WM QRS West Midlands Quality Review Service

NHS

Formative Review
Care of Frail Older People

Coventry and Rugby Health Economy

Visit Date: 13th May 2014 Report Date: August 2014

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INDEX

Introduction **3**

Care of Frail Older People **4**

Conditions & Therapeutic Interventions 4

Preventive & Supportive Interventions 5

Care (Health & Social) 5

Response to Urgent Need 6

Cross-cutting Patient Care 7

Underpinning Issues 7

Appendix 1 Membership of Visiting Team **8**

Appendix 2 Framework for Formative Reviews **9**

INTRODUCTION

This report presents the findings of the formative review of the care of frail older people in Coventry and Rugby that took place on 13th May 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 Coventry and Rugby 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. 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 Coventry and Rugby, and by independent and voluntary sector partners. 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 that may not have a full picture of local services. NHS Coventry and Rugby CCG has a particular responsibility for ensuring that 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 Coventry and Rugby 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

At the time of the review, Coventry and Rugby health economy served a population of 470,000 of whom 7% were aged 79 or over. This group of people had accounted for 31% of total admissions to acute hospitals (10,040 admissions), although in the year before the review this had increased to 35% of admissions.

The visiting team did not meet anyone with specific responsibility for the care of patients from Rugby, and this aspect of the health economy services may therefore be under-represented in this report.

All staff who met the visiting team were keen and committed to improving the care of frail older people. Although there was not yet a locally agreed strategy specifically for the care of frail older people, most staff who met the visiting team had a clear, shared understanding of the way in which they thought services should develop.

Conditions & Therapeutic Interventions

Working Well

1 In addition to the national CQUINs, a number of local CQUINs for acute and community services had been set; these related to falls, dementia and multi-disciplinary working. Staff reported that these CQUINS were working well and were incentivising improvements in care. Dementia and multi-disciplinary working CQUINS from 2013/14 had been included in the main quality schedule. This had resulted in increased staff training in dementia assessment and multi-disciplinary discussion of those with a positive screen.

2 A dementia 'Care Bundle' had been implemented in University Hospitals Coventry and Warwickshire (UHCW) NHS Trust. Actions within the Trust to care for people with dementia included the appointment of four dementia nurses, training on 'think delirium' for staff including those in the Accident and Emergency Department, and 'dementia champions' in place on all wards and in the imaging department.

3 In the Rugby area, mental health liaison support teams were working with nursing home staff to improve the care of people with dementia.

Plans in Place

1 Further improvements in the acute hospital care of people with dementia were planned, including the implementation of 'dementia-friendly' wards.

2 Local mental health services had begun to deliver age-independent services in April 2014. Single point of access services had been combined into two 'hubs'. Improvements to mental health liaison services were underway, and there were also plans to integrate into the crisis team a nurse with specialist expertise in the care of older people with mental health problems.

Change Needed

1 Reviewers suggested that a thorough evaluation of the changes to mental health liaison services may be helpful to check that the changes were not diluting the skills available. Ensuring staff have time to review and improve the way the service is working should help the implementation of robust and effective patient pathways.

2 Reviewers heard about some operational issues between the mental health liaison services and the acute trust; in particular, mental health staff had attended patients when physical health issues had not been addressed, which meant that the mental health staff were not able to intervene appropriately. Work on implementing 'think delirium' may help this.

Preventive & Supportive Interventions

Working Well

1 The Continence Service was well organised with a strong, enthusiastic focus on training and advice. The team had provided training for staff in nursing homes and for carers.

2 The Falls Service was also responding proactively to patients' needs. A 'falls class' was run five days a week. The service also worked with Age UK to provide ongoing support for those who had attended the 'falls class'. Patient-reported experiences and outcome measures from these interventions were both good. The services could be accessed by referral from hospital, through REACT, from ward-based physiotherapists, from consultants in elderly care, through falls clinics, or by GPs and other community-based staff. Transport was available so that patients could get to the classes, with ambulance and volunteer driver transport.

Return to *Index*

Care (Health & Social)

Working Well

1 The community matron teams were working well and had generally developed good, collaborative relationships with GPs through an alignment of teams with practices. Multi-disciplinary meetings were held in each practice, with community matrons attending about six practices each. Palliative care nurses also attended these meetings. Retention of community matrons was good, and a high proportion of staff had additional competences in prescribing or were advanced practitioners. There was also strong support for training and staff development. Community matrons were actively liaising with district nursing services.

2 A single point of access system for community services had been implemented and the appointment of a triage nurse as part of this system was in progress. Community services were grouped around GP practices. Community-based therapy services were in-reaching to care homes. Links with ambulance services were also working well, with ambulance staff diverting patients to community services whenever possible. Access to *Telehealth* was available, with monitoring of patients' use by text alerts.

3 Liaison between health and social care services appeared to be working well, especially with acute hospital services. The duty team was proactive in ensuring that same day access to social care was available. Care home beds could be 'spot purchased' for the short-term care of frail older people who were not weight-bearing, with good arrangements for returning home as soon as possible.

Plans in Place

1 Plans for a comprehensive education and training programme for staff in nursing homes were being developed with the aim of reducing the number of nursing home residents with frequent hospital admissions. The development of a matron role for people in residential care homes was also being considered.

Change Needed

1 Further development of the links between social care and community-based staff may be helpful as these did not appear to be working as well as the links between community-based staff and acute hospital services. This situation had arisen partly because of the grouping of community matron teams by general practices. Social workers were not integrated with these teams and did not attend practice-based multi-disciplinary team meetings.

2 The relationship between condition-specific specialist nursing teams and community matrons may also benefit from further consideration. Some condition-specific teams ran outreach clinics or undertook urgent

home visits but other patients were cared for by the community matrons or attended hospital-based out-patient clinics.

3 Social care was being commissioned from an increased range of providers and some communication difficulties were being experienced while new arrangements were being established.

4 Reviewers considered that there was potential for greater use of *Telehealth*, especially in relation to supporting people with dementia to stay in their own homes.

Return to *Index*

Response to Urgent Need

Working Well

1 The multi-disciplinary REACT team, including a social worker, worked within the Emergency Department from 7am to 7pm and provided multi-disciplinary assessment of patients aged over 65 who were frail, vulnerable or had had two or more admissions in the last three months. The team actively managed the care of those whose admission could be avoided, through liaison with community services, or supported care for those needing admission. The REACT team was based with the hospital social care team. Patients who met the visiting team were very positive about the work of the REACT team.

2 Community matrons had good seven day a week access to 'step-up' and 'step-down' beds in nursing homes, rehabilitation care and continuing care.

3 The Fast Response Team worked together with locality-based therapists to prevent avoidable admissions to hospital. The service was available seven days a week from 8am to 8pm.

4 An integrated discharge team was involved with transfer of care for elderly patients staying more than 24 hours in the acute hospital. This team was able to access short-term care packages and to reinstate care packages when patients had been in hospital for less than 14 days.

Plans in Place

1 UHCW NHS Trust was planning to develop a 12-bed 'frailty unit' from within its bed capacity.

2 Work was underway on improving the holistic assessment of frail older people in the Acute Medical Admissions Unit and those seen by trauma and orthopaedic services, possibly supported by a CQUIN.

Change Needed

1 Some staff in the acute hospital did not appear to be aware of the range of 'step-down' nursing home, rehabilitation and continuing care beds which were available, especially those available within Coventry.

2 Reviewers were also told by both health and social care staff of multiple pathways of care for patients 'stepping-up' to avoid hospital admission or 'stepping-down' following acute hospital care. All staff suggested that simplifying these pathways would help to make them work more smoothly.

3 Transport home for patients with more complex needs was delaying discharges for some patients. Reviewers were told of particular problems for patients being discharged on Fridays.

4 The integrated discharge team included both health and social care staff, but operational policies for these groups of staff were separate. Reviewers suggested that, as a minimum, arrangements for shared review and learning should be introduced.

5 Communication between acute and community health services at the time of discharge from acute care was not always working well. Reviewers were told of particular problems with the communication of 'do not attempt resuscitation' discussions with patients and families and communication about catheter care. Reviewers suggested that community and acute teams spend some time together learning from examples and case studies.

Cross-cutting Patient Care

Working Well

1 Practice-based multi-disciplinary team meetings were looking at risk stratification and identifying patients at high risk of hospital admission.

Plans in Place

1 Work on the identification of frailty was starting in three practices of similar size but with varying demographic profiles. Themes from this work were then going to be considered for wider adoption. The work was particularly looking at frailty rather than multiple diagnoses.

2 Health and social care services were working together on the development of an electronic care record. This work had an ambitious timescale for implementation. Work on integrating assessments was also underway.

Change Needed

1 The role and contribution of consultants specialising in the care of older people was not clearly understood by staff who met the visiting team. Links between care of older people consultants and other services did not appear to be well developed. Reviewers were told that, in addition to the 66 beds on the two elderly care wards at UHCW, there could be as many as 80-100 'medical outliers' who were supported by an 'outlier team'. Discussions were taking place about 'buddying' the ten (including one locum) care of older people consultants with other wards so that they could have an input in the care of frail older people.

2 The relationship between the REACT team, the proposed 'frailty' advanced nurse practitioner in the Acute Medical Admissions Unit and the care of older people consultants was not clear. It may be helpful to consider the arrangements for rapid input to holistic assessments by care of older people consultants when this is indicated.

3 Care of older people consultants did not have any community-based sessions or formal links with community matrons or practice-based multi-disciplinary team meetings.

Return to *Index*

Underpinning Issues

Plans in Place

1 A local five-year strategy was in place with a two-year operational plan. These included seven schemes, each of which had elements relating to the care of frail older people. Bringing together aspects relating to frail older people was under discussion, with the aim of ensuring clear, coherent pathways for this group of patients. This work was starting to consider 'frailty' and how this differed from 'people with several long-term conditions', with a clear vision of providing high quality, integrated care for frail older people.

2 Operational plans were being progressed through 'hot house' working groups. These involved multi-disciplinary and multi-agency groups looking at particular challenges through intensive three-day workshops. Frailty was one of the challenges being addressed. Teams then had 90 days to implement or pilot their proposals. The second meeting of the working groups was taking place on the day of the review visit.

Return to *Index*

APPENDIX 1 MEMBERSHIP OF VISITING TEAM

Clinical Lead

Dr Stuart Hutchinson	Consultant, Geriatrics	The Royal Wolverhampton NHS Trust

Visiting Team

Patricia Devane	Case Manager Long Term Conditions	Birmingham Community Healthcare NHS Trust
Amanda Futers	Clinical Nurse Specialist Older Adults	University Hospital of North Staffordshire NHS Trust
Wendy Godwin	Lead Commissioner Planned Care	NHS Walsall CCG
Diane Rhoden	Adult Safeguarding Lead Nurse	Sandwell & West Birmingham Hospitals NHS Trust
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Return to *Index*

APPENDIX 2 FRAMEWORK FOR FORMATIVE REVIEWS