A study to develop integrated working between primary health care services and care homes

Executive Summary

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Executive Summary

Key Messages

- In England, most long term care for older people is provided by the independent sector.
- Multiple NHS services visit care homes. These include initiatives to improve access to health care, reduce unplanned hospital admissions and work with care homes as providers of intermediate and end of life care. Models of service delivery to care homes however, are erratic, ill-defined and focus almost exclusively on the individual resident/patient encounter.
- The lack of shared organisational outcomes are likely to inhibit systematic integration of health and social care services, to sustain more stability and quality in care homes residents’ living arrangements and care.
- Care home residents do not have universally high levels of health services use or uniformly close involvement of primary care staff.
- Access to services and recognition of health care needs was a mediated and complex process. Primary care services were reliant on how care home staff interpreted residents’ health status, care home procedures and the quality of the relationship with the NHS staff.
- Financial incentives, governance processes or the use of shared protocols and assessments supported integrated working only when care home staff assimilated NHS patterns of working and priorities.
- NHS services favour models of care that focus on diagnosis, treatment and episodic involvement, whilst care home providers prioritise on-going support and relationships that foster a continuous review of care.
- The lack of an identifiable entity that is care homes means there is no one place for NHS commissioners and managers to go to engage with the sector, or establish contracts, for more than an individual or group of care homes.
- Integrative processes that enabled NHS and care home staff to achieve integrated care were, in the main, informally negotiated and based on confidence in the staff involved.
- There is a need to adjust patterns of working in the care home to ensure that health care is not “delivered” to individuals in care homes but organised to support the facilitation of care delivery, review and discussion of residents’
Background

People living in care homes have complex needs, and are the oldest and frailest of the population. Care homes that do not have on site nursing rely on primary health care services for medical and nursing support and access to specialist services and secondary health care. Research consistently demonstrates that people living in care homes have erratic and inequitable access to NHS services, particularly those that offer specialist expertise in key areas such as dementia and end of life care. Primary Health care providers are very aware of the need to improve how they work with care homes. This has led to the development of a range of initiatives that range from the funding of NHS beds in care homes to the creation of specialist roles designed to promote better working between primary care and care homes. This study aimed to make explicit what is known about developing integrated working between health and care home providers, assess the consequences for older people and provide guidance and recommendations for integrated working that can inform future service development and research in these settings.

Aims

The overall aim of the study was to establish how care homes and health care services achieve integrated working to promote the health of older people. The objectives were:

1. To review the evidence for the research effectiveness of different approaches and support tools used to promote integrated working between NHS services and care home staff.

2. To identify how integrated working is interpreted, organised and implemented in care homes across England, and at what cost.

3. To identify patient and organisational outcomes arising from integrated working between NHS services and care homes that reflect the priorities, experiences and concerns of older people that live in care homes.

4. To evaluate the impact of interventions that support integrated working between NHS and care home staff, on patient and organisational outcomes, including cost and effective use of resources.

5. To describe facilitators and barriers to integrated working between care home staff and health care practitioners.
6. To develop a typology of integrated working between health services and care homes

Methods

The three year study was organised in two phases. Phase one had two interrelated elements. A systematic review of the effectiveness of integrated working between health care and care homes and a national survey of how integrated working is achieved by NHS services working with, and for, care homes that do not have on site nursing.

Phase two involved prospective case studies of three models or approaches to integrated working (care homes with NHS/LA funded beds and linked multidisciplinary teams, care homes in receipt of specialist service support and care homes reliant on primary care services equivalent to those provided to people living at home). Older people in six care homes were tracked for twelve months to understand how they defined health care needs over time, their use of services and compare the different approaches to integrated working. Also interviewed over the twelve months were residents, relatives NHS and care home staff, and stakeholders who could provide an organisational perspective on the barriers and facilitators to integrated working.

An organisational framework based on the Kodner and Spreeuwenberg [1] model of integration was used to inform the analysis and synthesis of data and cross-case comparisons of how the different contexts and mechanisms affect the outcomes for the older person. Subsequently, thematic content analysis was used to identify key themes, common experiences and priorities of care from the categorised data including service delivery, organisational, funding, and clinical/health and social care and their sub-levels. The economic analysis focussed on investigating the collaborative working between the six care homes and their respective primary health care services, through an analysis of health and social services used by samples of the residents, and resident-level costs.

Results

The review, survey and case studies highlighted recurring concerns and persistent themes about how the NHS works with care homes that are not markedly different from research reports and policy documents on health care involvement with care homes published ten years ago.

At the resident level of care, access to services and recognition of health care needs was a mediated and complex process. Primary care services were reliant on how care home staff interpreted residents’ health status.
Internal care home procedures and the quality of the relationship with the NHS staff determined who accessed services. This process seldom involved joint review or discussion and even more rarely included the resident or a family member. In care homes that had nursing provision either within the building or nearby, there was evidence of nursing staff assimilating health care work that in other sites was provided by NHS services to residents categorised as receiving personal care only.

The study found that the integrative processes that enabled NHS and care home staff to achieve integrated care were, in the main, informally negotiated and based on confidence in the staff involved. These informal but acknowledged methods of care co-ordination could ensure that there was ongoing identification of resident need and those respective responsibilities and patterns of decision making were jointly understood and trusted. Financial incentives, governance processes or the use of shared protocols and assessments, either did not facilitate that process, or supported integrated working when care home staff assimilated NHS patterns of working (e.g. in the care homes with funded rehabilitation beds). It was all predicated on individual services’ and staff’s ability (and capacity) to engage with that process. At the service delivery level of integration, the findings suggest that it is investment in the development and creation of these personal relationships that have the most potential to improve how the NHS and care homes work together. Therefore, factors that facilitated integration at the level of the primary care and care home staff include:

- Engagement around resident care that focuses on specific domains of knowledge;
- The opportunity for staff from both sectors to collectively address the issue as they develop shared knowledge and therefore create a distinct social entity;
- The development and improvement of practice, built on shared resources and knowledge, which meets the needs of the older person.

One of the significant barriers for health service providers is identifying such places of engagement at strategic and organisational levels of the system are related to the lack of an identifiable entity that is care homes. There is no one place to go to engage systemically with the sector, or establish contracts, for more than an individual or group of care homes.

Conclusions

It is uncontested that closer working, proactive care, service specification, leadership and integration of different NHS services can promote the health care of older people resident in care homes. This study found that there is
not a particular model of service delivery that can achieve this. There is an inherent tension when NHS services favour models of care that focus on diagnosis, treatment and episodic involvement, whilst care home providers prioritise on-going support and relationships that foster a continuous review of care. The findings suggests this tension can be negotiated through the care home manager’s leadership, the quality of the working relationship between NHS practitioners and senior staff, and a focus on specific issues of mutual interest. For the older person, accessing, receiving and achieving health care was a co-constructed process. The significance of a mediator (care home staff or relative) who participated in communication and discussions with a range of professionals about residents’ health needs should be acknowledged by NHS services and incorporated into patterns of service delivery. There is a need to adjust patterns of working to ensure that health care is not “delivered” to individuals in care homes but organised to support the facilitation of care delivery and discussion of residents’ priorities and preoccupations, with the older person and their preferred representatives.