WM QRS West Midlands Quality Review Service

NHS

Formative Review
Care of Frail Older People

North Staffordshire and Stoke on Trent Health Economy

Visit Date: 20th March 2014 V2 Report Date: August 2014

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INTRODUCTION

This report presents the findings of the formative review of the care of frail older people in North Staffordshire and Stoke on Trent which took place on 20th March 2014. The care of frail older people was identified by several health economies as a topic for work with WMQRS during 2013/14. Formative review visits were agreed, with the aim of improving quality of life, quality of care and outcomes for frail older people and their families and, in particular:

1. Identifying areas which are working well
2. Identifying where improvements are needed
3. Informing future commissioning intentions
4. Sharing good practice and expertise

The report reflects the situation at the time of the visit. Appendix 1 lists the visiting team which reviewed the services in North Staffordshire and Stoke on Trent health economy. The review used a framework for the care of frail older people (Appendix 2) which has the following main areas:

a. Conditions and therapeutic interventions
b. Preventive and supportive interventions
c. Care (health and social)
d. Responses to urgent need
e. Cross-cutting patient care
f. Underpinning issues

During the course of the visit reviewers met service users and carers and representatives of a wide range of service providers and commissioners. For each area of the framework reviewers asked about what was working well, whether plans were in place and, in the view of reviewers, what changes were needed. Some issues emerged as common themes across all parts of the framework and are described once only.

This report describes services provided or commissioned by all the NHS Trusts, Clinical Commissioning Groups (CCGs) and Local Authorities in North Staffordshire and Stoke on Trent, together with independent and voluntary sector partners. The review used a framework of questions but not a detailed review against Standards and the findings therefore do not have the same level of rigour and consistency as full peer review visit reports Responsibility for addressing the issues identified in this report lies with all these organisations working in partnership, taking into account that this is a formative review which may not have a full picture of local services. North Staffordshire and Stoke on Trent Clinical Commissioning Groups have a particular responsibility for ensuring appropriate progress is made.

ABOUT WEST MIDLANDS QUALITY REVIEW SERVICE

WMQRS was set up as a collaborative venture by NHS organisations in the West Midlands to help improve the quality of health services by developing evidence-based Quality Standards, carrying out developmental and supportive quality reviews - often through peer review visits, producing comparative information on the quality of services and providing development and learning for all involved.

Expected outcomes are better quality, safety and clinical outcomes, better patient and carer experience, organisations with better information about the quality of clinical services, and organisations with more confidence and competence in reviewing the quality of clinical services. More detail about the work of WMQRS is available on www.wmqrs.nhs.uk

ACKNOWLEDGMENTS

West Midlands Quality Review Service would like to thank the staff and service users and carers of North Staffordshire and Stoke on Trent health economy for their hard work in preparing for the review and for their kindness and helpfulness during the course of the visit. Thanks are also due to the visiting team and their employing organisations for the time and expertise they contributed to this review.

CARE OF FRAIL OLDER PEOPLE

COMMON THEMES

In 2013 Stoke on Trent and North Staffordshire Clinical Commissioning Groups with its local providers began a three year transformation programme to deliver major changes to the way the local health economy provides care and support to older people with multiple long term conditions. Both Clinical Commissioning Groups (CCGs) shared this vision and were working well with provider organisations to move it into practice.

This programme aims to deliver multi-agency, community-based care under the leadership of general practice, using a case management approach. Different elements of the transformation programme are covered in different parts of this report. In general, however, reviewers met staff, patients and voluntary groups who understood the challenges facing the health economy and were keen to deliver the necessary transformation. At the time of the visit, the transformation programme had reached an important stage with delivery of expected changes the key priority.

Reviewers did not meet providers of GP out of hours services during the course of the visit and so this aspect of the services provided for frail older people may not be adequately represented in this report.

Working Well

1 Commissioners had a clear vision of the changes they wanted to achieve and a lot of work had been undertaken on starting the transformation process. Individual aspects of the plan were working well, although further work on pulling these together into an integrated system was still in progress. The particular elements of the strategy which impressed reviewers were:

   a. Frail Elderly Assessment Unit (FEAU): This unit is described in more detail in the 'Response to Urgent Need' section of this report but impacted on all aspects of the care of frail older people.

   b. The range of admission avoidance and discharge pathway options. These are also described in more detail below.

   Implementation of the strategy had been supported by significant investment in community services (£3.5m) and intermediate care (£1.2m).

2 Some elements of the transformation programme had already been implemented:

   a. "New model of care in community hospitals, recognising that the majority of patients using these services are elderly

   b. Support to Nursing Care Homes to help support patients in their own home, avoiding attendance at A&E and the potential for unnecessary admission

   c. Intermediate care which is the core service for avoiding unnecessary admissions to acute hospital and also to facilitate discharge from hospital at the right time for the patient

   d. Integrated Locality Care Teams which are based around GP localities where GPs lead case finding / case management appropriate to supporting people in their own homes

   e. Care co-ordination hub"

Plans in Place

1 Aspects of the transformation programme which were in progress were:

a. "Increased investment in community geriatricians to provide the level of expertise required for supporting GPs and other professionals to manage frail / complex elderly patients in their own homes where appropriate

b. Within the frail complex care initiative …… an elderly care capitated programme which will enable services to be commissioned in a new way with emphasis on integrated community care and better outcomes for patients"

Change Needed

1 Available literature and discussions with staff showed that, although the vision for transforming services for frail older people was clear and comprehensive, the organisational development and communication plan supporting its implementation was less obvious. Some patients who met the visiting team also had some concerns, including about changes to the provision of Day Centres. Further work on organisational development and communication may be useful.

2 The relationship between the generic 'frail elderly' pathway and services for people with long-term conditions, especially those with multiple long-term conditions, was not clear to reviewers. These pathways appeared uncoordinated and further work on the links between them may be helpful. Work on linking acute and community-based specialist long-term conditions nurses was being discussed.

3 Arrangements for pathway-related training for staff in the two main providers of care for frail older people were not clear and reviewers heard different views about how integrated training was being achieved. Implementation of the pathways may be helped by further work on joint training. Involving consultant medical staff from both providers in joint training activities may also support implementation.

4 The way in which short-term (winter pressures) projects supported the overall transformation process was not clear. These projects appeared to be functioning separately which could lead to a lack of clarity for staff and patients (see comments above about communication plan). Early planning for short-term funded work to pump-prime and drive the overall transformation agenda may be helpful.

5 IT systems between the acute, community and social services were not yet integrated. Everyone was well aware of this and the resulting problems. Reviewers were told about some access to shared records but several staff who met reviewers were not aware of this. Reviewers commented that *Graphnet* could provide access to a shared care record through the register if this was thought appropriate. There were plans to provide IT for community staff to work remotely.

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CONDITIONS & THERAPEUTIC INTERVENTIONS

Working Well

1 The 'RAID' service had been implemented within University Hospital of North Staffordshire NHS Trust and was providing a rapid response for people with mental health or dementia-related problems. Dementia specialist nurses had been appointed to join the team.

Change Needed

1 Mental health services did not appear to be involved in the strategy and planning of services for frail older people. Greater involvement may be helpful given the importance of mental health in the care of frail older people.

2 Shared care arrangements between the Memory Service and general practitioners for the initial stages of care of people with dementia did not seem well-developed. Further development of shared care may help to free up time in the Memory Service for patients with more complex needs.

3 Further work to ensure the RAID service is fully embedded and meeting expected Standards may be helpful.

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Preventive & Supportive Interventions

Working Well

1 The Falls Responder Service was working well. Referrals were seen promptly and advice given was consistent across the health economy.

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Care (Health & Social)

Working Well

1 The Integrated Locality Care Teams (ILCTs) were working well in providing integrated community-based health and social care. Some teams were led by social workers and some by health staff which had resulted in useful learning for all teams. There were good links between community hospitals and ILCTs.

2 Good triage arrangements were in place in community occupational therapy, physiotherapy and podiatry services which resulted in urgent cases being seen very quickly.

3 'The Hub' acted as a system for routing referrals, including telephone triage of referrals from GPs and other health care professionals, from 8am to 8pm Monday to Friday and from 9am to 5pm at weekends. Good links with the ambulance service were in place, including for telemedicine. This service provided good coordination of health care capacity for home-based and intermediate care services. It also supported admission avoidance through 'step up', reducing length of stay through 'step down' and support for more complex transfers of care from acute hospitals. (See also comments below).

Plans in Place

1 Stoke on Trent social services were working with public health colleagues to look at the extent of duplication of services with the aim of reducing duplication and freeing resources, especially for commissioning domiciliary care.

2 The possibility of providing social care assessments at weekends was being considered.

3 Plans were being developed with the ambulance services for an option, following triage, to divert 999 and 111 calls to 'The Hub' for routing to an appropriate local service.

Change Needed

1 Arrangements for triage by 'The Hub' were unclear and multiple referral processes were still in place. Several staff who met reviewers commented that further work on the way 'The Hub' worked may increase its potential for avoiding admissions, including of Care Home residents. They suggested that this could include developing access to out of hours medical and Advanced Nurse Practitioner support for 'step up' beds in community hospitals as well as direct referral to community hospitals from the ambulance service.

2 Occupational therapists and physiotherapists were linked to the Integrated Locality Care Teams (ILCTs). Reviewers commented that therapist staffing levels in these teams appeared low and waiting times for follow up were reported as relatively long. Reviewers suggested re-looking at a) the skill mix within ILCTs and b) the patient journey through these teams - in order to bring assessment by a registered therapist

earlier in the pathway with non-registered staff then working with patients on an agreed plan. Also, occupational therapists and physiotherapists in the ILCTs could not refer patients to the FEAU or Medical Assessment Unit, which appeared to add unnecessary steps to the referral process. Further work to ensure achieving consistently high standards of care are in place across all ILCTs may be helpful.

3 The nursing element of the ILCTs was available 24/7 365 days per year but access to other staff in the team was more restricted. Several staff mentioned that widening access to other team members would improve the responsiveness of the teams. Further work looking at potential demand for other team members and the impact it would have may be helpful.

4 Links between mental health services and ILCTs did not appear well developed. The Intermediate Care Team had recruited a mental health nurse to work within the team but the intended role for this individual was not clear. This had led to the practitioner developing their own role as a counsellor rather than integrating with dementia services. Assessment of other mental health needs was through specialist psycho-geriatric nurses. Arrangements for liaison with community mental health services following assessments were not clear. Also, the 'RAID' service did not cover community hospitals and mental health support for people in community hospitals with cognitive or mental health problems were not clear.

5 Access to 'step up' beds was available from 8am to 8pm Monday to Friday and from 9am to 5pm on Saturday and Sunday. Further work with GP out of hours services looking at the potential demand for 'step up' beds at other times, and the impact this would have, may be helpful.

4 Some difficulties in the provision of domiciliary care were reported, partly due to a shortage of providers for domiciliary care. This had been highlighted by two recent cases when providers had not been able to deliver care due to staff shortages and 30 and 20 cases respectively had been handed back at short notice.

5 Further work on integration within ILCTs may be helpful, for example, through joint training, shared protocols and team-building.

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Response to Urgent Need

Working Well

1 **Frail Elderly Assessment Unit and four acute Inpatient wards**

The Frail Elderly Assessment Unit (FEAU) had been operational since 2010. FEAU had been recognised as a 'centre of excellence', with a '*Gold Standard for Excellence in Practice'* Award assessed by Teesside University in 2013. The service had also been shortlisted in 2013 for the NPSA awards for acute care of the older adult. Access to the FEAU was from the Emergency Department, by referral from the community 'Hub' or by West Midlands Ambulance Service. The Unit also actively 'pulled' patients from the Acute Medical Unit and Emergency Department. All patients were screened using the Bournemouth Criteria prior to admission. This assessment tool identified frailty and complexity of needs. Frail older people who were admitted to the unit had early access to a review by a Consultant Geriatrician and an assessment by the nursing team and a full multi-disciplinary team of allied health professionals (although therapy services at weekends were only for discharge assessment and chest physiotherapy). This team liaised with staff from Staffordshire and Stoke on Trent Partnership NHS Trust to avoid admission whenever possible. The Unit had an average length of stay of two days.

In conjunction with FEAU, the Older Adults Unit had four inpatient admission wards solely for acute admission of older adults. These wards were used for patients with on-going acute needs which could not be managed within local community hospitals. The wards had an average length of stay of between three and eleven days.

Staffing for the FEAU was by eight Consultant Geriatricians who provided cover from Monday to Friday 9am to 8pm and from 9am to 3pm at weekends and Bank Holidays on a one in eight rota. Medical cover at other times was provided by a 'roving' Specialist Registrar and the on call Consultant for Medicine. Each ward had weekly length of stay reviews.

2 **Older Adults In-Reach Service (OAIRS)**

This service was provided by a Clinical Nurse Specialist and eight Consultant Geriatricians who actively supported the management of older people in the Acute Medical Unit who were waiting for transfer to Older Adult services and also provided a review service to other inpatient wards at University Hospital of North Staffordshire NHS Trust for specialist advice and support. Patients were reviewed daily by OAIRS. Reviewers were told that this input had substantially reduced the number of 'bed moves' and ensured that non-acute admissions were not transferred inappropriately into acute admission beds. FEAU and Older Adults inpatient wards aimed to discharge patients to their normal place of residence or to the lowest possible level of dependency. OAIRS was available from Monday to Friday, 8.30am to 4.30pm with support available from the FEAU when The Clinical Nurse Specialist was on leave.

3 **Range of discharge pathways**

A good range of discharge options was available, including:

a. Home with or without additional support

b. Intermediate care pathways

c. Step down to sub-acute care within community bed stock

d. Step down community assessment beds

e. 'Fast-track' palliative care

f. Hospital at Home scheme

The number of readmissions had been audited in 2012 and had reduced.

4 **Intermediate care and community hospitals**

Community hospitals had moved away from the traditional approach to a nurse-led model with consultant support. Reviewers were particularly impressed by:

a. A 'step up' model had been implemented on Grange Ward at Haywood Hospital. Staffing included a Physician's Assistant and 6.5 wte Community Advanced Nurse Practitioners. The ward had 32 beds and average length of stay had been reduced from 14 to 10 days. This facility gave the option for active management and rehabilitation with patients still close to home.

b. Other bed-based intermediate care facilities were managed as part of a coordinated approach to health and social capacity with an ethos of actively trying to get patients home. Average length of stay in these beds was eight days.

c. The Stoke ILCT was taking a proactive approach of case management and liaison with the 'Hub'. Holistic interventions were provided quickly to support both discharge from acute hospital and admission avoidance.

d. Good use was made of advanced practitioner roles in community hospitals and in the intermediate care teams. Staff grade doctors, under the supervision of three locum consultants, ensured consistent medical input to the care of patients (although see 'change needed' below).

Plans in Place

1 Plans for the development of a frailty register were being developed. Further work on care pathways to enhance care closer to home and reduce admission rates was also under discussion.

Change Needed

1 The need for closer integration between acute and community care of older people consultants had been recognised and options for achieving this were being discussed. Options included community consultants covering the advice line for part of the day and spending some time on the FEAU. Reviewers commented on the shortage of care of older people consultants and that recruitment may not be possible without innovative job planning. At the time of the review all community posts were filled by locums who had no job-planned time for acute care and the number of community-led specialist consultant clinics in community hospitals had been reduced. Reviewers suggested that all job plans should include an element of acute work. Reviewers strongly supported an integrated approach to care of older people consultant staffing – with the rationale that it is the same frail older person who spends the majority of time in the community interspersed with acute admissions when their needs increase. Reviewers also suggested that the skill mix of the overall medical staffing model should be carefully considered, including the possibility of recruitment of additional Physician's Assistants. As care of older people consultants develop their roles further, closer links with GPs and ILCTs may also be feasible.

2 Further work to ensure the FEAU is meeting the commissioner specification may be helpful.

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CROSS-CUTTING PATIENT CARE

Working Well

1 ICLTs were providing support to nursing care homes, including additional training, with the aim of avoiding hospital admissions.

Plans in Place

1 An 'elderly care capitated programme' was being planned. The aim of this initiative was for services to be commissioned in a new way with the emphasis on integrated community care.

2 Joint work was also taking place with general practitioners on engagement with the frail older people pathways including, in Staffordshire Moorlands, a commissioner working locally with GPs and nurses on admission avoidance options. Joint discussions with the ambulance service and community hospitals were also taking place.

Change Needed

1 Links between GPs and district nursing teams may benefit from further discussion. Reviewers were told that some district nurse could not attend locality-based multi-disciplinary team meetings because of time constraints and that communication with district nurses was not always as effective as it could be.

2 Good progress had been made with implementation of a risk stratification tool. The version used was not a predictive tool and may not provide the proactive information that will be needed in the future.

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UNDERPINNING ISSUES

Working Well

1 Reviewers were impressed with several workforce changes which had been made, including:

   a. UHNS had trained 20 Health Care Assistants with specific competences in the care of people with dementia.

   b. Advanced Nurse Practitioner roles were well developed in ILCTs and community hospitals.

c. The number of Consultant Geriatricians and plans to recruit to four posts.

Plans in Place

1 Plan for work on tele-medicine with voluntary sector providers were being developed.

Change Needed

1 Several staff were already thinking about the next stage of the transformational change. Supporting staff to work together further to develop the vision of integrated care of frail older people may yield long-term benefits. Areas suggested for further work included:

a. Health economy-wide engagement about achieving transfer from acute hospital care within 24 hours of referral.

b. Ensuring patients needing enhanced recovery could have their care provided in a setting with the lowest possible level of dependency.

c. More work on anticipatory care planning.

d. Improving access to diagnostics for people in community settings so that more admissions could be avoided.

e. Areas of particular concern to patients, including attitudes of nursing staff in the out-patient department, and ensuring good involvement and communication about changes in organisations providing care.

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APPENDIX 1 MEMBERSHIP OF VISITING TEAM

Visiting Team

Dr Neil Baldwin	Consultant Physician in Geriatric and General Medicine	Wye Valley NHS Trust
Kate Davis	Patient Representative	
Adele Dean	Clinical Quality Manager	West Midlands Ambulance Service NHS Foundation Trust
Joanne Gutteridge	Commissioning Manager, Preventative Care	NHS Dudley CCG
Emma Jewiss	MAU Ward Manager	Sandwell & West Birmingham Hospitals NHS Trust
Cath Molineux	Nurse Consultant, Primary Care	Shropshire Community Health NHS Trust
Om Sharma	Corporate Project Manager	Walsall Healthcare NHS Trust
Judith Whalley	Patient Representative	

WMQRS Team

Jane Eminson	Acting Director	West Midlands Quality Review Service
Sarah Broomhead	Assistant Director	West Midlands Quality Review Service

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APPENDIX 2 FRAMEWORK FOR FORMATIVE REVIEWS