SERVICE PROVISION

# What's the alternative?

A specialist GP practice for housebound older patients has saved money and improved care, say John Holden and colleagues

Eldercare is effectively a virtual ward, delivering care to patients in nursing and residential homes, as well as retirement villages, sheltered accommodation and in their own homes in St Helens.

One of two alternative provider medical services (APMS) "equitable access" GP practices in the area, it was established following Lord Darzi's next stage review in 2007. It is owned and run by a federation of three local Liverpool University training practices.

As there was no national template on which to model this new practice, Eldercare is an innovative model of delivering primary care services. It is designed for patients who are housebound and vulnerable, most of whom are over 65. Wherever they live in the borough of St Helens, all patients are visited twice a year for regular checks and when requested.

Eldercare's mission is to provide specialist GP services to this cohort of patients at their place of residence, to reduce health inequalities and to deliver greater choice and access to good care. In doing so, Eldercare fulfils the requirements of the Equality Act for the primary care trust.

Over the past three years the service has shown a typical Eldercare patient has healthcare needs that are 10 times greater than those of a person matched by age and sex who is not housebound. However, the current capitation formula is 3.5 times normal, thereby creating immediate workload and financing problems.

Eldercare looks after 660 patients, two thirds of whom are in residential care. For a significant number of older people, at the time of registration their life expectancy is short; 1,300 patients have registered in just over three years.

The prevalence of chronic disease at the service is very high compared with that at traditional practices (see table 1). A comparison of patient contacts and hospital admissions of patients in the year before and after registration at the practice showed an eight-fold increase in proactive visiting for problems such as palliative care and chronic disease management.

An unmet need for patient consultations prior to registering at Eldercare was also reflected in consultations with the practice nurse, which were 3.5 times more common than at the previous practice. In addition, telephone consultations are six times more likely after registering at Eldercare; these cover issues such as results of investigations, medication queries and minor ailments.

At registration, patients had, on average, four previously diagnosed chronic diseases. Within six months, this had risen by 28 per cent to an average of five chronic diseases, suggesting patients may have had conditions that were previously undiagnosed. Despite this, prescription numbers have remained fairly static, rising by only 4 per cent, reflecting the hard work undertaken by doctors, nurses and pharmacists to review medication.

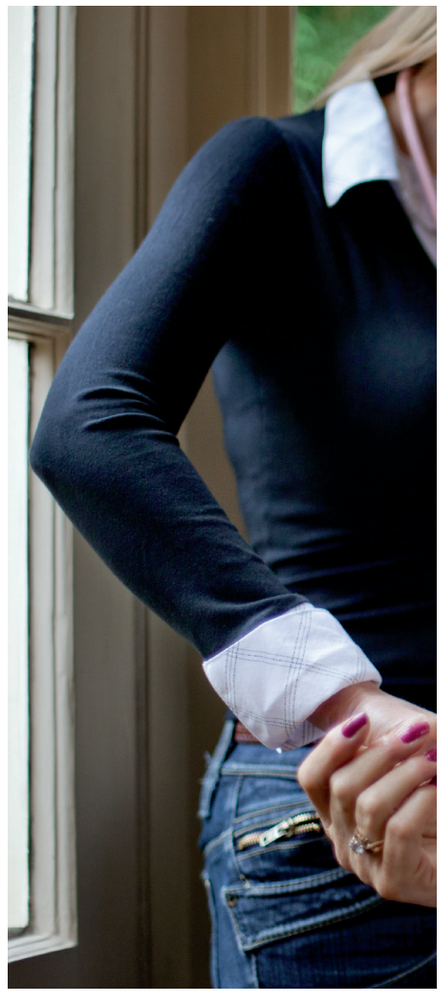

Table 1: Chronic disease prevalence

| Disease | Eldercare (%) | PCT average (%) |
|---|---|---|
| Dementia | 38.8 | 0.5 |
| Stroke/TIA | 22.9 | 1.9 |
| Diabetes | 14.9 | 5.4 |
| COPD | 11.4 | 2.7 |
| Cancer | 7.6 | 1.7 |
| Heart failure | 6.2 | 0.9 |

Table 2: Palliative care and death

| Year | Deaths | Palliative care patients |
|---|---|---|
| 2009-10 | 79 | 33 (42%) |
| 2010-11 | 149 | 60 (40%) |
| 2011-12 | 172 | 96 (56%) |
| **Total 2009-12** | **400** | **189 (47%)** |

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There are alternative ways to successfully care for older people who are vulnerable

Data from the North West quality observatory and the Advancing Quality Alliance supports this complexity:

- 95 per cent of people with dementia have at least one other chronic disease;
- 82 per cent of those with chronic obstructive pulmonary disease have at least one other chronic disease;
- 86 per cent of patients with diabetes have at least one other chronic condition.

This is reflected in prescribing: the average Eldercare patient has between seven and eight repeat medications.

Table 2 shows the number of patients receiving palliative care and the number of deaths for each year Eldercare has been open. To have so many deaths annually, of which nearly half have been of people who are terminally ill, is quite exceptional. Post-death administration – death certificates, coroner involvement, cremation forms, visits to mortuaries and discussion with other GPs and relatives – contributes to a large workload for Eldercare.

In 2010-11, 69 per cent of Eldercare patients died in the community under direct GP care compared with 39 per cent elsewhere in the district. This reflects widely expressed patient and family preferences but is demanding in terms of time, medication and other resources. When the complexity of Eldercare patients' needs is taken into account, this is a remarkable achievement and a significant contribution to the quality, innovation, productivity and prevention programme.

By improving access to GP care, Eldercare has reduced hospital admissions by 40 per cent prior to registering and reduced length of stay by 80 per cent overall.

Last year, the practice scored 100 per cent in 15 out of 20 clinical areas specified in the quality and outcomes framework, as well as 946 out of 1,000 QOF points. Annual savings averaging £120,000 have been made on patients' preregistration prescribing costs.

Early in 2012, in a survey of 78 patients and carers, 86 per cent of respondents said they usually got to see a doctor on the same day, with 13 per cent stating the next working day; 76 per cent said they were "very satisfied" with the care they received from Eldercare, with only one saying they were "fairly dissatisfied".

## A look to the future

Funding uncertainty, and assuring value for money, forms an ongoing discussion taking place with commissioners. This service is expensive on a patient by patient basis but admission avoidance and prescribing savings demonstrate value for money for the local healthcare economy.

Eldercare is a new model of delivering care for this group of patients. As we have learned that doctors recently completing vocational training struggle with managing complex patients, we have attempted to attract more senior clinicians to the service, both doctors and advanced nurse practitioners.

Eldercare proactively manages many patients who are housebound and controls their long-term conditions as best as possible to prevent complications. However, there are many people who are very frail who would benefit from more symptomatic care, rather than a vain attempt to prevent disease that is no longer preventable. This bypasses the QOF, leading to rationalisation of prescribing.

Discussions are under way with local teams to improve joint working, including the rotation of specialist trainees in older care through community posts involving Eldercare and palliative care teams. Step-up and step-down intermediate care facilities in conjunction with clinical commissioning groups and acute trusts would also be desirable developments that should considerably improve the efficiency of healthcare.

Eldercare is in discussions with the deanery to become a training practice. It would be an ideal training place for GPs with an interest in the care of older people, either as an innovative scheme or as part of a fourth year of extended GP training.

We believe the only way the local health economy is going to achieve financial balance is through collaborative working with partner organisations. As they have links to the local authority and social services, to the acute and mental health trusts, and to third sector organisations, practices such as Eldercare are well placed to do that.

It is vital that commissioners recognise that high-quality specialist primary care services are expensive but can save considerable amounts of money while also enhancing end of life care for people who are vulnerable. ●

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