WM QRS West Midlands Quality Review Service

NHS

Formative Review
Care of Frail Older People

South Staffordshire (West) Health Economy

Visit Date: 25th March 2014 V2 Report Date: September 2014

Images courtesy of NHS Photo Library





INDEX

INTRODUCTION

This report presents the findings of the formative review of the care of frail older people in South Staffordshire (West) which took place on 25th 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 South Staffordshire (West) health economy.

The review used a framework covering 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, representatives from a 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.

This report describes services provided or commissioned by all the NHS Trusts, Clinical Commissioning Groups (CCGs) and Local Authorities in South Staffordshire (West), 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. Stafford and Surrounds Clinical Commissioning Group and Cannock Chase Clinical Commissioning Group 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 South Staffordshire (West) 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.

Return to *Index*

CARE OF FRAIL OLDER PEOPLE

Cannock Chase CCG and Stafford and Surrounds CCG commissioned services for frail older people from a number of providers including Mid Staffordshire NHS Foundation Trust, Staffordshire and Stoke on Trent Partnership NHS Trust, South Staffordshire and Shropshire Healthcare NHS Foundation Trust and private and voluntary sector providers. Both CCGs were projecting a significant growth in the number of people aged 65 and over and, particularly, in the number aged 75 and over. Reviewers did not have any background information about the CCG strategy and plans for improving the care of the frail older people, but were told that health and social care commissioners had "plans to align their processes and commissioning frameworks to maximise opportunities and resources and to ensure services were integrated across the health economy during 2014/15". Reviewers noted differences in the provision of services across the two areas and CCGS said that this was due to historical and funding differences.

Reviewers were disappointed not to meet any patients or carers during the course of the visit. *HealthWatch* had been invited to meet the team but were unable to send appropriate representation. Reviewers met GPs from Stafford but not GPs from Cannock. Their perspective may not therefore be represented in this report.

CONDITIONS AND THERAPEUTIC INTERVENTIONS

Working Well

1 A clear strategy for the care of people with dementia was evident with progress on re-establishing Memory Clinics and setting up community dementia teams for people with more complex or challenging needs. A Dementia Liaison Team was based in Stafford Hospital with its office base close to Ward 10 (the ward specialising in the care of frail older people).

2 The Care Home Education and Support Service (CHESS) provided assessment and therapeutic support for older people in care homes who were suffering from both functional and organic mental health problems.

Plans in Place

1 A pilot project in Gnosall was trialling the use of an individual case worker and elderly care facilitators who would support patients on an ongoing basis. Discussions about extending this pilot to Stafford were taking place.

2 Improving the dementia pathway further, including improving links with GPs, was being actively discussed between commissioners and providers.

PREVENTIVE & SUPPORTIVE INTERVENTIONS

Working Well

1 A Falls Team supported by a broad multi-disciplinary team had been in place since 2011. Outcome measures had been developed and were being monitored and shared with commissioners. Self-referral to the service was available. The service could also access equipment loans and ran a 'let's work together' healthy lifestyle programme with the police and carers support services.

Change Needed

1 The Falls Service was commissioned for 900 contacts per annum but was receiving 100 referrals per month. The service was no longer commissioned to provide education and support to care homes although this was under active discussion at the time of the review.

CARE (HEALTH & SOCIAL)

Working Well

1 Integrated Local Care Teams had been established in each neighbourhood. Some teams, including the Cannock team, provided nursing care 24/7. All teams included nursing, therapy and social care staff. Reviewers were particularly impressed by the strength of the Cannock team which included hearing and sight assessors. Access to voluntary organisations was also provided. Social care staff were available Monday to Fridays with therapy staff also available at weekends in some teams. Intensive case management was actively being developed by the teams. This was being facilitated by community matrons with 'case holding' by band 6 staff. Multi-disciplinary meetings with GPs were held to discuss the care of people with more complex needs. Teams had a strong focus on enablement and holistic support.

2 All community teams were 'RAG' rating the acuity of patients using a standardised tool. This was giving valuable information for planning staffing levels. This exercise had also shown that the teams were providing ongoing care to a group of patients for whom primary care services alone were not sufficient.

3 Community matrons had direct access to the admissions unit and could access diagnostics and clinical advice through this route. This had been shown to have avoided some admissions.

4 The Stone Rehabilitation Team provided rehabilitation support, including domiciliary physiotherapy, Monday to Friday. This team had developed monthly multi-disciplinary meetings to consider the care of patients with more complex needs.

5 The Commissioning Support Unit had developed a dashboard for nursing homes which was to be implemented from April 2014. A quality improvement lead for care homes had also been established.

Plans in Place

1 Mobile electronic devices were being issued to all community services staff so that they had easier access to patient records while in the home and in order to reduce staff travelling. Training on use of these devices was in progress.

Change Needed

1 Social care staff in Integrated Local Care Teams were not available at weekends although access to the Emergency Duty Team was available. Reviewers considered that the work of the teams would be helped by some availability of social care assessments at weekends. Some policies and records systems were also different between health and social care staff. Social care staff also did not have access to nhs.net email accounts. Further development of integration through addressing these issues may be helpful.

2 The Stafford Integrated Local Care Teams commented that they had a waiting list.

3 Managers of some of the Integrated Local Care Teams had a large management responsibility as well as clinical responsibilities. It may be helpful to review whether the time allocated for management is sufficient given the size of some of the services. Reviewers were told of particular problems with and delays to staff recruitment because of a lack of timely human resources support.

4 Reviewers encouraged continuation of implementation of the model of integrated care developed in Cannock Chase and 'roll out' to Stafford and Surrounds. Evaluation of the service in Cannock Chase may help to inform the development of services in other areas.

5 Integrated Local Care Teams commented that it was sometimes difficult to access domiciliary care packages. Concerns about the quality of domiciliary services and about staff training were also raised.

6 The Stone rehabilitation service was originally commissioned by the local GP's and appeared to provide good, holistic care but for a small catchment population. A similar service was not available in other areas. It was not clear to reviewers why this service was needed in one area but not in others.

7 Changes were being made to the case management approach with responsibility being taken from community matrons and given to GPs, funded through an enhanced scheme. Multi-disciplinary Team (MDT) meetings to discuss case management, especially of people with more complex needs, no longer took place. The rationale for the change and how it linked with the development of Integrated Local Care Teams was not clear.

8 A 'Single Point of Access' scheme had been piloted for six months. This only covered five days a week and other routes of access were also available. A true 'Single Point of Access' was therefore not yet available.

9 The Local Enhanced Scheme relating to nursing homes had not yet been evaluated and it was not clear if further work was required on this.

Return to *Index*

RESPONSE TO URGENT NEED

Working Well

1 Individualised emergency care pathways had been developed and implemented, especially in Cannock, and were shared with the ambulance service (but see also 'change needed' below).

2 Standardised management pathways for urinary tract infection and community acquired pneumonia had been developed for use in care homes and implemented across the health economy, with data reported back to GPs.

3 Stafford Hospital had a good system for identifying frail older people who were not admitted to Ward 10. Support and advice was offered to other wards on the care of these patients.

4 The Fairoak Ward at Cannock Hospital provided good multi-disciplinary rehabilitation programmes and support for patients undergoing active rehabilitation. The ward had completed Stage 1 of the 'Quality Mark for Elder-Friendly Hospital Wards'.

5 The Stafford Community Intervention Service (CIS) provided multi-disciplinary support for admission avoidance and post-discharge from Stafford Hospital, including for intravenous antibiotic therapy. Assessment of needs was undertaken and patients signposted to other services. Nursing staff were available 8am to 8pm (7/7), therapy staff from 8am to 6pm (7/7) and social care and community mental health nurse from 8.30am to 5pm, Mondays to Fridays (4.30pm on Fridays). The service linked with the 'Integra' service which provided care packages for up to 10 days and also with 'Living Independently Staffordshire'. (See 'change needed' below).

Plans in Place

1 Stafford Hospital was considering the development of a Frail Elderly Assessment Unit.

Change Needed

1 Individualised emergency care pathways were not used by the GP out of hours service. Reviewers were also told that the new practice-based case management approach was developing a different format for emergency care pathways.

2 Staff who met the visiting team reported difficulties in contacting the GP out of hours service. Delays in call backs were being experienced and staff sometimes had to go via 111 in order to access the service. Staff

reported waiting up to six hours for drug amendments for palliative care patients. Commissioners said that the specification for the GP out of hours service was being revised.

3 Reviewers were given several examples of patients being admitted to hospital outside normal working hours when care and interventions may have been available in the community. The range of services with different numbers and different access criteria appeared to be leading to confusion and some people defaulting to 999 as a route for admissions. The Stafford area did have one phone number between 8am and 8pm.

4 'Hot clinics', other than those in the Emergency Department, were no longer available in Stafford Hospital, although care of older people consultants kept one 'slot' per clinic available for urgent review of patients. The lack of 'hot clinics' may impact on admission avoidance and reducing length of stay and should be kept under review.

5 The Stafford CIS did not always have capacity to provide support for all patients referred to the service. The service then 'closed' and evening and night district nursing services provided the support**.** The value of having separate services was not clear to reviewers. Reviewers were also told that assessments for care packages were made but these could not always be provided. Arrangements for transfer of care plans to the Stafford CIS may also benefit from review. Reviewers were told that it was not clear how medical oversight of the care of patients was being transferred.

6 Reviewers were told about particular difficulties in organising packages of care for people with persistent delirium with resulting delays in discharge from Stafford Hospital. This appeared to be related to different views about indications for 1:1 nursing. Reviewers suggested that a clear policy on 1:1 nursing for these patients was required, implementation of which could then be audited.

7 Integrated Local Community Teams (ILCTs) commented that they would appreciate greater involvement in discharge planning from acute hospitals.

Return to *Index*

CROSS-CUTTING PATIENT CARE

Working Well

1 A good end of life care strategy was in place, including an occupational therapist in Stafford Hospital specifically working to support the care of people nearing the end of their lives.

Change Needed

1 At the time of the review, neither CCG had robust data on the number of frail older people in the CCG area. An appropriate risk stratification tool was not yet in place. Some work on gathering data from care homes had started but would not provide information on the number of patients living in their own homes.

2 Two care of older people consultants were available but their time was largely committed to ward care and clinics. Time for work with Integrated Local Care Teams and to support patients in the community was limited. Three posts were vacant. The development of innovative job plans involving links with community based services as well as time on acute wards may make these posts more attractive.

Return to *Index*

UNDERPINNING ISSUES

Working Well

1 The CCGs had developed tools for measuring patient satisfaction and patent reporting outcome measures (PROMS).

Change Needed

1 The overall strategy and vision for the care of frail older people was not clear to many of the staff delivering patient care or to reviewers. As part of the development of the local health economy strategy for the care of frail older people, it may be helpful to involve patients, carers and clinical staff currently providing services. Several of the clinical staff who met the visiting team were unsure how to influence commissioners. Reviewers considered there was the potential further to improve the care of frail older people as highlighted in this report.

Return to *Index*

APPENDIX 1 MEMBERSHIP OF VISITING TEAM

Visiting Team

Karen Bowley	Rehabilitation and Ambulatory Care	The Royal Wolverhampton NHS Trust
Bernadette Faulkner	LTC Commissioning	NHS Solihull CCG
Jane Freeguard	Head of Medicines Management & Pharmacy	NHS South Worcestershire CCG
Dr Simon Harlin	GP Lead, Frail Elderly Pathway	Walsall Healthcare NHS Trust
Dr Stuart Hutchinson	Consultant, Geriatrics	The Royal Wolverhampton NHS Trust
Marcelle Rollings	Quality Manager - Midlands and East, Clinical Directorate	NHS Trust Development Authority

WMQRS

Sarah Broomhead	Assistant Director	West Midlands Quality Review Service

Return to *Index*

APPENDIX 2 FRAMEWORK FOR FORMATIVE REVIEWS