REVIEW OF RESIDENTIAL CARE

Inquiry by the Older People’s Commissioner for Wales

Response from BMA Cymru Wales

INTRODUCTION

BMA Cymru Wales is pleased to provide a response to the Older People’s Commissioner for Wales’ inquiry into residential care.

The British Medical Association represents doctors from all branches of medicine all over the UK; and has a total membership of over 150,000 including more than 3,000 members overseas and over 19,000 medical student members.

The BMA is the largest voluntary professional association of doctors in the UK, which speaks for doctors at home and abroad. It is also an independent trade union.

BMA Cymru Wales represents some 7,000 members in Wales from every branch of the medical profession.

RESPONSE

Introduction

Given the wide-ranging membership of BMA Cymru Wales, with the Association representing doctors working across different health institutions in Wales within all of its Health Boards and Trusts, and given that different members of BMA Cymru Wales will have quite different day to day interactions with older people in residential and/or nursing care, it is therefore not possible for us to provide representative responses to many of the questions posed in this review. As a result, we are confining this written submission to the questions posed by the Older People’s Commission which relate to access to primary care for people living in care and nursing homes across Wales.

Access to primary care services

General access

Our general observation is that across the primary health care team, as defined by the Commissioner (i.e. GPs, podiatrists, nurses, dentists, psychiatrists, community pharmacists, occupational therapists, physiotherapist etc.), access for those living in care and nursing homes varies between the different services provided.

We also note that some of these primary care services would appear to be dependent on services commissioned by care and nursing homes on behalf of their residents and this may therefore be contributing to the variability we observe. Levels of access are likely to also be influenced by commissioning decisions taken by individual Health Boards.

We are also aware that there will be a varying level of ability amongst patients to access primary care services in different types of home. For example patients living in residential care homes may be regarded as...
more mobile, and therefore able to attend community services, whereas the majority of those living in nursing homes would be viewed as being house bound by nature of their care needs, requiring such services to be provided within the home itself.

Access to general practice

Our members perceive that access to GPs is very good, as evidenced by the sheer volume of work that is undertaken within general practice for care and nursing home residents. For instance, it is our experience that care home residents often enjoy a greater level of access than some elderly people living alone or with their families.

However, it should be noted that additional support is offered to care homes via certain components of both Directed Enhanced Services (DES) and Local Enhanced Services (LES). These enhanced services have been put in place in recognition of the fact there is a significant additional workload associated with such patients over and above that which is covered by the General Medical Services (GMS) contract. This is because such additional work is not fully resourced or weighted within the Carr Hill formula that is used as a key determinant in calculating the funding provided to GP practices through the GMS contract. We would further note that in recent years the number of residents in care homes with complex needs not covered by the GMS contract has been increasing.

From the standpoint of delivering prudent healthcare, as recently defined by the Bevan Commission\(^1\), we consider that there are significant benefits to NHS Wales in investing in DES and LES relating to nursing homes. These can also play a role in fostering co-productive working, as well as in reducing unnecessary hospital admissions and 999 calls.

Before any home takes responsibility for the care of patients with complex needs that requires care not covered by the GMS contract, particularly when this may involve patients from outside Wales, we suggest that an appropriate assessment should be undertaken. We are aware, for instance, of a home in North East Wales which has taken on two patients from England who are home ventilated. Although a specialist team put in place by Betsi Cadwaladr University Health Board operates in North Wales to look after such patients, these particular patients are not covered by this service because they are from England. As such their care inevitably has to be picked up by GPs, including through out-of-hours (OOH) services, but these GPs may not be best placed to effectively deliver the care that is required and nor are they specifically funded to do so. In our view, a licensing system might deal with such a problem by ensuring Health Board approval would be required before a home could take on such patients. In cases where approval is given, this could then be dependent on the local Health Board instigating an appropriate care package that is funded outside of the GMS contract.

We are also concerned that a lack of sufficient investment in Welsh OOH services in general over a number of years means that the level of care provided may therefore be sub-optimal because the service is not sufficiently resourced, and is therefore too thinly spread. This may particularly impact on residents of care and nursing home who may be more reliant on such provision. We are aware that care home staff working at night may phone the OOH service for advice. When this happens during the day, care home staff can talk to GPs who are familiar with the patients and their care plans. At night this is not the case and this means that care plans, including end of life care plans, may be overlooked leading to hospital admissions that may not be necessary.

Care home staff, as well as other health and social care staff, may in our experience lack the ability to directly refer care home residents to services such as physiotherapy, occupational therapy and podiatry. In our view this is placing an additional burden on GPs that could otherwise be avoided. This is something we feel should therefore be reviewed.

BMA Cymru Wales also suggests that consideration could be given to extending the concept of virtual wards. GP members with experience of virtual wards report that they can enable some patients with more complex needs to receive appropriate care while remaining within a residential or nursing home setting, owing to a greater density of support and input from relevant healthcare professionals. We therefore suggest that Health Boards and localities should be encouraged to continue funding such models of care which can, in appropriate circumstances, reduce the need for hospital admissions.

Access to other primary care professionals – e.g. podiatrists, nurses, dentists, psychiatrists, community pharmacists, physiotherapists etc.

Owing to the fact that different members within BMA Cymru Wales will have different local experiences and levels of interaction with other primary care services, it is difficult for us to provide a meaningful overview of how we perceive access to other primary care professionals by care and nursing home residents. Members have nonetheless reported that they are aware of variability in access to such services. As we have referred to already, this may in some cases be the result of differing levels of commissioning by care homes and individual Health Boards. For instance, access to services such as podiatry and physiotherapy may be specifically dependent on such services being directly commissioned by care homes.

We would observe that access to community physiotherapy and nursing services may be difficult, particularly for patients who are funded as nursing patients, because NHS management tends to take the view that such services should fall within the remit of staff employed within homes themselves. However, such staff may not always possess the specific skills that may be required in particular circumstances, and we hear reports of variability in the nursing skills that may be held by the staff employed in care homes. This may be a particular concern in end of life settings.

Other issues:

We are aware that there are occasions when continuing care nurses may inappropriately be asking GPs to refer care home residents to secondary care services, something that perhaps needs to be reviewed due to the overall high level of demand that is placed upon general practice. It may for instance be more appropriate for such referrals to be made by continuing care nurses directly.

We would suggest that any residence describing itself as a care home should be appropriately designated. We are aware, for instance, that residents in some care homes appear to be more akin to hospital residents. For example, we understand that some patients with complex psychiatric needs are based in community homes rather than in hospitals and this may lead to them accessing services through primary care when they might be better served being in a secondary care setting.

Any community care homes which provide additional services, such as re-ablement or step up/down beds, and which have identified a need for specific enhanced service support from GPs should ensure that this support is commissioned on a 24 hours a day, 7 days a week basis. We would note that the need to ensure the inclusion of OOH provision is often forgotten when such services are planned.

We observe that investment in staff training in care homes is variable and this then impacts on the care that is given to patients. For instance, we believe it is important that such staff are effectively trained to appropriately identify deteriorations that may occur in patients’ conditions. In our experience, lack of effective training can have severe consequences on the delivery of care and the effectiveness of services provided. This can, for example, manifest itself in inappropriate 999 calls, especially in end of life settings.