programme of regular visits will need to be developed and agreed with each home. A minimum of two planned visits per home per week will be required to deliver the service specification outlined below. It will include:

- ❖ Regular prearranged presence in the nursing home.
  - Providing advice and support to care home staff on the care of residents.
  - Managing/treating general medical conditions as they arise.
  - Liaison with families re condition and planned care for patient.
  - Implementation of clinical guidelines e.g.,
    - Fall prevention and management
    - Diabetes Care
    - Dementia Care
  
- ❖ Individual holistic assessment of each patient (minimum of 6 monthly per patient).

- Identifying change in status and initiating action to address/secure other interventions (e.g. PAMs, specialist nursing advice, consultant advice).
  - cognitive impairment (including certification re adults with incapacity)
  - sensory impairment
  - mobility
  - continence
  - nutrition
  - tissue viability
  - specialist equipment
- Review of medical problems.
- Medication review (including liaison with pharmacist re poly pharmacy/drug interaction).
- Planning and delivery of palliative care.
  
- ❖ Public health/health promotion interventions (as required).
  - Undertaking preventative health measures (e.g. vaccination, calcium + Vit D).
  - Liaison with public health re communicable disease (e.g. flu, scabies, salmonella).
  
- ❖ Medical Record keeping (on-going).
  - Maintaining up to date case notes in home (including brief problem sheet and drug sheet – allows GP/GEMS access to up to date relevant current information).
  - Promoting multi-disciplinary record keeping and care plans.
  
- ❖ Multidisciplinary partnership working with range of professionals working with this patient group (it is envisaged that this will be developed through discussing the needs of individual patients rather than regular attendance at team meetings).
  - Range of primary care services including PAMS teams.
  - Consultants in Medicine for the Elderly.
  - Nurse Specialists outreaching from day hospitals to advise homes on the needs of complex/high dependency patients.
  - Mental health nursing home support services.
  - Acute services re specialist advice and support.
  - Community pharmacists.
  - Local social work team on care management.
  - Acute outreach services.
  
- ❖ Other elements of service would include:
  - Provision of daytime on call and arranging for out-of-hours cover.
  - Clinical governance.
  - Participation in local decision making about services for older people.
  
- Commitment to relevant continuing professional development. (The Post Graduate Education Centre and Consultants in medicine for the Elderly will develop a programme for local training appropriate to the needs of General Practitioners involved in delivery of this specialist service.)

Appendix 2: Practices and nursing homes involved, home bed and patient numbers plus percentage uptake

<b>Declined</b>	<b>Nursing Home</b>	<b>Bed No.</b>		
	Balmano	35		
	Clarence Crt	61		
	Craigbank	32		
	Hogganfield	38		
	Riddrie House	32		
	St Francis	40		
	St Joseph's	29		
	<b>Total</b>	<b>267</b>		
		<b>Bed No.</b>	<b>Pt. No.</b>	<b>% Uptake</b>
<b>Central Practice</b>		1167	885	<b>76</b>
<b>Assisting Practices</b>		2146	1805	<b>84</b>
<b>Total</b>		<b>3313</b>	<b>2690</b>	<b>81</b>

<b>Central Practice GP</b>	<b>Nursing Home</b>	<b>Bed No.</b>	<b>Pt. No.</b>	<b>% uptake</b>
Adamson (8.8 sessions)	Davenport	56	50	89
Adamson	Wyndford Locks	90	77	86
Ballantyne (11 sessions)	Buchanan House	23	21	91
Ballantyne	Buchanan Lodge	27	26	96
Ballantyne	Campsie House	22	20	91
Ballantyne	Campsie View	90	69	77
Ballantyne	Whitefield Lodge	60	29	48
Gray (11 sessions)	Cardonald	35	30	86
Gray	Cartvale	36	27	75
Gray	Florence	38	33	87
Gray	Sherbrooke	33	32	97
Gray	Sherbrooke	33	32	97
Hannah (1 session)	Parkhouse Manor	48	29	60
Hardie (5.5 sessions)	Ailsa Craig	60	43	72
Hardie	Lambhill Court	75	49	65
Hardie	Lilyburn	40	15	38
Locum (11 sessions)	Ashgill	60	37	62
Locum	Canniesburn	50	42	84
Locum	Deanfield	50	44	88
Locum	Manor Park	33	32	97
Locum	Mohsen	33	32	97
McGurk (11 sessions)	Ardencraig	90	77	86
McGurk	Glenafton	35	11	31
McGurk	Nithsdale	47	39	83
McGurk	Torbrae	36	21	58
	<b>Total</b>	<b>1167</b>	<b>885</b>	
	<b>%uptake</b>			<b>76</b>
11 sessions = 1.0 FTE				

Assisting GP Practice	Nursing Home	Bed No.	Tot. bed no.	Pt No.	Tot. pt. No.	% uptake
Barrett, Haworth	Cathkin	17		15		
	Greencross	94		79		
	Greenlees	58		48		
	Rodgerpark	90	259	72	214	83
Campbell	Eva Burrows	16		12		
	Flemington Hse	20	36	5	17	47
Collins	Burnfield	34	34	34	34	100
Grodan	Dunvegan	40		35		
	Eastbank	70		61		
	Eastview	31		22		
	Greenfield Park	30		30		
	Haydale	69		67		
	Mount Vernon	20	260	1	216	83
Hardman	Golfhill	91		69		
	Kerrvale	60	151	60	129	85
Haughney, Cairey	Eastwood	55		45		
	Wellmeadow	86		71		
	Westacres	38		24		
	Whitecraigs	58	237	58	198	84
McKendrick, McKinnon	Alexandra Crt	66		46		
	Baillieston	60		59		
	Clinton House	58	184	50	155	84
Mandeville	Allander Crt	60	60	44	44	73
Rogerson, McDevitt	Edinbarnet	60		44		
	Hillview	150	210	147	191	91
Shaw, Pinkerton	Quayside	150	150	121	121	81
Sweeney	Broomfield Crt	60		58		
	Heatherbank	70		58		
	Mavisbank	60		49		
	Stobhill	60	250	53	218	87
	Almond Court	42		47		
Wood	Almond View	48		40		
	Clevedon Lodge	48		30		
	Clyde Court	52		45		
	Lyndale	19		17		
	Knightswood	90		75		
	Munro Crt	16	315	14	268	85
<b>Total</b>		<b>2146</b>	<b>2146</b>	<b>1805</b>	<b>1805</b>	
<b>%uptake</b>						<b>84</b>

## **Providing Care in Care Homes – The Providers Perspective**

### **Background**

This study originated from a request by the Nursing Home Medical Practice Team who are undertaking an evaluation of their service. Although there is anecdotal evidence of the problems faced by professional carers in care homes no formal studies have been reported. Greater Glasgow Health Board's Area Clinical Effectiveness Office was approached about undertaking an independent study to identify areas for possible improvements in service and support for staff and residents.

### **Methods**

In the second week of August 2005 all 130 Care Homes in the Greater Glasgow Health Board area were sent an explanatory letter, two anonymous questionnaires and a freepost reply envelope.

Responses were requested by mid August. A second mailing was carried out at the beginning of September with responses requested by 12<sup>th</sup> September 2005. If managers/matrons had already replied, they were thanked and requested to ignore the reminder.

The content of the questionnaires was informed by focus group interviews carried out with managers/matrons at the end of 2004 and beginning of 2005. One questionnaire focused on Care Home Managers/Matrons views and opinions on the care their Home gave to residents, the type of primary medical care used by residents and the support provided by the Health Board. The other concentrated on their experiences of ordering and using aids and equipment provided by the Health Board.

The questionnaires were piloted by eight Care Homes outwith the GGNHSB area and minor modifications were made as a result.

The Department of Public Health, Greater Glasgow Health Board carried out the study.

### **Ethics**

This study was part of a larger research project for which ethical approval was obtained.

### **Data processing and analysis**

Questionnaires were designed using Formic scanning software. Return forms were scanned and data were analysed using SPSS.

### **Results**

#### **Response**

Seventy- five responses were received giving a response rate of 58%. This is comparable with response rates from other studies of this type.

#### **Care home characteristics**

Responses were received from care homes in all sectors of the city (Table 1). The poorer response rates from the east and south west of the city indicate that the data, while giving a deeper insight into the experiences and views of providers of care should be not viewed as from a representative sample of homes.

**Table 1 Area of response**

	<b>North</b> n=26 (%)	<b>East</b> n=21 (%)	<b>West</b> n=30 (%)	<b>South east</b> n=29 (%)	<b>South west</b> n=24 (%)
<b>Response</b>	14 (54)	8 (38)	15 (50)	16 (55)	8 (33)

*Number of beds*

The most common capacity of the homes was 31-40 beds. The smallest number of beds provided by any home was 10. Two homes had 150 beds (Table2).

**Table 2 Number of beds**

<b>Bed capacity</b>	<b>n=75 (%)</b>
10-20	11 (15)
21-30	4 (5)
31-40	18 (24)
41-50	11 (15)
51-60	16 (21)
61-70	2 (3)
71-80	1 (1)
81-90	4 (5)
91-100	1 (1)
≥101	7 (9)

*Type of care*

A variety of care was offered by the homes represented in the study (Table 3).

**Table 3 Type of care offered**

<b>Type of care</b>	<b>n=75 (%)</b> <b>(numbers not exclusive)</b>
Continuing nursing	46 (61)
Respite	42 (56)
Dementia	41 (55)
Residential	41 (55)
Alcohol related brain injury	15 (20)
Young chronic sick	11 (15)
Assessment	9 (12)
Rehabilitation	3 (4)
Other:	4 (5)
Specialist/advanced residential care	2
Housing support	1
Frail elderly	1

**Characteristics of respondents****Job status**

Fifty-five (73%) of the respondents were Care Home Managers or Matrons. Fifteen (20%) were depute or unit managers, three (4%) were senior social care workers and of the remaining two people, one was a proprietor of a home and the other a duty officer.

### **Qualifications**

Forty-five (60%) respondents had a first level nursing qualification and 11 (15%) had a second level qualification. Four people had both. Twenty-five people (33%) had a registered mental nurse qualification. Twenty-seven (36%) held an SVQ qualification at least to level three and eight (11%) at level one or two. Fourteen (19%) held a Higher National Diploma. In addition, 20 (27%) had other diplomas or awards and six (8%) had a degree.

### **Specific needs of residents**

#### *Young chronic sick*

The respondents from homes who cared for the young sick identified that their needs were complex but that social care and mental stimulation were the main specific needs. They were asked on an ascending scale of 1-10, where one is equivalent to 'not able to meet their needs at all' and ten equivalent to 'able to fully meet their needs', how well they felt they were able to meet these specific needs. All 6 (55%) of those who responded scored five or more. Lack of a specialist rehabilitation support service and shortage of staff were the main reasons given for not being able to meet needs. One home reported that at the time of completion of the questionnaire they had five empty beds designated for the young chronic sick.

*“Clients have difficulty accepting the situation. There is often poor staff awareness of the specific needs related to age.”*

*“There is a lack of specialist support and rehabilitation services. Everything stops once they are admitted. There is also a lack of training for staff.”*

#### **Alcohol related brain injury (Korsakoff's syndrome)**

Caring for people with alcohol related brain injury was seen as challenging. Providing the psychosocial support necessary to keep people off alcohol was seen as a priority. Encouraging development of a routine, development of life skills and maintaining motivation were viewed as successful interventions. Adequate training for people working with such clients was also viewed as important. All of the eight (53%) of those eligible who responded scored five or more on a similar ascending scale of 1-10, where one is equivalent to 'not able to meet their needs at all' and ten equivalent to 'able to fully meet their needs'. Aggressive behaviour towards staff, lack of motivation and memory loss were the main difficulties in providing care for people with alcohol related brain injury, together with the problem of lack of training for staff and their inability to understand the problems associated with the disorder. Lack of specialist support was also an issue.

*“Re-skilling, motivation and help maintaining a productive daily routine are all important.”*

*“Clients need support to abstain from alcohol.”*

*“Managing challenging behaviour and memory impairment are big problems.”*

*“Quicker assessment from psychiatric services would be appreciated.”*

### **Main health care needs of all residents**

Respondents were asked to indicate the three main health care needs experienced by their residents. There were 66 accurate responses (nine respondents were unable to indicate only three main health care needs and their responses were not included in the analysis). There was no clear package of three responses identified by the majority of people. Dementia and continence were identified as the main health care needs experienced by all residents (Table 4).

**Table 4 Main needs of residents**

Care need	n=66 (%) numbers not exclusive
Dementia	39 (59)
Continence	37 (56)
Personal/social assistance	32 (48)
Falls	28 (42)
Nutrition	25 (38)
Maintaining mobility	18 (27)
End of life care	13 (20)
Chronic disease management	6 (9)
Pain control	5 (8)
Pressure ulcers	0

All of the 73 (97%) respondents scored 5 or more and 58 (79%) scored 8 or more on an ascending scale of 1-10, where one is equivalent to 'not able to meet their needs at all' and ten equivalent to 'able to fully meet their needs'. The main problems were managing challenging and aggressive behaviour, communication with those suffering from dementia, managing multiple needs in individual clients (typically, falls, dementia, incontinence), lack of resources (financial and staff), lack of staff knowledge, providing adequate nutrition for those with problems eating, lack of appropriate equipment (wheelchairs) and specialist support (physiotherapy).

*“Striking the balance between independence and risk is the main problem.”*

*“The general frailty of people and consequent multiple disease management.”*  
(main problem)

*“Managing dementia.”* (main problem)

*“Lack of funding. Especially for social activities.”* (main problem)

### **General Practitioner services**

There were 74 responses to the question on GP service provision. Thirty-six (49%) homes used the Nursing Home Medical Practice, 28 (38%) used the clients own GP and ten (14%) used specific practices arranged by the home. Regularity of visits, consistency and continuity of care were the particular advantages of using the Nursing Home Medical Practice. The main reason for using a person's own GP were familiarity and the previous relationship built up between patient and practice. The main advantages of using practices arranged by the home were close proximity and the development of close working relationships between the home and the practice in the past.

### **Improvements/developments in General Practitioner services**

Provision of specialist nurse services and practice nurses were the main improvements/developments suggested for the Nursing Home Medical Practice. Other improvements identified were reducing the number of changes in GPs, better communication between GPs and hospitals, more time for GPs to spend with patients, more time for routine health checks and better ordering of medication.

For those using the patients' own GPs the main improvements/developments suggested were regular reviews of medication, easier and regular access to GPs, shorter waiting times for visits, providing a GP in the practice with expertise in old age medicine and better out of hours provision.

Main improvements/developments suggested for those using GP practices arranged by the home were improvements in out of hours service, more time for visits, automatic home visits for clients.

Provision of staff training and an allied health professionals support service were also suggested as other services to be provided by or complementary to the care provided by GPs.

*“Continuity and support is necessary for residents, relatives and care staff.”*

*“One doctor who could visit twice a week and has an interest in care for the elderly would make a big difference.”*

### **Services provided by NHSGG**

Most of the services provided by NHSGG were very well used by the care homes in the study (Table 5). Reasons for non-use were unavailability locally or inadequate provision. In general many homes try to provide or supplement provision of NHS dentistry, optometry and podiatry with private services. Occupational and physio therapies require a GP referral and responders indicated that sometimes these are not easy to obtain.

**Table 5 Services used by Care Homes**

<b>Service</b>	<b>n=75 numbers not exclusive</b>
Continence service	67 (89)
Hip protectors	60 (80)
Audiology	60 (80)
Podiatry	59 (79)
Speech therapy	55 (73)
Physiotherapy	54 (72)
Provision of other aids and equipment	52 (69)
Psychogeriatric services	51 (68)
Dentist/oral health	51 (68)
Adult psychiatry	43 (57)
District nursing	36 (48)
Occupational therapy	35 (47)
Palliative care	35 (47)
Optometry	33 (44)
Nursing liaison sister	31 (41)

Community learning disability team	12 (16)
Dietitian	6 (8)
Tissue Viability nurse	3 (4)
Mental health liaison	1 (1)
Brain injury service	0

---

The frequency and availability of the podiatry service was most commonly highlighted as needing improvement. The questions on service use and improvement were open questions and data were inappropriate for significance testing but there seemed to be particular problems with the provision of podiatry in the west, east and southeast. There was a general feeling that residents should not have to pay for private podiatry and people living in their own homes received a better, free service. Some services, for example palliative care support, are only provided in certain parts of the NHS Greater Glasgow area. A general need for improvement in the provision and system of referral to GGNHS services was also indicated; this includes hospital clinics, dentists, physiotherapy and audiology. There was a request for more input from psychogeriatricians. Better provision and access to aids and equipment were identified. Information and clarity about what services can be accessed, where and how was requested. The need for improved training for care home staff was again highlighted. There was also a request for better communication and a more teamwork approach to care for the elderly between the NHS, Social Services and care homes.

*“Please, please improve the podiatry service.”*

*“A multidisciplinary team approach (not them and us) and regular meetings with care home staff would be useful.”*

*“Better provision of podiatry, audiology and dentistry are needed. At present waiting lists are abominable.”*

*“Quicker and easier access to AHPs needed. At present GP referral necessary – this is difficult and takes time to obtain sometimes.”*

### **Main difficulties**

Using the wheelchair service and the amount of documentation in use in homes were cited as the main difficulties in providing care for residents, followed by obtaining the MRSA status of patients discharged from hospital. Obtaining any discharge information seemed to be a problem. Use of the wheelchair service has been explored further and findings will be reported in the study on the ‘Provision and Use of Equipment’.

**Table 6 Main difficulties in providing care**

<b>Difficulty</b>	<b>n=75 (%) numbers not exclusive</b>
Using the wheelchair service	46 (61)
Amount of documentation	46 (61)
Obtaining MRSA status from hospitals	41 (55)

Accessing information after hospital discharge	38 (51)
Lack of financial resources	36 (48)
Maintaining staffing levels	35 (47)
Attitude of NHS staff	31 (41)
Support and training of care assistants	26 (35)
Communication problems with NHS staff	26 (35)
Accessing equipment /services	26 (35)
Obtaining appropriate equipment	24 (32)
Inconsistency of service provision	16 (21)
Changing priorities in relation to different needs of residents	13 (17)
Inappropriateness of environment for some residents	13 (17)
Working with Care Commission	9 (12)
Infection control	8 (11)
Providing end of life care	6 (8)
Nurse prescribing	5 (7)
Liaising with district nurses	5 (7)

Out of a list of 17 options respondents were asked to prioritise the five things that would most affect improvement in the service care homes provide for residents. Thirteen respondents provided more than 5 options and were excluded from the analysis. No one package of five improvements was favoured by the majority. Training to support the extended roles now undertaken by care homes was the single main priority identified, followed by improved discharge information from NHS settings and improved staffing levels (Table 7).

**Table 7 Improvements of care**

<b>Care most improved by:</b>	<b>n= 62 (%) numbers not exclusive</b>
Training to support extended roles	30 (48)
Improved discharge information from NHS	27 (44)
Improved staffing levels	25 (40)
Improved support/provision of services from NHS	22 (35)
Better provision of specialist equipment	21 (34)
Opportunities for regular liaison/discussion with NHS staff	20 (32)
Provision of clear policies, protocols and guidelines	18 (29)
Provision of expert advice	16 (26)
Opportunities to network with other matrons/managers	12 (19)
More GP involvement	11 (18)
Opportunities for qualified nurses to work to their full abilities	10 (16)
Provision of a CPN service	7 (11)
Access to a geriatrician	5 (8)
Regular audit/evaluation of care	1 (2)
More beds	1 (2)

Weekend/out of hours service for NHS admissions 1 (2)

---

**Written information**

A booklet about the home was provided by 70 (93%) of homes and written care plans used by 62 (83%) homes. Only 12 (16%) homes provided information about end of life care (Table 8).

**Table 8 Provision of written information**

Written information on:	n=75 (%) numbers not exclusive
The home	70 (93)
Care plans	62 (83)
Admission and adjustment to living in a care home	59 (79)
Residents charter	49 (65)
Diet /nutrition	31 (41)
NHS support services	27 (36)
General health promotion	22 (29)
Exercise	18 (24)
Oral health	14 (19)
End of life care	12 (16)
Other:	6 (7)
Complaints procedure	
Care standards	
Insurance details	
Contract of care	
Risk assessment	
Newsletter	

Respondents would like to provide a variety of other information for residents and their carers, including a copy of the care commission standards and the opening times of the local registrar of deaths office. They would also like to provide information on financial help, support services available for relatives, sensory impairment, the local services available, translation/interpreting services for ethnic minorities and on the management of falls and dementia. A residents care manual and copies of NHS/GG protocols/guidelines were also suggested as suitable to be made available to residents and their carers.

**Assessment/care management tools in use**

The Waterlow Pressure Ulcer Risk Assessment Tool was the tool most frequently used by homes, followed by the Cannard Falls Risk Assessment Score and nutritional indicators or assessment tools (Table 9). Respondents cited dementia and challenging behaviour, dependency, restraint, nutrition and continence as health care needs for which standard assessment/management tools need to be developed.

**Table 9 Assessment and care management tools in use**

Tools	n=65 (%)
-------	----------

**numbers not exclusive**

---

Waterlow	45 (69)
Nutrition	42 (65)
Cannard	41 (63)
Barthel	7 (11)
Continence	5 (8)
Highland View	3 (5)
Isaac Neville	2 (3)

---

**Documentation**

The most common suggestion for the improvement of care plan documentation was less writing and duplication and more integration of care assessment and care planning. There was a desire for standardised documentation and clear guidance from the Care Commission about what is considered appropriate and adequate documentation. The importance of reviewing and updating documentation in line with care standards was stressed. The desire for standardisation of documentation for use in care homes was explored further by asking respondents to score on an ascending scale of 1-10, where one is equivalent to 'definitely a bad idea' and 'ten definitely a good idea'. Out of 74 responses 60 (81%) scored 5 or more 301 (41%) gave a score of 9 or 10.

*“Documentation needs to take into account more integration of care assessment and care planning.”*

*“Amount of writing and duplication are becoming problems. More tick box style recording would help.”*

**Comments**

Other suggestions provided by respondents were reinforcement of the need for their residents to be seen directly by geriatricians when they went into hospital rather than wait in Accident and Emergency Departments, which they found uncomfortable and distressing. Further support for improvement in the provision of the continence and audiology services and the standardisation of documentation was provided. The need for a combined social and medical model of care was highlighted. A consistency of approach from the Care Commission and the need for more funding and better staffing levels were also raised. Finally, there was a consistent wish for the quality of care provided in most Care Homes to be acknowledged and for providers of professional care in care homes to be viewed as colleagues and equals of NHS staff and the care they provided not viewed as a Cinderella service.

*“Our public image is a problem. Good care receives no publicity.”*

**Conclusions**

Although the response rate was comparable with those from similar studies, caution should be shown in generalising the study findings. The study did however provide insight into the experiences and problems experienced by professional managers of care homes in the Greater Glasgow Health Board area.

The study showed that a wide variety of care is provided in a variety of large and small homes to people with a variety of demanding health care needs. Caring for

people with dementia and other mental health problems was viewed as particularly challenging. Respondents felt that they were providing good quality of care, sometimes in difficult circumstances caused by lack of finance and staffing.

Lack of or limited general and specialist support from the NHS was also a perceived problem. This resulted in inequity of care across the Health Board area and some homes arranging some private provision for their residents. Provision of some services was only available in some areas of the city. Appropriate training for staff, especially if care homes are extending their traditional roles, was considered a priority. Ready availability, regular care home visits, shorter waiting times for appointments and continuity of care were identified as the characteristics of a good GP service. Better communication/liaison between GPs and hospitals was also highlighted. Provision and review of medication appeared to be a problem in some homes.

The interface between care homes and NHS hospitals was viewed as problematic, especially with regard to discharge information when a resident left hospital. Closer liaison and a better working relationship with NHS colleagues was considered very important in providing a quality service suited to elderly residents needs. There is scope for extending the provision of information for residents and carers. There was considerable support for review and standardisation of documentation.

### **Recommendations**

- A standardised training programme for all care home staff should be provided which is relevant to the type of care provided by the home.
- Specialist training should be available for senior staff. This should be relevant to the developing roles undertaken by the home.
- There should be more joint working/training between care home and NHS staff.
- Guidelines for the management of the main health care needs of the elderly and those with special needs should be developed.
- An easily accessible health and social service advice and support service should be provided for people working in care homes. This is particularly necessary when considering the mental health care needs of people in care homes.
- Consideration should be given to undertaking a strategic overview of need and providing support in the form of access to hands-on mental health teams across the health board area. This should include out of hours provision.
- Services provided by Allied Health Professionals need to be more widely and equitably available. This is particularly so for podiatry and audiology.
- Guidelines should be provided on what minimum information should be available to residents and their carers.
- There should be agreement on the risk assessment and other validated tools that can be used in care homes, including pain assessment tools.
- Unambiguous and consistent acceptable standards for care homes should be agreed with inspectorate bodies.
- Content and format of documentation should be standardised.

## **Job Description (DRAFT)**

### **1. JOB IDENTIFICATION**

**Job Title:**

**Public Involvement Officer**

**Responsible to (insert job title):**

**Dr J. Hannah, Clinical Director**

**Department(s):**

**Greater Glasgow Nursing Homes Medical Practice**

**Directorate:**

**Greater Glasgow NHS - Primary Care**

**Operating Division or GGHB:**

**Citywide Services**

**Job Reference number (coded):**

**No of Job Holders:**

**Last Update (insert date):**

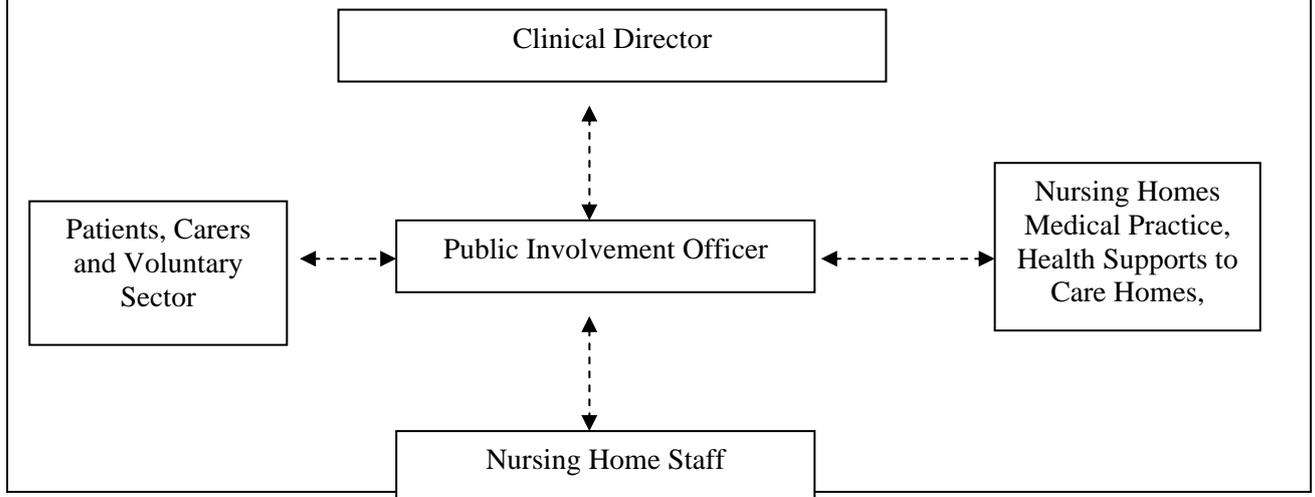
## **2. JOB PURPOSE**

To work in collaboration with the Nursing Homes Medical Practice, Palliative Care, Health Supports to Care Homes Group and Greater Glasgow NHS staff, nursing home owners, managers and staff, health partners, statutory and voluntary agencies, community groups and patients, carers and members of the public to deliver a Nursing Homes Medical Practice Patient Focussed and Public Involvement (PFPI) plan and promote a patient-centred approach to health and well being, linking the work to identified Nursing Homes Medical Practice priorities.

## **3. ROLE OF POSTHOLDER**

- Develop and deliver the Nursing Homes Medical Practice PFPI annual plan;
- Manage the Public Involvement budget (c£10k)
- Develop, support and facilitate the Nursing Homes Medical Practice (NHMP) Patients' Forum and the representatives on the NHMP working groups;
- Develop and maintain network connections with colleagues in the Palliative Care, Health Supports to Care Homes Group, LHCCs (CHPs), the Greater Glasgow NHS, Glasgow City Council, the Care Commission and local and national voluntary and community groups and bodies;
- Promote, support and facilitate a range of PFPI activities within the Nursing Homes Medical Practice, nursing care homes and the local communities, especially with respect to patient, carer and public engagement;
- Provide training and development support to nursing home staff and staff and members of voluntary and community groups to build their capacity to engage;
- Support specific patient, carer and public engagement projects;
- Develop, promote and support projects related to the needs of ethnic minority groups, including those of overseas nurses in nursing care homes
- Keep abreast of and contribute to local, national and international initiatives in PFPI;
- Represent the NHMP on local, Greater Glasgow and national bodies;
- Develop, maintain and manage a database of voluntary groups and bodies and NHMP and partners' staff for supporting communication;
- Build in monitoring, evaluation and review into PFPI activities to demonstrate their added value;
- Be responsible for developing, implementing and evaluating PFPI activities with specific regard to the PFPI objectives of the RCGP Quality Practice Award and
- Manage and operate a range of IT, audio-visual equipment and copying equipment to support quality communication.

#### 4. ORGANISATIONAL POSITION



#### 5. SCOPE AND RANGE

- Following a 3 month induction period, carry out a mapping exercise of 3 months duration of the needs of residents, carers and staff of nursing homes served by the Nursing Homes Medical Practice;
- Learn from good models of patient, care and staff support:
- Establish and roll out a network with 60 nursing homes served by the Nursing Homes Medical Practice, with an aim of 12 nursing home contacts per month;
- Provide operational support for a cycle of Patients' Forum meetings and of Patients' Forum representatives attending the Nursing Homes Medical Practice Advisory Group;
- Support the creation, publication and distribution of the Nursing Homes Medical Practice Newsletter;
- Collaborate with the Health Supports to Care Homes Group, Social Work Department, Care Commission and the Voluntary Sector;
- Manage and support major public engagement projects;
- Contribute to training events;
- Develop and maintain a Nursing Homes Medical Practice PFPI web site;
- Support nursing home staff PFPI initiatives;
- Produce and monitor a PFPI development plan and an annual PFPI report;
- Attend monthly staff meetings;
- Attend training events;
- Network with others in similar roles;
- Deal with a daily workload of e-mail, mail and telephone calls and
- Lead on future development of PFPI initiatives with other care homes.

## **6. MAIN DUTIES/RESPONSIBILITIES**

- Developing a strategic plan for delivering, monitoring and reporting on Patient Focussed and Public Involvement activities within the Nursing Homes Medical Practice;
- Promoting a range of effective Patient Focussed Public Involvement activities within the Nursing Homes Medical Practice;
- Supporting patients, carers, nursing home managers and staff, members of the public and local and voluntary groups to engage in the design and delivery of health and well-being services;
- Supporting Nursing Homes Medical Practice and partners' staff in engaging with patients, carers, member of the public and nursing home managers and staff;
- Supporting patient, carers and staff in developing a more patient/carer centred approach to Primary Care health and well-being services;
- Representing the Nursing Homes Medical Practice at local, Greater Glasgow and national level and
- Collaborating with NHS and health partners staff to ensure that local activities co-ordinate with Greater Glasgow NHS, Social Work, Care Commission and National priorities;
- Lead on future development of PFPI initiatives with other care homes.

## **7. a) EQUIPMENT & MACHINERY**

**Hardware** - Personal Computer, laptop, printers, photocopiers, video projector, file and digital camera and video camera and sound equipment.

**Software** – **Windows** XP, Word, Excel, Access, Publisher, Adobe Acrobat, Photoshop, Paint, video editing, Outlook, Internet Explorer and search engines.

### **b) SYSTEMS**

- Formulating, populating, analysing and reporting from databases and spreadsheets;
- Researching on the internet and
- Maintaining Intranet sites.

## **8. DECISIONS AND JUDGEMENTS**

- Strategically, the post requires the development of an annual plan and report and agreeing quarterly work plans with the line manager. Beyond this, the post holder is individually responsible for: -
- Developing, implementing and monitoring the annual PI budget;
- Planning independently monthly, weekly and daily priorities, workload and time allocation: and
- Responding to contingencies (a large part of the work involves this).

## **9. COMMUNICATIONS AND RELATIONSHIPS**

- The job holder is required to communicate with the fullest range of individuals from Government Ministers to people of wide ranges with complex needs and communication disabilities;
- The communication varies from national strategy to an individual concerned to have their views heard;
- As there is a considerable amount of work with individuals and small, medium sized and large groups, the job holder must be able to cope with robust engagement at all of these levels.
- Engagement, particularly in the course of consulting on service redesign, can require the jobholder to deal with assertive, occasionally aggressive, behaviour.
- PFPI work requires communication in print form, requiring considerable skills in analysing, summarising, presenting and the use of plain English;
- As many of the community groups and individuals have little confidence in discussion as a means of sharing information and ideas, the jobholder requires experience of and facility with a range of alternative means of engagement.

## **10. PHYSICAL, MENTAL, EMOTIONAL AND ENVIRONMENTAL DEMANDS OF THE JOB**

- Dealing with the complexities of individual and group relationships, in particular the adjustment processes involved for patients and carers when an individual moves into a nursing home;
- Considerable concentration is required, mainly due to the high level of contingency demand and very tight deadlines;
- The emotional demands of the job can be challenging when dealing with aggrieved individuals or groups;
- Excellent communication skills and sensitivity are required when dealing with fragile individuals or groups who face loss and bereavement within the care home;
- The very considerable volume of reports to digest and summarise is demanding.

## **11. MOST CHALLENGING/DIFFICULT PARTS OF THE JOB**

- Maintaining and developing multiple network connections;
- Comprehending and working effectively within the complex agendas of all the groups and individuals and
- Time management – balancing proactive planning with the often short notice demands from the Scottish Executive, Greater Glasgow NHS, LHCCs (CHPs), partners and community groups – there is a need to keep insisting on schedules for meetings and efficient minutes and agenda systems.

## **12. KNOWLEDGE, TRAINING AND EXPERIENCE REQUIRED TO DO THE JOB**

**Knowledge:** The post holder must have detailed knowledge of -

- the PFPI policies of NHS Scotland and the Community Engagement policies of the Scottish Executive;
- the governance frameworks of the NHS and local authorities;
- the processes supporting committee and group working;
- communicating and engaging successfully with a wide range of individual capabilities and
- a wide range of IT and AV equipment and software.
- Care Commission standards for Care Homes

**Skills:** The post holder must have:

- advanced interpersonal skills, particularly in relation to being able to engage with the full range of abilities and personalities within the patient group and the public.
- respect that we all have a responsibility to uphold confidentiality for patients.
- excellent abilities to communicate with a wide range of individuals with complex needs and their carers.

**Training:** The post holder must have had formal training in –

- engaging with individuals and groups;
- collecting, analysing and reporting on data;
- operating a wide range of IT and AV equipment and software.

**Experience:** The post holder must have considerable, practical experience of -

- working with NHS, local authority or voluntary bodies;
- working effectively with a wide range of individuals and community groups;
- capacity building to support individuals contributing to formal processes;
- delivering presentations to medium sized and large groups and
- operating a wide range of IT and AV equipment and software.

### 13. JOB DESCRIPTION AGREEMENT

**Job Holder's Signature:**

**Date:**

**Head of Department Signature:**

**Date:**

**JOB DESCRIPTION APPENDIX –  
ADDITIONAL ROLES AND RESPONSIBILITIES**

<p><b>1. TITLE OF JOBHOLDER’S SUBSTANTIVE POST:</b> <u>Public Involvement Officer</u></p>	
<p><b>2. DEPARTMENT:</b> Nursing Homes Medical Practice</p>	
<p><b>3. DESCRIPTION OF ADDITIONAL ROLE/RESPONSIBILITY:</b></p> <ul style="list-style-type: none"> <li>• Developing and supporting a Public Partnership Forum for the emerging Nursing Homes Medical Practice;</li> <li>• Developing the Staff Support Group for a PPF and</li> <li>• Supporting nursing home and partner staff’s patient and public engagement.</li> </ul>	
<p><b>4. AGREEMENT OF ABOVE DESCRIPTION</b></p> <p><b>Job Holder’s Signature:</b></p> <p><b>Head of Department Signature:</b></p>	<p><b>Date:</b></p> <p><b>Date:</b></p>

Appendix NHMP SCOT Analysis: April 2004

<p><b>Strengths</b>  Co-ordination  Standardisation  Continuity of care  Holistic reviews  Increased time for patients  Improved patient care – “massively better”  Twice weekly visits  More time effective medical input for NHs  NHs have identifiable GP  Improved team working  Integration with other services  Increased multidisciplinary links  Increased multidisciplinary training/PDP  GP with special interest  Advocacy  Enthusiasm  Opportunity to audit &amp; evaluate  Polypharmacy/cost issues  Training for care staff</p>	<p><b>Challenges</b>  IMT!!  Not all homes covered  Time  Twice weekly visits - ?could be less  NH generate work to fill GP time  Split between supporting practices and central service  Geography  Funding &amp; training for nurses within care homes – varying standards at present  Poor quality of communication with NH staff – especially language difficulties  Staff turnover  Lack of AHP input  “True” multidisciplinary working  Staffing levels – community &amp; NH  Outcome measure – is quality better?  Lack of patient choice  GPs need to be more accepting &amp; inclusive of the ability of the AHP CHTT to enhance &amp; give to the service  GPs lack of knowledge &amp; interest about what the AHP CHTT did</p>												
<p><b>Opportunities</b>  IMT  Residential patients  Training for GPs  Intermediate care service  Improved communication with 2Y care &amp; extended team  Preventative care  Audit &amp; measure quality outcomes  Address moral, staffing turnover etc  Identify training needs in NH staff  Maintain &amp; improve teamwork with NH staff  To manage increasing work  Pool experience  Involvement of district nurses</p>	<p><b>Threats</b>  Lack of IMT  Funding  Expansion of numbers of patients in nursing homes  Workload to increase  Quality of nursing homes themselves  Burnout  5 year lifespan of service  Care Commission – how responsible is our service for overall provision of care?  Perceive threats from other GPs  ?inclusion of residential homes  Threat to partnership in assisting practices if only some GPs involved in NH work  Temporary residents</p>												
<p><b>Educational needs identified by &amp; for those present</b></p> <table border="0"> <tr> <td>Dementia</td> <td>Drugs</td> </tr> <tr> <td>Challenging behaviour</td> <td>Dietetics</td> </tr> <tr> <td>Adults with Incapacity Act</td> <td>Diabetes &amp; other CDM</td> </tr> <tr> <td>Dysphagia training</td> <td>Non-malignant pain</td> </tr> <tr> <td>Wound care management</td> <td>Pain in those with dementia</td> </tr> <tr> <td>Legal entitlements</td> <td></td> </tr> </table>		Dementia	Drugs	Challenging behaviour	Dietetics	Adults with Incapacity Act	Diabetes & other CDM	Dysphagia training	Non-malignant pain	Wound care management	Pain in those with dementia	Legal entitlements	
Dementia	Drugs												
Challenging behaviour	Dietetics												
Adults with Incapacity Act	Diabetes & other CDM												
Dysphagia training	Non-malignant pain												
Wound care management	Pain in those with dementia												
Legal entitlements													
<p><b>Future format</b>  Fewer topics with more time spent on each  Include option of weekend away e.g. Friday lunchtime till Saturday about 3.30pm  Informal talk &amp; teambuilding</p>													

## Comments

During the analysis, recurrent themes kept emerging. There remained a strong enthusiasm for the service and its aims to provide an enhanced GP service to nursing home residents. However there were significant concerns about areas out with the control of the GPs themselves and the impact that these had on patient care. Examples of this related to the quality of staff in nursing homes, the lack of nursing support to the team from the community and other nursing services and the lack of AHP support. The Care Commission was seen as a threat especially with its links to perceived down-skilling of staffing levels within homes.

In many ways, the SCOT analysis did not fully reveal levels of concerns about the service and nursing homes. Individual chat afterwards was more open. There was a general positive “buzz” about the whole day as it was the first time so many of the teams had got together. However, this resulted in some people not wanting to open up too much as they did not want to appear to be moaning about the service or the difficulties they are experiencing.

There was more mixing than previously between the assisting practices and the central service. This is likely to continue over subsequent meetings, allowing for increased sharing of experiences and good practice. It is important too that this inclusivity extends further to the AHP CHTT – as a smaller group, it is easier for unintended exclusion to occur. To this effect, Anita Berekley and her team will be asked to lead a session for the GPs, explaining their roles and experiences with the nursing homes the service works with.

From the GP perspective, informal chat after the meeting and at the central service revealed great concerns about:

- Funding of the service & how this was determined. The level of GP staffing is regarded by many as woefully inadequate. This is particularly felt around chronic disease management and preventative issues which have not really been addressed yet
- Because of the lack of GP time, GPs are not able to carry out the service specification as originally described. They are not able to carry out audit, be involved in personal development or service evaluation
- Because of lack of other support either by the nursing homes or Health Board, GPs are spending time doing inappropriate tasks e.g. phlebotomy, ear syringing, catheterisation and wound management
- There has been a disparity throughout GGHB with community nursing support to nursing home patients. Those areas that have allowed community nurses to support the GPs in caring for nursing home patients have now begun to withdraw this service. This is occurring despite the fact that there is no evidence that nursing home staff are now able to carry out the procedures that community nurses were doing. The GPs are extremely worried about how this is going to impact on patient care.
- Many of the patients the GPs are looking after are particularly complex. They view the service increasingly as intermediate care rather than a long term care type of environment.
- Palliative care is an increasing but unsupported role in most of the GG nursing homes. Life expectancy in nursing homes is very short, thus patient turnover is

high. This again impacts on GP workload with a constant need to summarise notes, get to know patients and then manage their care. There is a view held that this has been one of the hidden factors that has resulted in the underestimation of GP time required.

- No provision has been made within the service for equipment needs for the homes. This has caused particular difficulties for ear syringing equipment, nebulisers and syringe drivers. The homes assume that the GGNHCT has been funded to provide these, whereas it has not.
- Due to the unforeseen workload associated with development of the service, the central service is now in a position that it will not be able to take on new homes until the current ones are up and running properly. The current backlog of work means that casenotes are not reaching the homes for weeks and there is great concern that this is impacting on patient safety. However, when casenotes are at homes, GPs remain concerned about safety issues because when they are at their base, they are unable to access the notes. Triaging calls is proving unreliable: examples of calls include the “urgent” one when the resident was then found by the GP to be having a perm on his arrival, and the “non-urgent” who turned out to be moribund.

The GPs involved have chosen to be so because they have been drawn to a service which has flown the flag for a quality level of care for an oft forgotten group of patients, whose care has been regarded as substandard for many years. The word “burnout” was mentioned by three of the groups. There is a genuine concern that the GPs are a sticking plaster for the care of the residents of nursing homes. However they cannot be held responsible for the many, many areas out with their control. The burden of this responsibility is already leading to some foreseeing their early departure from the service.