WM QRS West Midlands Quality Review Service

NHS

Formative Review
Care of Frail Older People

Dudley Health Economy

Visit Date: 29th April 2014 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 Dudley that took place on 29th April 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, to:

1. Identify areas which are working well
2. Identify areas where improvements are needed
3. Inform future commissioning intentions
4. Share good practice and expertise

The report reflects the situation at the time of the visit. Appendix 1 lists the visiting team that reviewed the services in Dudley Health Economy.

The review used a framework covering the care of frail older people (Appendix 2) that has the following main areas:

a. Conditions and therapeutic interventions
b. Preventive and supportive interventions
c. Care (health and social)
d. Response 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 what changes, in the view of the reviewers, were needed.

This report describes services provided or commissioned by all the NHS Trusts, Clinical Commissioning Groups (CCGs) and Local Authorities in Dudley, and by independent and voluntary sector partners. Responsibility for addressing the issues identified in this report lies with all these organisations working in partnership. Dudley CCG has a particular responsibility for ensuring appropriate progress is made. The review used a framework of questions but was 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.

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 at www.wmqrs.nhs.uk.

ACKNOWLEDGMENTS

West Midlands Quality Review Service would like to thank the staff and the service users and carers of Dudley 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

Services for frail older people in Dudley were commissioned by the five localities of Dudley CCG. Primary care was provided in 49 general practices, 25% of which were 'single-handed'. General acute and community services were provided by The Dudley Group NHS Foundation Trust. The visiting team did not meet representatives from mental health services or community-based care for people with dementia, and this report may therefore under-estimate the work that is taking place in these areas. Representatives from voluntary sector organisations met the visiting team, but the team did not meet any frail older people or their representatives.

The health economy had a good vision for the future development of services for frail older people and a great deal of work to improve local services for this client group was taking place.

Conditions & Therapeutic Interventions

Working Well

1 The community Heart Failure Team was providing a five day a week intravenous diuretics service, which meant that patients did not have to attend the hospital for this service.

2 The Telecare response service for patients with heart failure was available 24 hours a day, seven days a week, for patients who were registered with the service.

3 Three dementia 'gateways' were in place across the Borough providing assessment, specialist care and support.

Plans in Place

1 Plans for a GP-led community intravenous antibiotic service were being developed as part of the implementation of the health economy strategy for the care of frail older people.

Change Needed

1 Staff who met the visiting team were unclear of the referral pathway for access to the Telecare service. Some thought that referral was via the virtual ward, but in fact the service could take direct referrals. Reviewers suggested that further engagement with referring teams to explain the pathway may be helpful.

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Preventive & Supportive Interventions

Working Well

1 An Integrated Falls Service was in operation across acute and community health and social care services. The service had plans to introduce a 'trusted assessor' system for initial assessments, which would enable more time to be spent in dealing with those at greater risk of falls. Postural instability instructors were part of the Integrated Falls Team exercise pathway.

2 The Expert Patient Programme was working with GP practices to identify 'hard to reach' groups, such as those with particular diseases. Rates of completion were high for the programme, and reviewers were told that approximately 500 people out of the 1,000 who registered completed the course.

Plans in Place

1 An Age UK 'gateway' carers project had just started looking at 'social prescribing' for GPs and other front-line staff, plus onward referral to appropriate agencies for further assessment and support.

2 The Continence Team was planning to extend the five day a week service to an on-call service for advice at weekends.

Change Needed

1 A proportion of the Continence Service workload involved caring for those who required a 'trial without catheter'. Reviewers suggested that there may be greater potential for re-designing this service than could be seen in the work that was already taking place. Up-skilling community staff, more continence staff time and more bladder scanners would be needed for this.

2 Reviewers were told that Tiled House did not have any falls specialists, although physiotherapists and occupational therapists on site provided falls assessments. Further work on involvement of the Integrated Falls Team may be helpful.

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CARE (HEALTH & SOCIAL)

Working Well

1 Good integration between a variety of providers and the Intermediate Care Teams (ICT) based at Tiled House (47 beds) was evident. Reviewers were particularly impressed that services were co-located with social care. The ICT provided a seven day a week service until 10pm with good feedback from patients who felt that they received personalised care.

2 Weekly multi-disciplinary meetings with strong GP input took place in some nursing homes.

Plans in Place

1 Plans were in place to change from a virtual ward model to five 'community wards' in the five localities. The community wards would provide a greater geographical focus, make more efficient use of staff and improve links with local multi-disciplinary teams. This development was linked with the planned use of the Adjusted Clinical Groups (ACG) risk stratification tool.

2 The intermediate care strategy was being reviewed. Teams locally were keen to be engaged with the development of the intermediate care model.

Change Needed

1 The roles of the different community-based teams were not clear, and it appeared that some teams had overlapping remits but different resources. The relationship between the virtual ward, the Community Rapid Response Team (CRRT) and other community services was not clear. Arrangements for the care of patients previously supported by the health visitor for older people were also unclear. Reviewers were told that these patients were referred to the virtual ward by GPs, and this may not be appropriate for their level of need.

2 It may be helpful to disseminate learning from the GP-led multi-disciplinary team meetings in nursing homes with the aim of encouraging other practices to become involved.

3 Different providers of intermediate care (in ICTs and care homes) appeared to be working to different service standards and to be using different guidelines. It was not clear that all approaches were based on the most up-to-date evidence of effectiveness.

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Response to Urgent Need

Working Well

1 A CRRT was being developed with the aim of supporting people at home and reducing the number of hospital admissions. The team would be led by advanced nurse practitioners who would be able to respond within 60 minutes of referral. Five nursing home beds were available as 'emergency diversion beds' with the aim of avoiding admission to hospital. The role of advanced nurse practitioners in the CRRT was working well. These staff were educating and 'up-skilling' social care assistants and health care assistants, as well as providing direct patient care (such as phlebotomy and undertaking ECGs).

2 The IMPACT team was based in the Emergency Assessment Unit and comprised senior nurses, therapists and social workers. The team undertook twice daily ward rounds and patients were assessed in the Emergency Department. A proactive approach to the identification of patients was evident.

3 The dementia pathway in the acute hospital was clear and well organised. An 'Acute Confusional Team' which was based on C3 also provided support to patients with dementia in other areas. A dementia specialist nurse worked with orthopaedic surgeons to help with obtaining consent for surgery, and continued to support patients during their time in hospital. The process of transfer from acute hospital care for people with dementia had been adjusted to allow extra time for patient and carer support and to ensure that the transfer of care was well planned and appropriate. A dementia adviser was contacted for patients leaving acute hospital care. A Dementia CQUIN was being used to support this work.

4 A Frail Elderly Short Stay Unit had been piloted at Russells Hall Hospital. This unit had twice daily formal consultant ward rounds seven days a week. The unit had good pharmacist and social support to ensure early discharge from hospital. Reviewers were told that the unit would be established on a permanent basis.

5 Access to equipment was available 24 hours a day, seven days a week. 'Buffer stocks' were held locally and larger pieces of equipment could be accessed on request.

6 The Red Cross Home from Hospital service provided a shopping and befriending service. The Red Cross also assisted in transporting patient equipment.

7 An urgent care pathway manager was actively managing the process of discharge from acute hospital care and the care of patients while in 'step-down' beds.

Plans in Place

1 Arrangements for out of hours support for the advanced nurse practitioners in the CRRT were under review at the time of the visit.

Change Needed

1 Elderly care wards had only two consultant ward rounds per week with one 'board round' each day. Reviewers suggested that a daily consultant ward round may be helpful. Trust staff considered that discharges from the wards were well managed and were not delayed. Reviewers suggested the Trust may wish to consider an acute geriatric 'hot week' as well as developing the existing team and implementing nurse-led and therapies-led discharge from these wards.

2 Reviewers were given differing views about the timing of social care assessments. Some staff said that these assessments took place when patients were medically fit, whereas others said that assessments started earlier in the pathway. Access to care packages appeared to be delaying discharges. Delays in access to social care packages may also be impacting on the workload of the community team. Reviewers were told that delays in safeguarding investigations were delaying discharges from acute hospital care, and wondered whether 'step-down' beds could be used while safeguarding investigations were taking place.

3 Dieticians who met the visiting team said that they would like to be able to refer directly to gastroenterologists rather than having to route referrals via the patients' GPs.

4 Reviewers noted that several methods of identifying frail elderly patients in the acute hospital were in use. Some staff were not keen on using the 'butterfly' to identify patients with dementia. The Trust may wish to look at available evidence on the benefits of using 'signifiers' to highlight information for other health professionals.

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Cross-cutting Patient Care

Reviewers were told that Dudley had implemented an ACG risk stratification tool that was able to provide data on those who were at higher risk of requiring health care interventions or admissions, and was also able to predict those who were emerging as high risk so that preventative work and interventions could be planned. Reviewers were interested in this approach but did not see any further information about it and so were unable to comment further.

Working Well

1 A working group across the health economy was gathering patient perspectives from patients' stories and ensuring that this information was used to improve the services available.

2 Palliative Care teams: Two teams were working proactively with providers across primary and secondary care. Both teams worked across a range of conditions and had undertaken particular work with some non-cancer services such as, for example, respiratory and cardiology services. Multi-disciplinary review and learning was in place looking at complaints and incidents. Access to specialist advice for users of the service and professionals was available 24 hours a day, seven days a week.

Plans in Place

1 A project was in place to review the provision of palliative care across the Borough. The Palliative Care Teams had been awarded a grant by Macmillan to look at the 'Midhurst' principle and different models of provision. As part of the re-modelling of the whole pathway, consideration was to be given to providing care for other non-cancer patients, particularly those with dementia or Parkinson's disease.

Change Needed

1 Further development of palliative care pathways may help to streamline referral and assessment processes. These appeared disjointed, lengthy and different in different parts of the Borough. This situation arose because there were two Palliative Care Teams with senior staff of different levels (a consultant in the acute team and a band 8A occupational therapist in the community team), and because two hospices were used. Reviewers commented that the referral form was particularly long (four to six pages) and assessments appeared to be being duplicated. Arrangements for longer-term nutritional support for patients were also not clear.

2 Reviewers were told that GPs were not all using the Gold Standards Framework or a similar process, which could create problems for other services involved in patients' care, although reviewers were told of plans to address this.

3 Some services, for example the heart failure and palliative care services, had good access to benefits advice, including input from the Citizen's Advice Bureau. This advice did not appear to be generally available, and some patients who met the visiting team reported that greater use could be made of benefits advice and ensuring appropriate care packages are in place.

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UNDERPINNING ISSUES

Working Well

1 GP leads in each locality were working to drive improvements in the care of frail older people as part of a programme to develop 'the accountable GP'.

2 Good education programmes for GPs were in place and education programmes for practice nurses had started. Protected learning time covered by the GP out of hours services was in place, with good attendance at learning events.

3 A dietician was looking at the use of nutritional supplements across the health economy and was working with GPs and practice staff to improve the prescription and management of nutritional supplements.

4 Forty-one patient groups were in place across the 49 GP practices in Dudley.

Plans in Place

1 Implementation of a shared electronic patient record for frail older people was being considered.

2 The CCG had undertaken a mapping exercise looking at how greater autonomy could be given to the five localities.

3 Commissioners had a clear view of the changes that they wanted to see. Plans were in place for achieving these changes, and the resources for them were being prioritised. Reviewers did not see the detail of commissioners' plans and so were not able to comment further on them.

4 Reviewers were told of plans for the development of locality teams with GP leads. Further work on communicating and explaining this vision and its relationship with other services may be helpful, especially as reviewers heard both positive and negative reactions to the plans.

5 Education and training on the Malnutrition Universal Screening Tool (MUST) for all GPs and residential homes was planned

Change Needed

1 Implementation of the vision of GP-led integrated care will depend on improving the communication and links between GPs and both community services and secondary care. Reviewers did not see much evidence of effective communication of the vision to other clinical staff, some of whom had their own visions and plans for the development of services. Effective implementation may also be challenging given the high proportion of 'single-handed' GPs in the Borough.

2 Joint work between teams with the aim of helping them to understand the role of other services may be helpful. Greater patient involvement in such work and in the development of services, including greater involvement of *HealthWatch*, may also be helpful. Reviewers suggested that improving coordination and reducing duplication between existing services should help to improve care for frail older people.

3 Reviewers were told of difficulties of communication between the IT systems in different services. Progress was being made with bringing all GP practices onto EMIS but electronic communication with other services was limited.

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APPENDIX 1 MEMBERSHIP OF VISITING TEAM

Visiting Team

Karen Bowley	Rehabilitation and Ambulatory Care	The Royal Wolverhampton NHS Trust
Joan Buck	User/Carer Representative	Staffordshire
Jennet Cowles	District Nurse Sister	Wye Valley NHS Trust
Chris Groves	Service User	Rheumatology User Group
Dr Shahid Nadeem	Consultant Respiratory Physician	Walsall Healthcare NHS Trust
Tom Richards	Quality & Risk Lead	NHS Sandwell & West Birmingham CCG
Carole Roberson	Professional Practice Facilitator for District Nursing/District Nurse Team Leader	Worcestershire Health & Care NHS Trust
Julie Thompson	Head Nurse, Frail Older People& Dementia	Burton Hospitals NHS Foundation Trust

WMQRS Team

Sarah Broomhead	Assistant Director	West Midlands Quality Review Service

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APPENDIX 2 FRAMEWORK FOR FORMATIVE REVIEWS