Public Accounts Committee: Discharging Older People from Acute Hospitals Inquiry

Royal College of Physicians' submission

Introduction

The RCP welcomes the opportunity to submit written evidence to this consultation. The submission will feature learning from four frontline projects within the RCP's Future Hospital Programme which are improving, delivering and designing medical care for frail older people presenting at hospital.

Summary

- Building capacity within the NHS ensures there is the right number of doctors to care for patients
- Ensure that patients have access to the care they need when they need it, reduce number of admissions through multidisciplinary team working.
- Improve integration between hospital and community settings to ensure that transition of care is as smooth as possible
- Taking a whole service approach in service design will improve coordination and discharge of services
- Greater interoperability of data systems will improve patient experience and transition of care
- New ways of working including telemedicine will help prevent admission and readmission of care.

Changing needs of patients

The needs of patients are changing. Nearly two-thirds (65%) of people admitted to hospital are over 65 years old. People over 65 occupy more than 51,000 acute care beds at any one time, accounting for 70% of bed days. Hospital Episode Statistics (HES) show a 65% increase in secondary care episodes for those over 75 during the past 10 years, compared with 31% for those aged 15–59. An increasing number of patients are older and frail, and around 25% of inpatients have a diagnosis of dementia. Emergency hospital admissions account for over a third (35%) of all hospital admissions. We are facing an ageing population at a time when the NHS is already struggling to cope.

Supporting care for frail older people is a wider societal issue and the provision of services to support people for as long as possible in their own homes, living productive independent lives, requires close integration between health services, social care and the voluntary sector. The rising number of older people with complex conditions means that all physicians must have the skills to meet the needs of older patients, many of who, may present with a wide variety of illnesses and health conditions.

The service must adapt if we are to meet the challenge of providing person centred care, including for older people, with co-morbidities and complex needs. Poor service management and design introduces a number of barriers to the provision of appropriate, high quality care centred on the needs of the person. Health and social care professionals need to be supported by a system designed to promote the delivery of high quality care. The crisis in recruitment and retention of doctors is presenting looming challenges, and leads to

delayed discharge. Effective and timely discharge of patients into the community will only be achieved if a robust integrated healthcare model where patients have access to care outside of the hospitals walls is realised.

Significant staff shortages

Increasing patient need, coupled with increasing financial challenges and significant workforce gaps is making it increasingly difficult to care for patients. Our members and fellows are working in an underdoctored, underfunded and overstretched health service. Our own research conducted between 2014-2015 shows that 40% of advertised consultant vacancies remain unfilled, due to a lack of unsuitable candidates. These figures are concerning as the specialties most closely associated with caring for older people are seeing significant work force gaps; most notably **21%of consultant's report 'significant gaps** in the trainees rotas such that patient care is compromised'[1].

The staffing crisis is impacting on physicians' ability to swiftly assess patients presenting at hospital, to tailor their care plans and to work across disciplines to achieve safe and timely transfers of care. Studies suggest that as many as **40% of patients who die in hospital do not have the medical needs that require them to be there**. We must increase the number of doctors caring for patients.

Coordinating hospital services to prevent admission and better transfer of care in the community

A financially unstable NHS, coupled with an aging population and 'right now' expectations on healthcare, has led to the work of physicians becoming much more challenging[2]. Like many organisations and individuals with ambitions to support person centred care within the financial restraints of a fragmented NHS, preventing admission into hospital and encouraging innovation, best practice and high quality medicine will be the only way in which to achieve the best health and healthcare for all.

The RCP is working with local clinical teams through the ground breaking Future Hospital Programme (FHP) to develop new innovative models of care. Two of these programmes are working to reduce the admission of patients in hospital in the first instance. One of these sites is the Mid Yorkshire NHS Hospitals Trust which has established a Rapid Elderly Assessment Care Team (REACT) within the acute admissions unit at Pinderfields Hospital in Wakefield. The findings from the programme can offer solutions to relieve some of the pressing issues that prevent timely and effective discharge for frail older patients.

Mid Yorkshire has established a multi-disciplinary team made up of geriatric consultants, specialist nurses and therapists who work together to assess patients aged 80 and over, or those aged 65 and older who are care home residents, within 24 hours of their arrival at hospital. The multidisciplinary team meet daily to coordinate the care and treatment of patients to help them to be fit to leave hospital and prevent unnecessary admission. The multidisciplinary team is able to care for patients and person centred way as they can offer people access to both the health and therapeutic services they need.

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[1] https://www.rcplondon.ac.uk/projects/outputs/2014-15-census-uk-consultants-and-higher-specialty-trainees

[2] The King's Fund. *Avoiding hospital admissions: what does the research evidence say?* London: The King's Fund, 2010.

There has been a significant improvement in the number of patients receiving care in the community rather than being admitted to hospital. Comparing data from 2014 to 2015, the team has achieved a 24% increase in the number of patients with frailty being transferred to community care rather than moving onto a ward in hospital. The total number of hospital ward admissions for patients aged 80 and over decreased by 14% in the same period in 2014 to 2015. Preventing admission by implementing a multi-disciplinary assessment ensures a smooth transfer of care to the community if it is safe to do so and health and social care is in place.

A quality improvement project at East Lancashire Hospitals Trust is working to identify frail older patients who are available for discharge the same day they present at hospital by monitoring the medical assessment unit (MAU) intake. This includes identification of frail older patients potentially suitable for discharge the same day with the MAU nurse coordinator, rapid comprehensive geriatric assessment and joint working with professionals across the specialities and services to plan for safe same-day discharge.

Preliminary data of this care model suggests that 59% of admissions were avoided[3]. If admission can be avoided by streamlining the patient journey by coordinating with social care, frail older patients can be supported to leave hospital quickly and to live independently in the community. Working with professionals from across the disciplines and specialities has prevented delayed discharge for frail patients; mapping their patient journey in a holistic way coupled with quick and effective geriatric assessment achieves better patient outcomes and experience. Work is now progressing to include mental health care workers, which the RCP believes is a step forward in breaking the boundaries between physical and mental healthcare not just for frail older patients.

Improving integration between hospital and community services

Patient needs are complex and do not neatly sit within one part of care delivery. In addition to improving patient access in the multi-disciplinary teams when presenting at hospital, the REACT team has been working closely with services in the community including third sector providers to improve the transfer of care from the hospital to the community. The REACT team has also established joint partnerships with third sector professionals, namely Age UK, to ensure that patients are receiving safe transfers of care into the community[4]. Age UK regularly come into the acute assessment unit at the hospital and physically help patients return home; they offer transport and a grocery shopping service so that vulnerable older people are not discharged without adequate support. Working collaboratively with health and social care professionals outside of the hospital building has enabled frail older patients to receive personalised care in the community and has helped them to maintain their independence which in turn prevents readmission.

The improved working between hospital and community services has reduced delayed discharge. Patients should be transferred from hospital to community services as soon as patients are well enough to receive care in a community setting. Areas with integrated services for older people have lower rates of bed use; these hospitals also tend to have lower admission rates and deliver good patient experience[5].

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[3] http://futurehospital.rcpjournal.org/content/3/1/13.full.pdf+html
[4] http://www.ageuk.org.uk/brandpartnerglobal/wakefielddistrictvpp/documents/frailty%20conference/frailty%20in%20secondary%20care.pdf
[5] Imison C, Poteliakhoff E, Thompson J. *Older people and emergency bed use. Exploring variation*. London: The King's Fund, 2012.

The hospital does not operate in isolation of the wider health and care system, and neither do physicians[6].

New ways of working to prevent readmission to hospital

The use of telemedicine for supporting effective and timely discharge of frail older patients should be explored and implemented if there is local infrastructure able to support its introduction. The FHP development site at Betsi Cadwaladr University Health Board in rural Wales is using telemedicine to offer people who live far away from specialist care follow-up appointments with their consultants via video conferencing which is hosted at their local community hospital.

For people with comorbidities, multiple trips to the hospital to see separate specialists for each health condition are intrusive, unsettling and can be detrimental to recovery. The telemedicine initiative has overcome the barrier that people face in accessing specialist care and has seen continuing progress in travel time averted for patients to acute hospital, with 450 minutes traveled on average before the project which has reduced to 275 miles traveled for December 2015. To ensure that all patients who can benefit from this service do, the team has employed an inclusion officer so that patients with visual impairments or hearing loss are not excluded. The team is working hard to broaden their reach and hope to be able to trial telemedicine appointments within care homes and GP practices to further support frail older people access specialist care. Telemedicine should be further explored for frail older people who require regular contact with specialist care because it allows for quicker discharge for patients.

The use of information technology across the health system

One of the main barriers that our members face when trying to achieve a smooth transition between both in hospital services and between community and hospital settings for their patients, is fragmented and complex IT infrastructures and patient records. There is often little standardisation of clinical data in source systems, either in the headings under which data are recorded or in the definition of individual clinical terms. This has led to huge variations in record structures and clinical language, and major problems with the coding of clinical concepts. There are often large inconsistencies with regards to recording clinical data. For example, ICD10 codes used in hospitals (secondary care) contain very high level information. Read codes however which are used in primary care are very detailed; there are 47 read codes for asthma. This makes it very difficult to compare data coded at different levels of care.

The RCP believes that it is that vital information technology is used to achieve the goal of data sharing and improved communication between acute and community settings. In particular, health service providers should use an agreed standardised structure and content for electronic records. The RCP has produced a standardised structure for electronic records, which includes a uniformed format for discharge and transfer of care notes. In a response to the recent NICE consultation on the transition between inpatient hospital settings and community or care home settings for adults with social care needs, the RCP with support from the Academy of Medical Royal Colleges called upon NICE to recommend the standardised templates for all discharges. The RCP welcome the recommendations made in the Public Accounts Committee report on

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[6] https://www.rcplondon.ac.uk/guidelines-policy/nhs-doctors-view

primary care about the use of information technology and giving all healthcare professionals the ability to instantly update patient records and would like to see a solution to the barriers that poor information technology systems pose for seamless transfers of care[7].

Conclusion

We are already seeing the impact of an underfunded social care system adding to the pressures being experienced in our hospitals. Across the country patients fit for discharge are waiting to leave hospital, in many cases because social care support is unavailable. Increasing the level of social care funding will alleviate pressures on all sectors of the NHS, and would likely save money as a result. This is an issue which was highlighted by a number of Royal Colleges in a letter to the Chancellor, George Osborne MP ahead of the 2016 budget[8]. Patient centred care and shared decision making are achieving better patient outcomes and experiences and these models of care should be promoted across the NHS.

About the RCP

The Royal College of Physicians (RCP) aims to improve patient care and reduce illness in the UK and across the globe. We are patient centred and clinically led, and our 32,000 members worldwide work in hospitals and the community across 30 different medical specialities, diagnosing and treating millions of patients with a huge range of medical conditions.

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[7] https://www.parliament.uk/business/committees/committees-a-z/commons-select/health-committee/news-parliament-20151/primary-care-report-published-15-16/
[8] http://www.bbc.co.uk/news/health-35785848