Portsmouth Hospitals NHS
NHS Trust

TRUST BOARD PART I – JULY 2012

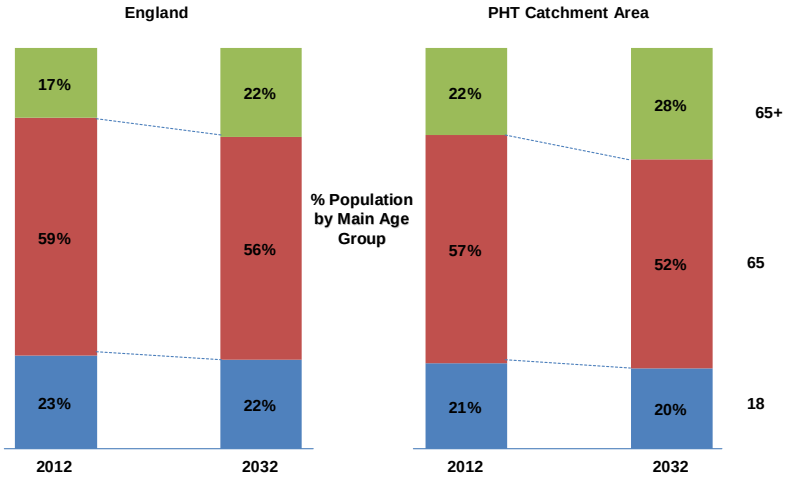
Agenda Item Number: 110/12
Enclosure Number: (5)

Subject:	**Older Persons' Partnership (OPP)**
Prepared by: **Sponsored & Presented by:**	Dr Jane Williams, Chief of Service, Medicine for Older People, Rehabilitation and Stroke Ursula Ward, Chief Executive
Purpose of paper *Why is this paper going to the Trust Board?*	To brief the Board regarding a pilot project between the Trust and Southern Healthcare Foundation Trust, that is focused on the development of a more innovative model of care for frail elderly people.
Key points for Trust Board members *Briefly summarise in bullet point format the main points and key issues that the Trust Board members should focus on including conclusions and proposals*	The Older Persons' Partnership was formed in the Autumn of 2011. This work is a pivotal component of the unscheduled care transformation project. The OPP is focused on the end to end pathway management of complex and frail older people. The OPP project will aim for completion in March 2013. The intended outcome is a clearly articulated seamless pathway focused on improving quality and led by one organization with overall accountability.
Options and decisions required *Clearly identify options that are to be considered and any decisions required*	To seek Board approval to take the take the project to the next stage.
Next steps / future actions: *Clearly identify what will follow the Trust Board's discussion*	Appointment of a PHT Project Manager for unscheduled care to be appointed. Development of the Business Case to take the project to the next step.
Consideration of legal issues (including Equality Impact Assessment)?	None
Consideration of Public and Patient Involvement and Communications Implications?	The CSC will work with the Trust Communication team and ensure the positive changes to the management of frail older people are shared with media colleagues. Since the project begun, key stakeholders have been kept briefed. A formal communication to all key stakeholders will follow as soon as we have Commissioning support for the Business Case moving forward.

Introduction and Background

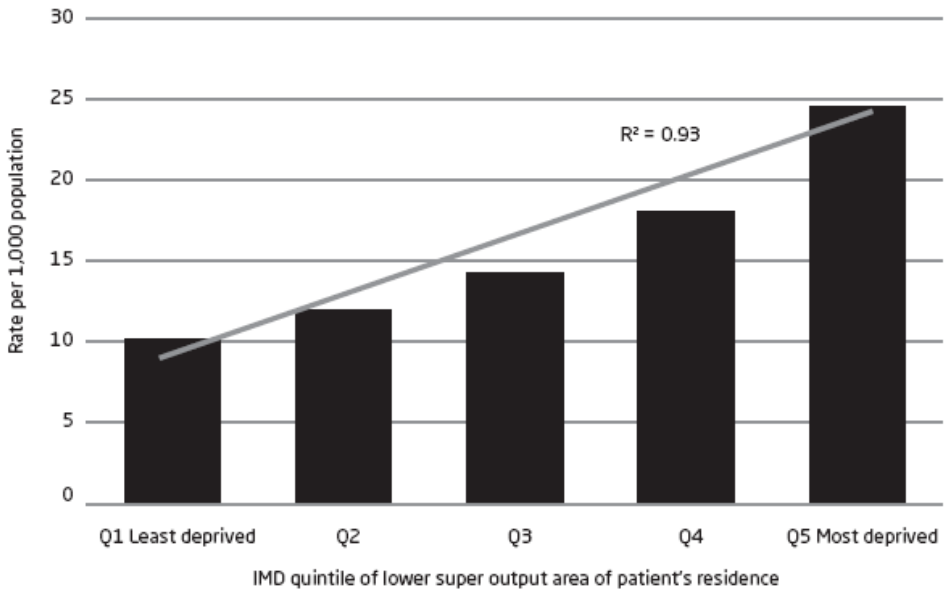
In recent years there has been much focus on the implications for the rising elderly population on health and social services. The literature points to many studies that have reviewed different models of care for frail older people and those with long term conditions. It has been more recently identified that ambulatory care-sensitive conditions (ACSCs are conditions for which effective management and treatment should prevent admission to hospital) account for 1 in 6 emergency admissions, and it is estimated that these could be reduced somewhere by 8 -18%. Older people (aged 75 years and over) account for 40 per cent of total spend[1].

The evidence on population growth clearly shows that the population served by the Trust is older than the average across England as a whole. Over the next five years the local population is forecast to grow in line with the England average. However, over a longer time-frame, the population growth is due to outstrip that of England. By 2032 28% of the catchment population will be over 65. These facts combined with high levels of deprivation in some areas result in higher attendance rates and admission to hospital.



Source: Analysis of HMSO Sub-National Population Forecasts

Rate of emergency hospital admissions for ACSCs by deprivation quintile of patients' area of residence, England, 2009/10



There have been a range of admission avoidance schemes introduced over many years with little evidence to demonstrate that these have been sufficient to stem the tide of emergency admissions. The King's Fund advocates a move away from hitherto small scale unconnected projects, to the development and implementation of comprehensive admission avoidance programmes. This approach is supported by the local commissioning organizations who are seeking to commission models of care that are more integrated, and underpinned by robust clinical and financial analysis.

"For many health economies developing and delivering integrated care is a priority to enable health and social care to keep pace with the changing demographics of national populations. The UK is no exception and in order to meet the increasing demands on our health and social care systems a more inclusive approach to collaborative partnerships needs to become a commonplace, and standard, model of delivery. However, integration has never been a key feature in the traditional UK NHS model where silo working is still too prevalent. Good integrated services bring enormous advantages to a healthcare system. They drive up the quality of patient care, encourage innovation and development, benefit the different organisations involved and deliver cost savings to the public purse"[2].

The Older Persons' Partnership
In response to the above, the Trust and Southern Health Foundation Trust (SHFT) entered into a collaborative arrangement from which the Older Persons' Partnership (OPP) was formed in August 2011. To date this has been run as a pilot within a governance framework (a partnership Board) that has the support and oversight of the Executive Directors from both Organisations. It was agreed at the outset that the emphasis would be on developing the most appropriate model of care, and thus there would not be changes to the payment mechanisms through the pilot phase. Both Solent Health and Adult Social Services organisations are closely involved with the partnership.

The Vision:
The Older Persons' Partnership aims to be a national exemplar of true integration of services, working to provide the most effective management for frail older people and those with long term conditions.

Strategic Aims:
To maintain where possible the independence, health and wellbeing of older patients and those with long term conditions

To build Trust, confidence and relationships amongst statutory and 3rd Sector organisations

To promote effective and comprehensive partnership working across all stakeholders.

The OPP is focussed on 4 key domains.

Domain 1 – Health promotion and the continuing management of care
Domain 2 –Timely and effective intervention
Domain 3 – Crisis Prevention
Domain 4 – Rehabilitation and re-ablement

These four domains are underpinned by a programme of work that is in turn aligned to the unscheduled care system-wide work as part of the overall Portsmouth and South East sustainability plan, and the CQUIN arrangements for 12/13.

The programme of clinical redesign throughout the whole pathway is significant. This will need to be supported in terms of non recurrent funding, recognising the time lag for change with such a complex patient group. Further there will be the need to sustain the community services, required to provide the alternative model of care for those patients currently being cared for in the acute sector.

Work in Progress
Work is already underway to progress the redesign of services:

Older Persons' Assessment Service (OPAS)
Providing a Comprehensive Geriatric Assessment within the emergency corridor. Since November 2011 a geriatrician and a nurse specialist have been supporting clinical teams in the emergency department and the medical assessment unit in assessing and supporting the management of frail older patients. The overarching aims of the OPAS are to:

- Increase the number of frail older patients who get a comprehensive geriatric assessment within the emergency corridor
- Avoid admissions to hospital where clinically appropriate
- Reduce length of stay for patients requiring an intensive short stay intervention
- Transfer earlier patients requiring admission to appropriate wards
- Facilitate the transfer of patients to more appropriate care (for example rehabilitation, community wards, or home with virtual ward management support.

A key indicator of the success of the OPAS is the triage outcome. The information below sets out the historical outcome rates from the post-take ward round.

Triage Outcome	% Split
Acute - patients requiring acute admission to an inpatient ward for ongoing management	60
Short Stay – a patient has an acute medical need and the consultant believes that there is a window of opportunity to manage this aggressively and to enable the patient to return to their home	17
Community - a patient has no acute medical needs, but has a care need best met outside of QAH	23

The information below shows the impact of OPAS on the clinical plans for the frail older patients. This illustrates a 20% reduction in the patients being triaged for an acute admission to the Medicine for Older Peoples' wards. The majority of these patients are now being managed on a short stay basis within the Medical Assessment Unit, with 89% being discharged within 48hours. Of the remaining 11% half are admitted due to a clinical deterioration, with the remainder being subject to discharge delay. Those patients whose need is best met outside of the acute hospital also grew with 27%, or an average of 3-4 patients per day, attending and not requiring admission.

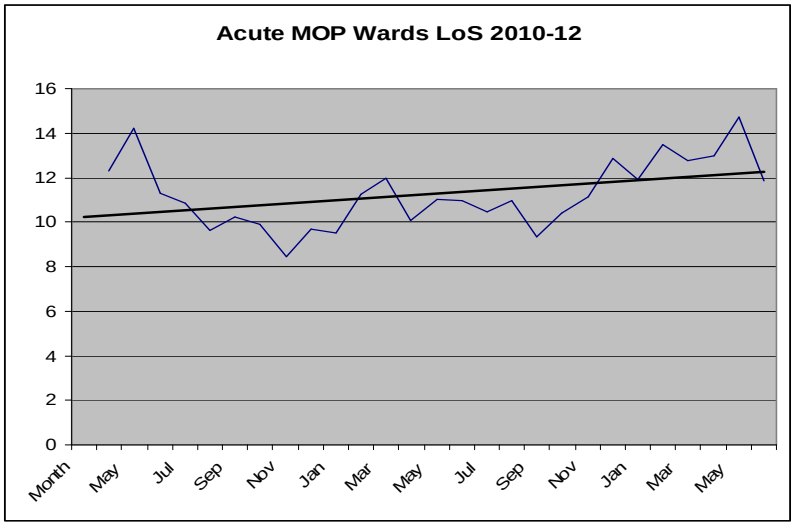
Total Number Screened	Result of Screening	Triage Outcome	Number	%
5.382				
	Negative		**1763**	**33%**
	Positive		**3619**	**67%**
		Acute Admission	1516	42%
		Short Stay	1125	31%
		Community	978	27%

To note:
- 89% of Short stay Admissions discharged with in 48 hours

- 72% of Community triages discharged with 24 hours and 88% within 48 hrs. Increased understanding of the system requirements to support turnaround and minimise conveyance based on data from November 2011 to June 2012.

Unintended consequences

The Implementation of OPAS has provided a number of challenges to the system. It has identified the true demand for older persons' requiring specialist assessment and management. The OPAS process has encouraged the management of short stay patients on the MAU, which whilst clinically appropriate has, at times, created capacity constraints on the MAU in periods of very high demand. In addition, the patients who do now get admitted are of greater acuity (case mix change) with a resultant increase in length of stay, which has in turn created a mismatch of acute bed capacity.



This will be addressed through the bed rebalancing work currently underway. The Clinical Service Centre is regularly managing circa 30 outliers with a range of 24-62 over the last 8 months. In addition, an options appraisal for an Older Persons' Assessment Unit is currently being developed, which should enable the provision of assessment capacity and short stay beds in addition to the current MAU capacity.

Older Peoples Mental Health Psychiatric Liaison

Provision of a 7 day nurse and consultant psychiatrist led service to support older patients with mental health needs

The national requirement to improve the assessment, diagnosis and management of people with dementia is well documented. It is estimated that people with dementia over 65 years of age are occupying up to one quarter of hospital beds at any one time. 42% of patients over 70 years with unplanned admissions to an acute hospital have dementia, rising to 48% in those aged over 80 years. Within the Trust, patients with dementia and other mental health disorders have a length of stay that is, on average, 6 days longer than a matched population of frail elderly patients with no mental health conditions.

The new service will see any patient aged 65 and over who is being assessed and treated by the Emergency Department or any inpatient age 65 and over regardless. Patients identified as having an unmet mental health need can be referred using the standard referral form to a single fax number. In addition, for urgent referrals, the team can be contacted by telephone or bleep.

Initial assessment and screening will be performed by a nursing member of the team. All patients will be discussed with a consultant psychiatrist at regular supervision meetings, and where necessary, a psychiatrist will review complex patients. An entry will be made into the patients medical records and a full assessment will be recorded in the appropriate mental health electronic record (RiO). Patients may be followed up on the ward by the OPMH liaison team until either, they

have completed their assessment and treatment and therefore can discharge the patient from the service, or the patient is discharged from hospital.
Upon discharge from the service, a formal letter detailing the assessment and mental health intervention will be sent to the medical (or other specialty) consultant who was responsible for the patient as well as the General Practitioner and Community Mental Health Team consultant and care coordinator. Another important role is for the team to participate in the mental health education and training of QAH staff.

Since the launch of this service, the OPMH team have seen a large increase in referrals and a significant proportion of patients with previously undiagnosed dementia assessed.

- Referrals from January to March 2012: 251
- Only 64 out of 160 patients diagnosed with dementia previously known to OPMH

Integrated Community Teams
Provision of an integrated service offering physical and mental health services with social care to defined practice populations underpinned by risk stratification.
Work will continue towards developing the integrated community teams. The clinical service Centre have for some years organised the geriatrician workforce into locality based teams. Progressing plans to align other teams and services will enhance efficiency and effectiveness.

Frailty MDTs and Community Assessment and Treatment Units
Supporting the integrated care teams with consultant geriatrician led multidisciplinary teams.
The geriatrician resource is central to this work and the business case and is included in the business case to the commissioners.

Future work streams would aim to deliver:

Primary Care Integration – bringing together the community and practice teams to provide seamless services across the practice population, minimising duplication and increasing the flexibility of the skilled workforce
Discharge Processes – through improved pre admission planning and alignment with social care providers, ensure that patients are discharged as soon as their acute episode has ended
Risk stratification and timely information – underpinning the model is the requirement to target and support the cohort of patients with greatest needs and when they are being managed within the system that all partners have immediate access to accurate clinical information.

Next Steps

The formation of an Integrated Care Organisation (ICO) is complex and will require robust partnership working and support. The unscheduled care transformation project will facilitate the next steps and work streams have been identified.

SHFT have appointed a project manager who will assist with the production of a blueprint for future development and will work hand in hand with the PHT project manager when the latter post holder has been finalised. There will be steps along the journey toward the launch of a full ICO which will encompass other patient groups from the range of ambulatory care-sensitive conditions. Delivery of the OPP is pivotal to the full delivery of the ICO.

A Business case is to be prepared by October 2012 at which point it will be shared with the Commissioners

Conclusion
Medicine for Older People, Rehabilitation and Stroke are working closely in partnership with local providers to improve care for frail older people. Progress to date has been achieved and maintained through excellent collaboration and determination of the workforce to streamline and improve services. There is ambition to fundamentally redesign the service and all involved parties

have been flexible and responsive to the changing needs of our local population. This work has the potential to be a national exemplar of innovation and provider of quality care. It is imperative to work alongside clinical commissioning GPs to ensure full engagement with the redesign of services.

Dr Jane Williams
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References

1. The Kings Fund, 2012. Data Briefing Sheet - *Emergency hospital admissions for ambulatory care-sensitive conditions: identifying the potential for reductions*

2. NHS Partners Network, NHS Confederation, 2012. *A Stitch In Time – the Future is Integration*